

SB2354

Measure Title:
RELATING TO MEDICAL LIABILITY.

Report Title:
Medical Tort Liability; Noneconomic Damages

Description:
Limits noneconomic damages that may be recovered in medical tort actions. Limits the amount of attorney's fees that may be collected in connection with a medical tort action. Amends the definition of "health care provider" and "medical tort". Sunsets on the earlier of the date on which an insurer does not comply with the premium rate caps, or July 1, 2015.

Introducer(s):
CHUN OAKLAND

Current Referral:
HTH, JDL



HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

Written Testimony

The Senate

Committee on Health
Senator David Y. Ige, Chair
Senator Carol Fukunaga, Vice Chair

February 13, 2008 at 1:15 PM
Conference Room 016
Hawaii State Capitol

Testimony Supporting SB 2354 Relating to Medical Liability

Limits non-economic damages that may be recovered in medical tort actions. Limits the amount of attorney's fees that may be collected in connection with a medical tort action. Amends definition of "health care provider" and "medical tort". Sunsets on the earlier of the date on which an insurer does not comply with the premium rate caps, or July 1, 2015.

Thomas M. Driskill, Jr.
President and Chief Executive Officer

Thank you for the opportunity to provide testimony in support of SB 2354 that addresses medical liability.

Expensive malpractice insurance is among the increasing pressures on physicians and is a factor in their decision-making to remain in practice. As a safety-net health care system with five regions located on Hawaii, Kauai, Maui, Lanai and Oahu, the Hawaii Health Systems Corporation (HHSC) continues to experience the need to attract and maintain health care professionals particularly in Hawaii's rural communities.

HHSC supports HB 2354 that addresses medical liability reform and will help to stabilize medical malpractice insurance premiums that contributes to the high costs of healthcare and also impacts access to healthcare. This measure is needed to improve the healthcare environment for providers and patients in Hawaii. Thank you.

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4028

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February 13, 2008

The Honorable David Ige, Chair
The Honorable Carol Fukunaga, Vice Chair

Senate Committee on Health

Re: SB 2354 – Relating to Medical Liability

Dear Chair Ige, Vice Chair Fukunaga and Members of the Committee:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans (“HAHP”). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.

MDX Hawai‘i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify in support of SB 2354 which would lower medical malpractice insurance premiums by adopting legislation that directly affects elements impacting medical malpractice insurance rates. HAHP supports the intent of this bill as a good first step toward helping to contain the spiraling cost of medical malpractice insurance.

HAHP believes the time has come for the Legislature to seriously consider significant changes to Hawaii statutes regarding medical malpractice, including especially the key elements of this bill, namely establishing caps on non-economic damage awards and limiting the amount of attorney’s fees which may be collected.

• *AlohaCare* • *HMAA* • *HMSA* • *HWMG* • *MDX Hawaii* • *UHA* • *UnitedHealthcare* •
HAHP c/o Howard Lee, UHA, 700 Bishop Street, Suite 300 Honolulu 96813
www.hahp.org

We agree with statements made by local physician organizations that the current medical tort system drives significant “defensive medicine” costs and has led to neighbor island shortages in key surgical specialties. In our role as health insurance providers, the members of HAHP see these facts daily in our medical claims costs and in limitations in the numbers and types of our contracted physicians on neighbor islands.

Thank you for the opportunity to offer comments today.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Jackson", written in a cursive style.

Rick Jackson
President

HAWAII PSYCHIATRIC MEDICAL ASSOCIATION

1360 S. Beretania Street, 2nd Floor, Honolulu, HI 96814

Ph: (808) 263-3070 Fax: (808) 262-5966 www.Hawaiipsychiatric.org

To: Sen. David Ige MD, Chair
Sen. Les Ihara, Vice-Chair
Members of the Senate Health Committee

From: Wm Sheehan, MD, President
Steven Williams, MD, Legislative Chair

Re: SB 2412, Relating to Medical Liability
SB 2354, Relating to Medical Liability

*Please deliver
Clerk in 215 for
HTH Hearing
2/13/08 at 1:15
Conf. Rm 016*

POSITION: SUPPORT

The Hawaii Psychiatric Medical Association submits its testimony in support of SB 2412 and SB 2354, both relating to medical liability.

The measures propose to establish a cap on non-economic damages and limit attorney fees. The HPMA supports these actions because they will help to stabilize now volatile medical malpractice insurance premiums, which is a major cause of Hawaii's patient access to care crisis.

Thank you for your consideration to pass one or both of these measures.

HAWAII PSYCHIATRIC MEDICAL ASSOCIATION

**TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE CONSUMER
LAWYERS OF HAWAII (CLH) IN OPPOSITION TO S.B. NO. 2412 and S.B. No.
2354**

February 13, 2008

To: Chairman David Ige and Members of the Senate Committee on Health:

My name is Bob Toyofuku and I am presenting this testimony on behalf of the Consumer Lawyers of Hawaii (CLH) in strong opposition to S.B. No. 2412 and S.B. No. 2354. I am addressing both bills in this testimony as the provisions are identical except for the insurance provisions in S.B. No. 2354.

I am presenting this written testimony in sections to first focus on the issues at hand, then to set forth specific information to illustrate why these bills are harmful to the public and consumers injured or die due to medical negligence, and why it will not solve the problems facing the health care industry and the allegations of the doctors.

ISSUES AND ALLEGATIONS

1. Extent of medical errors and malpractice
2. Capping Recoveries will hurt the victims
3. Allegations
 - a. Too many Lawsuits and Frivolous Claims
 - b. Medical Malpractice Insurance Premiums are too high
 - c. Doctors are leaving the State
 - d. Hospitals cannot get enough doctors to go on-call
4. Medical Malpractice "Reform" will not solve these problems
5. The Rollback of Insurance Rates

6. Attorney's Contingency Fees
7. The facts behind the Texas "situation"

I. EXTENT OF MEDICAL ERRORS AND MEDICAL MALPRACTICE

It is undisputed that medical errors occur and there is medical malpractice committed where patients are injured or die. It occurs in every state in the country.

In 1999, a credible book published by the Institute of Medicine estimated that medical errors contribute to as high as 98,000 deaths per year, making it the eighth leading cause of deaths, higher than motor vehicle accidents, breast cancer, and AIDS. It went further to state that the annual cost to hospitals stemming from these errors has been estimated to range from 17 to 29 billion dollars. (The reference was to deaths and did not include other injuries). The obvious conclusion is that if the incidents of medical error and malpractice are reduced, the specific issue that health providers complain about, the cost of malpractice insurance premiums, would be substantially reduced.

Instead of focusing on patient safety or studying the medical system to prevent medical errors and medical malpractice and the resulting injuries to patients, the advocates of the so-called medical malpractice "reform" have always tried to: (1) Reduce potential recovery for the injured patient (cap damages); and (2) Reduce attorney's fees for the attorneys who represent these injured patients.

The primary question that faces legislators as the policy decision makers is **whether capping damages and limiting attorney's fees will solve the problems set out above.** The following information and arguments will shed light on why CLH strongly feels that it will not.

II. CAPPING DAMAGES WILL HURT VICTIMS

Two of the major purposes of tort law are compensation for the victim and deterrence of negligent behavior. The suggested cap on non-economic damages (i.e. – pain and suffering, loss of enjoyment of life), as evidenced in this bill, clearly will adversely impact the right to recover adequate compensation by the victims who suffer injury as a result of medical malpractice. **Caps are unfair, arbitrary, and unnecessary and unfairly punish the most severely affected victims**, whose quality of life has been destroyed in many instances. The arbitrary nature of a cap also takes away the right of a jury to determine the proper damages for a particular injury. It should also be pointed out that where a victim has no economic damages, that injured person is clearly unfairly limited by an arbitrary cap.

Example: An elderly person who is no longer employed is injured because of medical malpractice. There is no wage loss as compared to a working adult and any recovery for medical expenses or long term care goes to third parties who provide these services. The devastation to this person and his or her family is enormous in terms of the grief experienced and the fact that they must live with this situation for the rest of their lives. Capping non-economic damages for this kind of victim is especially unfair.

Further, CLH has always urged that before drastic changes are made to the civil justice system, it is necessary that the legislature be provided with good reliable data and information in order to properly analyze the need for “reform”.

III. ALLEGATIONS

a. TOO MANY LAWSUITS AND FRIVOLOUS CLAIMS

1. The Number of Claims Filed In Hawaii Have Declined

The number of medical malpractice claims filed in Hawaii fell from 173 in 2001 to 94 last year – about a 45% reduction.

The MCCP Annual Reports to the Legislature document the fact that the number of claims filed has steadily and dramatically dropped during the past seven years.

Year	Claims Filed
2001	173
2002	166
2003	132
2004	128
2005	105
2006	123
2007	94

The MCCP data confirms that there is **no litigation explosion** in medical malpractice claims in Hawaii as the medical profession and the insurance industry would like you to believe. Consider this data in this way – out of the millions of instances where Hawaii residents have contact with physicians, hospitals and other medical personnel, only 94 claims were filed in 2007. With the number of claims going down, the question is why premiums are supposedly escalating significantly. Proponents may say it is because the awards are higher. If that is true, this committee's follow-up should be to determine the extent and nature of the injuries and circumstances that allegedly

caused a “high” award. Is it the economic damages? Is it because a child is blinded for the rest of his or her life? Is it because a person’s injury has impaired that person for the remainder of his or her life? These are basic questions this committee needs to look at before any major social policy changes are made.

2. The Myth of the Frivolous Lawsuit – the Medical Claims Conciliation Panel (MCCP) and Merit Screening Process

Hawaii was one of the first states to implement a claims screening process to prevent the filing of frivolous claims. Claims must first be submitted to the MCCP before a lawsuit can be filed.

Further, the Legislature enacted an additional merit screening procedure in 2003. Medical malpractice claims must first be reviewed by a doctor in the same specialty involved in the claim. The claim cannot be filed unless there is a certificate of consultation filed with the claim that the claim has merit. The measure was codified as HRS section 671-12.5 and applied to claims filed after 2003. The effectiveness of the procedure is reflected by the fact that only two of the claims heard during the past four years was found to be frivolous. The 2005 MCCP Annual Report, for the 2004 year, specifically states: “there were no claims in which the Panel found the underlying claim to be frivolous.” The 2006 MCCP Annual Report states that “there was one claim in which the Panel found the underlying claim to be frivolous.” The 2007 MCCP report found no frivolous claims filed and the 2008 MCCP report found one frivolous claim filed.

b. MEDICAL MALPRACTICE INSURANCE IS TOO HIGH

The Hawaii Medical Association (HMA) has always maintained that their premiums are too high and have increased tremendously over the past few years. What this committee needs are specific facts and information to make a reasoned decision on actually how costly the premiums are for individual doctors and for what specialties; for example: (1) What is the amount of the premiums and does it vary from physician to physician in Hawaii? (2) what is the amount of gross income that these physicians make? (3) what is their net income? (4) what percentage of their gross income is the premium cost? and (5) what is the net cost because these premiums are fully tax deductible so its impact is reduced considerably when it is deducted from both federal and state taxes?

1. Hawaii Insurance Premiums vs. California Insurance Premiums

We mentioned this situation last year but I thought it was important to reiterate what happened in a committee hearing. A chart was submitted to the Senate Judiciary Committee at a hearing held in March 2005 to show premiums in Hawaii as compared to other locations. However, it only showed a comparison between Hawaii and Northern California where it is indicated that the premiums in Hawaii were higher. Please keep in mind that these bills are proposing the adoption of basically the California model of medical malpractice tort reform, which was adopted in California in 1975 and found constitutional by the California Supreme Court in 1985.

During the question portion of the hearing, the chairperson of the Senate Judiciary committee asked whether MIEC insured physicians in Southern California to which the answer was "yes." The follow-up question inquired as to the rates in southern California to which the answer was that it was higher than Northern California, and in fact about

40% to 70% higher. The chair noted that the substance of the bill before the committee was the California model (MICRA) of medical malpractice reform and their own data indicates that the California premiums would be equal to those in Hawaii or higher in some instances. The conclusion reached by the committee was Hawaii should not pass such a law because after 30 years since MICRA was passed in California, the premiums in California were not significantly lower, and in many instances were higher than in Hawaii which does not have a MICRA model of “reform.”

Our recent research shows that the highest MIEC rates in Los Angeles in 2007 are much higher than the highest rates in Hawaii. Here are some examples:

<u>Specialty</u>	<u>Hawaii</u>	<u>Los Angeles</u>
Neurosurgery	\$77,104	\$107,936
OB/GYN	\$61,684	\$ 86,348
Orthopedic Surgery	\$51,404	\$ 71,956
Family Practice	\$10,284	\$ 15,832

2. Tort Reform Has No Significant Impact on Malpractice Premiums

The insurance industry and independent studies on the impact of tort reform on medical malpractice insurance premiums confirm that there is no significant relationship.

Following the medical malpractice “crisis” of the mid 1970’s in California, the doctors formed their own member insurance companies that insure about 60% of the doctors. The second largest of these was SCPIE (Southern California Physicians Insurance Exchange). After almost 30 years of experience with MICRA, the insurance company declared under oath in connection with its contested rate filing:

“While MICRA was the legislature’s attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California.”

SCPIE and Norcal Mutual, California’s two largest malpractice insurers have raised their rates significantly in recent years because MICRA does not lower premiums. SCPIE has raised its rates 23% and NORCAL 26%.

Our point is that insurance companies themselves have indicated that medical malpractice tort reform has no significant impact on premiums.

An independent insurance industry rating service, Weiss Ratings Inc., confirmed that premiums are not driven by claims payouts or damage caps. Weiss Ratings published the results of its study in 2003. Weiss Ratings revealed that premiums actually increased by 33% higher in states with caps than states without caps. Also, states without caps were twice as likely to retain stable premiums as states with caps.

Weiss Ratings confirmed that caps on damages and tort reform do not translate into reduced medical malpractice premiums, stating:

“These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts.”

Weiss identified these other factors as the medical inflation rate, insurance business cycle, decline in investment income, and market conditions.

The National Bureau of Economic Research recently published a 2004 study of malpractice insurance by Dartmouth College economics professors Baicker and Chandra, *The effect of Malpractice Liability of the Delivery of Health Care*. A comprehensive

study of data regarding the relationship between premiums and payments yielded an unexpected conclusion.

“Surprisingly, there seems to be a fairly **weak relationship between malpractice payments** (for judgments and settlements) **and premiums** - - both overall and by specialty.”

The economic study confirms that **“past and present payments do not seem to be the driving force behind increases in premiums.”**

c. DOCTORS ARE LEAVING THE STATE

The HMA has made statements that doctors, especially specialists, are leaving the state because of malpractice premiums and the risk of medical malpractice lawsuits in general. The implication is that they are leaving in droves and the health care system is on the verge of collapse.

CLH has no specific information as to who is leaving and in what specialty of practice. However, the following data will give you an overview of the number of doctors currently with Hawaii addresses in Hawaii and the increase over the past few years. We used information gathered from the Hawaii Data Book and the Yellow Pages Telephone Directory.

The Hawaii data indicates that the number of physicians in Hawaii increased each year from 2000 to 2008. The information up to 2006 was determined from the resources mentioned above. The information obtained for the number of physicians for 2007 and 2008 was obtained from the DCCA Professional and Vocational Licensing Division on-line information for current licenses for physicians. The information is as follows:

Year	Physicians/Surgeons
2000	3,044

2001	3206
2002	3251
2003	3363
2004	3445
2005	3616
2006	3680
2007	3735
2008	3917

In 2006 during a hearing in the House on SB 3279, Relating to Medical Liability, a doctor who was leaving for the mainland testified as to the high cost of living in Hawaii and medical malpractice insurance premiums for the reasons why she was leaving. One of the Judiciary Committee members during the question portion of the hearing asked if she would consider staying in Hawaii if the state paid her insurance premium. The doctor said “no” because she had a unique opportunity to work with a renown physician on the mainland in her specialty.

There also have been several articles and letters to the editor where it has been mentioned by doctors that a major reason to relocate is the **low reimbursements** in Hawaii.

Further, there have also been studies as to access to health care in relation to insurance premiums. Studies indicate that access is not significantly affected by malpractice premiums. The same 2004 study by Dartmouth College confirmed that malpractice premiums were not a major obstacle to access to medical treatment. This was the same conclusion reached by the GAO study of 2003. The Dartmouth study’s

findings are consistent with those of the GAO study, which was unable to substantiate claims by the medical profession that rising premiums were dramatically reducing the supply of physicians.

The fact is that doctors generally prefer to live in urban rather than in rural areas because of greater professional opportunities, access to modern facilities and equipment, better schools for their children, availability of cultural, artistic, sports, shopping, dining, and other recreational activities, and of course, higher incomes.

d. HOSPITALS CANNOT GET ENOUGH DOCTORS TO GO ON-CALL

Pursuant to Senate Concurrent Resolution No.150 (2006), the report of the task force stated, in summary, that it identifies “reimbursement” as the principal cause of the on-call crisis.

IV. MEDICAL MALPRACTICE “REFORM” WILL NOT SOLVE THE PROBLEMS

The **dots do not connect** between capping damages and lowering premiums, keeping doctors in the State, giving them the incentive to take on call duty at hospitals, move to rural communities, and reduce medical errors. This is a major objection to these bills. Ask yourself, how will capping damages on victims stop medical errors? It has no impact on making doctors more careful. What is the relationship between capping damages and a neurologist moving to Kona? These bills do not solve the problems.

V. THE ROLLBACK OF INSURANCE RATES

S.B. No. 2354 also provides for a rollback of medical malpractice insurance rates to what they were in 2005. The question for you as policy makers is what will the savings be to the physicians and will the specialists then move to underserved areas,

volunteer to be on-call physicians at hospitals, and make quality health care more accessible to all of our citizens?. If implemented, the reduction of rate should be tied to a percentage of the current premiums. If the medical profession is so certain that capping damages will reduce premiums then the provision in this bill calling for a rollback should be at least 25% to 40% of the 2007 premium rates.

VI. ATTORNEY'S FEES LIMITATION

1. Contingency fees

It appears that the proponents of medical malpractice reform are again trying to restrict lawyer's fees. The contingency fee mechanism provides access to the courts by relieving the injured victim and the family of the necessity of paying legal fees and expenses up-front which is often impossibility for one who is injured, unemployed and beset with medical and family expenses. It is important to note that the contingency fee is negotiated between the attorney and the client. If the client is unhappy with the handling of the fee arrangement, disciplinary action can be taken. Further, proponents are trying to put up obstacles for injured persons who have legitimate claims against a health care provider.

VII. THE FACTS BEHIND THE TEXAS SITUATION

The Hawaii Medical Association (HMA) has more recently pointed to the situation in Texas in an attempt to argue that medical malpractice tort reform has created an influx of physicians into Texas and into the rural areas. CLH would like to set forth some of the facts that are not being presented to the public or to the legislature.

A brief background on this issue in Texas is needed. The Texas Medical Association in conjunction with other groups waged an expensive campaign in 2003 to

enact medical malpractice tort reform. One of the strategies to achieve this was a public relations effort to convince residents, especially those in rural areas, that doctors were fleeing Texas, leaving many counties with no obstetricians to deliver babies, and no neurologists or orthopedic surgeons to take care of them.

The HMA refers to this situation in Texas as an example of why Hawaii should pass medical malpractice tort reform. So let us first look at the specific information as to whether doctors moved to rural areas. This is one of the major arguments of the HMA.

In an article written by freelance writer Suzanne Batchelor for the Texas Observer publication, she observed that the far-reaching changes “was built on a foundation of mistruths and sketchy assumptions. The number of doctors in the state was not falling, it was steadily rising, according to Texas Medical Board data.” She also observed that the population in Texas grew 12.7 percent between 2000 and 2006 compared with 6.4 percent in the country as a whole.

Also, her research revealed that there were 152 counties in Texas that did not have an obstetrician prior to 2003, and that four years later, there are still 152 counties in Texas without an obstetrician. She then stated that “The campaign’s promise, that tort reform would cause doctors to begin returning to the state’s sparsely populated regions, has now been tested for four years. It has not proven to be true.” Batchelor goes on to point out that several areas led the gain in obstetricians; namely, Collin County and Montgomery County (basically the urban centers of Dallas and Houston), and not the rural areas in Texas. Her article, entitled *Baby, I Lied*, is attached to this testimony for your reference as a resource.

In another article by Alex Winslow for the Texas Watch organization, a consumer watchdog, he also states that “Statistics from the Texas Medical Board (TMB), the state agency responsible for licensing doctors, show that since 1997, Texas has seen a steady increase in the number of doctors licensed to practice medicine.” Between 1997 and 2003 he found through his research that the percentage increase of practicing physicians moving into Texas prior to 2003 is generally a similar percentage subsequent to 2003. He further has stated that there is now a problem of access to the legal system for Texas residents who feel they have been injured by medical malpractice.

VII. CONCLUSION

This bill is a radical change in social policy and I urge this committee to do a thorough analysis before you vote to strip away consumer rights.

Because of the reasons stated above, CLH strongly opposes these bills and requests that they not pass out of this committee. Thank you for the opportunity to testify.

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Baby, I Lied

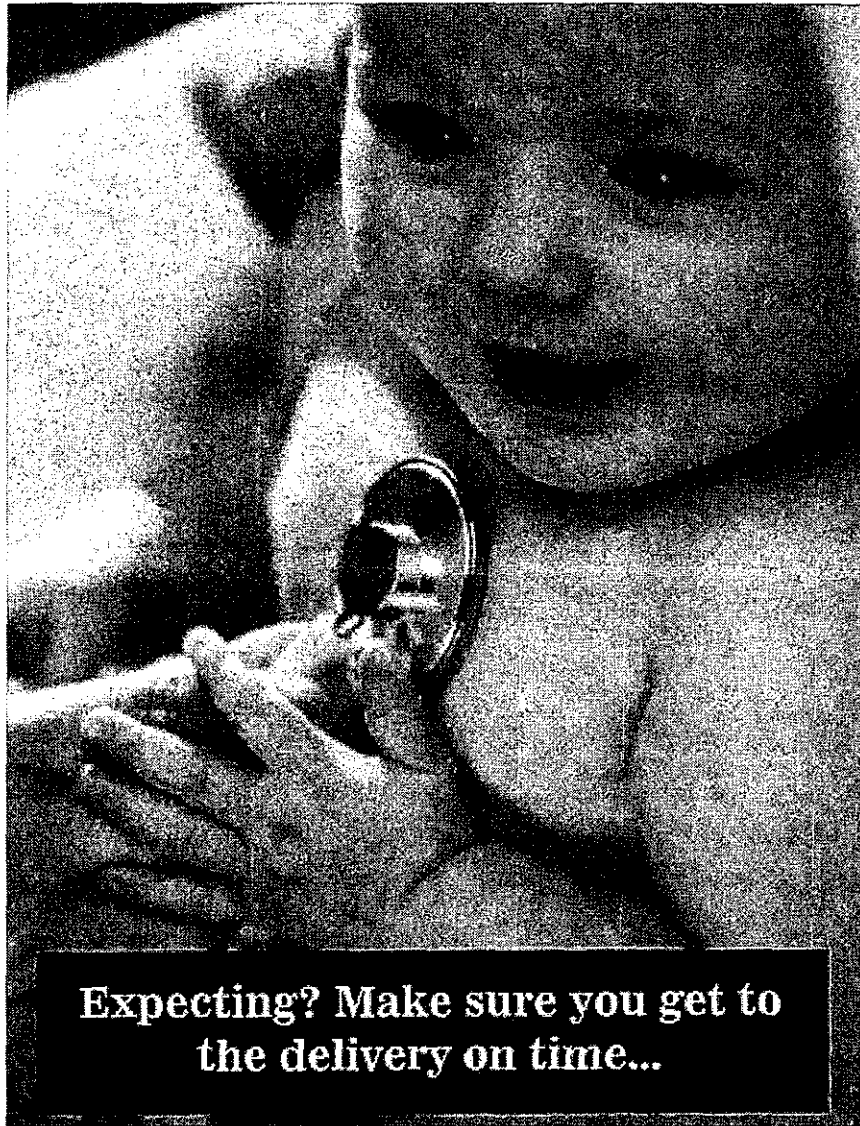
RURAL TEXAS IS STILL WAITING FOR THE DOCTORS TORT REFORM WAS SUPPOSED TO DELIVER.

Suzanne Batchelor | [October 19, 2007](#) | Features

The flood of beguiling baby photographs began cascading into mailboxes across Texas as the 2003 fall election drew near. Gracing the cover of a slick brochure, the infant smiled as a stethoscope—held by an unseen but presumably kind physician—was pressed to its chest. “Who Will Deliver Your Baby?” the mailer asked.

The direct-mail pitch was one of many churned out by insurance and medical interests as they spent millions urging voters to pass Proposition 12, a constitutional amendment that would limit the amount of money patients or their survivors could recover in medical malpractice lawsuits.

Swaddled in the glossy brochures was a dire threat. Greedy lawyers were besieging doctors with unwarranted lawsuits that were making malpractice insurance rates skyrocket. Doctors were fleeing Texas, leaving scores of counties with no obstetricians to deliver babies, no neurologists or orthopedic surgeons to tend to the ill. Without Proposition 12, the ad campaign warned, vast swaths of rural Texas would go begging for health care.



Choosing between greedy trial lawyers and cuddly babies was no contest for most Texas voters. Proposition 12 passed. Four years later, vast swaths of rural Texas are going begging for health care.

Proposition 12, and the far-reaching changes in Texas civil law that it dragged behind it, was built on a foundation of mistruths and sketchy assumptions. The number of doctors in the state was not falling, it was steadily rising, according to [Texas Medical Board](#) data. There was little statistical evidence showing that frivolous lawsuits were a significant force driving increases in malpractice premiums.

Perhaps the most insidious sleight of hand employed by Proposition 12 backers was their repeated insistence that medical malpractice insurance rates were somehow responsible for doctor shortages in rural Texas.

"Women in three out of five Texas counties do not have access to obstetricians. Imagine the hardship this creates for many pregnant women in our state," Gov. Rick Perry told a New

York audience in October 2003 at the pro-tort-reform Manhattan Institute for Policy Research. “The problem has not been a lack of compassion among our medical community, but a lack of protection from abusive lawsuits.”

The campaign’s promise, that tort reform would cause doctors to begin returning to the state’s sparsely populated regions, has now been tested for four years. It has not proven to be true.

Since Proposition 12 passed, insurance companies—many grudgingly—have lowered their rates. More doctors are coming to Texas, as a recent New York Times article trumpeted. That is proof, say Proposition 12’s backers, that so-called tort reform is working.

“Texas has seen a tremendous success in luring doctors to practice in our state thanks to tort reform passed in 2003,” says Krista Moody, Perry’s deputy press secretary. Moody noted that the Texas Medical Board is having to add staff to handle a backlog of doctors applying for state licenses.

Those doctors are following the Willie Sutton model: They’re going, understandably, where the better-paying jobs and career opportunities are, to the wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities.

On a Texas map inside the beguiling-baby mailer, blood red marked the 152 counties in Texas that did not have obstetricians in 2003. Rural doctor shortages were kept front and center as the state’s physicians, led by the Texas Medical Association and the Texas Association of Obstetricians and Gynecologists, campaigned for Proposition 12.

A flier printed by the TMA in English and Spanish and posted in waiting rooms across the state told patients that “152 counties in Texas now have no obstetrician. Wide swaths of Texas have no neurosurgeon or orthopedic surgeon. ... The primary culprit for this crisis is an explosion in awards for non-economic (pain and suffering) damages in liability lawsuits. ... vote “YES!” on 12!”

As of September 2007, the number of counties without obstetricians is unchanged—152 counties still have none, according to the *Observer*’s examination of county-by-county data at the state Medical Board.

Nearly half of Texas counties—124, or 49 percent—have no obstetrician, neurosurgeon, or orthopedic surgeon. Those specialists aside, 21 Texas counties have no physician of any kind. That’s one county worse than before Proposition 12 passed, when 20 counties had no doctor.

The TMA counts 186 new obstetricians in Texas since Proposition 12 passed, and President Dr. William Hinchey offers that as proof of tort reform’s effectiveness.

No independent study has shown what caused the increase, though Texas medical schools have graduated increasing numbers, by the hundreds, of physicians every year since 1997, the earliest year for which TMB posts data. And the state’s growth probably played some part. According to the U.S. Census Bureau, Texas’ population grew 12.7 percent between 2000 and 2006, compared with 6.4 percent for the country as a whole. The number of obstetricians in Texas increased only 4.27 percent over the same six years, including three years under tort reform.

More telling is where the new obstetricians—and neurosurgeons and orthopedic surgeons—decided to go.

The Medical Board's latest obstetrician data for the 254 Texas counties reveals that several counties led the gains.

Collin County, the Dallas suburb that is the wealthiest in Texas in terms of per capita income, gained the most obstetricians. Its 34 new ones increased its obstetrician ranks by an impressive 45 percent since Proposition 12 passed.

In second place is Montgomery County, Houston's northern neighbor along the booming Interstate 45 corridor, and the state's fourth-fastest growing county, according to the U.S. Census 2006 estimate. Montgomery gained 19 obstetricians. Tarrant County followed with 17.

Next, at 12 each, are Galveston and Hidalgo counties. Among the rest, a few counties gained in single digits, a few lost, and the majority of counties—two thirds—remained the same.

With well-equipped, well-staffed hospitals, plenty of colleagues, and insured patients, it's not hard to see why Collin County would attract the most obstetricians or offer them the most jobs. Collin's population grew 42.1 percent from 2000 to 2006; the county encompasses Plano, Carrollton, and a small part of Dallas.

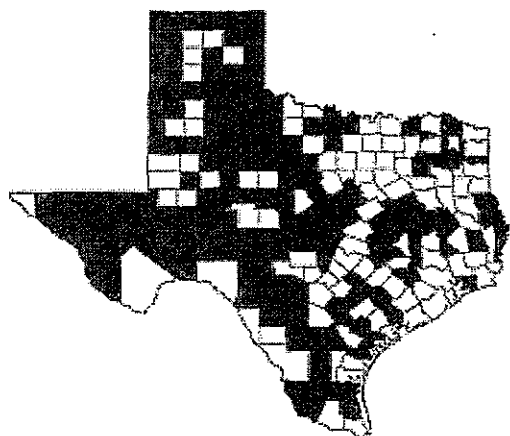
The county's Presbyterian Hospital of Plano alone has 73 obstetricians and 30 neonatologists for newborns. Two allied hospitals serve nearby Allen and Dallas, and the three are far from Collin's only hospitals.

Margot and Ross Perot gave \$6 million last October to the Presbyterian Hospital of Plano for maternal and infant care. The Margot Perot Center for Women and Infants has been named "Best Place to Have a Baby" by *DallasChild* magazine 11 years in a row. The Presbyterian system has even been honored locally for its baby sign-language classes.

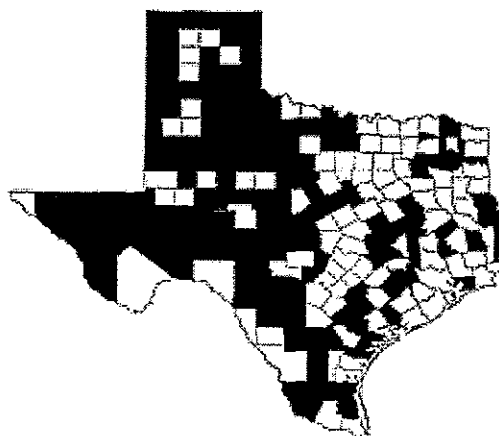
The pattern of doctors' opting to practice in more affluent, urban areas holds true for Texas' overall gains in neurosurgeons (36) and orthopedic surgeons (185) since 2003.

The number of neurosurgeons statewide increased 8.8 percent in the past four years. The biggest share, again, went to Collin County, which gained seven. Bexar and Harris counties each gained five, while Lubbock gained four, and Tarrant, three. At last count 216 counties, or 85 percent, have no neurosurgeon.

Texas has added 185 orthopedic surgeons since 2003, a 10.3 percent increase. Harris County gained the most with 25, followed by Dallas County with 21, Tarrant County with 19, Travis County with 16, and Collin County with 15. There are no orthopedic surgeons in 169 Texas counties.



Texas counties without obstetricians in 2003 before Proposition 12 passed.



Texas counties without obstetricians four years after Proposition 12 passed.

Source: Texas Medical Board

Surely, state leaders and the TMA knew that tort reform wouldn't deliver doctors and specialists to rural Texas.

The persistent struggle to get rural, underserved Texans care by obstetricians, brain surgeons—any specialists—has little to do with lawsuits or high premiums.

Rural health care has been strained by a steady, decades-long migration of Texans from rural to urban areas. Rural areas have fewer hospitals and facilities, and tend to have higher concentrations of patients on Medicaid. "The enormity of Texas ... can serve as a great obstacle for those seeking and providing health care," TMA's own Web site notes. "Approximately 15 percent of Texas' population lives in rural counties, yet only 9 percent of primary care physicians practice there."

It's hard for an obstetrician to make a living in Deaf Smith County in the Panhandle, or Pecos County out west. Understandably, most specialists choose financial security over scraping anxiously by—if for no other reason than to pay back medical school loans. They like to practice near a large community of colleagues, have access to more elaborately equipped hospitals, and treat patients with private insurance coverage.

Yet some of those who pitched Proposition 12 as a cure for rural health care woes now seem surprised that doctors aren't surging into the countryside.

"You limited your line of questioning to a single issue we have not yet revisited," said an e-mail sent by Jon Opelt, spokesman for the pro-Proposition 12 Texas Alliance for Patient Access, when asked about the rural obstetrician situation. The alliance represents more than 200 insurance companies, hospitals, medical clinics, doctors' associations, and nursing homes. It donated \$500,000 to the political action committee, Yes on 12, in 2003, according to the *Houston Chronicle*.

Dr. Charles W. Bailey Jr., a plastic surgeon who was TMA president during the Proposition 12 campaign, said he wonders if perhaps new doctors aren't out there and the Medical Board

simply hasn't been able to keep up its count. "They have a lot of stuff to do, and maybe they haven't really reassessed all the counties," Bailey said. "We have to realize that many of these counties have so few people in them, they won't support a specialist. They'll have family practice physicians delivering babies. Like many towns won't support a neurosurgeon or plastic surgeon or cardiologist. I would just, I don't know if they've really, with all the applications they're processing, if they have the time and manpower to really determine, to do another head count. From all I've heard, they can be hard pressed to keep their head above water."

Medical Board spokeswoman Jill Wiggins expressed confidence in the agency's count. Fortunately, she said, the 2003 Legislature boosted its funding and allowed the agency to add staff. When the board's license applications became backlogged in 2006, Wiggins said, the agency received even more new funding and now has about 142 full-time employees, compared with 101 seven years ago, a 41 percent increase.

Dr. Ralph Anderson, a University of North Texas obstetrics and gynecology professor and legislative adviser in 2003 with the obstetricians and gynecologists association, said the overall statewide increase in obstetricians might still yield a trickle-down effect in rural areas.

"If you bring more obstetricians to the state, a portion of those are going to go into the underserved areas, the Rio Grande Valley. If you have a lot of personalities coming in, they will disperse themselves to the area where they feel comfortable," he said. "The more people interested, the more chance you'll find somebody who's looking for that kind of opportunity. Those communities have benefited because of the increased numbers of people coming into the state."

So how did doctors become poster children for the sweeping tort-reform agenda pushed by the business and insurance lobbies in 2003?

Former TMA lobbyist Kim Ross recalled his firing just before the 2003 legislative session. Ross, who now runs his own public relations firm for national and regional medical clients, said he was canned in December 2002 by the TMA under pressure from Perry.

"There was a strongly held belief that I was personally responsible for TMA endorsing (Democratic nominee) Tony Sanchez over Rick Perry," said Ross. "I definitely took the fall on that."

The doctors' Democratic endorsement had resulted from Perry's earlier, unexpected veto of a bill they had supported requiring prompt payment from health maintenance organizations. "Perry vetoed that in an ambush without any warning. There was a huge response from physicians," Ross said. The governor also was unhappy, Ross said, because he and other TMA staff were then negotiating with trial lawyers over what they would and would not support in 2003 tort-reform legislation.

Though they fired him under political pressure, Ross said, he doesn't believe TMA supported tort reform's claims of bringing health care to rural areas just to gain Perry's favor. "There's always been an article of faith, even among OB-GYNs themselves and family practitioners, who are the mainstay of rural practice, that if we just had some liability relief and less fear of lawsuits, that would translate into a restoration of access," Ross said. He characterized that belief as an "urban myth."

Yet “the cost of liability is a relative fraction of rural healthcare cost—it’s a high part of trauma [emergency] costs—but access is driven by reimbursement,” Ross said. “Reimbursement from Medicare, Medicaid, commercial managed care ... You need some liability stability, but the primary driver is the economics of reimbursement. For all its emotional charge of fairness, liability cost for the most part is not the issue.”

Why did physicians readily believe it when insurance companies blamed greedy, out-of-control plaintiff’s lawyers for high liability rates in 2003? One reason may be that the largest malpractice insurer in Texas is their own.

The TMA and the Legislature created the Texas Medical Liability Trust in 1978 as a self-insured trust solely for TMA members. The trust’s doctor-insureds elect a board of directors via mail-in ballot every three years. Besides insurance, the trust provides defense attorneys to doctors who are sued, and pays doctors’ expenses when the investigators of the Medical Board fine them.

The trust is not regulated by the Texas Department of Insurance. As former Insurance Department Associate Commissioner Birnie Birnbaum noted, the trust can charge what it chooses, while regulated companies must charge the rates they file with the department. (The trust isn’t Texas’ only unregulated malpractice insurer; “risk retention” insurers are also free of state oversight. There’s no federal regulation of insurance companies.)

Since 2003, the trust has reduced its insurance premiums: 12 percent in 2004; 5 percent in 2005; 5 percent in 2006; 7.5 percent this year; and 6.5 percent for 2008. In 2008, the trust will charge doctors 68.7 percent of the charge before tort reform.

Dr. Donald A. Behr, head of TMA’s rural physician group, speaks enthusiastically about his rural practice in Graham, seat of Young County in North Central Texas. Behr and his wife, a nurse, left Fort Worth six years ago and say they love treating the smaller community of neighbors and friends, “not just insurance cards.”

Graham’s hospital is better off than most rural facilities, said Behr, a general surgeon. An old oil town, Graham was flush with millionaires 25 years ago; their philanthropy keeps the hospital afloat.

Of the five counties bordering Young, only one has an obstetrician. Graham has one, but no neurosurgeon, orthopedic surgeon, or cardiologist. Specialists ride in weekly or monthly, like pioneer circuit riders, from Wichita Falls, Mineral Wells, and Abilene.

Graham Regional Medical Center draws from Jack, Stevens, Throckmorton, and Archer counties. “Part of that is because of our obstetrician, part probably because of me,” Behr said.

A frantic edge comes to Behr’s otherwise confident voice when he describes the hospital’s financial fragility despite philanthropy.

“Most of the obstetrics patients in rural Texas are Medicaid,” which pays rural physicians less than urban ones, he said. Just to offer obstetrics, Graham’s hospital has to jump through a few hoops.

First, the hospital has to have a minimum of two doctors who deliver babies and accept

Medicaid, Behr said. Fortunately, Graham has three family practice physicians who also provide obstetrics to back up its lone obstetrician.

“A little hospital with one doctor doesn’t fly,” Behr said. “You’ve got to have anesthesia, and if you don’t have enough volume for a full-time anesthetist, you can’t have obstetrics, basically.”

Graham’s hardworking obstetrician sees patients six days a week, traveling to five towns, and his nurse-practitioner sees the women at other times.

In an interview, Behr scarcely mentions liability insurance as a factor facing rural health care. Adequate reimbursement—getting paid—by Medicare, Medicaid, and private insurers to cover costs topped Behr’s concerns, expressed in a long conversation.

“The only way to keep doctors in rural Texas and anyplace is, somehow we have to find a way to practice medicine cheaper,” he said. “We spend too much, yet there’s a lot of doctors who can’t make a living.”

Tort reform may have failed to brighten health care for rural Texans, but two state agencies are trying to lure physicians and other health care professionals to underserved areas.

The seven-year-old Office of Rural Community Affairs gives doctors stipends of up to \$15,000 a year for residency practice after medical school in underserved areas. A separate program in the state office uses \$112,500 a year in interest from the state’s share of the massive tobacco lawsuit settlement to recruit and retain licensed nonphysicians, such as nurses and physical therapists, in underserved areas. Another \$2 million in tobacco money is distributed by the office to small rural hospitals.

The 2007 Legislature increased funding for a doctor education-loan repayment program administered by the Texas Higher Education Coordinating Board. For the current biennium, the program will hand doctors \$1 million annually.

Loan program Director Lesa Moller said doctors willing to practice in underserved areas can receive up to \$9,000 for each year they complete. After two years, the doctor becomes eligible for federal matching funds of up to \$18,000.

“Unfortunately, there’s been way more applicants than there’s been dollars,” said TMA lobbyist Helen Kent Davis of the assistance programs, adding that the TMA has advocated for the rural programs at the Legislature for many years.

TMA does not fund any rural doctor programs, Davis said.

The irony that tobacco-settlement money is put to work year after year sustaining rural health care professionals and hospitals should not be lost on Texas physicians who campaigned for Proposition 12.

The massive tobacco settlement was the work of trial lawyers, the very folks TMA leaders demonized in their quest for cheaper insurance and fewer lawsuits.

Suzanne Batchelor is a freelance writer in Austin.

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PLEASE DELIVER TO ROOM 016 FOR THE STATE SENATE HEALTH
COMMITTEE HEARING, WEDNESDAY 02/13/2008, 1:15 P.M.

February 11, 2008

To: Senator David Ige, Chair
Senator Carol Fukunaga, Vice Chair
Senate Health Committee

From: Helen Ing, M.D.
642 Ulukahiki Street, Suite 211
Kailua, HI 96734
808-261-0765

Rc: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB 2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$ 250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I support limits on attorney fees, which will give money to the injured plaintiff.

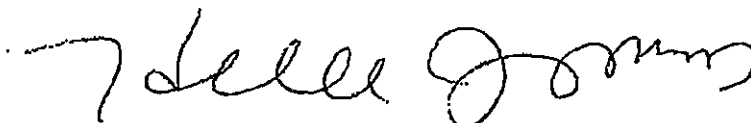
An interview with Senator John Edwards by Joyce Frieden in the Internal Medicine News, November 1, 2007, he proposed that "before a medical malpractice case could be filed, the plaintiff's attorney would have to conduct a complete investigation, including independent review by at least two experts in the field who determine if the case is, first, meritorious, and second, serious. Then you require that the lawyer certify that it has been done as part of the filing. If they fail to certify, the lawyer should bear the cost. If they do it three times, it's three strikes and you're out--you lose your right as a lawyer to file these cases."

Medical liability reform will help to keep physicians in practice and to recruit new doctors.

Unless legislators act now, doctors will continue to limit their practices, quit early or leave Hawaii. I quit my Internal Medicine practice in Kailua at the end of July 2007. Access to care is a critical problem to my Windward community.

Medical liability is a very important part of the solution.

Thank you for the opportunity to provide this testimony.



testimony

From: Linda Jane Irwin [ljirwin@hawaii.rr.com]
Sent: Monday, February 11, 2008 2:06 PM
To: testimony
Subject: Medical liability reform testimony

*To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee*

*From: Linda-Jane Irwin, MD
PO Box 37
Volcano, HI 96785*

*Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability*

I am a Hawaii resident and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

Hawaii is unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements.

As a result, physicians are leaving Hawaii and its residents are unable to obtain the medical care they need.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms. I know this because the bulk of my medical practice was in Texas. I was born and raised in Hawaii and have been fortunate enough to briefly practice here and then retire here. I am acutely aware of the health crisis as I live in East Hawaii Island.

I would like to share with you the following excerpt from the president of the Texas Medical Association. While it does not directly relate to the tort reform issue, which when addressed significantly improved the doctor shortage in Texas, it should help to clarify the other side of the coin relating to re-imbusement issues. Unfortunately, health insurance companies use the pitiful reimbursement schedules created by Medicare as a standard, suggesting that their minimally higher fees are somehow therefore satisfactory. That is far from the case. This second issue will ultimately need to be addressed as well. Doctors simply cannot afford to live and practice here. This is a portion of what he had to say:

I reviewed President Bush's State of the Union Address last month, and I must tell you in all honesty that I was appalled. I heard the president say the following: "We share a common goal: making health care more affordable and accessible to all Americans." My initial reaction was, "Really?"

My next thought was this:

Read my lips, President Bush. If you sincerely want to make health care more affordable and accessible for all Americans — let's start with our fastest-growing patient population, our senior citizens, and bring the broken Medicare system into the 21st century. We find it disturbing that in the past seven years, the Bush administration has not taken steps to resolve Medicare's flawed payment formula. It doesn't make any sense that individual doctors are being forced out of Medicare.

2/11/2008

Meanwhile, Medicare Advantage insurance plans and Medicare HMOs are receiving double-digit, multimillion-dollar bonuses for simply brokering existing medical services. Worse yet, America's senior citizens and people with disabilities don't have access to a doctor and the health care they deserve.

President Bush is asking seniors and their doctors to fall for a reckless sleight-of-hand trick where both lose and the insurance companies still win. The president claims he will approve a 10-percent payment increase for physicians, providing Medicare funding is cut for hospitals, nursing homes, hospices, ambulances, and home care agencies — all the health care services Medicare patients need. President Bush would rather help health insurance companies increase their profits than ensure our Medicare patients can get the health care they need and deserve.

We've been operating under government price controls since 1987. Physicians have not had a payment increase that kept up with practice expense increases since 2001. More and more of us, at least those who could, have been forced to close our practices to Medicare patients or to limit the number of new Medicare patients we take.

William W. Hinchey, MD
President
Texas Medical Association

These are sad times for patients, doctors and other care-givers. Please help. We desperately need to be able to recruit more physicians to rural areas in particular, but if this goes on much longer even Honolulu is going to start feeling the effects that we have been suffering for some time.

Thank you for the opportunity to provide this testimony.

- o Limited metered parking available on the corner of Punchbowl & Beretania Streets (Dept. of Health). 25 cents for 15 minutes. Anything over 2 hours is 25 cents for 7.5 minutes.

SEND TESTIMONY BY TUESDAY, 2/12/08, 1PM

Feel free to put your testimony in your own words. The sample testimony is intended to be a guide.

- In person: Deliver 1 copy of testimony to the committee clerk, Room 215, State Capitol.
- Fax: Less than 5 pages, to the Senate Sergeant-At-Arms Office at 586-6659 or 1-800-586-6659 (toll free for neighbor islands)
- Email: Less than 5 pages, to testimony@capitol.hawaii.gov.

Sample Testimony:

Include these instructions: Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice C
Senate Health Committee

From: Your name
Your address
Your phone number



Rob Mastroianni MD Inc.
Family Practice and Urgent Care

Pukalani Square
81 Makawao Ave #100
Makawao, HI, 96768

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

For more information contact:

Paula Arcena, Executive Director
Hawaii Medical Association • 1360 S. Beretania St. # 200 • Honolulu, HI 96814 • (808) 536-7702 phone
(temporary emails, our network is down)
parcena@aol.com

Karla Sasser, Government Affairs Assistant
karla.sasser@gmail.com

Malcolm R. Ing, M.D.
1319 Punahou Street, Suite 1110
Honolulu, HI 96826
(808) 955-5951

February 11, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Malcolm R. Ing, M.D.
1319 Punahou Street, Suite 1110
Honolulu, HI 96826
(808) 955-5951

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support the limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now; doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part in the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Malcolm R Ing MD

UNIVERSITY OF HAWAII AT MĀNOA

John A. Burns School of Medicine
Department of Obstetrics, Gynecology and Women's Health

February 11, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

Re: **SB2412 Relating to Medical Liability**
SB2354 Relating to Medical Liability

Dear Senators Ige and Fukunaga,

I am a Hawaii physician and I strongly support SB2412 and SB2354. Medical liability reform will help to keep Hawaii's physicians in practice and bring new doctors to our state.

Both bills will help to stabilize medical malpractice insurance premiums. I support a \$250,000 cap on non-economic damages, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

There are no easy answers for our healthcare problems but unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most. Medical liability reform is an important part of the solution; states such as Texas have had great success in improving access to care since passing similar reforms.

Thank you for the opportunity to provide this testimony.

Sincerely,



Lynnae Sauvage, MD
Department of Obstetric, Gynecology
And Women's Health

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Medical Service Representatives Hawaii President (Amber Rose)
91-1008 Kaipuhinehu St. Ewa Beach HI 96706
808 232-4400

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

As the President of Medical Service Representatives Hawaii I support SB2412 and SB2354

As a medical representative in Hawaii, I have seen the pressure that has been placed on the physicians of Hawaii every day. Specialty doctors are leaving due in part to the medical malpractice premiums and the risk of liability. There are not enough new doctors moving to the islands and current doctors of Hawaii are closing down their practices because of the rising costs. This in turn drives the offices to be overcrowded while the surgeons of these practices are having to take on too many surgeries in a day. This has and will lead to less than favorable care for Hawaii residents.

I support both bills that will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Amber Rose

testimony

From: millicent khaw [khawm001@gmail.com]
Sent: Monday, February 11, 2008 9:46 PM
To: testimony
Subject: SB2412; SB2354 Medical Libability

Please deliver to room 016 for the Senate
Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Millicent Khaw, M.D.
1329 Lusitana Suite 604

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

testimony

From: Jean Shein [jeanshein@hotmail.com]
Sent: Tuesday, February 12, 2008 8:30 AM
To: testimony
Subject: malpractice insurance premiums

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Jean Shein, MD
4463 Pahee Street, Suite 206
Lihue, HI 96766

RE: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

Dear Senators:

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need. Do not put the health of the state's residents at risk!!!!

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Sincerely,
Jean Shein, MD

Shed those extra pounds with MSN and The Biggest Loser! [Learn more.](#)

testimony

From: Phoebe Lambeth [phoebel@msn.com]
Sent: Tuesday, February 12, 2008 8:06 AM
To: testimony
Subject: Testimony for SB2412, SB2354

Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/2008, 1:15pm

February 12, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga Vice Chair
Senate Health Committee

From: Phoebe M. Lambeth
2284 Kaiwiki Road, Hilo Hawaii 96720
Phone: 808 961 3112

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

As a resident of Hawaii I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also strongly support limits on attorney fees, which will give more money to the injured plaintiff.

We are unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements.

As a result, physicians are leaving Hawaii and its residents are unable to obtain the basic medical care they need. Many residents are leaving Hawaii just for the very reason that they are unable to find a physician to care for them even if they have medical insurance. Employers are unable to keep their employees in Hawaii because they are not able to find a physician to care for their families.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to medical care since passing reforms.

Thank you for the opportunity to provide this testimony.

testimony

From: Vince K. Yamashiroya [yamashirv002@hawaiiantel.net]
Sent: Tuesday, February 12, 2008 11:46 AM
To: testimony
Subject: SB2412 and SB2354

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Vince Yamashiroya, MD
1010 South King Street, Suite 105
Honolulu, HI 96814

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Vince Yamashiroya, M.D., FAAP
General Pediatrics in Private Practice and Clinical Associate Professor of Pediatrics at the University of Hawaii

Medical Arts Building
1010 South King Street, Suite 105
Honolulu, Hawaii 96814

Tel: (808) 596-2030; Fax (808) 596-2034
yamashirv002@hawaii.rr.com; www.vinceyamashiroya.yourmd.com

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2/12/2008

testimony

From: rhoads2@hawaiiantel.net
Sent: Monday, February 11, 2008 1:12 PM
To: testimony
Subject: SB 2412 and SB 2354

Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Rhoads E. Stevens, M.D.
1329 Lusitana St., Suite 209, Honolulu, HI 96813
808-545-4488

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

As a Hawaii physician/ophthamologist and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most. Already a colleague of mine gave up surgery due to increased expenses and reduced payments.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

testimony

From: John Estes [estes.john@gmail.com]
Sent: Monday, February 11, 2008 8:18 AM
To: testimony
Subject: Pass this bill, now



February 09, 2008

*To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee*

*From: John P. Estes
73-4690 Kahualani Road
Kailua Kona, HI 96740-9144
808.325.5400
enaestes@hotmail.com*

*Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability*

I am a Hawaii resident and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

Hawaii, the state, and especially Hawaii Island are unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements.

As a result, physicians are leaving Hawaii and its residents are unable to obtain the medical care they need.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

John P. Estes

Kanoe Kamanao

From: Joseph Harding [ainoni167@hotmail.com]
Sent: Monday, February 11, 2008 12:08 PM
To: Sen. David Ige
Subject: SB2412 & SB2354

Senator David Ige, Chair, Senate Health Committee

I am a health care patient, and I strongly support the subject bills relating to health care.

Both bills aim to stabilize, and hopefully reduce medical malpractice insurance premiums. I have lost two physicians due to this issue. I also support a cap of \$250,00 on non-economic damages, since this has been proven by other states to be an effective means of stabilizing premiums. Furthermore, a limit on attorney fees will give more money to the injured plaintiffs.

We need to act NOW to keep our physicians in practice, as well as to be able to recruit new doctors. Unless the legislature acts swiftly on this issue, we will lose more doctors, and we patients will not get the care we need when we need it most!

I know that Texas and other states have been very successful in improving patients' access to care since enacting reforms, and medical liability reform has made this possible.

Thank you for the opportunity to weigh in on these Bills.

John J. Harding
167 Ainoni Street
Kailua, HI 96734
262-1826

February 11, 2008

**To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee**

**From: Stefan Carl Harmeling, MD
232 Punahale St., Hilo, HI 96720
808.961.1400**

**Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability**

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

**Stefan Carl Harmeling, MD
Aloha Nui Family Practice, LLC
Hilo, Hawaii**

***Beverly LP Chang, RN
Veteran's Administration
Clinical Nurse Supervisor
1285 Waiannuanne Avenue, Suite 211
Hilo, HI 96720
(808) 935-0530***

February 11, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii resident and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

I have been in the medical profession for the last 17 years and felt the need personally when I moved to the Big Island 2 years ago. It took me 18 months to get a primary care physician and only after begging a clerk to take my husband and I on as patients.

Hawaii is unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements. As a result, physicians are leaving Hawaii and its residents are unable to obtain the medical care they need.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Regards,


Beverly LP Chang

HENRY K. LEE LOY, M.D., INC.

INTERNAL MEDICINE

670 PONAHAHAWAI STREET, SUITE 218

HILO, HAWAII 96720

TELEPHONE (808) 969-2011

FAX (808) 969-3480

February 13, 2008

Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

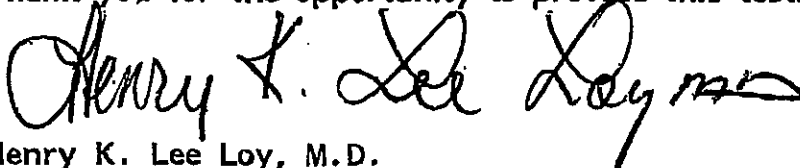
Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's Physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.



Henry K. Lee Loy, M.D.

testimony

From: Gautam A. Deshpande, MD [drdeshpande@gmail.com]
Sent: Monday, February 11, 2008 8:17 AM
To: testimony
Subject: testimony - SB2412, SB2354

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Gautam A. Dedhpande, MD
1025 Wilder Ave #12A, Honolulu, HI 96822
832-215-3120

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Sincerely,
Gautam A. Deshpande, MD

--

UH Internal Medicine Training Program
Asst Professor, Clinical Medicine
Kuakini Hospital
Chief Medical Resident

This message and its contents are strictly provided for the recipient of this e-mail. Any unauthorized viewing of this e-mail by other parties for which it is unintended shall be considered as a breach of confidentiality rules as defined by UH Internal Medicine and Kuakini Hospital.

testimony

From: Daphne Hemmings [daphnehemmings@aol.com]
Sent: Sunday, February 10, 2008 8:28 PM
To: testimony
Subject: Medical Liability Reform

February 10, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Daphne E. Hemmings, MD, MPH
550 South Beretania St. Ste 501
Honolulu, HI 96813
528-4144

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Sincerely,

Daphne E. Hemmings, MD, MPH

2/11/2008

testimony

From: Dick & Ellen Fearing [defearing@ix.netcom.com]
Sent: Monday, February 11, 2008 7:24 AM
To: testimony
Subject: Support for SB2412 and SB2354

February 11, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Richard R. Fearing
76-871 Palila Place
Kailua Kona, HI 96740
(808) 329-1271

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a **Hawaii resident** and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

Hawaii is unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements.

As a result, physicians are leaving Hawaii and its residents are unable to obtain the medical care they need.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

2/11/2008

Sincerely,

Richard R. Fearing

TO: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

FROM:
Racquel Smith Bueno, MD, FACS
321 North Kuakini Street #201
Honolulu, HI
808-523-8611

RE: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support **SB2412** and **SB2354**.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

In combination, Hawaii's high medical malpractice premiums, high cost of living, and low physician reimbursements have made it difficult to recruit and retain an adequate physician workforce. While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care that they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.



Racquel Smith Bueno, MD, FACS
Assistant Professor of Surgery
John A. Burns School of Medicine, Department of Surgery

testimony

From: Sylvia Pager [sypager@hawaii.edu]
Sent: Monday, February 11, 2008 10:50 PM
To: testimony; Galen Chock; Paula A.
Subject: SB2412, SB2354

/February 13, 2008/

//

/To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair,
Senate Health Committee ///

/From: *Sylvia R. Pager,* MD, FAAP, IBCLC 1380 Lusitana St., Ste.907/ / Honolulu//,
Hawaii, 96813//.

//

Re: /**SB2412*/ Relating to Medical Liability *_ SB2354*_ _ _Relating to Medical
Liability//_

/ ///

/I am a Hawaii pediatrician, and I strongly support SB2412 and SB2354.

/

/Both bills will help to stabilize medical malpractice insurance premiums, I support a
\$250,000 cap on non-economic damages, which has been proven by other states to be
effective in stabilizing premiums. I also support limits on attorney fees, which will
provide more compensation to the injured plaintiff.

/

/While there is no single solution for our complex multifaceted healthcare problems,
medical liability reform will help to keep Hawaii's physicians in practice and recruit new
doctors, especially for the under-served rural areas.

/

/Unless legislators act now, doctors will continue to cut back on their practices or leave
the state and Hawaii's residents will be left without the medical care they need, whenever
the time should arise.

/

/Medical liability reform is an important part of the remedy. Texas and other states have
shown improved access to care since passing similar reforms.

/

/We hope you may see beyond the legal lobby, and pass these bills into law.

/

/ Thank you for the opportunity to provide this testimony./

//

/ Sincerely,/

//

/ Sylvia R. Pager, //MD, FAAP, IBCLC
Pediatrician./

--

Sylvia R. Pager, MD, IBCLC

Pediatrician, Lactation Consultant
Clin. Assoc. Prof., Dept. of Pediatrics
JABSOM, University of Hawaii
AAP Hawaii Chapter Breastfeeding Coord.
1380 Lusitana St. Ste 907
Honolulu, Hawaii 96813
Tel: 808 524-2885 w, 732-2384 h, 389-8155 c
Fax: 808 524-2886 w, 739-1600 h

testimony

From: Junji Takeshita [junji001@gmail.com]
Sent: Tuesday, February 12, 2008 6:23 AM
To: testimony
Subject: SB2412/2354

Please deliver to room 016 for the Senate
Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Junji Takeshita, M.D.
1356 Lusitana Street, 4th Floor
Honolulu, HI

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no simple solution for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

2/12/2008

testimony

From: Carl Lehman [lehmanc001@hawaii.rr.com]
Sent: Tuesday, February 12, 2008 12:19 AM
To: testimony
Subject: SB2412 & SB2354 both relating to Medical Liability

February 13, 2008

To: Senator David Ige; Chair
Senator Carol Fukunaga; Vice Chair
Senate Health Committee

From: Carl Lehman MD
1329 Lusitana Street,#603
Honolulu, HI 96813

I am a Hawaiian physician who strongly supports SB2412 and SB2354.

If enacted, both bills will help to stabilize medical malpractice insurance premiums. I support a cap on non-economic damages of \$250,000 which has been shown by other states to be effective in stabilizing premiums. I also support limits on attorney fees, in order to award more to the injured plaintiff.

Admittedly the healthcare system with its' related problems is too complicated to address in its' entirety but legislators have the power and responsibility to at least pass these two bills to bring about medical liability reform that will help to keep Hawaii's physicians in practice and recruit new doctors.

Medical liability reform is an important start of the resolution. States that have passed similar reforms have demonstrated improvement of access to care.

Thank you for the opportunity to provide this testimony.

Carl Lehman MD

sb2354

2/12/2008

testimony

From: Concept Construction (Suzy) [suzy@conceptconstructionhawaii.com]
Sent: Monday, February 11, 2008 1:47 PM
To: testimony
Subject: SB2412 & SB2354

February 13, 2008

*To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee*

*Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability*

I am a Hawaii resident and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

Hawaii is unable to recruit and retain an adequate supply of physicians due to the lack of liability reform and other issues such as inadequate reimbursements.

As a result, physicians are leaving Hawaii and its residents are unable to obtain the medical care they need.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

*Mahalo,
Suzy Lauer - Office Manager
Concept Construction, Inc.
558 Kanoiehua Avenue
Hilo, Hawaii 96720
Voice (808) 935-0279~Fax (808) 935-7597
suzy@conceptconstructionhawaii.com*

No virus found in this outgoing message.
Checked by AVG Free Edition.
Version: 7.5.516 / Virus Database: 269.20.2/1271 - Release Date: 2/11/2008 8:16 AM

PLEASE DELIVER TO ROOM 016 FOR THE STATE SENATE HEALTH
COMMITTEE HEARING, WEDNESDAY 02/13/2008, 1:15 P.M.

February 11, 2008

To: Senator David Ige, Chair
Senator Carol Fukunaga, Vice Chair
Senate Health Committee

From: Michael Yee, M.D.
642 Ulukahiki Street, Suite 211
Kailua, HI 96734
808-261-0765

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB 2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$ 250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I support limits on attorney fees, which will give money to the injured plaintiff.

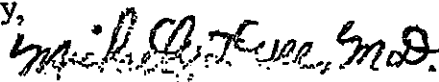
Medical liability reform will help to keep physicians in practice and to recruit new doctors.

Unless legislators act now, doctors will continue to limit their practices, quit early or leave the state. Hawaii's residents will not get the care that they need. Access to care is a critical problem to my Windward community.

Medical liability is a very important part of the solution. Please support these bills.

Thank you for the opportunity to provide this testimony.

Sincerely,



Michael Yee, M.D.

February 12, 2008

To: **Sen. David Ige, Chair**
Sen. Carol Fukunaga, Vice Chair
House Health Committee

From: Pete Crackel
1005H Kailua Road, Kailua, HI 96734
(808) 561-0621

Re: **SB2412 Relating to Medical Liability**
SB2354 Relating to Medical Liability

I am a Hawaii resident and I strongly support SB2412 and SB2354.

I support these bills because we can no longer ignore the fact that Hawaii is unable to retain or recruit adequate numbers of physicians/specialists. We know this is due to the high cost of living and doing business in this State compounded by inadequate (and continually declining) reimbursement for services and the constantly increasing costs of liability insurance in the absence of any reforms.

Failure to address the critical issue of Doctors continuing to leave Hawaii, retiring early or reducing their practice to defensive medicine already is having far-reaching effects with unintended consequences.

I was born and raised on the Big Island as was my mother and her mother. I was a paratrooper-medic in Vietnam with the 101st Airborne. I have a Masters in Social Work and a limited background in the mental health field. I have been exposed to a myriad of situations outside "the norm," and I now see my home at a frightening tipping point.

While the condition is no different anywhere in our State, it is intensely troubling on the Neighbor Islands. Look at the Big Island, where approximately 49 doctors have left in the past 18-24 months. The remaining patients backlog to the remaining doctors. Since there are only so many hours in the day, not all patients can be seen within reasonable periods. Some patients simply opt to use the ER as their primary care clinic because of the backlog. Some patients, particularly seniors, don't have the energy or will to follow through and abandon their medical care. (There are no statistics to gauge the adverse impact on longevity in these cases.) Other patients who have lost a specialist and cannot afford the expense of travel simply lose their access to care.

Result: the dreaded “R” word – rationed medical care in Hawaii. On any given day, depending on who you are, where you are and what has happened to you, the unintended consequence is RATIONING.

Another unintended negative consequence is that of doctors with young families who are at high risk of dysfunctional relationships. Parents, even doctors, who work 16–18 hours a day cannot possibly make adequate quality time for their children because there is no time available. The high stress environments, the exhaustion, the breakdown of the family unit evolve into additional negatives.

As we slip toward third world medical care access status, we read un-researched editorial commentary touting the Commonwealth Fund, a NYC based private foundation, which rates Hawaii as the number one state for its “access to care.” Doing some research reveals that the reference was to Hawaii having more people with insurance coverage than any other State. Every reasonable, thinking person will recognize that the best insurance plan on the planet is no substitute for a competent array of doctors on each island or the specialist you require when needed.

Both bills will help to stabilize medical malpractice insurance premiums. I support a \$250,000 cap on non-economic damages and reasonable limits on attorney fees. These have proven to be effective in stabilizing premiums in other states like Texas.

Medical liability reform is not the total answer, it is a critical part of the solution. We need to start today to move in the direction of improving access to care in our State.

Thank you for the opportunity to provide this testimony.

Pete Crackel

Testimony of
Phyllis Dendle
Director of Government Affairs

Senate Committee on Health
The Honorable David Y. Ige, Chair
The Honorable Carol Fukunaga, Vice Chair

February 13, 2008
1:15 PM
Conference Room 016

SB2354 Relating to Medical Liability

Chair Ige and committee members, thank you for this opportunity to provide testimony on SB 2354 which amends the law regarding medical liability.

Kaiser Permanente supports this legislation.

We believe that compensating individuals that are injured is essential. It is also essential that individuals have access to specialty care when they need it. The dramatic rise in medical malpractice insurance costs is decreasing the availability of specialist in many places on the mainland and many places in Hawaii.

California addressed this problem with the Medical Injury Compensation Reform Act of 1975 (MICRA). The bill before you provides many of the same kind of provisions that stabilized insurance rates in California.

We urge you to pass legislation that is similar to that successful law.

Thank you for your consideration on this matter.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Elizabeth Chen Christenson, MD, LAc., ABHM, FAAMA, FCAP
934 Maunawili Circle, Kailua, HI, 96734
808-261-7801

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

It will take many different kinds of incentives to make Hawaii competitive for a physician workforce with other jurisdiction. The physician shortage is national and is expected to last for the next several decades. Medical liability reform is part of the equation that will help Hawaii attract and retain doctors.

The Hawaii State Legislature needs to act now. Medical liability reform can be adopted with no cost to the State of Hawaii, an important point given that Hawaii is expected to experience an economic downturn.

Texas, in particular, has compelling data showing vast improvements in patient access to care since passing medical liability reform in 2003.

Given Hawaii's remote location, high cost of living and other disadvantages, medical liability reform would help Hawaii to compete with other jurisdictions.

Please review - our life as medical doctors in Hawaii:

I feel that my husband's professional life is affected by these issues in Hawaii:

1. Higher mal-practice insurance rate,
2. Low insurance reimbursement,
3. High cost of living in Hawaii.

Both my husband and I were drawn to Hawaii because we sensed an open-mindedness missing in the traditional Midwest mentality and the exquisite beauty of the land with the year round idyllic climate, so unlike the unruly weather of Ohio. In May 2004 we made a decision to radically change our professional and personal lifestyles and come to Hawaii where the intercultural exposure would be more receptive toward the cooperation of eastern and western medical modalities. We recognized there may not be that kind of professional growth in the Ohio area as we saw possible in Hawaii. I have a vision of Hawaii as the perfect healing environment to bridge the best of East and West Medicine. Since Hawaii State acupuncture license board does not recognize my acupuncture training in US I put my family practice and my income on hold for three years while I enrolled in acupuncture school in order to be eligible for the national acupuncture license exam. I got my acupuncture license early last year and started to incorporate my medical practice incorporating the best of east and west medicine. This business has started to pick up in the past couple months.

Meanwhile, my husband's anesthesiology job was put on hold since February 2006 due to physical exhaustion after 1.5 years of worked very long hours (sometimes over 24 hours straight) without any breaks or worked 36 hours with only 1 or 2 hours of sleep. Based on the calculation of his billable time he worked more than double time than regular full time job.

Now his health problem has been resolved throughout one and half year of rehabilitation and treatments and his doctors are supporting him returning to work. But for more than 7 months of applying hospital privileges in various hospitals in Oahu he was getting signals that hospitals credentialing committees are reluctant to take him back. I sense our medical community is operating under a FEARFUL condition. Here we have a healthy and capable bright doctor who is ready to return to work. He was asking for a reasonable working hour and hospitals are reluctant to take him back. Meanwhile he began to apply anesthesia job through locum tenum agency and he was told that there are positions available for him in March and other future months at hospitals in Massachusetts and various job opportunities in many other States. He will pack and leave for those positions. There is a crisis of shortage of physician in Hawaii and hospitals are reluctant to take him back. How can we make sense of this?

I dare not recommend my physician friends / colleagues to move to Hawaii **unless** there is a way that we can show them that we can make a living here. My husband is also afraid of other doctors including his own primary care physician and colleagues burning out due to overwork. The downward spiral of overwork and no vacation is unsustainable and as doctor leaves this will put further pressure on the remaining doctor leading to further burn out. We both are very weary about our son who is a medical student at Tulane Medical School returning to Hawaii to practice because of these unhealthy working conditions.

Since my husband has 18 years history of unblemished professional record as an anesthesiologist in Toledo, Ohio, I believe what happened to him in Hawaii due to overworked which is a transient condition and can be remedied. There is no benefit to anyone by destroying a lifetime career because of a short series of issues that are now resolved.

It is a well known fact that sleep deprivation impinges upon a person's clarity of thoughts and critical decision-making as well as dexterity of body movements. There have been extensive studies and publications both in the civilian and military reports that "Sleep loss of less than 30 hours reduced physicians' overall performance by nearly 1 standard deviation and clinical performance by more than 1.5 standard deviation." (article available upon request). A recent article in the magazine entitled "Approach" – The Navy & Marine Corps Aviation Safety Magazine, September-October, 2007 an article on fatigue pointed out that sleep deprivation is worse than flying under the influence of alcohol because people know not to fly when they are drunk but don't know not to fly when they are fatigue. Now the military is setting up rules and guidelines of work load to prevent mishap due to fatigue. The article concluded with the following: "we don't need more training, more discipline, more regulation, more safeguards, or bigger instructions. Perhaps, we just need more sleep." (article available upon request). Medicine should also have such guideline to ensure patient and doctor's safety.

We want to help Hawaii Medical Association to be a strong advocate for physician's wellbeing. If physicians are not well we cannot take care of anyone. Therefore

"Physician Heal Thyself" comes first. This is a practice I learned from Chinese Medicine – a very old knowledge that benefits everyone.

I am one of few physician in the State of Hawaii possess duo Degrees and Licenses in both Eastern and Western Medicine and duo professorships and teaching positions at John A. Burns School of Medicine and acupuncture school. This enables me to accomplish the task of bridging the best of the East and West medicine, spirituality in medicine as well as music and medicine in the 21st century. Being an Associate Clinical Professor and my husband an Assistant Clinical Professor at the Department of Complementary & Alternative Medicine (CAM) of JAB School of Medicine we are able to work with CAM's dream – making Hawaii a world class healing center.

Thank you for the opportunity to provide this testimony.

Best Regards,

Elizabeth Chen Christenson, MD, LAc, ABHM, FAAMA, FCAP
Medical Director
CHI (Comprehensive Health Innovations) Medical Center, LLC
Associate Clinical Professor
Department of Complementary & Alternative Medicine
John A. Burns School of Medicine at UH
Associate Professor, Institute of Acupuncture and Oriental Medicine
808-261-7801 www.chimedicalcenter.com

testimony

From: Linda J. Rasmussen [lindamd1@juno.com]
Sent: Tuesday, February 12, 2008 9:22 PM
To: testimony
Subject: Please deliver to room 016 Senate Health committee 2/13 hearing 1:15pm

Please Deliver to room 016 for Senate Health Committee Feb. 13 at 1:15pm

February 12, 2008

To: *Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee*

From: *Janae Rasmussen
649 Kanaha St.
Kailua, HI 96734
(808) 927-5388
janae@hawaii.edu*

Re: *SUPPORT FOR SB2412 Relating to Medical Liability
SUPPORT FOR SB2354 Relating to Medical Liability*

As the daughter of a physician in Hawaii, I would like to comment on how their busy schedule affect their family.

I am an 8th grader at University Lab School. I love Hawaii and it's people.

My Mom is a physician in Hawaii. Over the years, the time she spends at work has increased. She is also more stressed and worries about being sued. She has had to tell people "no" to taking complex cases and taking call because of the liability risk. She is not able to spend as much time with me and my brother and sister.

When I look at my future, medicine is certainly a consideration, however, unless some changes are made with the malpractice climate here, I won't be practicing in Hawaii. I know that my Mom let the legislature know what is happening and yet I can not understand why you won't do anything. Oh, yes, the lawyers give the legislators much more money that the doctors do. That is so sad!

Please don't listen to the powerful lawyers and listen to the people. They are screaming for help. Access to medical care is a critical issue in Hawaii.

With Aloha, Janae Rasmussen

2/12/2008

testimony

From: John Hunter [hunterj008@hawaii.rr.com]
Sent: Wednesday, February 13, 2008 9:35 AM
To: testimony
Subject: SB2412 & SB2354
Importance: High

Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: John M Hunter, MD
46-133 Punalei Pl
Kaneohe, HI 96744
808-542-3969

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also strongly support limits on attorney fees, which will give more money to an injured plaintiff.

While there is no cure-all for our healthcare problems, medical liability reform is a start. It will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices and leave the state. Hawaii's residents will not get the care they need when they need it most. As the population ages, more people will be requiring quality health care, and unless we make strides to effect change now, we will face a major crisis in the future.

Medical liability reform is an important part of the solution. Texas, Louisiana and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Mahalo,

John M Hunter, MD

2/13/2008

testimony

From: Briana Lau [brielau@gmail.com]
Sent: Wednesday, February 13, 2008 6:21 AM
To: testimony
Subject: Tort Reform

Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Briana Lau
820 15th Avenue
Honolulu, HI 96816

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a medical student at the University of Hawaii John A. Burns School of Medicine and I strongly support SB2412 and SB2354.

As a future practicing physician I have been increasingly concerned about the ability to sustain a medical practice in Hawaii. With the rising prices of malpractice insurance as well as the decreasing amount of medical reimbursements, it appears that Hawaii is becoming less hospitable environment and we need to create incentives for Hawaii's budding physicians to come back to the islands. While there is no magic cure, these bills will assist in achieving this goal.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Thank you for the opportunity to provide this testimony.
Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Sincerely,

Briana Lau

2/13/2008

testimony

From: Kerry Shannon [kshannon36@comcast.net]
Sent: Tuesday, February 12, 2008 11:29 PM
To: testimony
Subject: SENATE MEDICAL LIABILITY REFORM HEARING

Importance: High

This e-mail was originally sent on Monday but for some reason, it was sent back as undeliverable. Although it is past the Tuesday 1 PM deadline, please accept this testimony. Due to the extreme distance, I will be unable to attend in person and I had no control over the e-mail system.

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Kerry Shannon
6942 Prism St SE Lacey WA 98513
360-412-1582 (H) or 808-542-4463 (Cell)

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I was a Hawaii resident for over 35 years. I would like to submit testimony in which I strongly support both SB2412 and SB2354.

As i understand it, these bills will help to stabilize medical malpractice insurance premiums. and to cap "non-economic damages", I support a fair cap of between \$200,000 and \$250,000. Furthermore, I also support strict limits on attorney fees, which will give more money to the injured plaintiff.

While I was living and working in Honolulu, I was injured. Among other injuries, I have a broken back and disc damage in my neck. This condition makes me unable to ever work again. I tried to get medical treatment but found it very difficult to find a doctor who could handle my case or who was willing to handle it. My injury is considered very high risk and given what damages could be awarded in a lawsuit, doctors did not want to risk taking me as a patient. Therefore, I was forced to move to Washington state where I was able to find doctors to treat my condition.

My mother lives on Kauai and is often unable to find a doctor to handle any problems she or my step-father may have. When my step-father recently had heart problems they had to fly him to Oahu for treatment. That delay in treatment cost him his life.

Unless legislators do something now, doctors will continue to leave the state or take only select patients. Hawaii's residents will not get the care they need and will either have to leave the state as I did or pay a very high price as my step-father did.

I believe that reforming the medical liability laws is a very important start to keeping good doctors in Hawaii and keeping them accessible to all people, not just a few low risk ones.

Thank you for the opportunity to provide this testimony.

Windward Eye Physicians and Surgeons

David J. Randell, M.D.

Peter A. Roney, M.D.

George F. Nardin, M.D., M.P.H.

Board Certified Ophthalmologists

Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Senator David Ige, Chair
Senator Carol Fukunaga, Vice Chair
Senate Health Committee

From: Peter Roney, M.D.
46-001 Kamehameha Hwy., Ste. 405
Kaneohe, HI 96744
808-247-5456

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii physician and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, which will give more money to the injured plaintiff.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Sincerely,



Peter Roney, M.D.

Kaneohe Office: 46-001 Kamehameha Highway, Suite 405, Kaneohe, Hawaii 96744 (808) 247-5456

Kailua Office: 407 Ulukoua Street, Suite 214, Kailua, Hawaii 96734 (808) 262-2990

testimony

From: Laurence G Rotkin [rotkin@hawaii.edu]
Sent: Wednesday, February 13, 2008 9:18 AM
To: testimony
Subject: Senate Health Committee Hearing 2/13/06

Please deliver to room 016 for the Senate
> Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

>
> February 13, 2008

>
> To: Sen. David Ige, Chair
> Sen. Carol Fukunaga, Vice Chair
> Senate Health Committee

>
> From: Laurence Rotkin, MD
> 642 Ulukahiki St
> Kailua, HI 96734
> 263-5454

>
> Re: SB2412 Relating to Medical Liability
> SB2354 Relating to Medical Liability

>
> I am a Hospitalist Physician at Castle Medical Center and I strongly support SB2412 and SB2354.

> I have seen access to care erode substantially on the windward side during my 2 years of practice at Castle. We do not have neurosurgical coverage, our orthopedic coverage has been

reduced, and anesthesia coverage is difficult to find. As hospitalist I am often asked to admit patients that I cannot properly care for without subspecialty coverage that is not available.

>
> Both bills will help to stabilize medical malpractice insurance premiums.

> For a cap on non-economic damages, I support a \$250,000 cap, which has been proven by other states to be effective in stabilizing premiums.

> I also support limits on attorney fees, which will give more money to the injured plaintiff.

>
> While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

>
> Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most.

>
> Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

>
> Thank you for the opportunity to provide this testimony.

>
>
> -- Laurence Rotkin, MD
>

Testimony of Bert Sakuda
In Opposition to S.B. No. 2412 and S.B. No. 2354

Thank you for this opportunity to testify in opposition to S.B. No. 2412 and S.B. No. 2354.

A fair solution to the medical malpractice issue must begin with the recognition that malpractice claims are caused by the occurrence of medical malpractice, not by patients who are injured or killed by malpractice. Studies by leading medical institutions such as the Harvard Medical School, Johns Hopkins Medical School and the Institute of Medicine Now leave no doubt that the driving factor in medical malpractice is the astonishing frequency and severity of malpractice.

The Harvard Medical Practice Study of 1990 studied the records of 30,121 patients in 51 New York hospitals during 1984. The study identified medical malpractice only when two separate doctors independently concurred that malpractice had occurred. Its conclusion was that "there is a substantial amount of injury to patients from medical management, and many injuries are the result of substandard care." The study reported: "Even more disturbing was the number of adverse events caused by negligence. We estimated that 27,179 injuries, including 6,895 deaths and 877 cases of permanent and total disability, resulted from negligent care in New York in 1984."

Until the Harvard study, it was popularly believed that the occurrence of malpractice was few and far between. Subsequent studies have shown that the Harvard study was just the tip of the iceberg and that malpractice occurs with widespread regularity. Studies by the Institute of Medicine and Annals of Internal Medicine estimated that between 100,000 to 200,000 patients are killed by malpractice every year. Studies published in the Journal of the American Medical Association and Journal of Health Affairs estimate that medication errors injure or kill three-quarter million patients a year and that 30% of patients receive the wrong medication, improper treatment or incorrect test.

A Johns Hopkins University study found that lawsuits are not driving up health care costs in the United States. The Johns Hopkins study, reported in the Health Affairs Journal, found:

There is a popular misconception that we pay much more for health care in the United States compared to European and other industrialized countries because malpractice claims drive up costs and there are waiting lists in most other countries. But what we found is that we pay more for health care for the simple reason that prices for health services are significantly higher in the United States than they are elsewhere.

There is also a misconception that America suffers from runaway medical malpractice jury verdicts. In fact, the Johns Hopkins University study found that the

average medical malpractice award in the United States is lower than the average award in Britain or Canada.

Every year proponents of limitations on patient rights claim that the number of claims is skyrocketing, yet DCCA statistics show a huge drop in claims over the past six years. Proponents claim that there is a mass of frivolous claims filed annually, yet DCCA statistics show that there is no more than one in some years and none in many other years. Proponents claim that non-economic damages must be capped because of runaway jury verdicts, yet they have not been able to identify a single Hawaii malpractice case where a jury has rendered a runaway award. They claim that California's MICRA restrictions on patient rights will significantly lower insurance premiums, but the fact is that MIEC, which insures doctors in both Hawaii and California, charges much higher premiums for doctors in Los Angeles than in Honolulu.

The reason that proponents of these measures cannot substantiate their claims with Hawaii data is that Hawaii has the best system for preventing the filing of frivolous claims and eliminating weaker claims of any state in the nation. Hawaii requires certification that a doctor has confirmed malpractice before a claim can even be filed; and then processing through the MCCP before a lawsuit can be filed.

It has been acknowledged by California insurers that MICRA's limitations, including caps on non-economic damages, do not work to reduce premiums because non-economic damages are only a small component of the overall cost of insurance. This is reflected by the high cost of insurance in California today . . . decades after MICRA was supposed to solve the problem of high premiums.

This measure seeks to limit attorneys' fees for patients, but not for insurance companies. This proposal gives an unfair advantage to insurance companies by allowing them to spend unlimited resources against patients and does nothing to lower the cost of insurance because patients' attorneys' fees are paid by the patient, not the insurance company. Thus, limiting fees does not reduce the amount of an award to the patient and does not reduce the cost to the insurer. In addition, this measure will simply make it more difficult for patients to obtain competent legal representation.

Patient rights must not be sacrificed by unsubstantiated claims when the real focus must be on improving medical procedures to reduce malpractice from happening in the first place. Only a reduction in malpractice will improve patient safety and reduce claims.

Hawaii Data

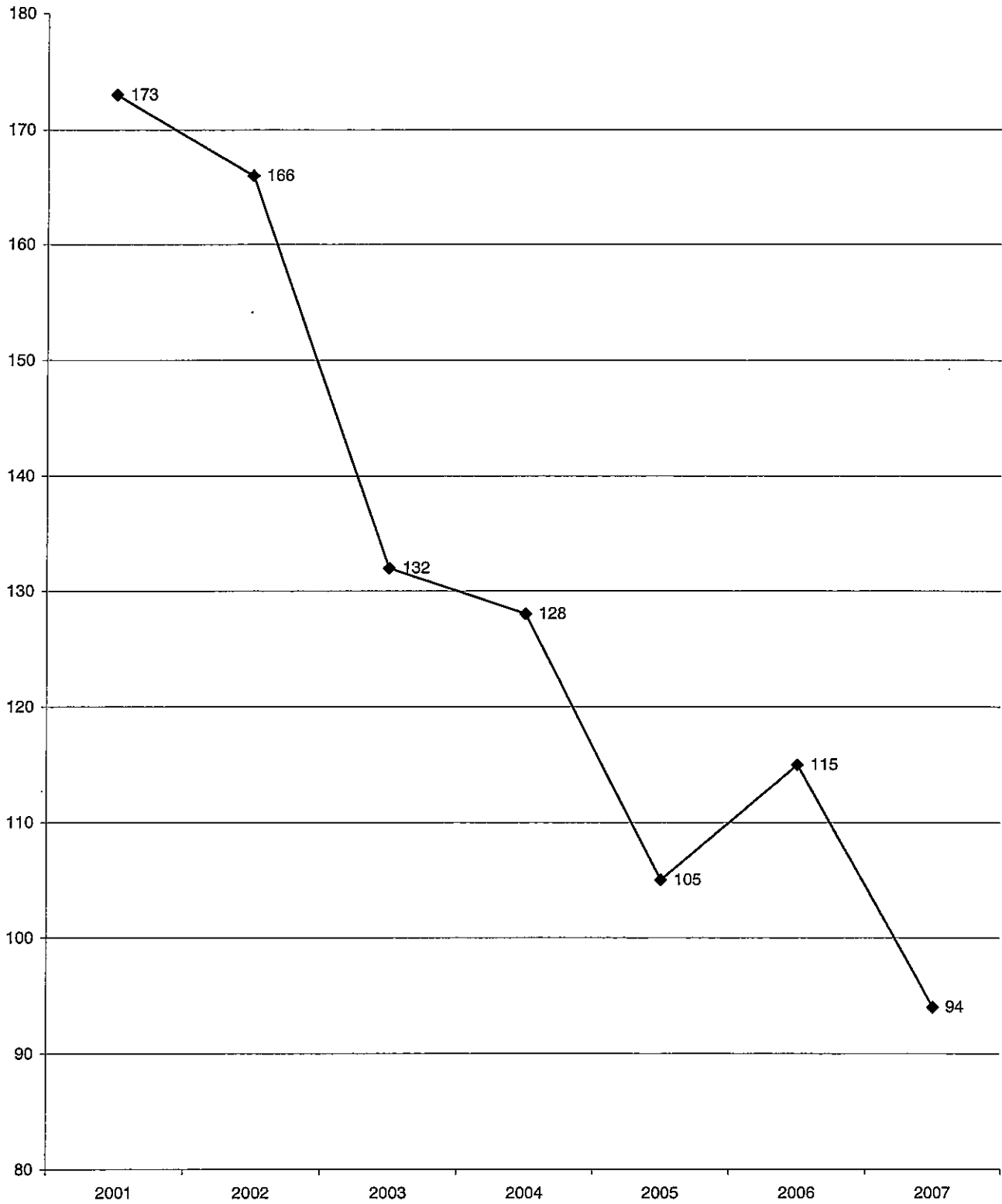
Hawaii Data show without doubt that the number of medical malpractice claims in Hawaii has plummeted over the past six years from 173 MCCP claims in 2001 down to 94 in 2007. The latest MCCP report filed with the legislature this session confirms the drop in the number of claims as reflected in a following graph.

MIEC claims payments have also experienced a similar dramatic drop as confirmed in the latest report of the Insurance Commissioner submitted to the legislature this session. This most recent Insurance Division report documents a steady drop in MIEC claims payments from 8.2 million in 2004 to a current 3.7 million. At the same time, MIEC collected premiums of \$15.3 million. Recent MIEC premiums collected and claims paid as reported by the Insurance Division is reflected in a following chart.

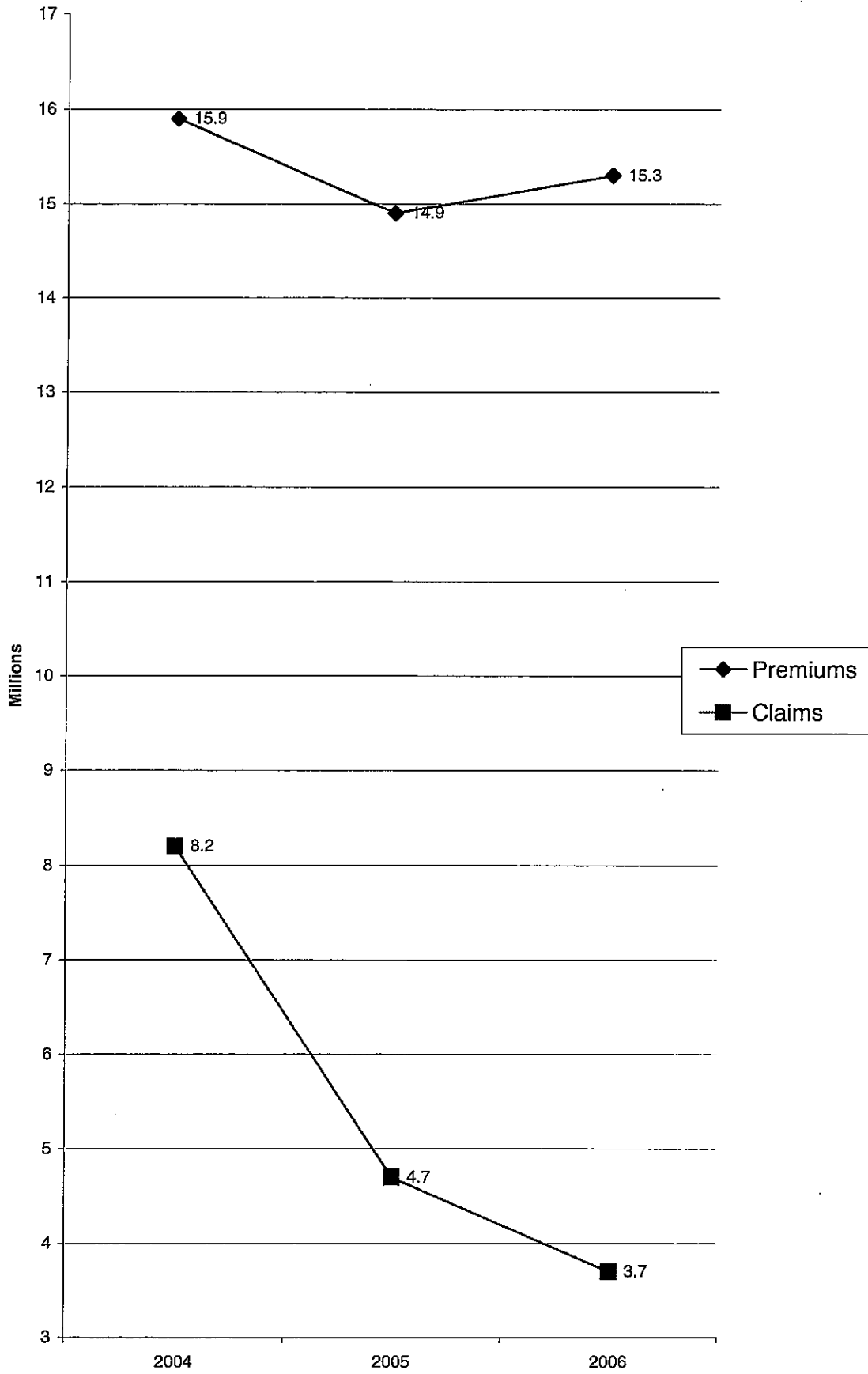
The current National Association of Insurance Commissioners (NAIC) report issued on November 20, 2007, shows a profitable medical malpractice insurance business in Hawaii with a healthy return on net worth of 14.1%.

Charts showing medical malpractice claims in Hawaii as reported by the MCCP, MIEC premiums collected and claims paid as reported by the Insurance Division, a copy of the Insurance Division's report on the profitability of MIEC in Hawaii, and a copy of the NAIC profitability report for medical malpractice insurance in Hawaii follows.

MCCP Claims



MIEC Premiums & Claims



**Table 1: INSURANCE COMPANIES AUTHORIZED TO TRANSACT INSURANCE IN HAWAII
AS OF DECEMBER 31, 2006 (INCLUDING FRATERNAL BENEFIT SOCIETIES)**

NAME OF COMPANY	HAWAII BUSINESS FOR THE YEAR ENDED DECEMBER 31, 2006							
	DIRECT PREMIUMS WRITTEN			CLAIMS BENEFITS PAID				
	LIFE	ANNUITIES	FIRE, CASUALTY, & MISC.	LIFE	ANNUITIES	FIRE, CASUALTY, & MISC.		
FOREIGN - PROPERTY & CASUALTY - Continued								
GREAT AMERICAN ASSUR CO.....	\$	--	\$	2,396,667	\$	--	\$	1,522,418
GREAT AMERICAN INS CO.....	--	--	--	3,774,133	--	--	--	1,360,475
GREAT AMERICAN INS CO OF NY.....	--	--	--	1,541,024	--	--	--	123,495
GREAT AMERICAN SECURITY INS CO.....	--	--	--	--	--	--	--	--
GREAT AMERICAN SPIRIT INS CO.....	--	--	--	--	--	--	--	--
GREAT DIVIDE INS CO.....	--	--	--	3,219,294	--	--	--	1,135,174
GREAT NORTHERN INS CO.....	--	--	--	26,791	--	--	--	--
GREAT NORTHWEST INS CO.....	--	--	--	--	--	--	--	--
GREENWICH INS CO.....	--	--	--	2,420,728	--	--	--	470,647
GUARANTEE INS CO.....	--	--	--	--	--	--	--	--
GUIDEONE MUT INS CO.....	--	--	--	2,249	--	--	--	--
HANOVER INS CO.....	--	--	--	462,227	--	--	--	--
HARBOR POINT REINS US INC.....	--	--	--	863	--	--	--	--
HARLEYSVILLE MUT INS CO.....	--	--	--	15,821	--	--	--	--
HARTFORD ACCID & IND CO.....	--	--	--	(78)	--	--	--	(39,947)
HARTFORD CAS INS CO.....	--	--	--	693,220	--	--	--	898
HARTFORD FIRE IN CO.....	--	--	--	3,145,262	--	--	--	592,486
HARTFORD INS CO OF THE MIDWEST.....	--	--	--	16,597	--	--	--	3,523
HARTFORD STEAM BOIL INSPEC & INS CO.....	--	--	--	2,830,874	--	--	--	1,511,160
HARTFORD STEAM BOIL INSPEC INS CO CT.....	--	--	--	--	--	--	--	--
HARTFORD UNDERWRITERS INS CO.....	--	--	--	32,304,533	--	--	--	15,536,017
HERITAGE CASUALTY INS CO.....	--	--	--	--	--	--	--	--
HERITAGE IND CO.....	--	--	--	1,757,532	--	--	--	873,365
HOMESITE INS CO.....	--	--	--	--	--	--	--	--
HSBC INS CO OF DE.....	--	--	--	--	--	--	--	--
HUDSON INS CO.....	--	--	--	594,137	--	--	--	(16,182)
ICAT SPECIALTY INS CO.....	--	--	--	1,471,275	--	--	--	--
IDS PROP CAS INS CO.....	--	--	--	301,455	--	--	--	4,091
ILLINOIS NATL INS CO.....	--	--	--	1,709,662	--	--	--	299,768
INDEMNITY CO OF CA.....	--	--	--	117,522	--	--	--	--
INDEMNITY INS CO OF NORTH AMER.....	--	--	--	2,844,366	--	--	--	1,708,359
INDEPENDENCE AMER INS CO.....	--	--	--	--	--	--	--	--
INFINITY INS CO.....	--	--	--	--	--	--	--	--
INSURANCE CO OF NORTH AMER.....	--	--	--	(678,815)	--	--	--	152,052
INSURANCE CO OF THE STATE OF PA.....	--	--	--	9,923,631	--	--	--	13,242,561
INSURANCE CO OF THE WEST.....	--	--	--	1,258,404	--	--	--	(484)
INTEGON NATL INS CO.....	--	--	--	--	--	--	--	--
INTERINS EXCH OF THE AUTOMOBILE CLUB.....	--	--	--	1,204,234	--	--	--	242,345
INTERNATIONAL FIDELITY INS CO.....	--	--	--	277,032	--	--	--	--
INTERSTATE IND CO.....	--	--	--	(25,417)	--	--	--	--
INTREPID INS CO.....	--	--	--	--	--	--	--	--
JEWELERS MUT INS CO.....	--	--	--	991,179	--	--	--	402,921
KEMPER CAS INS CO.....	--	--	--	--	--	--	--	--
LANCER INS CO.....	--	--	--	21,083	--	--	--	59
LANDMARK INS CO.....	--	--	--	--	--	--	--	--
LAWYERS TITLE INS CORP.....	--	--	--	483,934	--	--	--	(7,488)
LEXINGTON NATL INS CORP.....	--	--	--	--	--	--	--	--
LEXON INS CO.....	--	--	--	121,088	--	--	--	--
LIBERTY INS CORP.....	--	--	--	4,038,075	--	--	--	968,393
LIBERTY INS UNDERWRITERS INC.....	--	--	--	2,396,214	--	--	--	505,182
LIBERTY MUT FIRE INS CO.....	--	--	--	44,176,669	--	--	--	19,830,168
LIBERTY MUT INS CO.....	--	--	--	12,178,053	--	--	--	1,576,593
LINCOLN GENERAL INS CO.....	--	--	--	2,144,936	--	--	--	156,288
LM INS CORP.....	--	--	--	92,544	--	--	--	--
LM PROPERTY AND CASUALTY INS. CO.....	--	--	--	--	--	--	--	--
LUMBERMENS MUT CAS CO.....	--	--	--	76,789	--	--	--	492,791
LYNDON PROPERTY INS CO.....	--	--	--	77,103	--	--	--	20,038
MAJESTIC INS CO.....	--	--	--	124,180	--	--	--	596,006
MAPFRE INS CO.....	--	--	--	--	--	--	--	--
MARKEL AMERICAN INS CO.....	--	--	--	559,240	--	--	--	37,026
MARKEL INS CO.....	--	--	--	57,601	--	--	--	3,140
MARYLAND CAS CO.....	--	--	--	(56,307)	--	--	--	76,715
MBIA INS CORP.....	--	--	--	5,769,146	--	--	--	--
MBIA INS CORP OF IL.....	--	--	--	--	--	--	--	--
MEDICAL ASSUR CO INC.....	--	--	--	240	--	--	--	375,014
MEDICAL INS EXCH OF CA.....	--	--	--	15,310,509	--	--	--	3,707,040
MEDICAL PROTECTIVE CO.....	--	--	--	(1,980)	--	--	--	--
MEDMARC CAS INS CO.....	--	--	--	31,534	--	--	--	--
MENDOTA INS CO.....	--	--	--	--	--	--	--	--
MERCHANTS BONDING CO (MUTUAL).....	--	--	--	28,889	--	--	--	--
MERITPLAN INS CO.....	--	--	--	--	--	--	--	--
METROPOLITAN PROPERTY & CAS INS CO.....	--	--	--	437,686	--	--	--	150,927
MGIC ASSUR CORP GENERAL ACCOUNT.....	--	--	--	--	--	--	--	--
MGIC CREDIT ASSUR CORP.....	--	--	--	6,592	--	--	--	--

2006 Profitability Report Hawaii

	Percent of Direct Premiums Earned								Percent of Net Worth						
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(8A)	(8B)	(8C)	(9)	(10)	(11)	(12)
Line Of Business	Direct Premiums Earned (000s)	Losses Incurred	Loss Adjust Expense	General Expense	Selling Expense	Taxes License Fees	Divs To Plyhldr	Under- Writing Profit	Invest Gain On Ins Trans	Tax On Ins Trans	Profit On Ins Trans	Earned To Net Worth	Inv Gain On Net Worth	Tax On Inv Gain On Net Worth	Return On Net Worth
Private Passenger Auto Liability	418,710	45.1	8.5	5.7	14.9	3.7	0.4	21.6	5.5	8.9	18.2	105.7	5.4	1.3	23.3
Private Passenger Auto Physical	240,866	53.8	9.5	5.6	14.7	3.7	0.5	12.3	1.2	4.6	8.9	160.0	5.4	1.3	18.3
Private Passenger Auto Total	659,576	48.2	8.9	5.7	14.8	3.7	0.4	18.2	3.9	7.3	14.8	120.6	5.4	1.3	21.9
Commercial Auto Liability	91,549	37.8	8.0	5.6	17.0	2.4	0.0	29.2	6.7	11.9	24.1	85.1	5.3	1.3	24.5
Commercial Auto Physical	25,480	46.8	7.2	6.4	17.8	2.0	0.0	19.8	1.1	7.2	13.7	132.8	5.3	1.3	22.2
Commercial Auto Total	117,029	39.7	7.8	5.8	17.2	2.3	0.0	27.2	5.5	10.8	21.8	92.3	5.3	1.3	24.2
Homeowners Multiple Peril	252,216	14.6	4.0	4.6	18.3	3.2	0.6	54.7	3.7	20.0	38.4	115.1	5.3	1.3	48.2
Farmowners Multiple Peril	582	26.3	13.2	5.7	41.0	0.4	0.0	13.5	2.0	5.2	10.2	130.5	5.9	1.4	17.8
Commercial Multiple Peril	141,912	41.4	11.3	5.7	23.1	2.6	0.0	15.9	7.2	7.3	15.8	81.9	5.4	1.3	17.0
Fire	63,684	15.4	1.5	5.5	16.6	1.4	0.1	59.4	2.5	21.4	40.6	111.3	5.4	1.3	49.2
Allied Lines	77,454	36.1	3.5	4.5	14.8	1.6	0.2	39.4	2.3	14.3	27.3	129.1	5.4	1.3	39.4
Inland Marine	43,020	96.1	6.6	4.9	19.0	3.2	0.1	(29.8)	3.3	(9.6)	(16.9)	109.0	5.4	1.3	(14.3)
Medical Malpractice	37,907	36.8	34.5	5.6	8.8	2.6	4.1	7.7	14.9	6.3	16.3	61.6	5.4	1.3	14.1
Other Liability	313,823	31.8	17.9	4.3	21.2	1.9	0.0	22.9	11.1	10.7	23.3	63.2	5.4	1.3	18.8
Workers Compensation	362,945	38.5	8.6	5.3	11.6	4.7	0.1	31.2	5.6	12.3	24.5	72.1	5.4	1.3	21.7
All Other	182,148	68.2	5.9	7.8	16.1	3.5	0.0	(1.5)	6.5	1.1	4.0	75.4	5.4	1.3	7.0
Total All Lines	2,252,296	40.7	9.4	5.4	16.3	3.3	0.3	24.6	5.8	10.0	20.3	89.2	5.4	1.3	22.2

It is once again claimed that caps on non-economic damages will solve the on-call crisis in our hospitals. Proponents, however, completely ignore the fact that the Legislative Reference Bureau conducted a comprehensive investigation into and issued its report in 2006 entitled "On-Call Crisis in Trauma Care: Government Responses." The LRB study confirmed that the major causes of the on-call physician shortage in Hawaii were: (1) inadequate or uncompensated care due to treatment of the uninsured and significant decreases in reimbursement rates by government and private health insurers, (2) adverse lifestyle effects on physician private practices, family and recreational lifestyles, (3) a national shortage of trauma specialties, (4) the increasing number of specialists who no longer need hospital privileges because they work in outpatient surgical centers, and (5) the decrease in the number of physician training slots available for trauma specialties. The LRB study, in contrast, found that data on the effect of medical malpractice liability insurance was insufficient to conclude that it was a significant factor.

Texas Data

The restriction on recovery of non-economic damages is modeled on the California MICRA legislation passed in 1975. Proponents of these restrictions no longer reference California because 30 years of experience with MICRA has shown that caps on damages do not significantly affect medical malpractice premiums. Instead, proponents now point to an increase in the number of physicians in Texas and a reduction of medical malpractice claims there as proof that capping non-economic damages is the solution to their perceived medical malpractice crises. Texas data shows that capping non-economic damages was not the factor responsible for reduced medical malpractice claims and has not significantly increased rural access to health care. In addition, the Texas data shows that there are significant differences in the legal handling of medical malpractice claims (where there is no MCCP procedure and pre-filing requirement of a certificate of merit documenting that a physician of the same specialty has reviewed the claim and deemed it meritorious), in the medical malpractice insurance situation, and in the general growth of each state's economies.

The Texas Department of Insurance reports the number of medical malpractice claims made in the state. Its most recent report of claims for the year 2005 show that there were 5,350 medical malpractice claims filed for cases valued at \$10,000 or less. There are approximately another 1,000 claims with payments in excess of \$10,000. A copy is attached as Exhibit 1.

There is no comparison between the litigation climate in Texas with over 6,000 claims per year and Hawaii with just 94 claims in 2007. In addition, a study of medical malpractice claims in Texas by professors at the University of Texas, University of Illinois and Columbia University found that there was no correlation between skyrocketing medical malpractice insurance premiums and claims in Texas. This is the most comprehensive study of medical malpractice claims and insurance premiums ever undertaken in the United States covering 15 consecutive years of claims in Texas

between 1988 and 2002. The study confirmed that the so-called medical malpractice crises was caused by insurance market dynamics and was not related to claims.

We do not find evidence in claim outcomes of the medical malpractice insurance crises that produced headlines over the last several years and led to legal reform in Texas and other states. At least in Texas, the rapid rise in insurance premiums that sparked the crises may reflect, in significant part, insurance market dynamics rather than changes in claim outcomes.

A copy of the study is attached as Exhibit 2.

Texas medical malpractice insurers have determined that the cap on damages does not significantly lower premiums. The Medical Protective Company, subsidiary of the nation's largest medical malpractice insurance company GE Insurance, is one of the largest medical malpractice insurers in the State of Texas with earned premiums of over \$82 million in 2006 as reported by the Texas Department of Insurance. The medical protective company submitted an actuarial analysis of the impact of the Texas \$250,000 cap on non-economic damages and stated: "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%." The actuarial report cautioned: "When applied to premium rates, the savings will be even less." The actuarial report and calculation is attached as Exhibit 3. This actuarial calculation that capping non-economic damages has no significant impact on premiums is consistent with Medical Malpractice Insurance Company actuarial analyses of capping non-economic damages in California. The Southern California Physician Insurance Exchange which had 30 years of experience with the California MICRA cap on non-economic damages of \$250,000, submitted an actuarial analysis to the California court on April 30, 2003. It confirmed that the cap had no substantial impact on medical malpractice insurance in California:

While MICRA was the legislature's attempt at remedying the medical malpractice crises in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California. MICRA placed a cap of \$250,000 per claimant on non-economic damages, defined as pain and suffering, inconvenience, etc.

A copy of the actuarial analysis is attached as Exhibit 4.

Proponents of the cap on non-economic damages claim that it should be adopted in Hawaii to solve the rural patient access shortage because it has solved and eliminated the rural patient access problem in the State of Texas. Data from Texas, however, confirms that the rural access problem has not been solved and has not been significantly impacted by tort reform. Just this past summer, the Texas Department of State Health Services issued a study entitled "Highlights: The Supply of Pediatricians in Texas – 2006." The study showed that there is a "persistent geographic maldistribution

of the supply of pediatricians in rural and inner-city communities” in Texas. The study found that the ratio of the number of pediatricians per 100,000 children actually had a significantly higher rate of increase before the passage of tort reform than after tort reform was enacted. The study documents that there were 11.9 pediatricians per 100,000 children in rural communities in 1996. That number increased to 16.9 pediatricians (an increase of five more) just four years later in 2000. However, following the enactment of tort reform in 2003, that number increased by only one to 17.9 pediatricians per 100,000 children. By contrast, the increase in pediatricians in the major urban cities of Texas increased during that same time between 1996 and 2006 from 33 per 100,000 to 47.4 (an increase of 14.4). The Texas data thus conclusively shows that following tort reform, physicians flocked to the city as in all other states (with or without tort reform) and that tort reform did not significantly solve the Texas rural doctor problem.

The study confirmed that there continued to be a significant shortage of all types of doctors (not just pediatricians) in rural Texas: “As of April 2007, 111 Texas counties were designated as whole County Health Professional Shortage areas . . . 84 were rural counties.” The data by the Texas Department of State Health Services documents that tort reform passed four years earlier has not in fact solved the rural doctor access problem in Texas.

The study analyzed the reasons for the rural doctor shortage and concluded that the primary reasons were: (1) lack of health insurance coverage in rural and underserved areas, (2) size of community too small to support a profitable medical practice, (3) “health professionals’ attitudes and exposure to rural and urban underserved areas,” (4) lower proportion of recent medical school graduates practicing in rural settings, (5) “the increase of female physicians and their tendency to practice in urban areas,” and (6) “the racial/ethnic disparities in physician distribution.” Medical malpractice was not even mentioned as a factor in the rural doctor shortage crisis.

The study also addressed the shortage of specialists in areas such as obstetrics-gynecology and orthopedic surgery. The study confirmed a shift among medical students to specialties that provide “controllable lifestyle . . . with practice styles that allow for more control over the timing and number of hours worked, and more personal time for leisure, family and avocational pursuits.” It noted that obstetrics-gynecology, orthopedic surgery and general surgery fell under the “uncontrollable lifestyle specialty category” that have fallen out of favor with medical students.

The study concluded by confirming that “Due to disproportionate distribution of general pediatricians, rural and underserved areas continue to suffer severe shortages despite a 45% increase in the supply ratio in Texas.” Thus, doctors in Texas continue to favor urban practices rather than rural practices, and the trend after tort reform is for an even smaller proportion to practice in rural areas of Texas. A copy of the Texas Department of State Health Services report is attached as Exhibit 5.

A recent study of doctor distribution in Texas published in October 2007 by the Texas Observer confirmed the results of the Texas Department of State Health Services study. The Texas Observer study is attached as Exhibit 6. The study found that there were 152 counties in Texas that did not have any obstetricians in 2003 before tort reform was enacted, and that there were still 152 counties in Texas without obstetricians as of September 2007. The study further found that there were more Texas counties without any physicians at all after tort reform was passed in 2003 than before.

The Texas media continues to highlight the critical shortage of doctors in rural Texas. An article published this past November by the Austin Bureau of the Globe-News reported that 28 counties in West Texas have no doctors at all. The dean of the medical school at Texas Tech University declared that "It is definitely a very critical problem . . . we have a shortage of doctors in the United States but it is more severe in West Texas."

The article points out that the Texas Office of Rural Community Affairs offers stipends of \$15,000 to doctors willing to work in a rural community for at least a year. The program director, however, stated: "We are seeing a downward trend in applicants. Most doctors, especially those just out of medical school, are not all that interested in moving to rural areas." A copy of the article is attached as Exhibit 7.

The reason Texas is attracting new doctors is obvious from even a cursory look at Texas doctor want ads. Those ads show positions for orthopedic surgeons paying between \$800,000 - \$1 million, neurosurgeons paying \$750,000 plus productivity bonuses, dermatologists paying \$500,000, cardiologists paying \$450,000 plus a \$25,000 signing bonus plus relocation and loan payment assistance, internal medicine paying \$300,000 plus full benefits, neurology paying \$425,000 plus signing bonus, gastroenterology paying \$400,000 plus signing bonus, relocation allowance and full benefits, and ob-gyn paying \$270,000 plus \$20,000 signing bonus, \$10,000 relocation assistance plus benefits and retirement. Texas want ads for physicians are attached as Exhibit 8.

The astronomical rise in oil prices over the past five years has led to a boom in the Texas economy that has resulted in a population growth that is twice the national average. This booming economy has fueled a demand for professional services with commensurately high compensation. This phenomenon is not restricted to doctors. Just last month, the Texas Lawyer published a review of 2007 Christmas bonuses for new lawyers in Texas as well as their current starting pay. The current Texas starting base salary for first year lawyers fresh out of law school is now \$160,000. 2007 Christmas bonuses ranged from \$10,000 to \$120,000 with the majority appearing to be in the \$50,000 to \$80,000 range. The Texas Lawyer article is attached as Exhibit 9.

Conclusion

When emotion is set aside and data is examined, an objective analysis of the medical malpractice insurance situation leads to the obvious conclusion that there is an insurance problem, not a claims problem in Hawaii given the undeniable declines in both the number of claims and claims payments. Capping non-economic damages does not result in substantial reduction in premiums, while having significant impact on the individual patient who has suffered significant injury due to medical malpractice. The enormous disparity between premiums collected and claims paid shows that high premiums are not being driven by high claims and that there is ample room for significant reduction of premiums without any compromise of patient rights or quality of care.

We appreciate this opportunity to testify and ask that the Committee not pass legislation restricting patient rights.

*The 2005 Texas Liability Insurance
Closed Claim Annual Report*



Texas Department of Insurance

EXHIBIT 1

2005 Calendar Year Annual Aggregate Closed Claim Report

The 2005 Calendar Year Annual Aggregate Closed Claim Report was filed on an annual basis for bodily injury indemnity payments of \$10,000 or less. Three hundred forty-eight insurance companies and five self-insured entities are included in the Annual Aggregate Closed Claim Database. A summary of the Aggregate Closed Claim Report is presented below.

	(1) Aggregate Number of Claims \$0 Indemnity Payments	(2) Aggregate Number of Claims \$1 to \$10,000 Indemnity Payments	(3) Total Number of Claims (1 + 2)	(4) Aggregate Dollar Amount Paid Out
General Liability	21,968	3,421	25,389	\$8,653,842
Other Professional Liability	4,600	125	4,725	\$425,810
Commercial Auto Liability	19,325	17,000	36,325	\$57,399,603
Commercial Multi-peril Liability	7,060	2,520	9,580	\$6,713,057
Medical Professional Liability	5,152	198	5,350	\$793,422
Total	58,105	23,264	81,369	\$73,985,734

**STABILITY, NOT CRISIS: MEDICAL MALPRACTICE CLAIM
OUTCOMES IN TEXAS, 1988-2002**

Bernard Black,^{*} University of Texas
Charles Silver,^{**} University of Texas
David A. Hyman,^{***} University of Illinois
William M. Sage,^{****} Columbia University

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^{*}Hayden W. Head Regents Chair for Faculty Excellence, University of Texas Law School, and Professor of Finance, University of Texas, Red McCombs School of Business. Tel. 512-471-4632, email: bblack@law.utexas.edu

^{**}McDonald Endowed Chair in Civil Procedure, University of Texas Law School. Tel. 512-232-1337, email: csilver@law.utexas.edu

^{***}Professor of Law and Medicine, University of Illinois. Tel. 410-706-2147, email: dhyman@law.uiuc.edu

^{****}Professor of Law, Columbia Law School. Tel. 212-854-5332, email: wsage@law.columbia.edu

STABILITY, NOT CRISIS: MEDICAL MALPRACTICE CLAIM OUTCOMES IN TEXAS, 1988-2002

Bernard Black, Charles Silver, David A. Hyman and William M. Sage

<http://ssrn.com/abstract=678601>

Abstract

Using a comprehensive database of closed claims maintained by the Texas Department of Insurance since 1988, this study provides evidence on a range of issues involving medical malpractice litigation, including claim frequency, payout frequency, payment amounts, defense costs, and jury verdicts. The data present a picture of stability in most respects and moderate change in others. We do not find evidence in claim outcomes of the medical malpractice insurance crisis that produced headlines over the last several years and led to legal reform in Texas and other states. At least in Texas, the rapid rise in insurance premiums that sparked the crisis may reflect, in significant part, insurance market dynamics rather than changes in claim outcomes.

Controlling for population growth, the number of large paid claims (over \$25,000 in real 1988 dollars) was roughly constant from 1990-2002. The number of smaller paid claims declined. Controlling for inflation, payout per large paid claim increased over 1988-2002 by an estimated 0.1% (insignificant) - 0.5% (marginally significant) per year, depending on the dataset we use to define "medical malpractice" claims. Jury awards increased by an estimated 2.5% (insignificant) - 3.6% (barely significant) per year, depending on the dataset, but actual post-verdict payouts in tried cases showed little or no time trend. Real defense costs per large paid claim rose by 4.2-4.5% per year. Real total cost per large paid claim, including defense costs, rose by 0.8-1.2% per year.

STABILITY, NOT CRISIS: MEDICAL MALPRACTICE CLAIM OUTCOMES IN TEXAS, 1988-2002

Bernard Black, Charles Silver, David A. Hyman and William M. Sage *

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I. INTRODUCTION

The medical malpractice (“med mal”) “crises” of the 1970s, 1980s, and 2000s had the same cause: sharp spikes in insurance premiums. They also had the same political effect: demands by doctors and hospitals for liability-reducing reforms. Health care providers sought caps on pain and suffering and punitive damages, limits on contingent fees, abrogation of the collateral source rule, screening panels, and pre-filing expert reports, among other changes. In many states, including Texas, they got at least some of what they wanted. President George W. Bush has made federal legislation limiting malpractice liability a priority for his second term.

Attempts to address insurance crises by reforming liability rules assume that insurance rates are closely linked to claim outcomes. Med mal liability is the disease, insurance rate spikes are the symptoms. This has been disputed. Researchers who study the tort system have found only a loose connection between changes in filings and outcomes and premium spikes.¹ If the connection between tort processes and insurance rates is weak, liability reforms may not prevent future insurance crises.

To determine whether litigation outcomes are tightly connected to malpractice insurance rates, one needs good data on claim outcomes, including claim frequency and payout frequency and amounts, from both jury verdicts and settlements. Historically, these data have been lacking. To address this problem, Texas and a handful of other states require insurance carriers to file reports of closed claims.² Until recently, however, academic researchers have ignored these databases. Only the states themselves have studied them, and their reports have serious shortcomings.

In this article, we examine fifteen years of closed medical malpractice claim reports gathered by the Texas Department of Insurance (*TDI*). Texas is the second most populous state in the country and was among those identified by the American Medical Association as being caught in the recent malpractice insurance crisis.³ Texas began collecting closed claim reports after the prior insurance crisis in the 1980s. The Texas Closed Claim Database (*TCCD*) is rich in length (1988-2002), comprehensive in covering all closed claims, and provides detailed information about payments, defendants, trial outcomes, defense costs, and other matters.⁴

¹ See, e.g., Tom Baker, *Medical Malpractice Insurance Reform: “Enterprise Insurance” and Some Alternatives in MEDICAL MALPRACTICE REFORM IN THE UNITED STATES: NEW CENTURY, DIFFERENT ISSUES* (Ronen Kersh and William Sage, eds., forthcoming 2005); Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle* (working paper 2005), <http://ssrn.com/abstract=616281> (arguing that “the insurance cycle, not dramatic changes in medical malpractice claim payments,” underlay the early 2000s malpractice crisis); Katherine Baicker and Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care* (NBER Working Paper 10709, 2004), at <http://ssrn.com/abstract=583707> (finding “a fairly weak relationship between malpractice payments . . . and premiums—both overall and by specialty”).

² See, e.g., TEXAS DEPARTMENT OF INSURANCE, 2002 TEXAS LIABILITY INSURANCE CLOSED CLAIM ANNUAL REPORT 1 (2004), at <http://www.tdi.state.tx.us/general/forms/report4.html> (Texas established its reporting requirement to address “an absence of reliable information concerning liability insurance claims, related court actions and other information pertinent to the claims settlement process and the civil justice system in Texas”).

³ AMERICAN MEDICAL ASSOCIATION, *AMA ANALYSIS: A DOZEN STATES IN MEDICAL LIABILITY CRISIS* (June 2002).

⁴ Florida maintains a similar but less comprehensive database of closed insurance claims. In contemporaneous work, Neil Vidmar and coauthors have used this dataset to study medical malpractice claims in Florida for 1990-

The *TCCD* allows us to assess changes over time in the number and cost of malpractice claims. We find that malpractice claims and payments were stable over the period for which we have data. More specifically (unless otherwise noted, all dollar values in this article are in real 1988 dollars):

- Adjusted for population growth, the total number of closed claims, the number of “large” paid claims (payouts of at least \$25,000 in 1988 dollars), and the percentage of claims that produced large payouts were stable over 1990-2002. Adjusted for physician growth (a measure of the intensity with which people use the health care system), the total number of paid claims and the number of large paid claims declined.⁵
- The number of smaller paid claims (less than \$25,000 in 1988 dollars) declined sharply.
- Mean and median payouts per large paid claim rose by an estimated 0.1 (insignificant) - 0.5% (marginally significant) per year over 1988-2002. The mean payout in 2002 was about \$528,000 and the median was about \$200,000, in 2002 dollars.
- In large paid claim cases that were tried, jury verdicts increased by an estimated 2.5% - 3.6% per year, with the increase and its significance depending on the dataset we use. However, actual post-verdict payouts showed little or no time trend.
- Total payouts to patients were about \$515 million in 2002 (in 2002 dollars) and were roughly constant over time. In 2002, total payouts equaled about 0.6% of total Texas health care spending (\$93 billion in 2002 dollars).
- Defense costs per large paid claim rose by 4.2-4.5% per year, depending on the dataset, but the increase was gradual and the dollars involved are a fraction of payout dollars. (We lack data on defense costs for zero-payout and small payout claims.)
- Total cost (payout plus defense cost) per large paid claim rose by 0.8-1.2% per year, depending on the dataset. The total annual cost for all large paid claims was roughly flat as a percentage of Texas Gross State Product or Texas health expenditures.
- Paid claims averaged 4.6 per 100 practicing Texas physicians per year in 2000-2002, down from 6.4 per 100 physicians per year in 1990-1992. Total claims averaged 25 per 100 physicians per year in 2000-2002, of which about 80% closed with no payout.

This evidence suggests that no crisis involving malpractice claim outcomes occurred. It thus also suggests a weak connection between claims-related costs and short-to-medium term fluctuations in insurance premiums. If so, litigation reforms may not prevent future insurance crises. To be sure, malpractice claims typically involve a several year lag between initial claim and payout. It is theoretically possible that the spike in insurance premiums was driven by a spike in number of new claims or expected cost per claim that is not yet reflected in the closed claims that we study. But the more likely explanation is that the rise in premiums reflects insurance market dynamics, and not litigation dynamics.

2001. See Neil Vidmar, Paul Lee, Kara MacKillop, Kieran McCarthy and Gerald McGwin, *Seeking the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, DEPAUL L. REV. (forthcoming 2005).

⁵ *TDI* found evidence of incomplete claim reporting for 1988 and 1989. Thus, our statements about trends in number of claims rely on data from 1990-2002.

To offer evidence that the medical malpractice claims process is not in crisis is not to defend the malpractice litigation system, which has important known problems. Nor is it to suggest that the current level of malpractice litigation is optimal. Our hope is that better understanding of the claims process will lead to reforms that address real shortcomings in the malpractice litigation and claims payment systems, rather than respond to anecdotes or the rhetoric of crisis.

Part II describes the state closed claim databases and the limited work that has been done on them. Part III provides details on our dataset. Part IV discusses our principal results. Part V describes limitations and complications that result from our use of closed claim data and lack of access to data on open claims. Part VI concludes.

II. STATE CLOSED CLAIM DATABASES

Table 1 lists the non-proprietary closed claim databases of which we are aware, the periods they cover, and whether researchers have access to claim data.⁶ The only national database, the National Practitioner Data Bank, covers only physicians, not hospitals, and has problems as to completeness.⁷ Only Florida and Texas make claim reports, without identifying information, available to researchers. An appendix, available from the authors on request, summarizes the information on medical malpractice claims and payouts over time that is available from the states' reports on their own databases.

⁶ NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MALPRACTICE CLAIMS: FINAL COMPILATION, MEDICAL MALPRACTICE CLOSED CLAIMS, 1975-1978 (1981). The Physicians Insurance Association of America has maintained a closed claim database since 1985 but does not make its data available to researchers (we asked). Some other private databases of uncertain completeness also exist. For example, Jury Verdict Research, Westlaw, and Lexis collect information on jury verdicts and settlements.

⁷ See, e.g., Lawrence Smart, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW AND CONTEMPORARY PROBLEMS 59-79 (1997); Joseph Hallinan, *Attempt to Track Malpractice Cases is Often Thwarted*, WALL STREET JOURNAL, Aug. 27, 2004, at 1.

Table 1. Non-Proprietary Closed Claim Databases

All non-proprietary closed claim databases of which we are aware, the periods they cover, and whether information on individual claims is publicly available, and hence available to researchers.

National databases	Years covered	Researcher access
National Association of Insurance Commissioners	1975-1978	No
National Practitioner Data Bank	1990-present	yes
State databases		
Florida	1975-present	yes
Illinois	1980-present	No
Missouri	1979-present	No
Minnesota	1982-1987	No
Massachusetts	1987-present	No
Nevada	2002-present	No
Texas	1988-present	yes

No academic study has previously used the *TCCD* to examine malpractice litigation.⁸ One recent study by Neil Vidmar and coauthors uses the Florida database to assess changes in malpractice claim frequencies and payouts over time.⁹ Vidmar et al. study closed Florida claims from 1990 through 2003. They have data on claims against *non-self-insured* entities (many hospitals and some physicians self-insure), which were closed *with* payments for the entire period; and on claims closed *without* payment for 1990-1997 (after which Florida ceased collecting this information). They do not have data on jury verdicts. Vidmar et al. report that total claim frequency was stable over 1990-1997, averaging about 2,600 per year. The number of zero-payment claims dropped over this period. The number of paid claims increased over 1990-2003, but roughly in line with Florida's population growth and more slowly than its supply of physicians. The number of paid claims per 100,000 Florida residents declined slightly from 9.96 in 1990 to 9.74 in 2003, and the number of paid claims per 100 doctors fell from 3.98 in 1990 to 3.33 in 2002.

Turning to payment amounts, Vidmar et al. found that mean (median) payments for paid claims increased substantially. In real 2003 dollars, the mean (median) payment increased from \$177,000 (\$49,000) in 1990 to \$300,000 (\$150,000) in 2003. The authors attribute these changes to (1) a significant increase in the severity of the injuries claimants sustained, and (2) larger awards within injury severity categories, possibly driven by the growing cost of health

⁸ The only uses we know of are summary annual reports published by *TDI* and brief discussion in a study commissioned by a partisan interest group as part of the tort reform debate in Florida. See FLORIDA HOSPITAL ASSOCIATION, *MEDICAL MALPRACTICE ANALYSIS* (2002) (prepared by Milliman USA, Inc.). The only academic uses of the *TCCD* we know of are Herbert J. Kritzer, *Advocacy and Rhetoric vs. Scholarship and Evidence in the Debate over Contingency Fees: A Reply to Professor Brickman*, 82 WASHINGTON UNIVERSITY LAW QUARTERLY 477 (2004); and Martin Grace, *Tort Reform: Are There Real Benefits?* (working paper 2004), at <http://www.rmi.gsu.edu/rmi/research/papers/tortreformarethererealbenefitsaug2004.pdf>. Neither article focuses on medical malpractice.

⁹ See Vidmar et al. (2005), *supra* note 4. Several studies use the Florida database but do not study claim frequency or payouts over time. See Frank A. Sloan and Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW AND SOCIETY REVIEW 997 (1990); FRANK A. SLOAN, PENNY B. GITHEN, ELLEN WRIGHT CLAYTON, GERALD B. HICKSON, DOUGLAS A. GENTILE, AND DAVID F. PARTLETT, *SUNG FOR MEDICAL MALPRACTICE* (1993); James W. Hughes and Edward A. Snyder, *Litigation and Settlement Under the English and American Rules: Theory and Evidence*, 38 JOURNAL OF LAW AND ECONOMICS 225 (1995).

care. Vidmar et al. did not perform a regression analysis to estimate the relative importance of these or other factors.

III. THE TEXAS CLOSED CLAIMS DATABASE

Texas is a useful setting for assessing trends in health care, including medical malpractice. Texas is the 2nd largest state measured by population and the 3rd largest in total health care spending. It is often thought to be a pro-plaintiff state. During the period we study, it enacted only limited medical malpractice reforms, and thus offers a good laboratory to study a mostly “unreformed” jurisdiction. The principal legal change during this period was 1995 tort reform which capped punitive damages and de facto required plaintiffs in medical malpractice cases to provide an expert report supporting their claim at the time of filing a lawsuit.¹⁰

A. Description of the Data

The *TCCD* is an extraordinary resource. Since 1988, *TDI* has received detailed reports of closed claims relating to five lines of insurance: General Liability, Medical Professional Liability, Other Professional Liability, Commercial Automobile Liability, and Liability Portion of Commercial Multi-Peril Insurance. Closed claims data are currently available through 2002. The forms and accompanying instructions that insurers use when submitting information have remained substantially the same.

The *TCCD* contains two kinds of reports: individual level reports of claims involving indemnity payments of more than \$10,000 in nominal dollars; and aggregate level reports of all other closed claims. Over 1988-2002, it includes 158,695 individual reports across all lines of coverage. Table 2 provides a breakdown of individually reported claims, including duplicate claims, by coverage category. In addition, aggregate reports cover more than 1 million claims with zero payout or payout of up to \$10,000 in nominal dollars.

¹⁰ A memorandum describing changes in Texas law affecting medical malpractice suits from 1980-2002 is available from the authors on request. The principal changes were as follows. In 1988, the Texas Supreme Court struck down a \$500,000 statutory cap on all damages except those relating to “expenses of necessary medical, hospital, and custodial care . . . for treatment of the injury.” Texas enacted this cap in 1977 in response to the 1970s malpractice crisis. The court also invalidated an alternative \$150,000 cap on non-economic damages. *Lucas v. U.S.*, 757 S.W. 2d 687, 691 (Tex. 1988.) In 1990, the court upheld both caps for wrongful death cases and held that the caps applied to each defendant individually, rather than all defendants combined. *Rose v. Doctor’s Hospital*, 801 S.W. 2d 841 (Tex. 1990). A 1995 tort reform statute (i) capped punitive damages for all torts at the greater of (a) \$200,000 or (b) 2 times other damages, but no more than \$750,000; (ii) limited venue to the county in which the accident occurred or the defendant maintained its principal place of business; (iii) required plaintiffs in medical malpractice cases to either post a bond or provide an expert report supporting their claim when filing a lawsuit; and (iv) limited prejudgment interest. In 1998, the Texas Supreme Court held that a hospital is vicariously liable for errors committed by an emergency room physician only when the hospital held out the physician as an employee or allowed the physician to so represent. *Baptist Memorial Hospital System v. Sampson*, 969 S.W.2d 945 (Tex. 1998).

Table 2. Overview of the Texas Closed Claim Database (TCCD)

Number of closed claim reports filed with TDI with payout of over \$10,000 in nominal dollars, including duplicate reports (reports by two or more defendants involving the same incident), by type of insurance policy, from 1988-2002.

Insurance line	Number of reports	Percent
Commercial auto liability	82,452	52%
Mono-line general liability	36,957	23%
Texas commercial multiperil	21,633	14%
Medical professional liability	16,437 (14, 697 without duplicates)	10%
Other professional liability	1,215	1%
Unidentified	1	0%
Total	158,695	100%

A “claim” is an incident causing bodily injury and resulting in a request to an insurer by a policyholder for coverage. In medical malpractice cases, the policyholder is normally a health care provider. If a single incident involves multiple possible defendants, each policyholder's request for coverage is a separate claim. We define a “claimant” as the injured person (plus any others who, because of the injury, may be entitled to compensation, such as a patient’s spouse or children).¹¹

An insurer must file a report with *TDI* in the year when a claim “closes” -- when the insurer “has made all indemnity and expense payments on the claim.”¹² When total known payments to a claimant by all defendants equal \$25,000 (nominal) or more, the primary carrier for each defendant must complete a “Long Form” that includes extensive description of a claim’s characteristics and history. When total payments are \$10,001-24,999 (nominal), each primary carrier must complete a somewhat less extensive “Short Form.”¹³ For example, the Short Form does not ask for the cause of injury. If total payments are \$0-\$10,000 (nominal), insurers do not file individual reports. Instead, beginning in 1990, they file an aggregate annual report which indicates, by line of insurance, the number of zero-payment claims, the number of claims with \$1-10,000 payments, and total dollars paid.

Claim reporting from 1990 on is more complete than for 1988 and 1989 because *TDI* experienced reporting problems in the early years. *TDI* began an annual claim reconciliation and review process in 1990, and believes that reporting from 1990 on is reasonably complete. Below, for findings that depend on complete reporting (number of claims per year, total dollars paid per year, etc.), we rely primarily on the 1990-2002 times series. For findings that involve *per claim amounts*, we use the entire 1988-2002 time series; we get similar results in robustness checks that exclude 1988-1990.

¹¹ The *Closed Claim Reporting Guide*, Reporting Unusual Circumstances, p. 9, states that multiple reports must be filed if a single incident produces multiple demands for compensation because the incident caused multiple injuries. Also, when the number of claimants exceeds 10, insurers use different forms and their reports are not contained in our dataset. These exceptions to the “one incident, one claim” rule are not likely to be significant for medical malpractice.

¹² See *Closed Claim Reporting Guide*, at 18.

¹³ The *Closed Claim Reporting Guide* (containing reporting instructions, the most recent version is from 2002), the long and short forms, summary *Closed Claim Annual Reports* (through 2002), and the core data on which we rely are available at <http://www.tdi.state.tx.us>. In some cases, the online data is incomplete and was completed through information provided to us directly by TDI.

TDI's review process makes Texas's post-1990 data more reliable than Florida's data, which have never been audited for accuracy by the Florida insurance department.¹⁴ Even so, the review process does not eliminate all ambiguity. For example, a primary carrier is supposed to indicate the total amount a claimant received from all sources. An insurer knows what it paid to settle the claim but may not know how much other carriers paid. Thus, in cases with payments by multiple carriers, reports of total payments may be inaccurate. *TDI* also does not verify non-financial information. For example, although carriers must identify the type of injury a patient sustained (e.g., death, brain damage, or spinal cord injury), *TDI* does not investigate the accuracy of insurers' descriptions.

Medical malpractice cases often involve multiple defendants and multiple insurers. Beginning in 1991, *TDI* sought to identify multiple filings relating to the same incident ("duplicate reports"), but its approach is imperfect. In particular, *TDI* does not identify reports filed in different years as related. To identify duplicate reports for 1988-1990 and to correct for *TDI*'s under-identification of duplicate reports in later years, we reviewed all individual claims. We identified 1518 duplicate reports, versus 951 identified by *TDI*.¹⁵ Below, unless otherwise stated, we exclude duplicate reports when reporting claim frequencies and payouts. To measure defense costs (which each insurer reports individually), we sum all insurer reports involving the same incident.

The \$10,001 and \$25,000 reporting thresholds are not adjusted for inflation. Thus, some claims that are individually reported in later years would have involved less detailed or only aggregate reporting in earlier years, assuming the same real payout. To address this "bracket creep," we convert all payouts to real 1988 dollars using the *Consumer Price Index for All Urban Consumers (CPI)* as a price index. A payout of \$25,000 in 1988 is equivalent to \$38,017 (nominal) in 2002.

Identifying claims involving medical malpractice is more complicated than one might expect. The *TCCD* offers three plausible ways of identifying medical malpractice claims, based on the type of insurance, the care provider, or the cause of harm. One definition ("A" claims) includes all claims covered by medical professional liability policies. It misses medical malpractice claims covered under other types of insurance, notably "other professional liability" and "general liability." A second definition ("B" claims) involves claims against medical providers, the relevant reporting choices being physicians or surgeons (we refer to this group below as "physicians"), hospitals, nursing homes, dentists, and oral surgeons. This definition misses claims where the defendant is coded as "other," which might occur when the defendant is a nurse, nurse practitioner, chiropractor, medical clinic, or home health care agency. A third

¹⁴ See DELOITTE CONSULTING, *MEDICAL MALPRACTICE FINANCIAL INFORMATION, CLOSED CLAIM DATABASE AND RATE FILINGS* (2004), Appendix F (Florida data "has never been audited or checked for accuracy or completeness," and the Florida insurance officials "suspect[] that errors and inconsistencies in the data submitted are likely").

¹⁵ Some decisions on whether to treat reports as duplicates involved subjective judgments about whether two similar reports actually related to the same incident. A summary of *TDI*'s duplicate identification procedures, our procedures, and why we identify duplicates that *TDI* missed is available from the authors on request. The presence of multiple defendants and multiple reports creates other risks of inaccurate reporting, besides failure to identify duplicates. For example, an insurer for one defendant may not know how much another defendant paid in settlement. One advantage of malpractice defense unified under a single defendant or insurer would be improved data reporting. See Kenneth S. Abraham and Paul C. Weiler, *Enterprise Medical Liability and the Choice of the Responsible Enterprise*, 20 *AMERICAN JOURNAL OF LAW AND MEDICINE* 29 (1994).

definition (“C” claims), available only for Long Form claims, involves claims coded as arising from “complications, misadventures of surgical/medical care.” This definition misses some claims, including those where the harm is coded as a “fall” (in a hospital or a nursing home) or as “other.” Below, we report results for three slices of the claim universe:

A “*broad superset*” (“BRD”). The BRD superset includes all nonduplicate large claims (payout over \$25,000 in 1988 dollars) that were paid under medical professional liability insurance (A claims) or were against a health care provider (B claims) or involved injuries caused by complications or misadventures of medical or surgical care (C claims). The BRD superset includes 12,840 claims. During 2000-2002, the annual BRD flow averaged 987 cases, with mean (median) payout of \$343,000 (\$134,000) per claim.

A *medium-sized “med mal insurance” set* (“MED”). The MED set includes all nonduplicate large (payout over \$25,000 in 1988 dollars) claims covered by medical professional liability insurance (A claims). This definition is similar to the Florida definition. Claims under medical liability insurance are the only ones for which we have data for claims with \$0-10,000 (nominal) payout. Thus, these claims are the best choice for tracking the total number of malpractice claims and the fraction of claims that result in a payout. The MED set includes 11,967 claims. During 2000-2002, the MED annual flow averaged 926 cases, with mean (median) payout of \$351,000 (\$134,000) per claim.

An extended version of MED (MED_{all}) includes 2,440 cases with payout of at least \$10,000 in nominal dollars but less than \$25,000 in 1988 dollars, plus aggregate reports covering 4,643 paid claims with payouts from \$1 to \$10,000 in nominal dollars and 63,274 zero-payout claims. When using the MED_{all} dataset, we sometimes include duplicate reports from the MED dataset because we cannot exclude these reports from the zero-or-small claims.

A *narrow “core med mal” set* (“NAR”). The NAR set includes all nonduplicate large claims (payout over \$25,000 in 1988 dollars) that were paid under medical professional liability insurance (A claims) and were against a physician, hospital or nursing home (B claims) and involved injuries caused by complications or misadventures of medical or surgical care (C claims). This set excludes some cases that would be considered medical malpractice cases, but we can be confident that a claim within NAR involves medical malpractice as conventionally defined. NAR claims account for about 83% of dollars paid in the BRD superset. The NAR set includes 10,439 claims. During 2000-2002, the NAR annual flow averaged 810 cases, with mean (median) payout of \$351,000 (\$137,000) per claim.

We exclude claims against dentists and oral surgeons from the BRD and NAR datasets. We lack the data to do so for the MED dataset.¹⁶

As we show below, time trends for the different datasets are similar. We therefore report data and findings mainly for the BRD superset, and report findings for other datasets when there is particular reason to do so. We also create expanded “10k” versions of the BRD, MED, and NAR datasets, which include claims with payouts from \$10,001-25,000 in 1988 dollars. We use these datasets to test the robustness of our findings for large paid claims and to assess whether there are different trends for smaller claims than for large claims.

¹⁶ There are 475 dentist cases (3.6% of all cases). Payouts in these cases are usually small. The average payout on BRD dentist cases was \$93,000 during 2000-2002 compared to \$343,000 for other BRD cases (in 1988 dollars).

B. Data Limitations

We discuss below some important limitations of our study. Some involve data availability that limits what questions we can address with our dataset. Some arise because this article is only the first in a series of planned projects to study the rich, detailed *TCCD* database. We have not yet had the time to ask all of the questions one might want to ask.

1. Time Period Available for Study

We have 15 years of data. However, there was underreporting of large paid claims for 1988-1989, so we have only 13 years of reliable data on the number of these claims. There was underreporting through 1994 of claims with payout less than \$10,000 nominal, so we have only 8 years of reliable data on the number of these claims. Below, except as explicitly noted, we report regression results for the entire period for which reliable data is available. We thus let the dataset determine the starting date for our analysis, rather than making that choice ourselves. In Figures 2, 3, 9, and 11, we visually report results for number of claims, total payout per year, and total cost per year including 1988 and 1989, to avoid any claim that we have intentionally suppressed the results for these years.

2. Open Claims

We have data only on closed claims, not still-open claims. Thus, we cannot rule out the possibility that malpractice premium spikes were driven by a large increase in claims that remained open at the end of 2002. Nonetheless, this explanation seems unlikely. First, premiums began spiking in 1999, while our data run through 2002. If the number of new claims had risen sharply in 1999 (or earlier), that would likely be reflected in the number of claims that were closed in 2001-2002. In fact, large paid claims, adjusted for population, were lower in 2001-2002 than in 1999-2000 (see Figure 3). There is also no significant time trend in the total number of closed claims. Turning to payout per claim, adjusted for inflation, there is no strong overall time trend in either payout per large claim (see Figure 8) or jury verdicts (see Figure 14). Insurers base their estimates of future payout on past experience. The experience that was available to them when premiums began spiking does not seem especially alarming.

3. Defense Costs for Zero-or-Small Claims

Some malpractice claims generate small payments, and many lead to zero payments. We have defense cost data only for claims with at least \$10,000 (nominal) payouts. Defense costs rose over time for these claims (see Figure 10). They likely rose for other claims as well. However, defense costs per claim are much more under insurers' control than payouts. They likely change smoothly over time. Moreover, defense costs remain only a fraction of total insurer costs. Thus, defense costs are unlikely to explain more than fraction of the increase in malpractice insurance premiums from 1999-2003. We expect to investigate defense costs more closely in future work.

4. Unreported Payments

Mutual risk-pooling groups and self-insured entities that rely on captive insurers must report closed claims to *TDI* in the same manner as primary insurers. For "pure" self-insured entities (which don't rely on captives or risk-pooling), excess insurance carriers must report as if they are primary carriers, if the payout triggers a payment by the excess carrier. Still an unknown number of pure self-insured entities don't report closed claims. Thus, our data miss some percentage of overall Texas payouts on malpractice claims. We have no reason to believe

that the number of these missing claims change over time as a percentage of the total. In any event, for the purpose of understanding the connection between claim outcomes and malpractice insurance rates, payments on uninsured claims should not matter.

5. *Claim Frequencies and Physician Specialties*

We cannot study physicians by specialty because the *TCCD* does not include this information. Claim trends for surgeons and obstetricians may differ from those of pediatricians and oncologists. Specialists in different areas often pay vastly different amounts for malpractice insurance, may face different premium trends, and may differ in their near-term ability to adjust their fees to reflect changes in premiums. Still, micro-shifts seem unlikely to explain more than a fraction of the average 135% premium increase faced by Texas physicians over 1999-2002.

We also do not analyze claims based on provider type. Doctors receive a modest fraction of all health care dollars, but pay a majority of malpractice premiums.¹⁷ If the fraction of payouts made by doctors rose relative to other providers (principally hospitals and nursing homes), our study would miss the resulting pressure on doctors' premiums and incomes. We expect to study claims by provider type in future work.

6. *Claim Frequency and Payouts by City or County*

Below, we report statewide experience. Just as our macro-level data can hide variation by physician specialty, it could hide variation across cities or counties within Texas. The *TCCD* includes county information. We expect to explore in future work what can be learned from county-level examination of claim outcomes. The county-level insurance rate information collected by *Medical Liability Monitor* and by *TDI* for its 2003 study of medical malpractice insurance show some variation in insurance premia by county, but on the whole do not suggest large county-level variation in premium trends. This, in turn, suggests that insurers are not seeing large county-level variations in claim trends.¹⁸

7. *Underlying Rate of Medical Negligence and Severity of Harm*

We cannot directly measure the rate of medical negligence. We have available only crude controls for the number of medical encounters (such as population and number of physicians per capita). If the fraction of medical encounters that involve negligence decreased (increased) over time, while the fraction of negligent encounters that lead to claims increased (decreased), this could produce the stable number of large paid claims, adjusted for population, that we observe. Similarly, if severity of harm increased (decreased) over time, while the ratio of payout to harm decreased (increased), this could produce the stable payout per large paid claim that we observe.¹⁹

¹⁷ See William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in 2003 HEALTH LAW HANDBOOK 1 (Alice G. Gosfield ed., 2003).

¹⁸ See *Medical Liability Monitor* (annual surveys of malpractice insurance rates for 1995-2004); TEXAS DEPARTMENT OF INSURANCE, MEDICAL MALPRACTICE INSURANCE: OVERVIEW AND DISCUSSION (2003), at <http://www.tdi.state.tx.us/general/pdf/spromptpay.pdf>.

¹⁹ A recent report found "little evidence that patient safety has improved in the last five years." HEALTHGRADES, PATIENT SAFETY IN AMERICAN HOSPITALS 1 (2004), at http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf.

8. *Jury Verdicts and Post-Trial Payouts*

Jury verdicts are inherently hard to study, because they are limited in number and highly skewed in distribution. We find some evidence of a trend toward higher jury awards over time, though the trend is not statistically reliable and is sensitive to choice of dataset, . However, there is a much smaller trend, if any, in post-trial payout amounts. We expect to investigate jury verdicts and post-verdict payouts more closely in future work.

9. *The Link Between Insurance Premiums and Claim Outcomes*

We report here evidence on malpractice claim outcomes. If claim-based accounts of the malpractice insurance crisis are correct, we should find significant increases in claim frequencies, payout per claim, jury verdicts, etc. Because, by and large, we do not find these changes, our study suggests that claim-based accounts of the insurance crisis are incorrect at the macro-level. We do not, however, study insurance premiums in detail. Nor do we assess the year-by-year connection between insurance premiums and claim outcomes or other factors that might predict insurance rates. Even if insurance market forces largely explain the recent spikes in insurance premiums, claims and premiums should vary together over the long term. We plan to study the connection between claim outcomes and insurance rates in future work.

10. *The Effect of Liability Caps*

In response to a surge in malpractice insurance rates (see Part IV.A below), Texas adopted comprehensive tort reform, including caps on non-economic damages, effective for claims filed after Sept. 1, 2003. These changes postdate the period we study, so we cannot assess how they will affect claim outcomes. On economic grounds, one would expect liability caps to reduce both the number of large paid claims and the average payout per claim. In the long run, this should lead to lower insurance premiums.²⁰ An open question is whether caps on non-economic damages or other reforms will affect the volatility of insurance premiums *in percentage terms*.

C. Other Variables

We use, in various portions of our analysis, the following variables. We provide definitions when these are not self-evident. Sources for each are listed in Appendix A.

- *real 1988 dollars*: We convert current dollars in each year to 1988 dollars (or, occasionally 2002 dollars) using the Consumer Price Index for All Urban Consumers as a price index.
- *Texas population*
- *real Texas Gross State Product (GSP)*: Texas GSP adjusted for inflation.
- *Texas physicians*: Nonfederal physicians in active practice in Texas, as reported by the Texas Department of Health.

²⁰ For evidence of this effect, see W. Kip Viscusi and Patricia H. Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance* (working paper, 2004), at <http://ssrn.com/abstract=607203>. But see Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 NYU LAW REVIEW (forthcoming 2005), at <http://ssrn.com/abstract=668023> (arguing that changes in behavior by plaintiffs' lawyers could partly offset this effect).

- *Texas real health care spending*: Texas health care spending in real 1988 dollars (or, occasionally, 2002 dollars). Real health care spending is adjusted for general inflation but *not* for inflation that is specific to health care.
- *real medical care services cost index*: Medical care services cost index, adjusted for general inflation
- *real rate of increase in health care costs*: Trailing three year geometric annual average real increase in medical care services costs. For 2002, this is the geometric average annual increase for 1999-2002, and similarly for earlier years.
- *nominal interest rate*. Annual average interest rate on 10-year U.S. Treasury bonds.

IV. FINDINGS

This section proceeds as follows. In Part A, we briefly describe the increases in medical malpractice premiums for Texas physicians that occurred 1999-2003. In Part B, we describe the magnitude of malpractice litigation in Texas by presenting aggregate statistics. In Parts C-I, we report results for, respectively, the number of paid claims, payout per claim, total payout per year, defense costs, total costs (payouts plus defense costs), jury verdicts, and claims per physician.

A. Malpractice Premiums in Texas

In 2003, *TDI* surveyed malpractice carriers and found that the three carriers who collectively dominate the market raised their rates for physicians dramatically after 1999. The unnumbered figure below (taken from the *TDI* report) shows the trends. Table 3 summarizes the rate histories for these insurers. This insurance crisis led to extensive malpractice liability reform in Texas in 2003, including a \$250,000 cap on non-economic damages per defendant and a \$500,000 aggregate cap on recovery of non-economic damages from all physicians and health care institutions.²¹ We address below whether there have been changes in claim outcomes of a magnitude sufficient to explain this premium surge.

²¹ Other 2003 reforms include: (i) a requirement that damages based on expected future medical expenses be paid as expenses accrue and terminate on the patient's death; (ii) a requirement that other future damages be paid periodically rather than in a lump sum; (iii) a limit on hospital liability for charity care; (iv) a limit on insurer liability for wrongful failure to settle; (v) a 10-year statute of repose; and (vi) a variety of procedural changes relating to jury instructions, standards of proof, bond requirements, and expert witnesses.

Texas Malpractice Insurance Rates, 1999-2003

Changes in physician malpractice insurance rates for principal Texas carriers, based on data collected by TDI. Percentage increase is relative to rates in effect at Dec. 31, 1998. Percentage changes are *not* adjusted for inflation. Source: TDI, *Medical Malpractice Insurance: Overview and Discussion* (2003), chart 1.

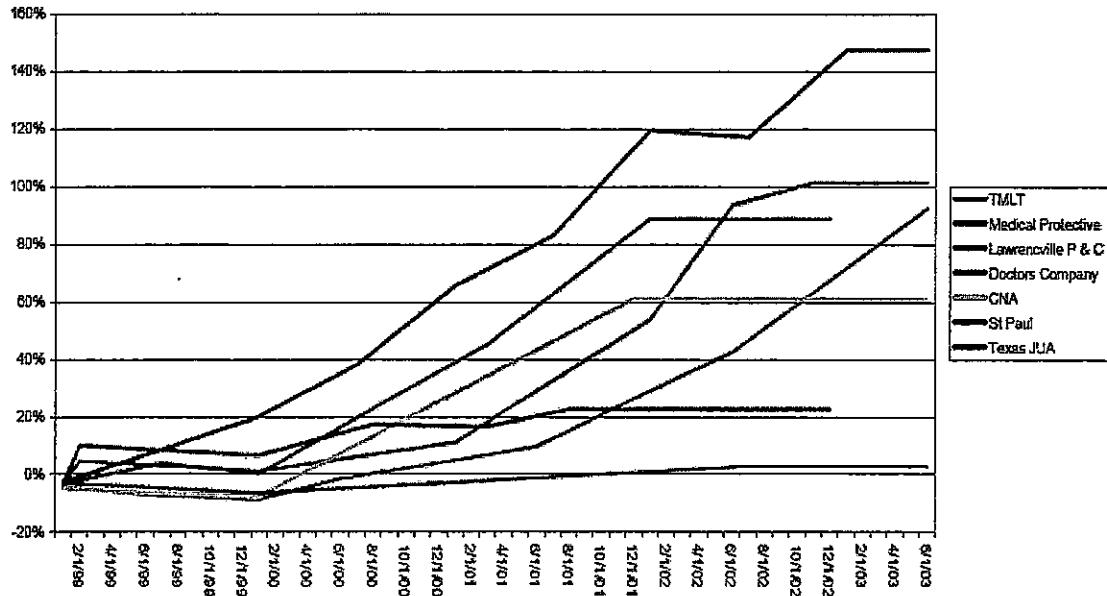


Table 3. Texas Medical Malpractice Rate Increases, 1999-2003

Percentage increases in medical malpractice insurance rates over the indicated periods. The last column is adjusted for inflation based on the Consumer Price Index for All Urban Consumers. The table reflects rate increases, not rates. A company with a larger (smaller) percentage rate increase could still charge a lower (higher) premium than another company. The Texas Joint Underwriting Association is a rate-regulated insurer of last resort for physicians who cannot find coverage elsewhere. Its rates are generally higher than those available from other carriers. Source: TDI, *Medical Malpractice Insurance: Overview and Discussion* (2003).

Company	Physicians covered (in 2002)	Increase (1999-2003, nominal \$)	Inflation-adjusted increase
Texas Medical Liability Trust	9,964	155%	128%
The Medical Protective	5,235	107%	85%
The Doctors' Company	1,456	99% (2000-2003)	82%
Weighted average increase		135%	110%
Texas Joint Underwriting Ass'n	510	10% (2000-2002)	2%
All other surveyed insurers	432	varies	varies

B. Malpractice Litigation: Aggregate Statistics

Number of Claims and Claim Distribution. Table 4 provides summary information about our largest class of individually reported claims, *BRD*_{10k}. The largest payouts, over \$1 million, account for only 5% of paid claims but 42% of payment dollars. Payouts over \$250,000 account for 25% of paid claims over \$10,000, but 78% of payouts. The tendency for a small fraction of paid claims to account for a large fraction of dollars paid would be even sharper if the table included payouts of less than \$10,000, which (in the *MED*_{all} dataset) account for about 28% of all paid claims, but only 0.5% of payout dollars. Based on the *BRD* dataset, the mean (median)

payout per large paid claim was \$490,000 (\$205,000) for the entire period, and \$528,000 (\$200,000) in the most recent year (2002), in each case in 2002 dollars.

Table 4. Summary Statistics for *BRD*_{10k} Claims

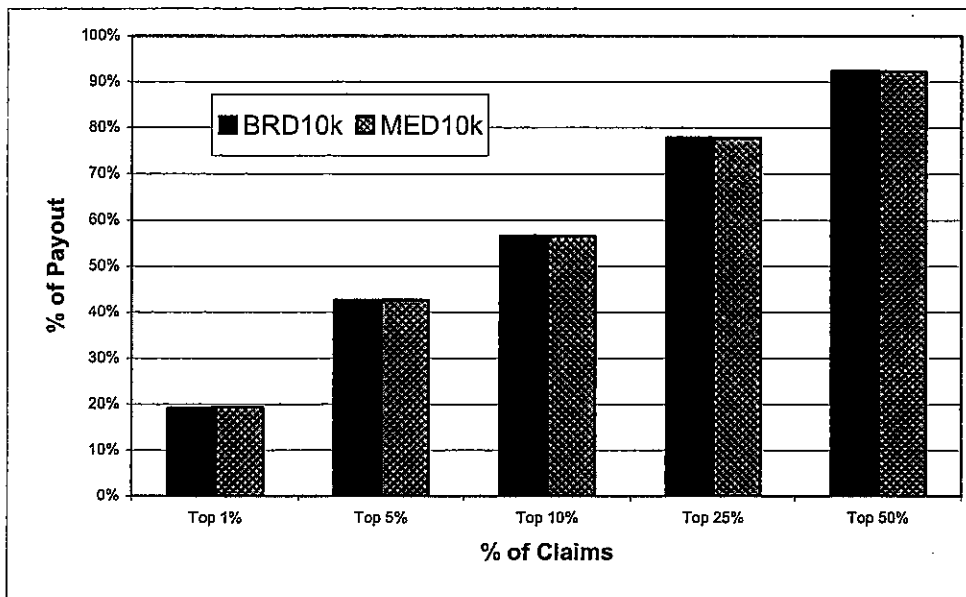
Number of medical malpractice claims from 1988-2002 with payouts in various size ranges (in 1988 dollars), based on the *BRD*_{10k} dataset (nonduplicate claims with payout over \$10,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care).

Payout	Number of claims	% of total	Payout	% of total
\$10,000 - 25,000	2,738	17.6%	\$46 million	1.1%
\$25,000 - 100,000	5,235	33.6%	\$291 million	6.9%
\$100,000 - 250,000	3,745	24.0%	\$601 million	14.4%
\$250,000 - 1,000,000	3,099	19.9%	\$1,484 million	35.5%
over \$1,000,000	761	4.9%	\$1,763 million	42.1%
Total	15,578	100.0%	\$4,185 million	100.0%

Figure 1 provides similar information in visual form for the *BRD*_{10k} and *MED*_{10k} datasets. The largest 1% of paid claims generated almost 20% of the payout dollars. The largest 10% of paid claims accounted for more than half of the total payout. And the largest 50% of claims accounted for 90% of the payout dollars.

Figure 1. Percentage of Total Payout by Payout Size Percentiles

Fraction of total payout for all medical malpractice claims from 1988-2002 accounted for by claims at or above various percentiles, based on payout size, based on the *BRD*_{10k} dataset (nonduplicate claims with payout over \$10,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care) and the *MED*_{10k} dataset (nonduplicate claims with payout over \$10,000 in 1988 dollars that were paid under medical liability insurance).



Plainly, one could learn much about malpractice claims by studying only large paid claims. Yet doing so would miss an important part of the story. Not only do smaller paid claims account for few payout dollars; claims resolved without payments are the most common by far.

A distinctive feature of malpractice compensation is the high frequency of claims closed with zero payment.

Only the *MED*_{all} dataset contains information on zero-payment claims, so we use it to illustrate this point. The *MED*_{all} dataset contains no reports of zero-payment claims in 1988 and 1989 (TDI began to collect this information in 1990) and understates the frequency of zero-payment claims in 1990-1994 because reporting in those years was incomplete. Table 5 therefore reports data only for 1995-2002. About 81% of claims were closed with zero payment, while another 5% closed with a small “nuisance” payment of under \$10,000. Note, however, that the 81% of claims closed with no payout overstates the fraction of *incidents* that were closed with no payout because many claimants sued multiple defendants.

Table 5. Payout Distribution, Including Zero-Payout and Small Paid Claims

Number of claims and percentage of total claims in various payout size ranges for medical malpractice claims in the *MED*_{all} dataset (all claims reported under medical liability insurance), including duplicate claims, for 1995-2002. Payouts are in 1988 dollars.

Time period	1995-2002	
	Number of claims	Percent
Payout (1988 \$)		
\$0	48,064	80.8%
\$1-10,000	2,815	4.7%
\$10,000-25,000	1,299	2.2%
\$25,000-250,000	5,136	8.6%
over \$250,000	2,188	3.7%
Total <i>MED</i>_{all} claims	59,502	100.0%

Medical associations and tort reform groups cite the frequency of zero-payment claims as evidence of frivolous litigation. Plaintiffs’ attorneys may have incentives to pursue weak cases when large damages are possible. They may also bring peripheral defendants into cases to increase the odds of collecting from someone. These tactics will often produce zero-payout claims. But the number of zero-payout claims seems too large to explain on these grounds alone. Moreover, empirical studies report that plaintiffs’ attorneys screen med mal cases carefully and reject small or weak claims.²² This makes sense because malpractice lawsuits are expensive, well defended, and usually brought on contingency. One must therefore look for explanations for zero-payout claims despite gatekeeping by plaintiffs’ attorneys.

Several explanations are possible. First, some closed claim reports may not involve demands for compensation. When a mishap occurs, a provider may report a potential claim without waiting for a patient to seek compensation. The insurer will then open an incident file. If the injured patient fails to seek relief, the incident file will be closed without payment. Other studies have reported significant volumes of these types of claims.²³ Second, carriers also open

²² See, e.g., Herbert M. Kritzer, *Contingency Fee Lawyers As Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22 (1997); Henry S. Farber and Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND JOURNAL OF ECONOMICS 199 (1991).

²³ See MINNESOTA DEPARTMENT OF COMMERCE, MEDICAL MALPRACTICE CLAIM STUDY 1982-1987, at 6 (1989) (discussing incident reports and insurer reserving practices); *id.* at 21 (finding that 36% of insurance files were closed without payment because the claim was not pursued). See also Herbert L. Weisberg and Richard A. Derrig, *Fraud and Automobile Insurance: A Report on Bodily Injury Liability Claims in Massachusetts*, 9 JOURNAL OF INSURANCE REGULATION 497, 503 (1991) (reporting that 18.3% of closed claim files “were screened out [of the

claim files when patients (or their attorneys) request medical records for review, with or without filing lawsuits. This information is often not otherwise available.²⁴ After records are produced, many claims are dropped and, again, zero-payment files are produced. TDI does not require a closed claim report for these sorts of inquiries, but its instructions on this point are not clear, and some insurers may report these inquiries as claims. Third, medical malpractice claims that seem possibly valid based on initial evidence often appear weaker after further discovery. When plaintiffs' attorneys drop these cases, more zero-payment files are produced. Fourth, plaintiffs may need to sue all plausible defendants to ensure that the named defendants do not point to non-defendants as the harm-doers.²⁵

Some of these sources of zero payments indicate that insurance processes and the tort system are working as they should. Others suggest that better informal procedures for providing information to injured patients might reduce the number of zero-payout insurance files or zero-payout lawsuits. Unfortunately, the data that *TDI* collects on zero-payout claims does not let us estimate the importance of different sources of zero payouts.

Who Gets Sued? *TDI* requires insurers to identify the nature of both *their client* (whom we will call the "principal defendant") and "*other defendants*". Table 6 summarizes the distribution of claims across provider types. Manifestly, multiple defendants are a common feature of medical malpractice litigation. The first column lists the total number of defendants of each type (sometimes multiple physicians or hospitals are named in a single claim). The second column lists the number of *claims* in which a given type of provider is named. Physicians are the most common defendants, and are named in about 80% of closed claims. Hospitals are named 46% of the time. The sum of these percentages exceeds 100% because many reports identify more than one provider type (for example, a physician and a hospital) as co-defendants.

study] because no claim had materialized"). Most patients who suffer harm due to malpractice never sue. See, e.g., STEPHEN DANIELS AND JOANNE MARTIN, *CIVIL JURIES AND THE POLITICS OF REFORM* (1995).

²⁴ See David A. Hyman and Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution*, CORNELL L. REV. (forthcoming 2005), at <http://ssrn.com/abstract=526762> (discussing studies of communications between providers and patients about risks and mistakes); Gerald B. Hickson, Ellen Wright Clayton, Penny B. Githens, and Frank A. Sloan, *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*. 267 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1359 (1992) (finding that patients often sue to obtain information).

²⁵ For additional explanations of zero-payment claims, see Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System--And Why Not?*, 140 UNIVERSITY OF PENNSYLVANIA LAW REVIEW 1147, 1217-25 (1992); Samuel R. Gross and Kent D. Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 UCLA LAW REVIEW 1, 54 & n.78 (1996).

Table 6. Medical Malpractice Cases by Provider Type

Number of times that particular provider types were named as defendants, and number and percentage of claims naming particular provider types as defendants, for large paid medical malpractice claims in the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002. Percentages in the last column sum to more than 100% because many claims name more than one type of defendant.

Provider type	Total number of times named	No. of <i>claims</i> in which named	% of claims in which named
Hospitals	6,367	5,802	45.2%
Physicians	17,422	10,206	79.5%
Nursing homes and other health care providers	5,367	2,984	23.2%
All other defendants	2,463	1,367	10.6%
Total	31,619	20,359	
Total <i>BRD</i> Claims	12,840	12,840	

Table 7 shows a breakdown of cases by number of defendants. About 59% of large paid claims involve two or more defendants. Almost 20% of large paid claims involve four or more defendants. The frequency of multiple defendants may illuminate the common complaint by physicians that plaintiffs often sue doctors who delivered appropriate care. It seems unlikely that many cases involve actual malpractice by four or more separate defendants. They problem may be that once plaintiffs' attorneys decide to bring cases, they often name as defendants physicians who were only tangentially involved. Many physicians may then perceive malpractice lawsuits as unjustified *as to them*, even if others were in fact negligent.

Table 7. Defendants per Large Paid Medical Malpractice Claim

Number of defendants per claim, for large paid medical malpractice claims in the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002.

Number of defendants	Number of reports	Percent
1	5,317	41.4%
2	3,247	25.3%
3	1,835	14.3%
4 or more	2,441	19.0%
Total	12,840	100.0%

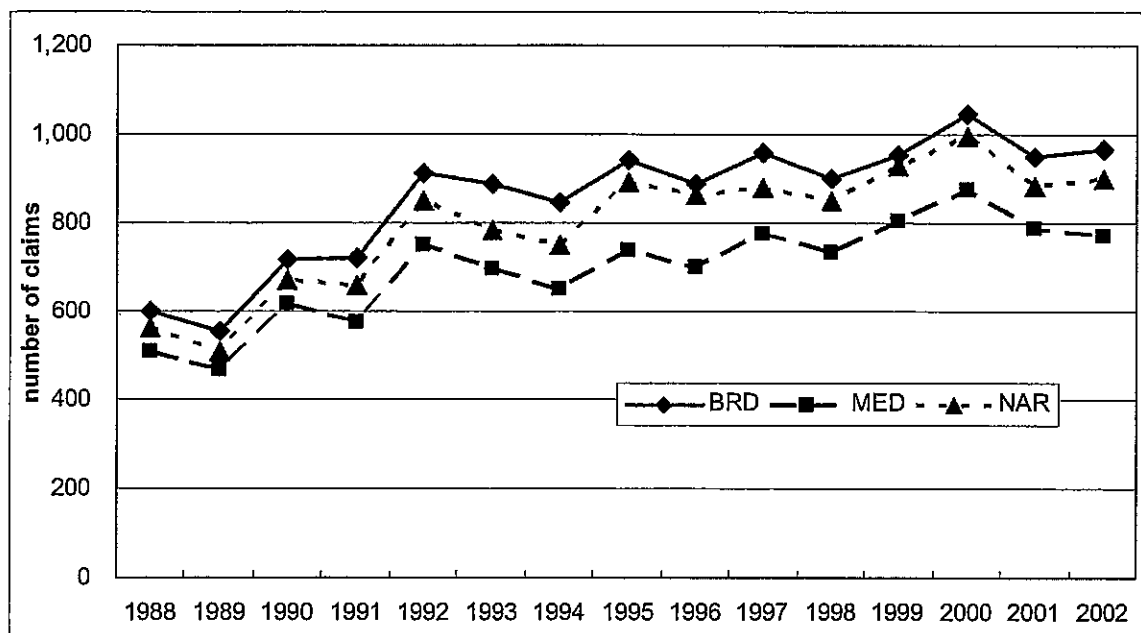
C. Number of Large Paid Claims

1. A graphical picture of large paid claims per year.

Figure 2 shows the annual number of large paid claims for the *BRD*, *MED*, and *NAR* sets. The trends for the three datasets are highly similar. Even if we exclude 1988-1989, when reporting was incomplete, a rising trend over time is apparent. A simple regression of number of claims (as dependent variable) against year and a constant term confirms a significant time trend, with the increase averaging 19 *BRD* claims per year over 1990-2002.

Figure 2. Number of Large Paid Claims per Year

Number of large paid medical malpractice claims per year from 1988-2002 for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), the *MED* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance), and the *NAR* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that are were paid under medical liability insurance *and* were against a physician, hospital or nursing home, *and* involved injuries due to medical care). Number of claims for 1988 and 1989 is lower than the actual number due to underreporting.

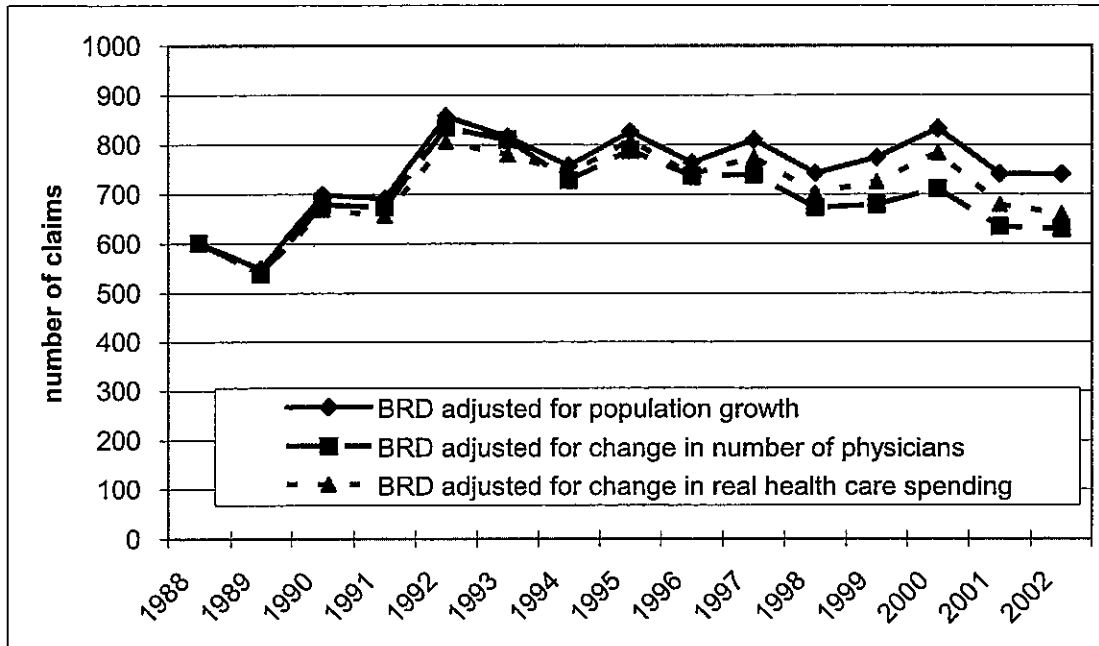


Some increase in number of claims should be expected, for two reasons. One factor is the growth in Texas population. A second is rising per capita consumption of medical services. Other things equal, an increase in either factor should predict an increase in medical malpractice claims. We use two imperfect proxies for the intensity of medical care service consumption. The first is the number of physicians per capita; the second is real health care spending per capita, adjusting for *medical care services inflation* (which is generally higher than overall inflation). Increases in these variables should predict higher service levels and therefore more claims. Other factors that we do not control for, including changes in the health, age, and ethnic composition of the Texas population, the mix of medical services (some services are more litigation prone than others), and the underlying rate of negligent medical care could also affect expected number of claims, payout per claim, or both.

Figure 3 shows the number of *BRD* claims per year, adjusted (respectively) for population, number of physicians (which is equivalent to adjusting separately for population and for physicians per capita), and real health care spending (which is equivalent to adjusting separately for population and for real health care spending per capita).

Figure 3. Adjusted Number of Large Paid Claims per Year

Number of large paid medical malpractice claims per year from 1988-2002 for the BRD dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), adjusted for Texas population, real Texas health care spending (health care spending adjusted for medical care services inflation) and number of physicians. Number of claims for 1988 and 1989 is lower than the actual number due to underreporting.



With a simple adjustment for population (the top line in Figure 3), the number of large claims per year shows little time trend. The number of claims peaks in 1992 but then declines, and by 2002 has almost returned to its 1990 level. The lack of a positive trend (or a possible decline after 1992) is stronger with if we also adjust for intensity of medical care consumption (the bottom two lines).

2. Regression analysis: methodology

We turn next to ordinary least squares (*OLS*) regression analysis of the time trend in number of claims per year. Our implicit model of the claims generating process is that people have some number Y of medical encounters per year, some fraction f of which lead to a malpractice claim. The number and nature of encounters can vary across time. The fraction of encounters that lead to claims and the amount of damages can vary across time and with the nature of the encounter and the personal characteristics of people. However, we assume that each person's outcome is independent of other persons' outcomes. The number of claims per year is then a count variable, which results from Y independent draws from a pool of encounters, each of which produces a claim with probability f . As long as the draws are independent and the number of claims per year is large, *OLS* is appropriate.

Ideally, we would want to use regression analysis to untangle the effects of time, population, intensity of medical services consumption, and other factors on claim frequency. However, the limited sample size (13 years from 1990-2002) and high colinearity among these potential influences makes this impractical (as an extreme example, the correlation between year

and population is 0.998). The best we can do is to assess whether paid claim frequency, adjusted for population, or further adjusted for medical intensity, has a time trend.

We make no claim that year causally predicts number of claims or, later in this article, per claim amounts. Instead year likely proxies for underlying changes in the world, which themselves have a time trend. We expect in future work to use the *TCCD* to conduct a finer-grained analysis of the underlying factors that influence claim outcomes.

3. Regression analysis: results

The regressions in Table 8 confirm the impression from Figure 3 that with any of these adjustments, there is no significant time trend for 1990-2002, and a negative trend from 1992-2002, especially if we adjust for medical intensity. In robustness checks, we obtain similar results for the *MED* and *NAR* datasets, and similar results if we exclude 1990 (to allow for the possibility that 1990 results include some catchup reporting of claims that should have been reported in 1988 or 1989).²⁶

Table 8. Adjusted Number of Large Paid Claims per Year

Ordinary least squares regression analysis of number of large paid medical malpractice claims per year for the indicated periods, for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care). The number of claims is adjusted respectively for Texas population, number of Texas physicians, and real health care spending (health care spending adjusted for medical care services inflation). We treat the first relevant year as year 0 (1990 for regression (1-3), 1992 for regressions (4-6)). We show results separately for the 1992-2002 subperiod to assess a possible trend over the latter time period, as suggested by visual inspection of Figure 2. *t*-statistics, based on robust standard errors, are in parentheses. *, **, *** indicate significance at the 10%, 5%, and 1% levels (omitted for constant term). Significant results (at 5% or better) are in **boldface**.

	(1)	(2)	(3)	(4)	(5)	(6)
Dependent variable	Number of large paid claims (<i>BRD</i> dataset)					
Adjusted for	population	physicians	health care spending	population	physicians	health care spending
Time period	1990-2002	1990-2002	1990-2002	1992-2002	1992-2002	1992-2002
Year	1.26	-8.50	-1.69	-7.13	-18.81	-11.06
	(0.32)	(1.98)*	(0.40)	(2.03)*	(6.91)***	(3.22)**
Constant	765.9	767.7	743.3	823.3	818.2	801.3
	(27.08)	(25.25)	(24.65)	(39.62)	(50.79)	(39.41)
Observations	13	13	13	11	11	11
R²	0.0090	0.2619	0.0141	0.3142	0.8414	0.5349

We focus in this article primarily on large paid claims (over \$25,000 in 1988 dollars), because these claims represent over 99% of payout dollars. These are roughly constant over 1990-2002. In addition, the number of smaller paid claims declined sharply during this period. The reasons are unclear. Perhaps plaintiffs' counsel realized that smaller claims were no longer worth bringing or seriously pursuing. But the outcome is clear. Figure 4 shows this decline. It presents, for the *MED*_{all} dataset, separate lines for "small" paid claims (less than \$10,000),

²⁶ Throughout this paper, unless otherwise stated, (i) when we report regression results for the *BRD* dataset, we obtain similar results with the *MED* and *NAR* datasets; (ii) when we report regression results for 1990-2002 (for number of claims, total payout per year, and total cost per year), we obtain similar results for 1991-2002; (iii) when we report results for 1988-2002 (for per claim amounts), we obtain similar results for 1990-2002 and for 1991-2002.

medium paid claims (\$10,000-25,000), large paid claims, and total paid claims. A sharp decline in small paid claims, from 740 in 1990 to 235 in 2002, is apparent. Less easy to see is that medium paid claims also declined, from 138 in 1990 to 109 in 2002, even before adjusting for population growth or medical intensity.

Figure 4. Number of Paid Claims by Size of Payout

Total paid medical malpractice claims from 1990-2002, and claims within the indicated payout ranges, in real 1988 dollars, for the *MED_{all}* dataset (all claims reported under medical liability insurance). We exclude nonduplicate claims with payout over \$10,000 in nominal dollars, but lack the data to identify duplicate claims involving payouts of less than this amount.

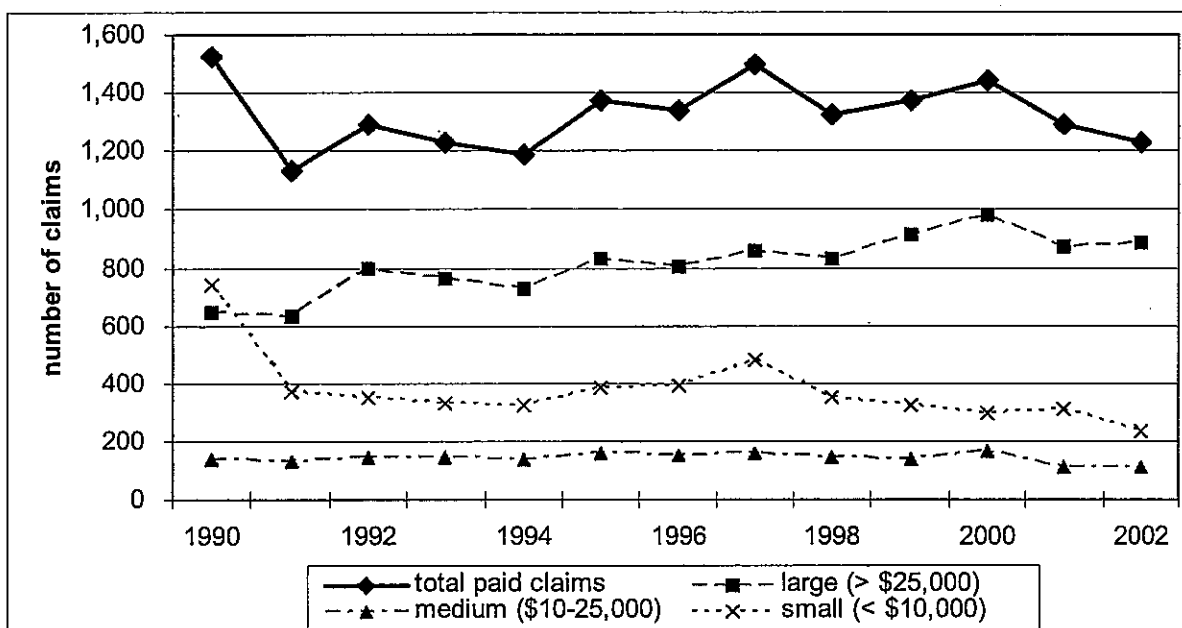
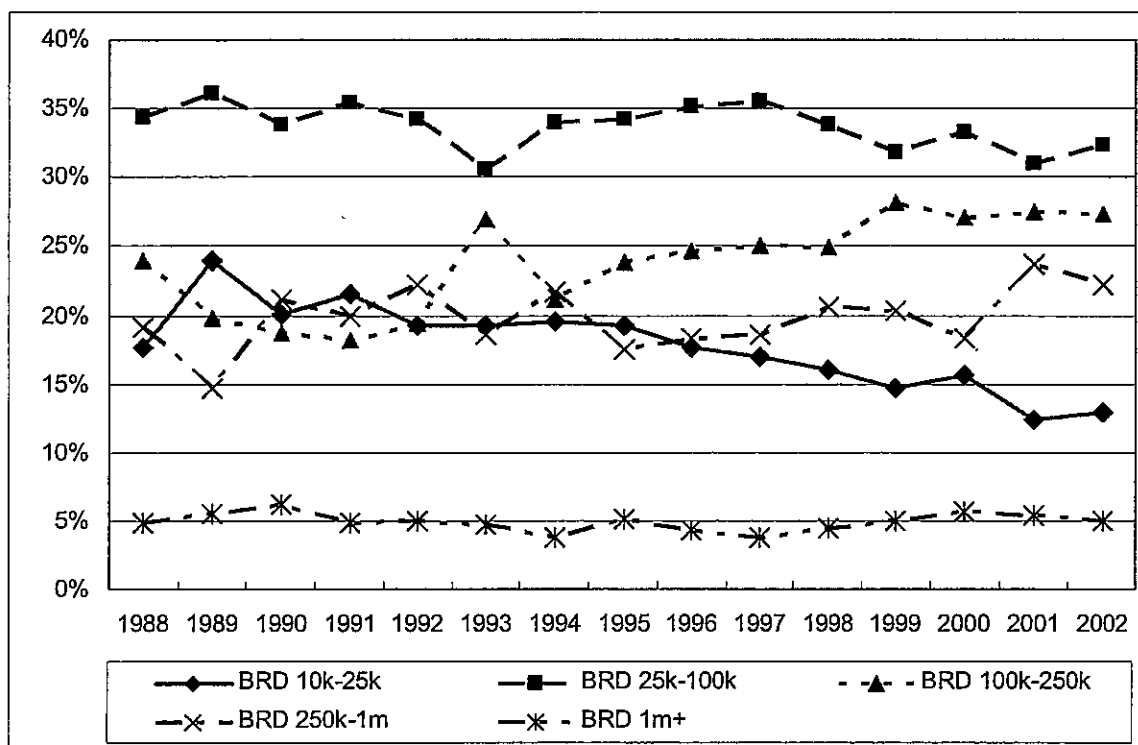


Figure 5 provides a more detailed breakdown of the size distribution of large and medium paid claims. It separates claims in the *BRD_{10k}* dataset into five size ranges—\$10,000-\$25,000; \$25,000-\$100,000; \$100,000-\$250,000; \$250,000-\$1,000,000; and over \$1,000,000. There were only limited changes in size distribution within this class of claims. As a percentage of all paid claims, the two smallest payment categories shrank, and the middle category (\$100-250,000) picked up the increase. Of particular note is the absence of a trend for "very large" claims over \$250,000. These claims represent almost 80% of payout dollars (see Table 4). Claims over \$1 million consistently represent about 5% of paid claims over \$10,000.

Figure 5. Percentage of Paid Claims Over \$10,000 by Size of Payout

Paid medical malpractice claims with payout of at least \$10,000 in 1988 dollars, within the indicated payment ranges, based on the *BRD*_{10k} dataset (nonduplicate claims with payout over \$10,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002,



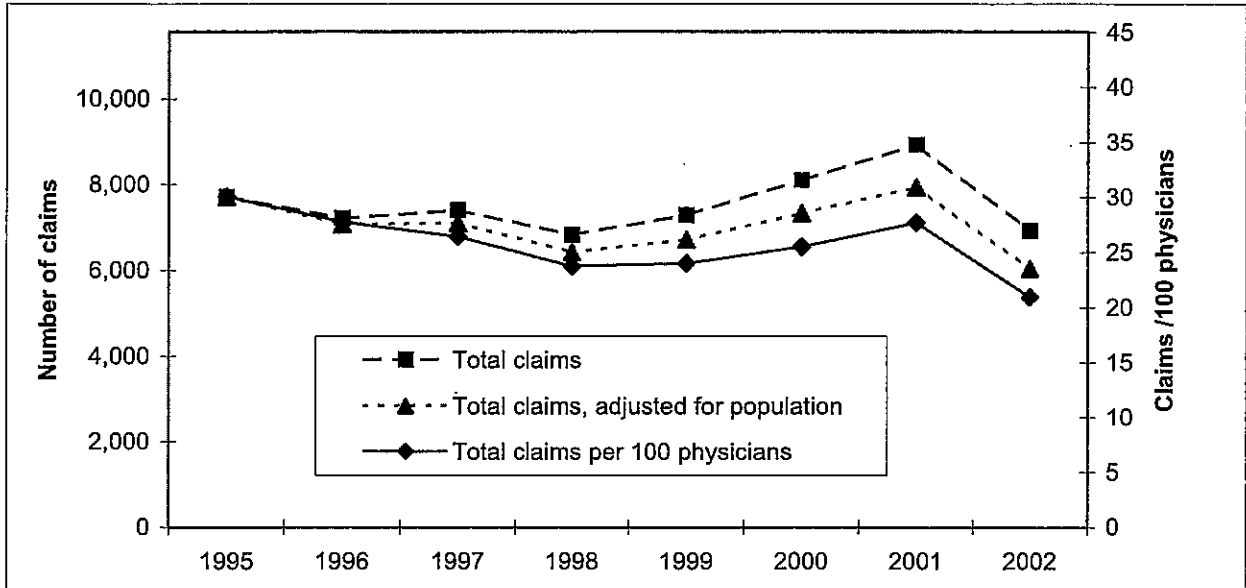
D. Total Claims and Total Paid Claims

We concentrated above on *large* paid claims. Physicians, however, are likely to care primarily about what affects them -- which includes their risk of being sued (related to total number of claims), and their risk of paying damages (related to total number of paid claims). Figure 6 presents information on the total number of claims, the number of claims adjusted for population, and the number of claims per 100 physicians per year, from 1995 on. We lack good data for prior years due to underreporting of zero-payout claims before then, which *TDI* believes was corrected in 1995. Figure 6 includes duplicate reports (reports by two or more defendants involving the same incident) relating to the same injury. This seems appropriate in assessing per-physician risk. The number of claims per 100 physicians per year overstates physicians' actual risk, because some claims involve other health care providers.

Figure 6 shows an apparent decrease over time in total claims per 100 physicians per year, which is marginally significant despite the very small sample size (see Table 9). While the trend in claims per physician is not alarming, the total claim rate is substantial. For 2000-2002, total claims averaged 25 per 100 physicians per year, meaning that the average physician faced a 1-in-4 annual chance of being involved in a claim, and perhaps a 1-in-2 chance of facing at least one claim during this 3 year period.

Figure 6. Total Malpractice Claims

Total medical malpractice claims, claims adjusted for population, and claims per 100 physicians, for the *MEDall* dataset (all claims reported under medical liability insurance), including duplicate claims, from 1995-2002.



At the same time, about 80% of all claims close without payment. Thus, a physician's risk of facing a payout is much smaller than the risk of facing a claim. This risk, too, has fallen over time. Figure 7 shows total paid claims and large paid claims per 100 physicians per year. *Total* paid claims declined from an average of 6.4 per 100 physicians per year in 1990-1992 to 4.6 per 100 physicians per year in 2000-2002. *Large* paid claims also declined, though more slowly, from 3.60 per 100 physicians in 1990-1992 to 3.26 per 100 physicians in 2000-2002. The shrinking space between the two lines in Figure 7 reflects the sharp decline over time in smaller paid claims (less than \$25,000 in 1988 dollars).

Figure 7. Paid Claims per 100 Physicians

Total paid medical malpractice claims and large paid claims per 100 physicians per year, including duplicate claims, for the *MED_{all}* dataset (all claims reported under medical liability insurance), including duplicate claims, from 1990-2002.

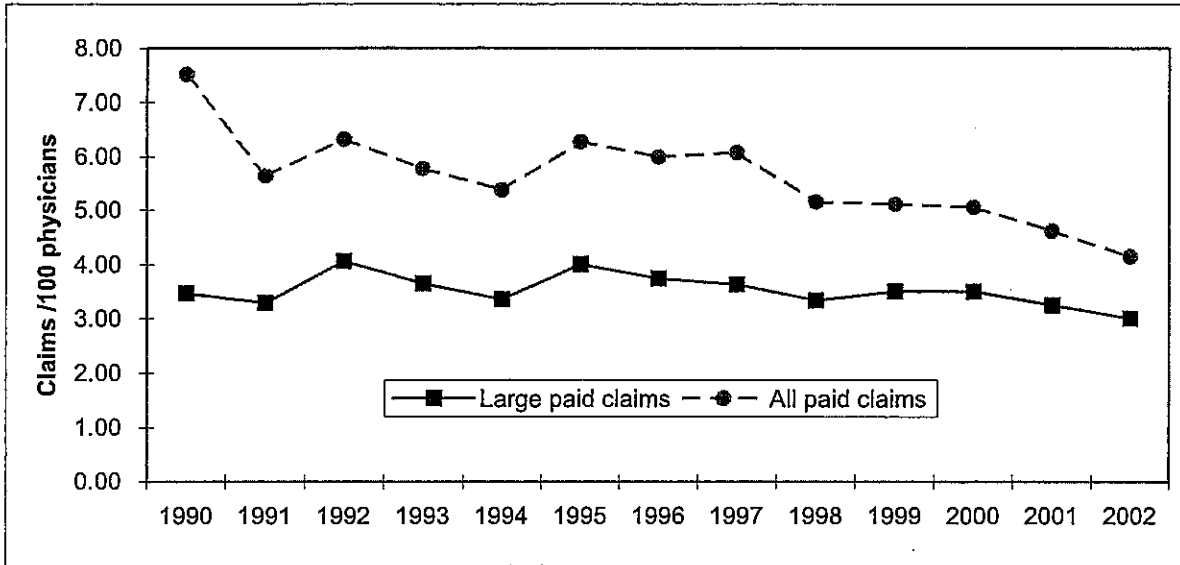


Table 9 provides regression analyses of total paid claims and total claims, first unadjusted, then adjusted for population and for number of physicians. The number of *paid* claims declines significantly over 1990-2002 when adjusted for either population or number of physicians. Physician-adjusted *total* claims also decline by an estimated 204 claims per year over 1995-2002, but the decline is only marginally significant due to the short time period. In robustness checks, we obtain similar results for total claims for 1990-2002, in regressions that include both a year variable and a 1995-dummy (=1 for 1995 and all later years) that is intended to capture the one-time jump in 1995 due to more complete reporting.

Table 9. Total Claims and Total Paid Claims

Ordinary least squares regression analysis of total number of paid medical malpractice claims per year for 1990-2002, and total medical malpractice claims per year for 1995-2002, for the *MED_{all}* dataset (all claims reported under medical liability insurance), including duplicate claims. *t*-statistics, based on robust standard errors, are in parentheses. We treat the first relevant year as year 0 (1990 for regression (1-3), 1995 for regressions (4-6)). *, **, *** indicate significance at the 10%, 5%, and 1% levels (omitted for constant term). Significant results (at 5% level) are in **boldface**.

	(1)	(2)	(3)	(4)	(5)	(6)
Dependent Variable	Total paid claims (<i>MED_{all}</i> dataset)			Total claims (<i>MED_{all}</i> dataset)		
Adjusted for	None	Population	Physicians	None	Population	Physicians
Time period	1990-2002	1990-2002	1990-2002	1995-2002	1995-2002	1995-2002
Year	1.8	-24.8	-39.1	67.9	-75.8	-203.7
	(0.18)	(-2.72)**	(-4.74)***	(0.6)	(-0.75)	(-2.27)*
Constant	1496.099	1453.088	1446.725	7317	7312	7332
	(20.70)	(22.50)	(24.82)	(15.55)	(17.21)	(19.56)
Observations	13	13	13	8	8	8
R ²	0.0028	0.402	0.6715	0.0573	0.085	0.4629

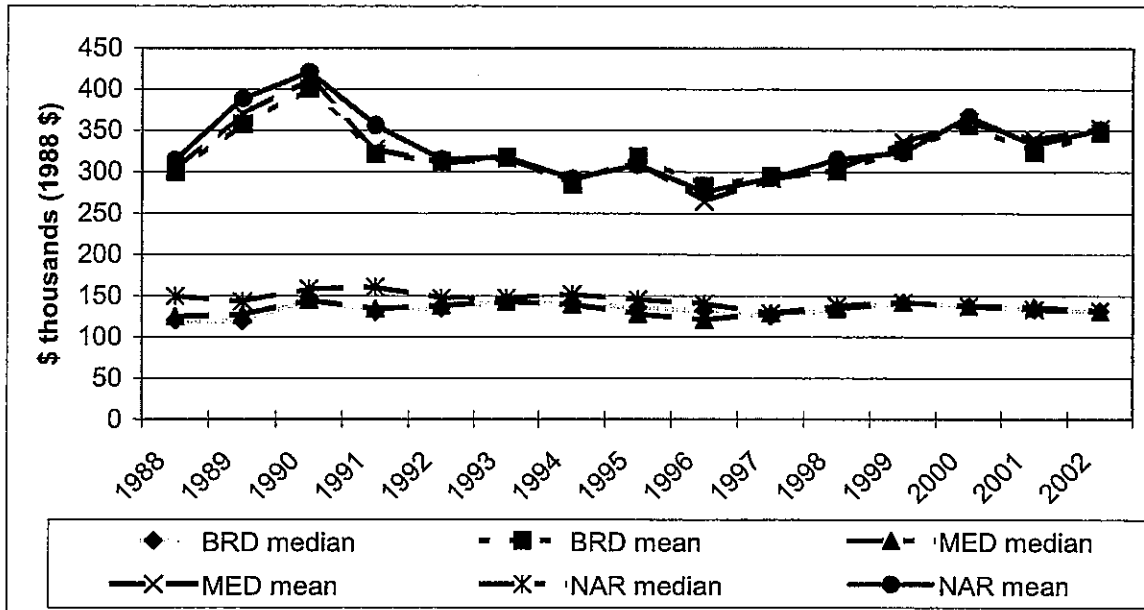
E. Payout per Large Paid Claim

The number of paid claims is one part of the malpractice liability equation. Payout per claim is the second key factor in assessing time trends in the dollar exposure faced by health care providers. Figure 6 shows the mean and median dollars per claim for the *BRD*, *MED*, and *NAR* datasets in 1988 dollars. The trend lines for the three datasets are nearly identical, confirming that it makes little difference to our results which dataset we use. The mean greatly exceeds the median, reflecting the skewed nature of malpractice payouts.

The central observation from Figure 8 is that both the mean and median payouts per large paid claim were relatively stable. For the *BRD* dataset, the mean payout was \$300,000 in 1988, peaked at \$401,000 in 1990, and was \$347,000 in 2002, all in 1988 dollars. The median payment was \$120,000 in 1988, peaked at \$145,000 in 1990, and was \$132,000 in 2002. These are large payouts, compared to other forms of tort litigation. But, contrary to conventional wisdom, they are not increasing.

Figure 8. Mean and Median Payout per Large Paid Claim

Mean and median payout in thousands of 1988 dollars, per large paid medical malpractice claim from 1988-2002, for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), the *MED* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance), and the *NAR* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that are were paid under medical liability insurance *and* were against a physician, hospital or nursing home, *and* involved injuries due to medical care).



The stability in real payout per claim shown in Figure 8 is especially remarkable given that health care costs account for a significant fraction of the harm from medical malpractice, and these costs rose significantly faster than overall prices between 1988 and 2002.²⁷ The geometric average real increase in an index of health care services over this period was 2.4% per year. Other things equal, one would therefore expect average and median payouts to rise simply to reflect the “real” (after general inflation) increase in medical care prices. No such increase occurred. We cannot determine what fraction of payouts reflect health care costs, but if we could measure this fraction and then adjust payouts for the effect of the real increase in health care prices (much as we adjust for overall inflation), the mean and median payouts would likely decline over the 1988-2002 period.

Regression results tell a similar story. Table 10 shows results for a regression of that natural logarithm of the payout amount for each claim against year. These are “per claim” regressions, in contrast to the “per year” regressions reported above for number of claims per year. For regressions involving claims per year, we excluded 1988-1989 because of incomplete reporting in those years. We have no reason to expect bias in which types of claims were reported in 1988-1989 compared to later years. We find no evidence of bias in the size

²⁷ Studying jury verdicts over 40 years, Seabury and coauthors found that rising medical costs are a significant contributor to jury verdicts. Seth A Seabury, Nicholas M. Pace, and Robert T. Reville, *Forty Years of Civil Jury Verdicts*, 1 JOURNAL OF EMPIRICAL LEGAL STUDIES 1 (2004).

distributions presented in Figure 5, nor a change in the skewness of the payout distribution after 1990. Thus, we use all *BRD* claims in the regressions. We confirm in robustness checks that results are similar if we exclude 1988 and 1989.

We use log (payout) as the dependent variable because of the strong skewness of raw payout. This reduces skewness (kurtosis) from 9.5 (154) to 0.62 (3.1). The payout distribution still violates the normality assumption underlying OLS regression, but not radically so. A second advantage of using log (payout) as the dependent variable is that the coefficient on year can be interpreted as the fractional change in *dollar payout*, as long as this coefficient is small. Regressions (1-3) show that there is no strong time trend in payout per claim for the *BRD*, *MED*, or *NAR* datasets. The coefficients on year are insignificant and the point estimates are small, at .005 (0.5%) per year for the *BRD* dataset, 0.3% per year for the *MED* dataset, and 0.1% per year for the *NAR* dataset. In robustness checks, we obtain similar results with dollar payout as the dependent variable, the coefficient on year is small and insignificant for all datasets. The low R^2 values confirm that year is not an important predictor of payout per claim.

Recall that there was a sharp decline over time in the number of paid claims involving less than \$25,000 in 1988 dollars. In regression (5), we switch to the *BRD*_{10k} dataset, thus including claims down to \$10,000. We now find a significant increase in payout, averaging .017 (1.7%) per year. This increase, however, is driven by a *decline* in the number of medium payout claims, with payouts from \$10,000 to \$25,000. To sharpen this point, regression (6) shows the trend in mean payout for *all* paid claims regardless of size, based on the *MED*_{all} dataset. We have only annual rather than per claim data for these claims. The decline in small claims then generates a 2.4% average annual increase in payout per claim. However, these claims account for a trivial fraction of total payout dollars (see Table 4). This is not the stuff of a crisis in malpractice claim payouts.

We ran robustness checks with a number of additional control variables, either instead of or in addition to year. These included year² (to test for possible nonlinearity); Texas GSP per capita; a real medical care services cost index; the nominal interest rate on 10-year U.S. Treasury bonds (to control for the time value of money); and the real rate of increase in health care costs (to control for the effect of health care costs on payouts). None were significant, nor, with one exception, did their inclusion lead to a significant coefficient on year. The exception, shown in regression (4), was rate of medical care cost increase. This has the predicted positive sign, and is significant. When this variable is included, the coefficient on year becomes significant but remains economically modest at .010 (1.0%) per year. This combination of variables aside, we find no significant time trend in payout per claim.

Table 10. Regressions for Log (payout per large paid claim)

Ordinary least squares regression of natural logarithm of payout per large paid medical malpractice claim for the *BRD*, *MED*, *NAR*, and *BRD*_{10k} datasets, for 1988-2002, and for all paid medical malpractice claims for the *MED*_{all} dataset for 1990-2002. Datasets are defined in Part III.A. We treat the first year of the time period (1988 or 1990) as year 0. *t*-statistics, based on robust standard errors, are in parentheses. *, **, *** indicate significance at the 10%, 5%, and 1% levels respectively (omitted for constant term). Significant results (at 5% level) are in **boldface**.

	(1)	(2)	(3)	(4)	(5)	(6)
Dependent Variable	Log (payout per large paid claim)					
Dataset	<i>BRD</i>	<i>MED</i>	<i>NAR</i>	<i>BRD</i>	<i>BRD</i> _{10k}	<i>MED</i> _{all}
Time period	1988-2002	1988-2002	1988-2002	1988-2002	1988-2002	1990-2002
Year	0.005 (1.92)*	0.003 (1.38)	0.001 (0.24)	0.010 (2.78)***	0.017 (6.51)***	0.024 (3.12)***
Rate of medical cost increase				2.679 (2.07)**		
Constant	11.87 (554.66)	11.89 (536.55)	11.95 (512.57)	11.78 (215.65)	11.39 (508.10)	12.03 (179.94)
Observations	12840	11967	10439	12840	15578	13
R²	0.0003	0.0002	0.0000	0.0006	0.0028	0.4698

F. Total Payouts per Year

In the previous section, we focused on payout *per claim*. If there is stability in adjusted number of claims (from Sections C and D), and in payout per claim (from Section E), there will necessarily also be stability in adjusted total payout *per year*. Figure 9 confirms this. It shows total payouts on all malpractice claims per year, adjusted for (i) Texas population; (ii) real health care spending; (iii) number of physicians, and (iv) real Texas GSP. Adjusting for GSP provides a measure of whether the social burden of malpractice payments, relative to the overall Texas economy, is growing or shrinking. From 1990 (the first year with complete reporting) through 2002, there is no trend in total payouts per year adjusted for population, and a decline in total payouts relative to Texas GSP.

To convey a sense of the magnitude of malpractice payouts, total payouts in 2002 were \$510 million, or about 0.55% of total Texas health care spending of about \$93 billion (both numbers are in 2002 dollars). This compares to payout of \$436 million in 1990, which was 0.8% of Texas health care spending of \$52 billion in that year (both numbers are in 2002 dollars). Note that Figure 9 uses 1988 dollars. We caution readers that while the decline in total payout adjusted for GSP is significant, the \$510 million payout underestimates the social burden of medical malpractice litigation. In particular, it excludes defense costs (addressed below), self-insured claims, and the potential cost of defensive medicine.

Figure 9. Total Medical Malpractice Payouts per Year

Total payouts on all large paid medical malpractice claims for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002. Payouts for 1988 and 1989 are lower than the actual amounts due to underreporting.

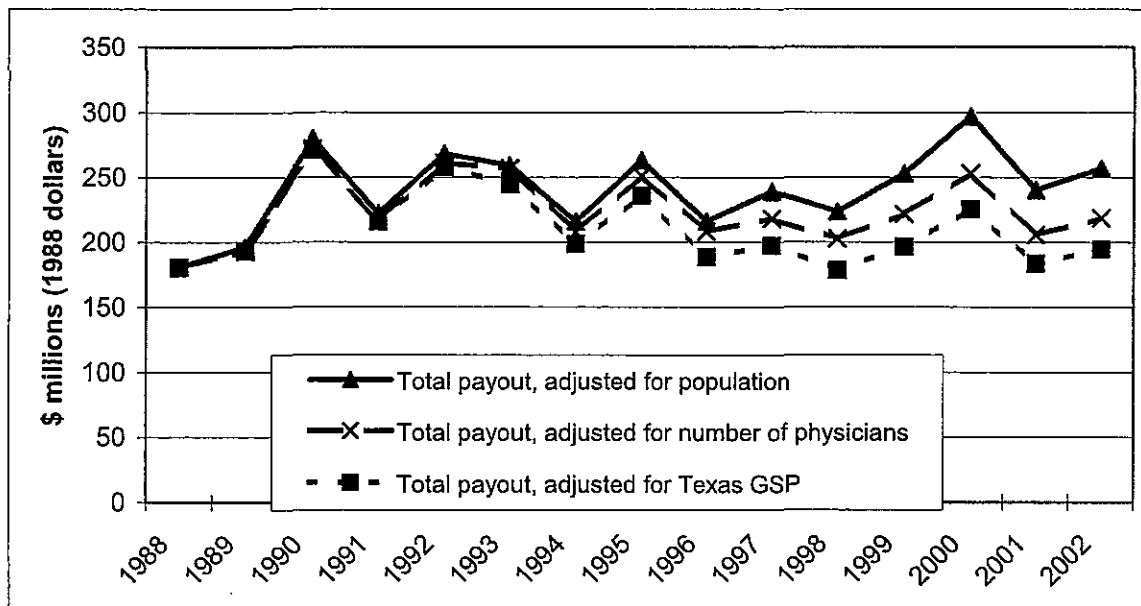


Table 11 provides regressions of total payout per year, first unadjusted, and then adjusted in the same ways as Figure 9, for 1990-2002. Unadjusted total payout increased by \$6 million per year. But if we adjust for population growth, the coefficient on year becomes close to zero and insignificant. Adjusted for Texas GSP, total payouts fell by \$5 million annually. Thus, the social burden of malpractice payouts declined, relative to ability to pay.

Table 11. Total Medical Malpractice Payouts per Year

Ordinary least squares regression of total payout per year for all large paid medical malpractice claims for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), for 1990-2002. *t*-statistics, based on robust standard errors, are in parentheses. We treat 1990 as year 0. *, **, *** indicate significance at the 10%, 5%, and 1% levels respectively (omitted for constant term). Significant results (at 5% level) are in **boldface**. Dollars in millions.

	(1)	(2)	(3)	(4)	(5)
Dependent variable	Total payout per year in \$ millions for large paid claims (<i>BRD</i> dataset)				
Adjusted for	None	Population	Physicians	Health care spending	Texas GSP
Time period	1990-2002	1990-2002	1990-2002	1990-2002	1990-2002
Year	6.34	0.23	-3.06	-0.76	-5.37
	(2.78)**	(0.12)	(1.82)*	(0.42)	(3.21)***
Constant	251.2	247.6	248.7	240.4	246.7
	(15.59)	(17.85)	(20.99)	(18.79)	(20.87)
Observations	13	13	13	13	13
R ²	0.4133	0.0012	0.2321	0.0160	0.4836

G. Defense Costs for Large Paid Claims

We have not yet taken account of defense costs. Many sources report that these costs account for a sizeable portion of total malpractice insurance costs.²⁸ Our dataset contains information on defense costs only for claims with payouts of at least \$10,000 in nominal dollars. Insurers must report total defense costs, broken down into expenses for outside counsel, in-house counsel, and other expenses such as court costs and stenographers. When two or more reports relate to the same incident, we sum defense costs across these reports to determine total defense costs for that incident. We lack information on defense costs for zero payout and small payout claims.

Figure 10 shows that defense costs per large paid claim rose steadily, from about \$21,000 in 1988 to about \$45,000 in 2002. The ratio of defense costs to payout increased from about 8% to about 15%. The increase in per claim costs drove an increase in total defense costs for all large paid claims, from \$27 million in 1990 to \$48 million in 2002. Payments to outside counsel accounted for most of this rise.

²⁸ See, e.g., INSURANCE INFORMATION INSTITUTE, MEDICAL MALPRACTICE INSURANCE 4 (June 2003) (citing study finding that defense costs account for 14% of total tort costs); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS WEB EXCLUSIVE, Jan. 21, 2004, at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1> (contending that “[d]efense costs have greatly increased,” contributing to insurers’ financial woes).

Figure 10. Defense Cost per Large Paid Claim and Ratio of Defense Cost to Payout

Average defense cost per large paid medical malpractice claim for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002. Ratio of defense costs to payout is based on total defense costs and total payout for each year. Defense costs for 1988 and 1989 are lower than the actual amounts due to underreporting.

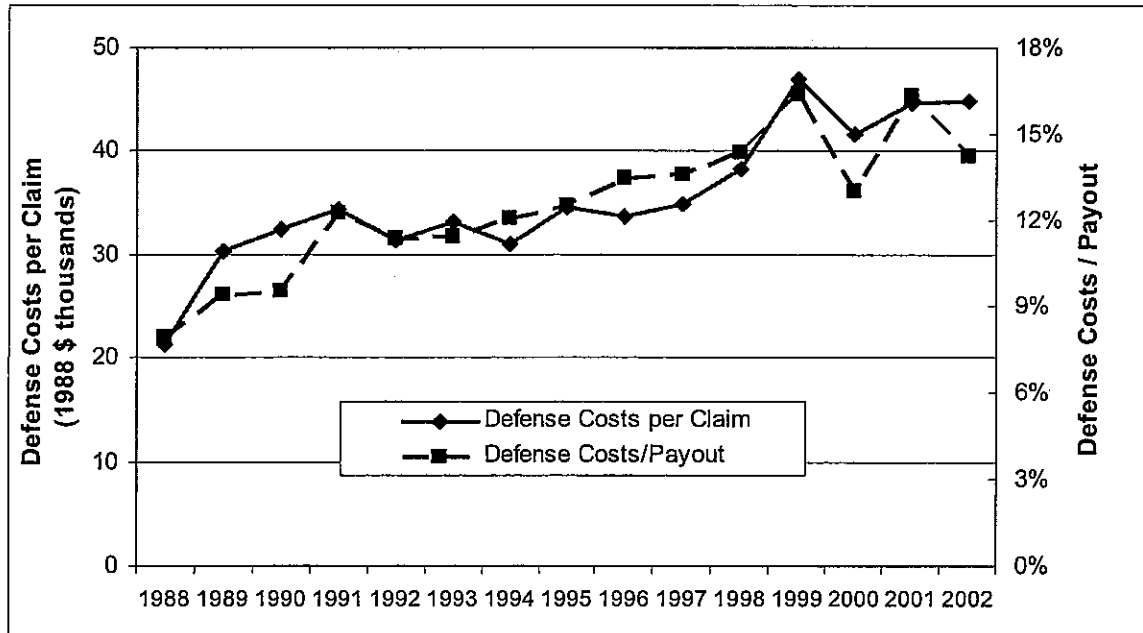


Table 12 provides a regression analysis of log (defense costs per claim) over time for the *BRD* dataset, with and without controls for log (payout per claim) and for the real increase in medical care costs. In robustness checks, we obtain comparable results for the *MED* and *NAR* datasets, and using raw dollars rather than log (dollars) for defense costs and payout. The .044 coefficient in regressions (1-2) indicates that defense cost per large paid claim rose by 4.4% per year -- a cumulative 83% increase over the 14 year period from 1988 to 2002. As regression (2) shows, there is a strong correlation between defense costs and payout. But the rise in defense costs still exists, with the same coefficient, controlling for payout. We plan to investigate defense costs further in future work. At this time, we can only speculate as to the cause of the increase. However, rising defense costs are not unique to Texas. A recent Washington study found rising defense costs, relative to payouts, there also.²⁹

²⁹ STATE OF WASHINGTON, OFFICE OF INSURANCE COMMISSIONER, MEDICAL MALPRACTICE CLOSED CLAIM STUDY: CLAIMS CLOSED FORM JULY 1, 1994 THROUGH JUNE 30, 2004 (2005). Several explanations for increasing defense costs are possible. First, insurers may have spent more per claim to prevent payouts from rising. Second, heightened demand for legal services during the 1990s may have caused defense costs to rise faster than inflation. Third, plaintiffs' attorneys may have selected stronger cases over time or invested more resources in case development, forcing insurers to respond. Two additional explanations may be partly Texas-specific. The 1995 Texas reforms that effectively require plaintiffs to file expert reports at the outset of litigation may have forced insurers to spend more as well. Also, the number of claims resolved using court-annexed alternative dispute resolution procedures increased over the period. This may have increased defense costs.

Table 12. Regressions for Log (defense costs per large paid claim)

Ordinary least squares regression of natural logarithm of defense costs per large paid medical malpractice claim for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), for 1988-2002. We treat 1988 as year 0. *t*-statistics, based on robust standard errors, are in parentheses. *, **, *** indicate significance at the 10%, 5%, and 1% levels respectively (omitted for constant term). Significant results (at 5% level) are in boldface.

	(1)	(2)	(3)
Dependent variable	Log (defense cost per large paid claim) (<i>BRD</i> dataset)		
Year	0.045	0.044	0.042
	(16.00)***	(17.20)***	(10.74)***
Log (payout per claim)		0.464	0.464
		(47.75)***	(47.77)***
Rate of medical cost increase			-1.201
			(0.75)
Constant	9.66	4.13	4.17
	(385.80)	(34.31)	(31.65)
Observations	12330	12330	12330
R²	0.0203	0.1761	0.1761

It would, however, be wrong to blame defense costs for more than a fraction of the recent premium increases. In 2002, defense costs for large paid claims were still only 15% as large as payouts on these claims. Payouts are still the dog, with defense costs the (growing) tail. Moreover, defense costs grew smoothly over time and insurers should have good ability to predict them. Thus, rising defense costs should not cause sharp premium spikes. Finally, the increase in total defense costs for large paid claims-- from \$27 million in 1990 to \$48 million in 2002 -- is not of crisis proportions, compared to total payouts of \$336 million for large claims in 2002.

To be sure, we lack data on defense costs for claims resolved for payments of \$10,000 or less. Aggregate defense costs in zero-payment cases can be substantial.³⁰ However, there are several reasons to doubt that zero- and small-payout claims generated defense costs that were either large enough or unpredictable enough to trigger an insurance crisis. First, these costs should be predictable. Second, claims that generate large payouts involve higher defense costs per claim than smaller claims, as we see from Table 12. Third, the number of zero- and small-payout claims did not increase over time. Table 13 shows, from 1995 to 2002, the number of claims in different size ranges (*TDI* data on zero-payout claims is incomplete prior to 1995). There is no time trend in total claims. Other than a one-time jump in 1995 when *TDI* corrected the cause of prior incomplete reporting, there is no trend in earlier years either. Adjusted for population growth, total claims declined (see Table 14).

³⁰ See, e.g., AMERICAN MEDICAL ASSOCIATION, *MEDICAL LIABILITY REFORM—NOW!* 4 (2004), available at <http://www.ama-assn.org/ama1/pub/upload/mm/450/mlrnowjune112004.pdf>. (defendants spend an average of \$16,160 in cases that are dropped or dismissed before trial); STATE OF WASHINGTON (2005), *supra* note 29, table 10 (in zero-payout cases *with defense costs*, these costs averaged \$16,500 for 2000-2004, amounts not adjusted for inflation). Note, however, that a significant fraction of zero-payout claims close with no defense costs. In Washington, 35% of zero-payout claims closed without defense costs in 2003-2004.

A recent Washington study reports that defense costs in zero-payout cases represent roughly half of all defense costs.³¹ If the same proportion holds true in Texas, then total payouts plus defense costs would have grown from \$374 million in 1990 to \$432 million in 2002. This is an important increase, but short of a crisis.

Table 13. Total Malpractice Claims per Year

Number of medical malpractice claims, including duplicates, for the *MED*_{all} dataset (all claims reported under medical liability insurance), from 1995-2002. We exclude nonduplicate claims with payout over \$10,000 in nominal dollars, but lack the data to identify duplicate claims involving payouts of less than this amount. We show separately zero-payment claims, small paid claims (less than \$10,000), medium claims (\$10,000-25,000 real), large paid claims, total claims, and population-adjusted total claims (base year = 1995).

Year	Zero-payout claims	Small paid claims	Medium paid claims	Large paid claims	Total claims	Population adjusted total claims
1995	6,108	388	194	1,028	7,718	7,718
1996	5,658	399	186	971	7,214	7,072
1997	5,699	490	192	1,019	7,400	7,107
1998	5,353	358	164	961	6,836	6,429
1999	5,738	330	158	1,063	7,289	6,722
2000	6,503	301	192	1,114	8,110	7,339
2001	7,450	310	132	1,051	8,943	7,945
2002	5,555	247	130	997	6,929	6,043
total	48,064	2,823	1,348	8,204	60,439	56,375

Lastly, trials are expensive. If the number of trials with defense verdicts increased, a cost increase could be hidden in the zero-payout claims. Trials are exceptionally expensive. We cannot test this hypothesis directly, but consider it implausible for several reasons. First, as we show below, the number of plaintiff verdicts in medical malpractice cases was roughly constant over time. Unless the fraction of trials won by plaintiffs fell (which no one has suggested), this implies a roughly constant number of defense verdicts as well. Second, studies of civil litigation consistently find that trials have become increasingly rare over time.³² This trend applies to medical malpractice as well. A study by the Bureau of Justice Statistics of trials in 46 of the 75 largest counties in the U.S. (including several large Texas counties) reports that total medical malpractice trials declined from 1,347 in 1992 to 1,156 in 2001.³³ The BJS study also found that the fraction of med mal trials won by plaintiffs was stable at around 25%.

H. Total Claim Costs (Payout Plus Defense Costs)

We next assess the extent to which rising defense costs led to higher total costs (including defense costs), either per year or per large paid claim. Below, we use "*total cost*" to refer to the sum of payout plus defense costs, with the caveat that we lack information on defense costs for zero- and small-payout claims.

³¹ STATE OF WASHINGTON (2005), *supra* note 29, Table 10. This percentage did not increase over time.

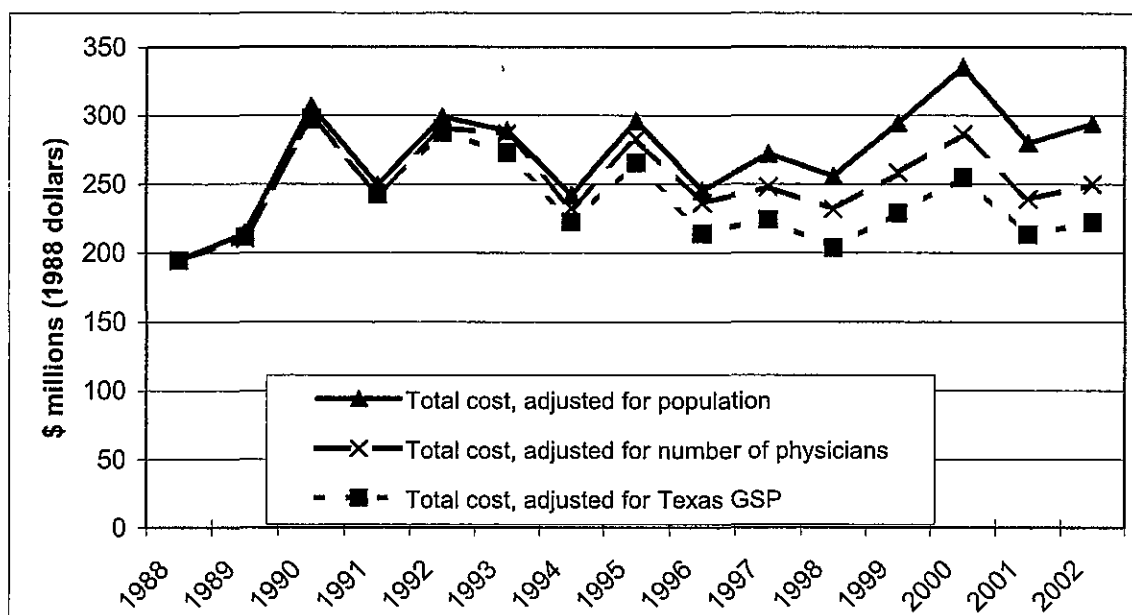
³² See, e.g., Marc Galanter, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts*, 1 JOURNAL OF EMPIRICAL LEGAL STUDIES 499 (2004).

³³ THOMAS H. COHEN AND STEVEN K. SMITH, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 2001 (Bureau of Justice Statistics 2004).

Figure 11 presents changes in the total cost of closed claims over time, adjusted separately for Texas population; real health care spending; number of physicians, and real Texas GSP. Qualitatively, the results are similar to those for total payout in Figure 9. From 1990 (the first year with complete reporting) through 2002, there is no trend in total cost adjusted for population, and there is a decline in total cost relative to Texas GSP. Adjusted for Texas GSP, total cost declined by 25%, from \$297 million in 1990 to \$222 million in 2002.

Figure 11. Total Cost per Year for Large Paid Claims

Total cost (payout plus defense costs) for all large paid medical malpractice claims, for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), for 1988-2002. Total costs for 1988 and 1989 are lower than the actual amounts due to underreporting.



We turn next from aggregate total cost per year to total cost per claim. Figure 12 presents data for the *BRD*, *MED*, and *NAR* datasets. From 1988 to 2002, the average total cost per claim in the *BRD* dataset rose from \$324,000 to \$397,000, about \$5,000 per year (1.5% per year). However, the high water mark was in 1990, with a trough in the mid-1990s.

Figure 12. Total Cost (Payout Plus Defense Cost) per Large Paid Claim

Total cost (payout plus defense cost) per large paid medical malpractice claim for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), the *MED* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance), and the *NAR* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that are were paid under medical liability insurance *and* were against a physician, hospital or nursing home, *and* involved injuries due to medical care).

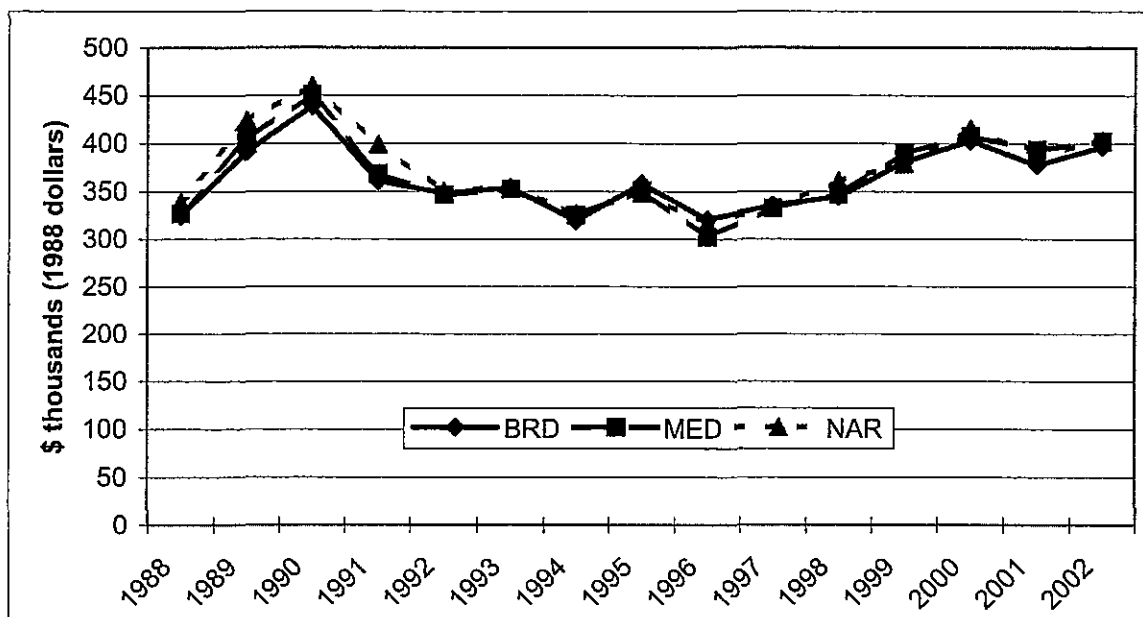


Table 14 provides results for regressions of log (total cost) against year plus a constant term for the *BRD*, *MED*, *NAR*, and *BRD*_{10k} datasets. We find a statistically significant increase of 1.2% per year for the *BRD* dataset. In robustness checks, we obtain similar results with total cost instead of log (total cost) as the dependent variable. Comparing Table 10 to Table 14, about 0.8-0.9% per year of this increase reflects rising defense costs. The rate of increase is higher, at 2.4% per year, for the *BRD*_{10k} dataset, but again, this reflects the declining number of small claims.

Table 14. Regressions for Log (total cost per large paid claim)

Ordinary least squares regression of natural logarithm of total cost (payout plus defense cost) per large paid medical malpractice claim for the *BRD*, *MED*, *NAR*, and *BRD*_{10k} datasets, for 1988-2002. Datasets are defined in Part III.A. We treat 1988 as year 0. *t*-statistics, based on robust standard errors, are in parentheses. *, **, *** indicate significance at the 10%, 5%, and 1% levels respectively. Significant results (at 5% level) are in **boldface**.

	(1)	(2)	(3)	(4)	(5)
Dependent Variable	Log (total cost per large paid claim)				
Dataset	<i>BRD</i>	<i>MED</i>	<i>NAR</i>	<i>BRD</i> _{10k}	<i>BRD</i>
Time period	1988-2002	1988-2002	1988-2002	1988-2002	1988-2002
Year	0.012	0.010	0.008	0.024	0.017
	(5.21)***	(4.45)***	(3.38)***	(10.15)***	(4.78)***
Rate of medical cost increase					2.227
					(1.84)*
Constant	12.03	12.06	12.11	11.59	11.95
	(596.60)***	(580.97)***	(555.39)***	(551.32)***	(233.45)***
Observations	12840	11967	10439	15578	12840
R²	0.0022	0.0017	0.0012	0.0067	0.0025

Over the same period, the real increase in health care costs averaged 2.2% per year. Thus, total costs per claim rose more slowly than health care costs. As explained above, health care costs account for a significant fraction of medical malpractice damages. If we were able to adjust for this component of damages, we would probably find a small or even zero increase in cost per claim. The lack of a crisis in claims remains clear.

I. Jury Verdicts

The stable performance of the tort system will surprise many who have heard that “out of control” juries are awarding ever larger amounts to plaintiffs, which supposedly then cause settlement payments to skyrocket. The results presented thus far show that, whatever juries were doing, payout per claim held steady. Only defense costs grew significantly.

In fact, juries weren't going crazy either. The TDI database includes data on tried cases that result in payouts of at least \$10,000. The *BRD* dataset includes 361 cases tried to juries, plus 13 cases tried to a judge. Of these, 40 jury cases and 2 judge cases resulted in defense verdicts.³⁴ At first glance, defense verdicts followed by payouts of over \$25,000 may seem odd. Anecdotal evidence suggests that many of these cases reflect pretrial “high-low” agreements between the parties, which limit the plaintiff's minimum and maximum recovery even if the actual verdict is outside the high-low bounds. Figure 13 shows the number of plaintiff jury verdicts per year, plus jury verdicts as a percentage of large paid claims. Although the number of trials fluctuated, from 11 in 1996 to 38 in 2000, plaintiff verdicts never accounted for more than 5% of large paid claims in any year and averaged about 3% over the period, with no time trend in this percentage. These findings comport with other studies showing that trials are rare.

³⁴ Eighteen of the “defense verdict” jury trials were entered as \$0 verdicts. The other 24 were entered as \$1 verdicts, with the most recent \$1 verdict in 1997. Neither *TDI* nor local med mal lawyers could explain how a \$1 verdict could occur. We surmise that these entries were entered by agreement to support (for some reason) a high-low settlement after a defense verdict.

Figure 13. Number and Percentage of Plaintiff Jury Verdicts

Number of plaintiff jury verdicts per year in large paid medical malpractice cases, and plaintiff jury verdicts as a percent of large paid claims, for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002.

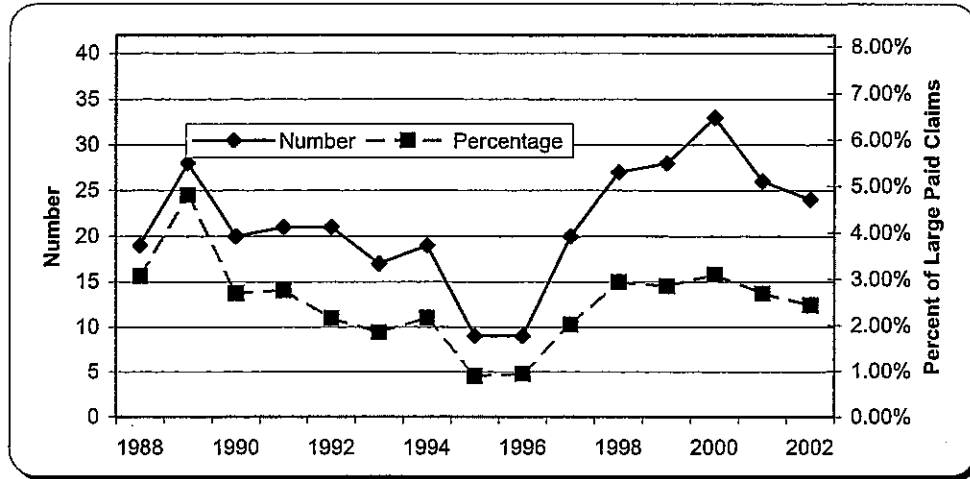
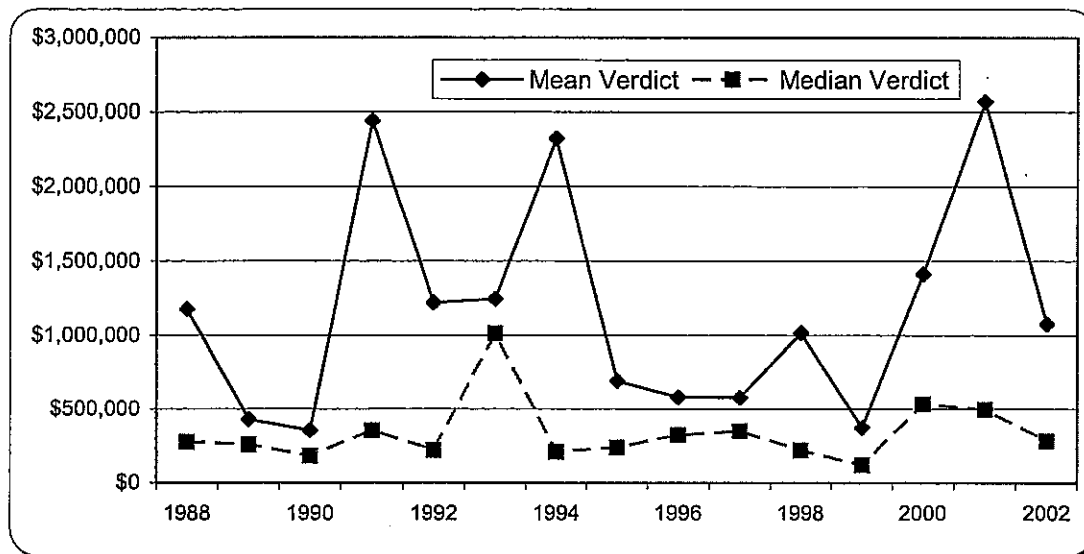


Figure 14 presents mean and median jury verdicts (in constant 1988 dollars) over time in cases where plaintiffs received reported payments, excluding \$0 and \$1 verdict cases. There is fluctuation, but no strong time trend. Across all 321 cases, the average verdict was \$853,584, while the median was far lower at \$394,302. The large difference between mean and median is consistent with other jury verdict studies.³⁵ The median verdict was more stable than the average verdict, although it too varied greatly. The lowest median verdict (\$121,929) occurred in 1999 and the highest median verdict (\$1,012,253) in 1993. In most years, the median verdict fell in the \$200,000-\$700,000 range.

³⁵ See, e.g., THOMAS H. COHEN, TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 (Bureau of Justice Statistics 2004) (reporting in constant 2001 dollars mean and median verdicts for tried tort cases in which plaintiffs prevailed of \$565,000 and \$27,000, respectively).

Figure 14. Mean and Median Plaintiff Jury Verdicts

Mean and median per year for plaintiff jury verdicts in large paid medical malpractice cases, for the *BRD* dataset (nonduplicate claims with payout over \$25,000 in 1988 dollars that were paid under medical liability insurance, were against a health care provider, or involved injuries due to medical care), from 1988-2002.



Assessing statistically whether jury verdicts are changing is hard, because verdicts are highly variable, highly skewed, and limited in number. To further assess whether there was a time trend in jury verdicts, we regressed $\log(\text{verdict})$ as dependent variable against year and a constant term, for the *BRD* and *NAR* datasets. The point estimates on year were positive and economically important, at 2.5% per year for the *NAR* dataset and 3.6% per year for the *BRD* dataset, but only the *BRD* estimate was statistically significant, and barely so ($t = 1.96$).³⁶ At the same time, there was no significant increase in actual payouts after verdict. When we regressed $\log(\text{payout after verdict})$ on year and a constant term, the point estimate for year was an increase of 1.4% per year for the *BRD* dataset, but a 0.2% per year decline for the *NAR* dataset. There was no time trend in the within-year standard deviation of jury verdicts. We plan to investigate jury verdicts and post-trial outcomes in more detail in future work.

V. DISCUSSION OF RESULTS AND LIMITATIONS

A. Outcomes in Closed Medical Malpractice Claims have been Stable

The most important findings in this study are negative. For Texas, the frequency of large paid medical malpractice claims, and the per claim cost of these claims, were relatively stable from 1988 to 2002 when one controls for inflation and population. The most important changes we find are that defense costs rose and smaller paid claims (less than \$25,000 in 1988 dollars) shrank in number. But rising defense costs cannot explain the premium spikes that occurred in

³⁶ Studying jury verdicts nationwide, the Bureau of Justice Statistics (BJS) found that the median jury verdict (in 2001 dollars) rose from \$287,000 in 1996 to \$431,000 in 2001, a sizeable increase THOMAS H. COHEN, *MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES, 2001* (Bureau of Justice Statistics 2004). Looking only at those two years, we also find an increase in the median verdict in Texas, from \$324,000 in 1996 to \$497,000 in 2001 (both figures in 1988 dollars). However, we find a much weaker overall time trend in jury verdicts.

1999-2003. Defense costs rose gradually, and the absolute size of these costs remains small relative to payouts.

The clear implication is that “runaway med mal litigation” makes a poor poster child for the cause of tort reform. From 1988 to 2002, the tort system in Texas processed medical malpractice claims in a reasonably stable and consistent way. The malpractice litigation system has many flaws, but at least in Texas, sudden increases in claim frequencies and costs appear not to have been among them, during the period we study.

B. The Decline in Smaller Paid Claims

We find that smaller paid claims became less common in Texas over time. Studying closed med mal claims in Florida, Vidmar et al. made a similar observation. They reported that mean and median payouts on malpractice claims rose from 1990 to 2003, and that the mix of cases changed substantially. Using a nine level injury-severity scale developed by the National Association of Insurance Commissioners, they found that claims in the two lowest categories declined sharply as a percentage of total paid claims, while average injury severity rose from 5.34 in 1990 to 6.12 in 2003. We lack data on injury severity, and Vidmar et al. do not report the extent to which their reported increase in mean and median payouts is due to a decline in the number of small claims rather than larger payouts on large claims. Still, their findings are consistent with our finding of a decline in the number of smaller paid claims in Texas.

The decline in smaller paid claims leads us to view with suspicion the publicly quoted statistics about rising average payouts and jury verdicts in med mal cases. When the nature of claims changes over time, an increase (or decrease) in the average payout or the average jury verdict tells one little. A rising average payment (jury verdict) may mean only that the fraction of small claims declined. Had we not taken the declining frequency of small claims into account in our analyses, we would have found that the mean payout for the *BRD* dataset rose 40% over our sample period. If we also did not adjust for inflation (a common failing in the public debate), the increase in mean payout would have been 112%! Yet, with these adjustments, our central estimate is that the mean payout per claim on large paid claims increased by only 0.5% per year.

C. What is Causing Malpractice Premium Spikes?

If the tort system is not primarily responsible for the recent spikes in malpractice premiums, what is? An answer to this question is beyond the scope of this article, but we offer here some brief speculations. Much of the answer likely lies in malpractice insurance markets. One set of explanations involves insurance generally. It may not be coincidental that insurance rates soared at a time when the stock market was falling and interest rates were low. As returns on investment declined, carriers could have responded by raising rates.³⁷ Another possibility is that the period starting with Hurricane Andrew in 1992 and continuing through the attacks on the World Trade Center was marked by a series of catastrophes that over time stressed insurance and reinsurance markets, leading to higher premiums across many lines of insurance. A third explanation centers on the “long-tail” nature of medical malpractice insurance, which makes this

³⁷ A regression analysis found a significant negative relationship between interest rates and malpractice insurance premiums. Stephen Zuckerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 *INQUIRY* 167 (Summer 1990).

form of insurance prone to dramatic price swings.³⁸ When policies have “overhangs” that extend forward many years, small changes in loss expectations or expected returns on “float” can exert significant (upward or downward) pressure on prices. Medical liability insurance also faces severe “developments risks,” ranging from changes in medical technology to changes in public expectations, that accentuate the uncertainty of actuarial estimates.³⁹

A fourth consideration is that many malpractice insurers are undiversified, single-line companies sponsored by state and local medical societies. In Texas, for example, the Texas Medical Liability Trust has a 57% market share in covering physicians. These member-owned insurers may feel pressure to estimate future losses on the low side, and then need to compensate for past underpricing when their reserves are depleted. To the extent that other insurers must follow their lead to attract business, the result may be industry-wide premium swings. Another source of underpricing could have been the limited tort reforms which Texas adopted in 1995. As part of those reforms, the legislature instructed *TDI* to estimate insurers' savings and require rate rollbacks during 1996-2000 designed to pass these savings on to policyholders. If the rollbacks overstated actual savings, insurers would have underpriced and a correction would have been inevitable.

With these features of the insurance landscape in mind, let us return to Figure 12, which shows total cost per large paid claim. Over the full 1988-2002 time period, total cost per large paid claim grew by an unalarming 0.8-1.2% per year. But from the low point in 1996 to the high point in 2000, total cost per large paid claim grew by 5.7% per year. If insurers naively took each year's experience as the best guide to the future (instead of using recent observations to partially update their prior expectations, as a proper Bayesian would), they might have become overly optimistic about future payouts by 1996, underpriced malpractice insurance, and then become overly pessimistic by 2000. There is evidence that insurers in Texas and elsewhere underpriced malpractice coverage in the 1990s.⁴⁰ Insurers might also have noticed rising average payout per claim, without realizing that this increase resulted from a decline in small claims, rather than a surge in large claims.

The rate spike during 1999-2003 would then reflect a combination of factors. One would be insurers catching up for past underpricing. A second would be insurers' overestimates of future losses that were based heavily on then-recent loss experiences from 1996 to 2000. A third would be external stresses on insurance markets, including disasters and a decline in investment returns. A fourth might be a modest uptick in claim frequency. Put these together and presto! -- one could have premium spikes that far exceed the increase in future claim-related costs that a rational Bayesian analyst would predict.

³⁸ See William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 3(4) HEALTH AFFAIRS 10 (2004); Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle* (working paper 2005), <http://ssrn.com/abstract=616281> ; William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, DEPAUL LAW REVIEW (forthcoming 2005).

³⁹ See Tom Baker, *Insuring Liability Risks*, 29(1) GENEVA PAPERS ON RISK AND INSURANCE 87 (2004); Sage (2003), supra note 17; Mark F. Grady, *Why Are People Negligent: Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NORTHWESTERN UNIVERSITY LAW REVIEW 293 (1988).

⁴⁰ See TDI, *MEDICAL MALPRACTICE INSURANCE: OVERVIEW AND DISCUSSION* (2003), supra note 18, at 43 (insurers in Texas earned unusually low returns on their net worth during 1991-2000). See also Joseph B. Treaster and Joel Brinkley, *Behind Those Medical Malpractice Rates*, NEW YORK TIMES, Feb. 22, 2005 (many insurers underpriced insurance during the 1990s).

VI. CONCLUSION

Paul Samuelson once quipped that the stock market predicted nine of the last five recessions. Malpractice insurance crises may signal changes in the performance of the tort system just as poorly. No sudden rise in claim frequency, payments, defense costs or jury verdicts preceded or accompanied the premium spike that occurred in Texas after 1998.

The apparent disconnect between stable claim-related outcomes and large swings in insurance premiums shows that for malpractice litigation, and perhaps for tort litigation more generally, one must be very cautious in inferring outcomes in civil justice processes from outcomes in insurance markets. In a tolerably competitive market (which Texas has), insurance premiums should reflect insurers' costs over the long run. But the long run may be long indeed. When considering tort reform, policymakers should heavily discount (if not simply disregard) short-term signals offered by insurance rates, despite the importance of those rates to health care providers. They should seek instead to obtain and rely instead on harder-to-collect, less visible data about claim rates and outcomes. Policymakers should also devote greater effort to generating data and databases that will cast light on the actual causes of the problems they seek to address, such as the Texas database on which this study relies.

In saying this, we mean to deny neither the importance of malpractice insurance rates nor the desire of policymakers to address significant rate increases. Liability insurance premiums can affect health care costs, access to services, physician supply, the level of defensive medicine, and other matters. Reforms that reduce the volatility of insurance prices may help providers to adapt to price changes, avoiding or ameliorating dislocations in health care markets. Our point, which has been largely neglected in the furious battle over malpractice liability, is that one needs to understand what is happening to claim outcomes as a basis for sensible policy changes. At least in Texas, not much happened to claim outcomes during the period we study.

References

- Abraham, Kenneth S., and Paul C. Weiler, *Enterprise Medical Liability and the Choice of the Responsible Enterprise*, 20 AMERICAN JOURNAL OF LAW AND MEDICINE 29 (1994)
- AMERICAN MEDICAL ASSOCIATION, AMA ANALYSIS: A DOZEN STATES IN MEDICAL LIABILITY CRISIS (2002)
- AMERICAN MEDICAL ASSOCIATION, MEDICAL LIABILITY REFORM—NOW! (2004)
- Baicker, Katherine and Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care* (NBER Working Paper 10709, 2004), at <http://ssrn.com/abstract=583707>
- Baker, Tom, *Insuring Liability Risks*, 29(1) GENEVA PAPERS ON RISK AND INSURANCE 87 (2004)
- Baker, Tom, *Medical Malpractice Insurance Reform: "Enterprise Insurance" and Some Alternatives* in MEDICAL MALPRACTICE REFORM IN THE UNITED STATES: NEW CENTURY, DIFFERENT ISSUES (Ronen Kersh and William Sage, eds., forthcoming 2005).
- Baker, Tom, *Medical Malpractice and the Insurance Underwriting Cycle* (working paper 2005), <http://ssrn.com/abstract=616281>
- COHEN, THOMAS H., TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 (Bureau of Justice Statistics 2004)
- COHEN, THOMAS H., AND STEVEN K. SMITH, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 2001 (Bureau of Justice Statistics 2004)
- COHEN, THOMAS H., MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 (Bureau of Justice Statistics 2004)

- STEPHEN DANIELS AND JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM (1995)
- DELOITTE CONSULTING, MEDICAL MALPRACTICE FINANCIAL INFORMATION, CLOSED CLAIM DATABASE AND RATE FILINGS (2004)
- Farber, Henry S., and Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND JOURNAL OF ECONOMICS 199 (1991)
- FLORIDA HOSPITAL ASSOCIATION, MEDICAL MALPRACTICE ANALYSIS (2002)
- Galanter, Marc, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts*, 1 JOURNAL OF EMPIRICAL LEGAL STUDIES 499 (2004)
- Grace, Martin, *Tort Reform: Are There Real Benefits?* (working paper 2004), <http://www.rmi.gsu.edu/rmi/research/papers/tortreformarethererealbenefitsaug2004.pdf>
- Grady, Mark F., *Why Are People Negligent: Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NORTHWESTERN UNIVERSITY LAW REVIEW 293 (1988)
- Gross, Samuel R., and Kent D. Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 UCLA LAW REVIEW 1 (1996)
- HEALTHGRADES, PATIENT SAFETY IN AMERICAN HOSPITALS (2004), at http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf
- Hickson, Gerald B., Ellen Wright Clayton, Penny B. Githens, and Frank A. Sloan, *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*. 267 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1359 (1992)
- Hughes, James W. and Edward A. Snyder, *Litigation and Settlement Under the English and American Rules: Theory and Evidence*, 38 JOURNAL OF LAW AND ECONOMICS 225 (1995)
- Hyman, David A., and Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution*, CORNELL L. REV. (forthcoming 2005), at <http://ssrn.com/abstract=526762>
- INSURANCE INFORMATION INSTITUTE, MEDICAL MALPRACTICE INSURANCE (2003)
- Kritzer, Herbert M., *Contingency Fee Lawyers As Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22 (1997)
- MINNESOTA DEPARTMENT OF COMMERCE, MEDICAL MALPRACTICE CLAIM STUDY 1982-1987 (1989)
- NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MALPRACTICE CLAIMS: FINAL COMPILATION, MEDICAL MALPRACTICE CLOSED CLAIMS, 1975-1978 (1981)
- Sage, William M., *Understanding the First Malpractice Crisis of the 21st Century*, in 2003 HEALTH LAW HANDBOOK 1 (Alice G. Gosfield ed., 2003)
- Sage, William M., *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 3(4) HEALTH AFFAIRS 10 (2004)
- Sage, William M., *Medical Malpractice Insurance and the Emperor's Clothes*, DEPAUL LAW REVIEW (forthcoming 2005)
- Saks, Michael J., *Do We Really Know Anything About the Behavior of the Tort Litigation System--And Why Not?*, 140 UNIVERSITY OF PENNSYLVANIA LAW REVIEW 1147 (1992)
- Seabury, Seth A, Nicholas M. Pace, and Robert T. Reville, *Forty Years of Civil Jury Verdicts*, 1 JOURNAL OF EMPIRICAL LEGAL STUDIES 1 (2004).
- Sharkey, Catherine M., *Unintended Consequences of Medical Malpractice Damages Caps*, 80 NYU. LAW REVIEW (forthcoming 2005), at <http://ssrn.com/abstract=668023>.
- Sloan, Frank A., and Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW AND SOCIETY REVIEW 997 (1990)

- SLOAN, FRANK A., PENNY B. GITHEN, ELLEN WRIGHT CLAYTON, GERALD B. HICKSON, DOUGLAS A. GENTILE, AND DAVID F. PARTLETT, *SUING FOR MEDICAL MALPRACTICE* (1993)
- Smart, Lawrence, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW AND CONTEMPORARY PROBLEMS 59 (1997)
- STATE OF WASHINGTON, OFFICE OF INSURANCE COMMISSIONER, *MEDICAL MALPRACTICE CLOSED CLAIM STUDY: CLAIMS CLOSED FORM JULY 1, 1994 THROUGH JUNE 30, 2004* (2005)
- TEXAS DEPARTMENT OF INSURANCE, *MEDICAL MALPRACTICE INSURANCE: OVERVIEW AND DISCUSSION* (2003), at <http://www.tdi.state.tx.us/general/pdf/spromptpay.pdf>
- TEXAS DEPARTMENT OF INSURANCE, *2002 TEXAS LIABILITY INSURANCE CLOSED CLAIM ANNUAL REPORT* (2004), at <http://www.tdi.state.tx.us/general/forms/report4.html>
- Vidmar, Neil, Paul Lee, Kara MacKillop, Kieran McCarthy and Gerald McGwin, *Seeking the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, DEPAUL LAW REVIEW (forthcoming 2005)
- Viscusi, W. Kip and Patricia H. Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance* (working paper, 2004), at <http://ssrn.com/abstract=607203>
- Weisberg, Herbert L., and Richard A. Derrig, *Fraud and Automobile Insurance: A Report on Bodily Injury Liability Claims in Massachusetts*, 9 JOURNAL OF INSURANCE REGULATION 497, 503 (1991)
- Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167 (Summer 1990)

Appendix A. Data Sources

- *inflation*: We convert current dollars in each year to 1988 dollars (or, occasionally 2002 dollars) using the Consumer Price Index for All Urban Consumers (annual average, 1988 = 100). Source: www.bls.gov/cpi/
- *Texas population*: Annual population estimates of Texas calculated by the U.S. Census Bureau are used. Source: <http://www.census.gov/popest/states/>
- *real Texas Gross State Product (GSP)*: Texas GSP reported by the Bureau of Economic Analysis, converted to 1988 dollars using the Consumer Price Index for All Urban Consumers. Source: <http://www.bea.doc.gov/bea/regional/gsp/>
- *Texas physicians: Texas physicians*: Nonfederal physicians in active direct patient care practice as reported by the Texas Department of Health. (Source: <http://www.tdh.state.tx.us/dpa/PHYS-1nk.htm>). An alternate data source, available for most years, is American Medical Association, active non-federal physicians in direct-patient care, gives physician totals about 20% higher than the Texas Department of Health measure.
- *Texas real health care spending*: Texas health care spending in real 1988 dollars (or, occasionally, 2002 dollars). Real health care spending is adjusted for inflation in health care costs using the Medical Care Services Cost Index (note: *not* the overall Consumer Price Index), available from www.bls.gov/cpi. Texas health care spending for 1988-1998 is from Center for Medicare Statistics, U.S. Department of Health and Human Services. Texas health care spending for 1999-2002 is estimated using Center for Medicare Statistics data for U.S. health care spending and assuming a constant 0.054 ratio of Texas to U.S. population adjusted health care spending. The 0.054 ratio is estimated based on 1988-1998 data. (Source: <http://www.cms.hhs.gov/statistics/nhe/state-estimates-provider/tx.asp>)

- *real medical care services cost index*: Medical care services cost index (1988 = 100), adjusted for general inflation using the Consumer Price Index for All Urban Consumers. Source: <http://www.bls.gov/cpi/home.htm>
- *nominal interest rate on 10-year U.S. Treasury bonds*: Average annual yield on 10-year treasury securities. Source: <http://federalreserve.gov/releases/h15/> (annual series)

Appendix B. Correlation Table

Correlation table for variables listed in Appendix A, plus selected variables for nonduplicate large paid claims, for the *BRD* dataset for 1988-2002, except when another dataset or time period is specified. * = significant at 5% level. Significant results in boldface.

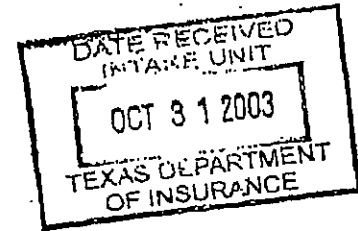
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
(1) Year	1.0000													
(2) Population	0.9981*	1.0000												
(3) Real Texas GSP	0.9860*	0.9924*	1.0000											
(4) No of physicians	0.9803*	0.9868*	0.9957*	1.0000										
(5) Real health care spending	0.9828*	0.9835*	0.9790*	0.9838*	1.0000									
(6) Real med care services cost	0.9745*	0.9630*	0.9261*	0.9146*	0.9368*	1.0000								
(7) Real rate of increase in med care services cost	-0.7394*	-0.7541*	-0.7986*	-0.7668*	-0.6947*	-0.6366*	1.0000							
(8) 10-year nominal interest rate	-0.9281*	-0.9187*	-0.8844*	-0.8678*	-0.9173*	-0.9495*	0.5559*	1.0000						
(9) No of <i>BRD</i> claims 1990-2002	0.7962*	0.7909*	0.7657*	0.7527*	0.7270*	0.8377*	-0.5297	-0.7608*	1.0000					
(10) No of paid claims (<i>MED_{all}</i>) 1990-2002	0.0858	0.0912	0.1511	0.1266	0.0265	-0.0058	-0.4960	0.1382	0.2269	1.0000				
(11) Total no of claims (<i>MED_{all}</i>) 1995-2002	0.2780	0.2776	0.2702	0.3271	0.2142	0.1620	0.0171	-0.0227	0.4300	0.0888	1.0000			
(12) Mean payout per <i>BRD</i> claim	-0.0766	-0.0747	-0.0098	0.0387	0.0178	-0.1960	-0.0121	0.1952	-0.1822	0.4002	0.3307	1.0000		
(13) Mean defense cost per <i>BRD</i> claim	0.8693*	0.8596*	0.8702*	0.8806*	0.8892*	0.8112*	-0.6717*	-0.7892*	0.5106	0.1131	0.3730	0.2275	1.0000	
(14) Mean total cost per <i>BRD</i> claim	0.1299	0.1294	0.1917	0.2388	0.2215	0.0064	-0.1661	-0.0021	-0.0723	0.3947	0.3599	0.9744*	0.4404	1.0000



The Medical Protective Company

October 30, 2003

Hon. Jose O. Montemayor, Insurance Commissioner
Texas Department of Insurance
Property & Casualty Intake Unit
Tower I, Room 460 A
333 Guadalupe Street
Austin, TX 78701



RE: THE MEDICAL PROTECTIVE COMPANY - NAIC #11843
TEXAS PHYSICIANS & SURGEONS
COMPANY FILING # 03- TX- 73
OCCURRENCE, ENHANCED AND STANDARD CLAIMS MADE PROGRAMS
Revised Base Rate Change (+ 15.3 %)
Revised Class Relativity Revisions (+ 1.0 %)
Revised Increased Limit Revisions (- 5.7 %)
Revised Territory Relativity Revisions (+ 7.8 %)
Claims Made Step Revisions (+ 0.6 %)

OCCURRENCE AND STANDARD CLAIMS MADE PROGRAMS
Add Deferred Premium Payment Rule

COMPREHENSIVE LIABILITY COVERAGE FOR HEALTH CARE PROVIDERS
Revise Section III - Physicians & Surgeons, State Rate Pages

PROPOSED EFFECTIVE DATE : June 01, 2004

Dear Hon. Montemayor:

The Medical Protective Company hereby submits for your review and consideration the above-captioned rate filing applicable to its Texas Physicians & Surgeons and Texas Comprehensive Liability Coverage for Health Care Providers programs. The company requests June 01, 2004, as the effective date for this submission.

The accompanying Actuarial Memorandum provides support for the proposed rate change, which consists of an increase to our filed base rate, revisions to the class relativity, increased limit revisions, territory relativity, claims made step revisions and a rule addition. The overall premium effect of this filing is + 19.0%.

In addition, please find revised manual pages for Section III - Physicians & Surgeons, for the Company's Comprehensive Liability Coverage for Health Care Providers program. The rates used for this program mirror those used for the Company's Individual Physician & Surgeon Program, and therefore are being included in this submission.

Revised manual pages reflecting the aforementioned modifications are enclosed along with a self-addressed stamped envelope. Upon completion of your review, would you please stamp the duplicate copy of this submission and return it to us in the envelope provided.

Should you have any questions regarding this filing, please do not hesitate to contact me. Thank you.

Sincerely,

Melissa Coker

Melissa Coker, Regulatory Specialist
The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
(800)-348-4869, ext. 6838
(260)-486-0733 (fax)

Enclosure(s)

EXHIBIT 3

MED 000007

THE MEDICAL PROTECTIVE COMPANY
TEXAS
PHYSICIANS AND SURGEONS
ACTUARIAL TORT REFORM MEMORANDUM

This memo explains our position in reducing our rates to reflect the potential impact of HB 4, effective on September 1, 2003, and Proposition 12, passed by the Texas Electorate on September 13, 2003. Exhibit I displays our rate need in the state of Texas of 27% for occurrence and 41% for claims made. These indications have been reduced by 6.5% to reflect potential savings from tort reform.

As outlined in a letter dated September 24, 2003, from Philip O. Presley, Chief Actuary, we quantified the impact that the three provisions in this letter would have on our rates.

- Reduction in the interest rate to measure pre- and post-judgment interest (Article 6).

We have no data to calculate the impact of this provision. We believe that adjustment of the interest rates in pre- and post-judgment constitute an insignificant effect on our overall book.

- Limitations on non-economic damages (Article 10, Subchapter G).

Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%. Please refer to Tort Reform Exhibit A.

- Periodic payment of future damages in cases where the present value of future damages exceeds \$100,000 (Article 10, Subchapter K).

This provision does not apply to damages already incurred and is a function of total damages paid and policy limits. Tort Reform Exhibit B illustrates that the estimated loss savings from this provision will be 1.1%.

Adding the three pieces gives us less than 3% in estimated savings in losses. When applied to premium rates, the savings will be even less. There are additional considerations as to why the potential impact of tort reform may be less than anticipated:

1. We write policy limits lower than some other companies. Therefore, our potential savings will be less.

2. Frequency has risen significantly this year. It will be at least a couple of years before we can tell how much can be attributed to filings to beat the September deadline and how much is a true increase in frequency.
3. The savings estimated by the 1996 Tort Reform did not materialize completely.
4. With big dollars at stake, plaintiff attorneys will find ways to shift costs from non-economic to economic damages.
5. It is unknown how the judicial system will react to the provisions. Medical malpractice victims with serious injuries who will be receiving less non-economic damages than before may be looked upon very favorably by juries and/or judges.
6. There may be "cap-busters." For example, in Jenkins v. Patel, Michigan Court of Appeals, 4/1/2003, it was ruled that the cap on non-economic damages does not apply to wrongful death cases.

The most significant reason for no further reduction is the uncertainty. Potential savings will not be seen for at least a couple of years. If these savings do not materialize we will have provided valuable services to physicians in Texas at inadequate rates. So we can continue our service we cannot reduce our rates more than 6.5%. In fact, because we are reducing our rates before savings can materialize we are putting ourselves at risk with possible inadequate rates. We view the 6.5% decrease in our indication as an act of faith with the Department and reflects a middle ground between the company's view of the impact of tort reform and the expected tort reform savings reflected in other estimates.

Each year we reevaluate our book, and fewer or greater savings will materialize in our data. We can then reflect any difference in future rate changes.

The Medical Protective Company

Tort Reform Exhibit A
\$250,000 Cap (Secure)

To estimate savings on a \$250,000 cap on non-economic damages for 2004, we stratified our losses into different layers. The losses are then projected to the year 2004. We then estimated what portion in each layer would be considered non-economic damages. The losses eliminated were calculated by subtracting \$250,000 from column (2) and dividing by the midpoint of the payment range.

Payments	(1) % of Projected Losses In Layer	(2) Losses Estimated to be Non-Economic	(3) % Eliminated by \$250,000 Cap	(4) (1) x (3)
1-\$100,000	10.0%	0	0.0%	0.0%
\$100,001-\$200,000	14.9%	0	0.0%	0.0%
\$200,001-\$500,000	36.6%	0	0.0%	0.0%
\$500,001-\$750,000	24.1%	100,000	0.0%	0.0%
\$750,001-\$1,000,000	8.4%	280,000	3.4%	0.3%
Over \$1,000,000	6.0%	400,000	12.5%	0.8%
Estimated Loss Savings				1.0%

The Medical Protective Company

Tort Reform Exhibit B
 Periodic Payments of Future Damages

To estimate savings on structured payments for 2004, we stratified our losses into different layers. The losses are trended to the year 2004. We then estimated the proportion of each layer would be paid in a lump sum. The remainder of each layer would be the part eligible for a structured payment.

Payments	(1) % of Projected Losses in Layer	(2) % of Losses Paid as Cost to Date	(3) % of Losses Paid for Future Benefits 1.0 - (2)	(4) (1) x (3)
1-\$100,000	10.0%	100%	0%	0.0%
\$100,001-\$200,000	14.9%	95%	5%	0.7%
\$200,001-\$500,000	36.6%	75%	25%	9.2%
\$500,001-\$750,000	24.1%	50%	50%	12.1%
\$750,001-\$1,000,000	8.4%	35%	65%	5.5%
Over \$1,000,000	6.0%	20%	80%	4.8%
Total				32.2%

Using a sample of our own data, 93% of our losses are paid outside of court verdicts. These amounts would not be subject to the law and would not be subject to the structured payments provision:

If we assume that the proportion of cases that resolve outside verdict decreases to 85%, the remainder subject to structured settlements would be approximately:

$$32.2\% \times (1.0 - 85\%) = 4.83\%$$

Discounting future payments at 5% over an average 10 year period, the savings on the future benefits is 22.8%. Therefore, the savings for losses for 2004 are estimated to be 4.83% * 22.8% = 1.1%.

1 RESPONSE OF JAMES ROBERTSON TO QUESTIONS 1(a), 1(b), 3(a), 4(b), and 7
2 IN ORDERS BY THE COURT DATED APRIL 21, 2003 AND APRIL 24, 2003
3 REQUESTING ADDITIONAL EVIDENCE

4
5 April 30, 2003
6

7 My name is James Robertson, Assistant Vice President and Associate Actuary for SCPIE
8 Holdings, Inc., the parent company of the Applicants in this case, SCPIE Indemnity
9 Company ("SIC") and American Healthcare Indemnity Company ("AHI") (together,
10 "SCPIE"). I am presenting this additional written testimony to several of the questions posed
11 by Judge Rasmussen's questions directed to SCPIE. Remaining questions will be addressed
12 by other SCPIE witnesses in this case.

13
14
15 **1. Referring to SCPIE Exhibit 38, page Bates stamp number 0434:**

16
17 (a) The trend factor from Model A in line item 10(a) under the 1999 data column
18 is listed as 1.285. Should this figure be 1.287 based on SCPIE page Bates stamp
19 number 0434?
20

21 The trend factor on Bates 0434 on Line 10(a) should be 1.287, not 1.285. As a
22 result of your question, I changed the factor to 1.287 and recalculated the
23 resulting indicated rate change on Bates 0434, Line 25. The resulting indicated
24 change is still +15.5% due to the fact that this change is so small and affects the
25 indicated rate change only in the fourth decimal place. A corrected Exhibit 20
26 (the indicated rate level calculation) of the Trued Up Rate Application (SCPIE
27 Exhibit 38, p. 0434) is attached hereto as SCPIE Exhibit 44 (Bates No. 00447).

28
29 (b) From where in SCPIE's Exhibit 38 did you get the development factors
30 1.0486, 2.6188 and 541.5097 in line item 8(c) on SCPIE 0434 for the 1999, 2000 and
31 2001 data columns? (I found the development factor listed in lines 8(a) and 8(b) on
32 SCPIE pages 0397 and 0401 but could not find the correlating factors for 8(c) on
33 SCPIE page 0405.)
34

35 The development factors on SCPIE Exhibit 38, Bates number 0434, Line 8(c) are
36 1.0486, 2.6188 and 541.507 for 1999, 2000, and 2001, respectively. They are not

1 to be found on Bates number 0405, but rather they are calculated from figures
2 elsewhere in Exhibit 38, on Bates 0409 and on Bates 0434. I will explain this in
3 more detail.

4
5 These three figures are the development factors that apply to the layer of losses
6 that is in excess of \$1 million per claim. For this layer of losses, the development
7 factors are not calculated in the same manner as for the underlying two layers.
8 They are calculated in a two-step procedure called a Bornhuetter-Ferguson
9 approach.

10
11 The first step in the calculation for this highest layer begins on Bates number
12 0405, which is similar to Bates 0397 and 0401 for the lower two layers. But it
13 does not stop there, as it does for the lower two layers of loss. The figures for
14 1999, 2000, and 2001 from the final column labeled "undeveloped" are then
15 transferred to Bates number 0409 and appear as percentages in column (2).
16 Taking 1999 as an example, the figure 0.0343 from Bates 0405 in the column
17 labeled "undeveloped" appears on Bates number 0409, column (2). It is then
18 combined with the figures in columns (1), (3), and (4) to result in the estimated
19 ultimate loss in column (5). For 1999, the result in column (5) is \$7,916,930.

20
21 This calculation that I described above, which appears on Bates 0409, is the
22 Bornhuetter-Ferguson calculation. To follow the process to its conclusion, I will
23 focus on the calculation for 1999. For 1999, the estimated ultimate losses of
24 \$7,916,930 from Bates 0409 in column (5) are then copied and appear on Bates
25 0434 (the indicated rate level calculation) on line 9(c) for 1999. When this figure
26 of \$7,916,930, which is the estimated ultimate developed losses, is divided by the
27 incurred losses as of 3/31/02, which is \$7,550,000 on line 5(c) of Bates number
28 0434, the result is the loss development factor of 1.0486. The development
29 factors for the other two years are calculated analogously. Hence, in this case the
30 loss development factor is actually done in this two-step process and the
31 development factors on SCPIE Exhibit 38 (Bates 0434, line 8(c)) are correct.

1 These, incidentally, are the same figures used by Mr. Schwartz in his calculation
2 on Bates FT CR 0004.

3
4 **3. Referring to Death, Disability and Retirement experience.**

- 5
6 a) **Is the data contained in SCPIE Exhibit 29, "12/31/2001 Reserve Review For
7 Future Utilization of DD&R Benefit" Bates Stamp 0340 and 0342 based on
8 California-only policyholder data?**

9
10 The "12/31/2001 Reserve Review For Future Utilization of DD&R Benefit," also
11 known as the DD&R Reserve Study was prepared by Tillinghast based on data
12 that SCPIE provided. SCPIE provided California-only data to Tillinghast for
13 utilization in the DD&R Reserve Study. Therefore, the DD&R Reserve Study
14 used California-only data. No data from any other state is used.

15
16 **4. Rate of Return**

17
18 (b) **Include in your analysis to question 4a your opinions(s) with respect to any
19 impact the statutory provisions of The Medical Injury Compensation Reform Act of
20 1975 (MICRA) have on the magnitude of the risk covered by medical malpractice
21 insurance in California.**

- 22
23 a. SCPIE believes that a rate of return of 15% has been supported as the
24 maximum permitted rate of return. Dr. Appel in his response to the court's
25 Question 4(a) supports his opinion of 15 percent, and provides an alternative
26 rate of return of 13 percent.

27
28
29 To understand the impact of MICRA on the risk of Medical Malpractice
30 Insurance in California, some historical background will be helpful. Medical
31 malpractice has historically been one of the most volatile and risky lines of
32 business in California. In the mid 1970s, California experienced a medical
33 malpractice crisis in which huge losses in that line of business caused insurers to
34 reduce or cease selling medical malpractice insurance and consequently restricted
35 the ability of doctors to purchase that insurance. As a result, physicians
36 themselves formed four different mono-line insurers to write the coverage and to

1 ensure availability of the insurance for physicians. These four companies
2 currently insure approximately 59.5 percent of the medical malpractice risks in
3 California. SCPIE's predecessor company, formed as a reciprocal for its member
4 physicians, was one of those four insurers. SCPIE reorganized in 1997 as a stock
5 insurance company and SCPIE Holdings Inc., its parent insurance holding
6 company, is publicly traded on the New York Stock Exchange. Many of its
7 stockholders are insured physicians, and 9 physicians serve on SCPIE Holding's
8 board.

9
10 SCPIE has experienced severe volatility in profits. In the last four years SCPIE
11 has experience losses averaging 11.2 percent, as reflected in Dr. Appel's Rebuttal
12 Testimony, at page 4. As SCPIE's policyholders, including some board members,
13 are physicians, they recognize the volatility and risk of this line of business.
14 Therefore the board authorized the rate filing with no resulting complaints from
15 insureds upon notification of the pending rate increase.

16
17 While MICRA was the legislature's attempt at remedying the medical malpractice
18 crisis in California in 1975, it did not substantially reduce the relative risk of
19 medical malpractice insurance in California. MICRA placed a cap of \$250,000
20 per claimant on non-economic damages, defined as pain and suffering,
21 inconvenience, etc. Nonetheless there are cases where economic damages can be
22 quite substantial and vary significantly from the average loss. Economic damages
23 are those that can be objectively quantified, including medical expenses, lost
24 wages and loss of use of property. The potential of high economic damage
25 awards increases the risk of the California medical malpractice line of business.

26
27 Many of the large claims experienced by SCPIE arise from what we call "XPL"
28 claims, meaning excess of policy limits. Medical malpractice, unlike other
29 liability lines of business such as automobile liability, operates such that the
30 insured doctor must give the insurer permission to settle a claim out of court
31 before the insurer can pursue this avenue of settlement. If the doctor does not

1 give his permission for the insurer to settle, and the claim instead goes to court,
2 and a verdict is reached which is higher than the policy limits, the insurer pays the
3 policy limits, but the individual doctor is responsible for the amount in excess of
4 the policy limits. As a result of the doctor's potential liability, doctors routinely
5 demand that the insurer settle his claim within the policy limits, and doing so in
6 writing eliminates his responsibility for any adverse judgment over the policy
7 limits should the case go to trial. This is because if there is an adverse judgment
8 in excess of the policy limits, the insurer must pay the entire claim, not just the
9 policy limits. As a result, there is potential for the insurer to pay claims that are
10 very large, in excess of the policy limits.

11
12 SCPIE has indeed experienced a number of very large losses over the years. The
13 following table displays incurred losses for California for report years 1997-2001
14 that are in excess of \$1 million each.

15
16 Table 1
17 California Physicians' Medical Malpractice
18 Claims in Excess of \$1 Million by Report Year
19 (\$ in millions)
20

<u>Report</u> <u>Year</u>	<u>Number</u>	<u>Dollar</u> <u>Amount</u>	<u>Average</u> <u>Size</u>
1997	3	\$10.5	\$3.5
1998	7	\$16.6	\$2.4
1999	3	\$11.9	\$4.0
2000	10	\$21.0	\$2.1
2001	8	\$9.7	\$1.2
Total	31	\$69.7	\$2.2

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1
2 Displaying these same large losses by size of loss produces Table 2:
3

4 Table 2
5 California Physicians' Medical Malpractice
6 Claims in Excess of \$1 Million by Size of Loss
7 (\$ in millions)
8

<u>Size of Loss</u>	<u>Number</u>	<u>Dollar Amount</u>	<u>Average Size</u>
Over \$1 Million	31	\$69.7	\$2.2
Over \$2 Million	9	\$40.7	\$4.5
Over \$5 Million	3	\$22.4	\$7.5

9
10 This riskiness translates into high premiums for insured physicians. However,
11 SCPIE's current rates, risky as they are, are not even the highest in the
12 marketplace. SCPIE's main competition is NORCAL, the largest writer of
13 medical malpractice insurance in California, insuring 23.5 percent of the market.
14 The following chart compares NORCAL's average rates with SCPIE's for three
15 Southern California counties. It also shows the average rates for San Luis
16 Obispo, a county in the northern section. I have not given a complete listing of all
17 the northern counties since SCPIE does not write much business there and
18 because there is not much variability among the rates in the northern counties, so
19 one example will suffice.

20
21 Accordingly, even though MICRA limited non-economic damages, the potential
22 of high economic damages in California makes medical malpractice a high-risk
23 line of business.
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Table 3
California Physicians' Medical Malpractice
Average Mature Annual Rates for All Specialties
(\$1 Million / \$3 Million Limits)

<u>County</u>	<u>2003 NORCAL</u>	<u>2002 SCPIE</u>
Los Angeles	\$23,085	\$15,591
Orange	\$23,085	\$17,079
San Diego	\$20,635	\$14,282
San Luis Obispo	\$12,205	\$10,744

7
8
9

A. Expense Trend:

(a) Show SCPIE's calculation for its fixed expense trend factor of 0.9967 used in Exhibit 35 and 37 and in support of Exhibit 38. From where did SCPIE obtain the data to use in the regulatory formula? Indicate the SCPIE Exhibits along with the Bates stamped page number for each supporting document.

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The expense trend calculation is displayed in the table below. The explanation of the data sources is contained in the footnotes to the table.

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When the expense trend was calculated for Exhibit 35, the miscellaneous losses were not included in the calculation. The expense trend factor at that time was 0.9967. However, when the miscellaneous losses were added into the calculation, the expense trend changed somewhat due to the inclusion of more losses and premiums, of which the expenses are a function. However, the resulting trend factor changed only in the fourth decimal place to 0.9970. If rounded to the third decimal point, as are most of the calculations associated with trend, the difference would disappear due to rounding.

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Expense Trend Calculation

Expense Item	1999	2000	2001
	(a)	(b)	(c)
(1) Non-ULAE fixed expenses	\$17,368,193	\$17,966,744	\$15,681,366
(2) ULAE expenses	\$8,867,432	\$10,137,731	\$7,802,233
(3) Disallowed expenses	\$331,876	\$317,060	\$217,797
(4) Total fixed expenses	\$25,903,748	\$27,787,415	\$23,265,802
(5) Exposures	16,807	16,187	15,398
(6) Average fixed expense	\$1,541	\$1,717	\$1,511
(7) Annual change		.1138	-.1198

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Notes to Expense Trend Table:

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(1) On SCPIE Ex. 38, Bates 423, non-ULAE fixed expenses are calculated as a percentage of premium for other acquisition, general, and taxes and fees other than CA premium taxes. For example, for 1999 this is 8.0% + 6.8% + 0.9% = 15.7%. Fixed expense dollars come from an internal allocation report done by SCPIE. This percentage is then applied to the total limits earned premium displayed on SCPIE Ex. 38, Bates 0434, line 2 to arrive at the non-ULAE expenses in this line. For example, for 1999, 15.7% times \$110,625,432 = \$17,368,193. Calculations for 2000 and 2001 are analogous.

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(2) ULAE expense dollars are taken from the Insurance Expense Exhibits, Part III. Since these figures are not California-specific, a ULAE percentage is then calculated by dividing these ULAE dollars by the sum of losses and AAE dollars. This percentage is then applied to the total limits ultimate loss and ALAE before trend is applied, which appears on SCPIE Ex. 38, Bates 0434, line 9. For example, the ULAE percentage for 1999 is 9.1% and 9.1% time \$97,444,305 = \$7,867,432.

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(3) Disallowed expenses are displayed on SCPIE Ex. 38, Bates 0425. These dollars come from an internal expense report of SCPIE. These dollars are then stated as a percentage of premium. These percentages are then multiplied by the total limits earned premium for each year to arrive at the disallowed expenses. For example, for 1999 disallowed expenses are equal to 0.3% of premium. Hence, 0.3% times \$110,625,432 = \$331,876.

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(4) (1) + (2) - (3)

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(5) Exposures are equal to the number of physicians insured for one year, stated in terms of Class 1 equivalents. That is, if a physician is insured for one year and is in a category such that his rate is 1.4 times the Class 1 physician rate, then the amount of exposures captured here is 1.4 units. Exposures are taken from internal SCPIE reports.

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(6) (4) / (5)

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1 The average change then is the average of the two factors on line (6) in Table 1, or $-.003$
2 which, stated in terms of an expense trend factor is 0.997 .
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I declare under penalty of perjury under the laws of the State of California that the foregoing testimony is true and correct.

Dated: April 30, 2003
at Los Angeles, California

James Robertson
JAMES ROBERTSON
Assistant Vice President/
Associate Actuary
THE SCPIE COMPANIES



Center for Health Statistics
Health Professions Resource Center
Statewide Health Coordinating Council



Highlights: The Supply of Pediatricians in Texas - 2006

June 2007

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Pediatrics is the medical specialty devoted to the delivery of care “to attain the optimal physical, mental, and social health and well-being of all infants, children, adolescents, and young adults.”¹ Family physicians, general practitioners, internists, and non-physician clinicians provide medical services to children as well especially in rural areas that may not have a pediatrician. This study, conducted by the Health Professions Resource Center (HPRC), focuses on the supply trends and current challenges for the pediatrician workforce in Texas. Data obtained from the Texas Medical Board’s licensing file were analyzed to study the supply of pediatricians - general pediatricians specifically - in Texas. Allopathic and osteopathic physicians who were actively involved in the direct care of patients, either full-time or part-time, were included in this report. Residents, fellows, locum tenens, federal or military physicians, and physicians primarily involved with research, teaching, or administration were excluded from this analysis. For this study, the pediatric population is defined as children 18 years or younger unless otherwise noted. US pediatric population data for 1996 and 2000 were obtained from US Census Bureau’s April 1 intercensal estimates. Texas pediatric population data were obtained from Texas State Data Center.

National and Texas Supply Trends of General Pediatricians

Between 1992 and 2001, the total number of active patient-care pediatricians in the US increased by 53% in absolute numbers while the US population of children less than 18 years only grew by 11%.¹ National projections estimate the growth in the general pediatrician workforce will continue to outpace the pediatric population growth.²

However, despite these projections many factors must be considered to understand the challenges in ensuring that an optimum workforce would be accessible for children everywhere:

- The persistent geographic maldistribution of the supply of pediatricians in rural and inner-city communities.^{1,3}
- The need for collaboration with other physicians as well as non-physician clinicians providing health care to children.^{3,4}
- The growing ethnic diversity of the nation compels a need for a diverse and culturally competent workforce to better serve the needs of the child population.^{1,3,5,6}
- Women comprise the majority of the pediatricians in the US and the trend points to continued growth in the number of females in the pediatrician workforce.^{1,3}

In Texas in 2006, there were 36,450 direct patient care (DPC) physicians who spent at least 50% of their time providing direct care of patients – of these, 15,895 were primary care physicians (PCPs are defined as those physicians who indicate a primary specialty of: family practice/medicine, general practice, internal medicine, pediatrics, obstetrics and/or gynecology, or geriatrics).

There were 2,943 general pediatricians comprising 18.5% of PCPs in Texas in 2006. The supply of general pediatricians between 1996 and 2006 grew by 67.8%, which outpaced the growth of the pediatric population (15.3%) by more than 4 times over the past decade. While the Texas general pediatrician-to-pediatric population ratio has been lower than that of the national average since at least 1996 (Table 1), it has increased by 45.5% between 1996 and 2006. In 2005, the American Academy of Pediatrics (AAP) ranked the general pediatrician supply ratio in Texas in 2001 as 37th among the 50 states and the District of Columbia.⁷ For all medical specialties, Texas ranks 42nd in supply to population.⁸

Table 1. General Pediatrician Supply Ratios: Texas and US

Year	Number of General Pediatricians in Texas	General Pediatrician Supply Ratio*	
		Texas	US [†]
1996	1,754	30.1	49.3
2000	2,435	39.2	53.2
2006	2,943	43.8	Not Available

*Ratio of the number of pediatricians per 100,000 children 0-18 years of age

[†]Calculated using the number of general pediatricians from United States Health Personnel Factbook 2003 and population ages 0-18 from US Census

Of the general pediatricians practicing in Texas in 2006, only 40.5% graduated from Texas medical schools, 26% graduated from US medical schools outside of Texas, and approximately one third (33.5%) were international medical graduates (IMGs). This is a considerably higher percentage of IMGs compared with 25.2% for DPC physicians of all specialties. Among the 986 IMGs, an estimated 91% were foreign-born. India was the place of birth for 20% of foreign-born IMGs, more than any other country, followed by the Philippines at 14.2%, Pakistan at 9.3%, and Mexico at 8.1%.

Geographic Maldistribution

As of April 2007, 111 Texas counties were designated as whole county Health Professional Shortage Areas (HPSAs) for the primary care specialties, including pediatrics, by the federal Shortage Designation Branch, in collaboration with Texas' Primary Care Office and the HPRC. Of the 111 whole county HPSAs, 84 were rural counties. An additional 60 counties had designations either for a portion of their geographic areas, facilities, or population groups – 32 of these were rural counties.

The problem of geographic maldistribution is directly affected by many factors including lack of health insurance coverage particularly in rural and underserved areas where poverty is prevalent.⁹ According to *The State of Texas Children 2006*, nearly one in four children in Texas lived in poverty and one in two children lived in low-income families (below 200 percent of the federal poverty level).¹⁰ In addition, Texas had the highest percentage of uninsured children (20.3%) among the 50 states and the District of Columbia during the period of 2003-2005.¹¹ Pediatric practices are also disproportionately dependent on Medicaid and the Children's Health Insurance Program (CHIP), and changes in Medicaid/CHIP eligibility and provider fee policies have significant impact on pediatric offices.⁸ In 2007, the 80th Texas Legislature passed HB 109 which was directed towards insuring more children through the Medicaid/CHIP program. The bill will expand healthcare coverage of most children by simplifying enrollment and eligibility requirements including continuous 12-month coverage on Medicaid/CHIP.¹² Moreover, the

legislature enacted a 25-percent overall increase in Medicaid payments to physicians for children's care which should result in increased physician participation in Medicaid/CHIP.¹²

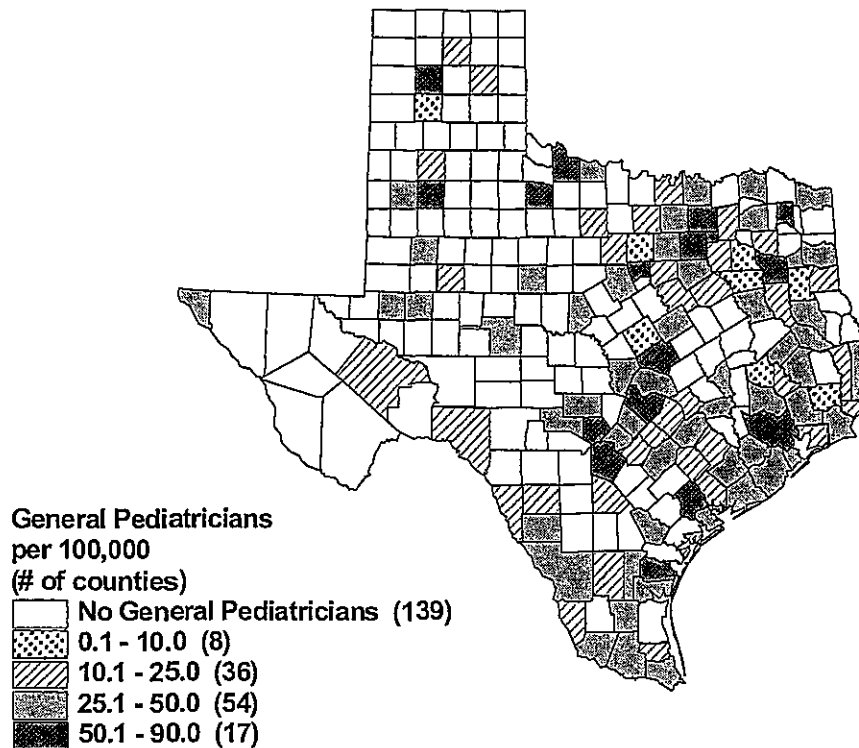
The size of the community and its proximity to urban areas combined with the growth of specialization also add to provider maldistribution as physicians hoping to establish a viable practice would require a substantial community size to serve.^{9,13} Texas' massive size and geographic make-up along with its diverse demographic composition serve as additional barriers to health care access. Other factors contributing to geographic maldistribution include health professionals' attitudes and exposure to rural and urban underserved areas; lower proportion of recent graduates, males and females, practicing in rural settings; the increase of female physicians and their tendency to practice in urban areas; and racial/ethnic disparities in physician distribution.⁹ To promote pediatrics to Texas medical students, the Texas Legislature created a statewide preceptorship program in general pediatrics in 1995. The four-week preceptorship provides hands-on training experience in which students learn from a community-based pediatrician. Eligible students receive a stipend of \$500 if their practice site is in an urban area and \$1000 if their practice site is in a rural, health professional shortage area, or a medically underserved area in Texas.¹⁴

Rural Supply of General Pediatricians

Texas is comprised of 254 counties, of which 177 are rural (non-metropolitan) as defined by the Office of Management and Budget (OMB) in 2003. An estimated 13.8% of children lived in one of the state's 177 rural counties while only 5% (146) of the general pediatricians practiced in these counties. Though the general pediatrician supply ratio has steadily increased in Texas in the past decade, it is likely to be severely inadequate in rural and underserved areas. There has been some improvement in access to pediatric care:

- In 1996, there were 157 counties without a general pediatrician. In 2006, 139 counties did not have one (Figure 1) – 119 of these were rural counties. Almost 400,000 children live in counties without a general pediatrician.
- In 2006, an estimated 18,398 children lived in one of the 28 counties that did not have a general pediatrician, internist, family physician, or general physician.
- Between 1996 and 2006, supply ratios increased in 100 counties; 49 of these were rural counties.
- Between 1996 and 2006, supply ratios decreased in 22 counties; 15 of these were rural counties. Of the 22 counties, supply ratios decreased by more than 50% in ten counties - eight of these lost all general pediatricians.
- Between 1996 and 2006, rural counties added 51 general pediatricians compared with 1,138 in urban counties.

Figure 1. General Pediatricians per 100,000 Pediatric Population, Texas, 2006



Both urban and rural areas saw improved access to pediatric care over the past decade (Table 2). Between 1996 and 2006, the general pediatrician supply ratio in urban areas increased by 14.4 per 100,000; this was a gain of one new general pediatrician for every 6,944 urban children. The supply ratio in rural Texas increased by 6.0 per 100,000, representing one new general pediatrician for every 16,667 rural children. The median age of general pediatricians reflected an older workforce in the rural areas (49 years) compared to the urban areas (45 years). While females comprised more than half of the general pediatricians, the majority practicing in the rural areas were males (55.5%). This reflects the general tendency for female physicians of any specialty to prefer practice in urban areas. Almost 44% of general pediatricians in rural Texas were IMGs, compared with 24% for rural physicians of all specialties.

Table 2. General Pediatrician Supply Ratios: Rural and Urban Areas

Year	General Pediatrician Supply Ratio*	
	Rural	Urban
1996	11.9	33.0
2000	16.9	42.5
2006	17.9	47.4

*Ratio of the number of pediatricians per 100,000 children 0-18 years of age

General Pediatricians in Border Counties

For this report, the term “border counties” refers to an area comprised of 32 counties (of which 28 are rural) within 100 kilometers of the US-Mexico border. This area has a mostly Hispanic pediatric population (Table 3). The poverty rate for the pediatric population in border counties was much higher than that of the state average. The supply ratio of general pediatricians in the

border counties almost doubled in the last 10 years from 17.9 to 35.1. The general pediatrician supply ratio in the rural border counties was much lower than that of Texas overall or the border counties.

Table 3. Demographics of Border Counties of 2006

	Texas	Border Counties	Rural Border Counties
Number of counties	254	32	28
General Pediatricians per 100,000 Pediatric Population	43.8	35.1	18.0
% of Pediatric Population who were Hispanic	44.7%	91.5%	89.1%
% of General Pediatricians who were Hispanic	15.7%	51.9%	45.5%
Poverty Rate Among Children*	22.7%	38.0%	37.2%
Average Age of General Pediatricians	47.0	47.3	48.1
Population 18 years or younger	28.6%	33.8%	32.3%

Source: 2006 Texas Medical Board's licensing database.

*Under age 18 Poverty rate from 2004 US Census Bureau estimates

Role of Non-Pediatrician Providers in Pediatric Care

Family physicians (FPs) and general practitioners (GPs) play prominent roles in providing care for children. Because of the flexibility inherent to the practice of family medicine and the discipline's deep ties to rural practice, FPs/GPs remain the predominant physician provider in rural communities.⁹ In 2006, FPs/GPs comprised 60.1% of the primary care physicians (PCP) practicing in rural Texas. Although less common than family physicians, internists provide care for children as well, particularly those who specialize in internal medicine-pediatrics.⁸

The National Ambulatory Medical Care Survey (NAMCS) in 1999 compared the number of primary care visits of children provided by general pediatricians and family physicians. This report revealed that family physicians provided 17% of primary care visits for children younger than 5 years, 28% for children ages 5-9, 43% for children ages 10-14, and 61% for adolescents 15-17 years of age.¹ As the population ages and requires additional care, this might exert further demand for family physician services thereby affecting pediatric access to care.¹

Non-Physician clinicians (NPCs), particularly nurse practitioners (NPs) and physician assistants (PAs), also have important roles to play in providing patient care and improving access to primary care services. Rural health clinics and community and migrant health centers rely heavily on NPCs to fill health care service gaps in medically underserved areas.¹⁵ Data from the 1995-1999 NAMCS approximated that 25% of visits to primary care office-based physicians used PAs and/or NPs.¹⁶ Studies indicated that the measures of quality of care provided by NPs and PAs are equivalent to those used to evaluate care provided by physicians.¹⁵ Acceptance by physicians and the public as well as expanded scope of practice laws for NPCs have contributed to the growth of NPC professions in Texas.¹⁷ Between 1996 and 2006, the number of NPs and PAs in Texas increased by approximately 174% and 165%, respectively. In 2006, of the 4,472 NPs and 3,630 PAs in Texas, an estimated 8.8% of the NPs and 11.4% of the PAs practiced in rural areas.

FPs/GPs, internists, and NPCs play significant roles in enhancing or covering service gaps in pediatric health care. This underscores the importance of utilizing new technologies such as telemedicine to maximize available resources through promotion of collaborative practice among pediatricians (generalists and subspecialists), other physicians, and non-physician clinicians.

Ethnic Disparity and Cultural Competence

Underrepresented minorities in medicine as defined by the Executive Council of the Association of American Medical Colleges (AAMC) are those “racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.”¹⁹ As previously mentioned, racial/ethnic disparities also contribute to geographic maldistribution. In a 1993 survey of 718 PCPs in 51 California communities, it was found that communities with predominantly black and Hispanic residents were 4 times more likely to experience physician shortages regardless of community income.¹⁸ Other studies have also shown that minority physicians are more likely to provide care to minority, low-income, and underserved communities.¹⁸⁻²¹ Congruently, higher patient ratings of care have been associated with patient-provider race concordance (patients sharing similar ethnicity to that of their provider).²² As the demographic composition of the population becomes increasingly diverse and health disparities among ethnic groups persist, these findings emphasize the importance of ensuring a diverse and culturally competent workforce.^{5,19}

The population of Texas was estimated to be less than 50 percent white by July 1, 2004 by the US Census Bureau, and Texas is projected to become a Hispanic-majority state between 2025 and 2035.²³ In examining the Texas pediatric population, the majority has been nonwhite since at least 1996 (Table 4). The racial/ethnic distributions of the general pediatricians in Texas and the children they provide care for are described below:

- Hispanic and black general pediatricians continue to be disproportionately distributed compared to the ethnic composition of children in Texas (Table 5). In 2006, Hispanics composed 44.7% and blacks 12.4% of the Texas pediatric population while comprising only 15.7% and 5.7% of the general pediatricians, respectively.
- Between 1996 and 2006, there was a 95% and 186% increase in the number of Hispanic and black pediatricians, respectively. The race/ethnicity specific general pediatrician-to-pediatric population ratio showed an increase for all groups. Despite the increase, ratios remain disparately represented across racial/ethnic groups (Table 6).

Table 4. Population distribution of children 0-18 years of age by race/ethnicity

Year	Total (N)	White (%)	Black (%)	Hispanic (%)	Other (%)
1996	5,824,729	48.9	12.9	35.8	2.5
2001	6,308,033	42.9	12.9	41.0	3.1
2006	6,717,292	39.4	12.4	44.7	3.5

Data were obtained from Texas State Data Center.

Table 5. General Pediatrician workforce distribution by race/ethnicity

Year	White (%)	Black (%)	Hispanic (%)	Other (%)
1996	66.7	3.4	13.5	16.4
2001	60.3	4.3	14.6	20.9
2006	56.4	5.7	15.7	22.1

Data were obtained from Texas Medical Board’s annual licensing file.

Table 6. General pediatrician to pediatric population ratio by race/ethnicity

Year	General Pediatrician Supply Ratio by race/ethnicity*				
	Overall	White	Black	Hispanic	Other
1996	30.2	40.3	7.7	11.2	196.5
2006	43.8	61.8	19.9	15.2	271.5

Data were obtained from Texas Medical Board's annual licensing file.

*General pediatrician supply ratio by race/ethnicity was calculated by dividing the child population of each ethnic/racial group by the number of general pediatricians of same ethnic background multiplied by 100,000.

Gender Distribution Trends

In 2004, women accounted for the majority (slightly more than 50%) of general pediatricians in Texas for the first time. In 2006, females comprised 52% (Table 7) of general pediatricians in Texas compared with 27.7% of internists or 27.6% of family physicians. In the past decade, the number of female general pediatricians in the state more than doubled from 719 to 1,530. As the proportion of female general pediatricians continues to increase, there are several implications to consider:

- Based on previous findings, female physicians are less likely to practice in rural areas than males although the disparity seems to be less pronounced with recent graduates.^{18,20}
- According to a survey of pediatricians by Brotherton et al,²⁴ female pediatricians are more likely to practice as a generalist than a subspecialist.
- Previous studies have also found female pediatricians are more likely to practice part-time and earn lower income than their male counterparts, in part to accommodate family responsibilities such as child-rearing and providing care for the family.²⁴⁻²⁶ It is important to note that part-time employment status, not gender, explains the lower number of direct patient care hours for women.^{1,26} Direct patient care hours of full-time men and women were similar, thereby they have comparable productivity.^{1,26}
- Strong interest by women in pediatrics has led to a more stable growth pattern for pediatrics over the past decade in contrast with family medicine, particularly among U.S. medical graduates. In 2007, 60% of pediatric-primary entry-level training positions were filled by US graduates compared with 42% for family medicine.⁸

Table 7. Gender Distribution of General Pediatricians in Texas

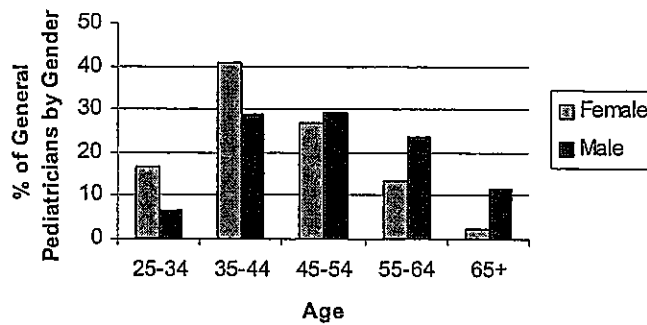
Year	Female (%)	Male (%)
1996	40.9	59.1
2006	52	48

Data were obtained from Texas Medical Board's annual licensing file.

Characteristics of male and female general pediatricians in Texas

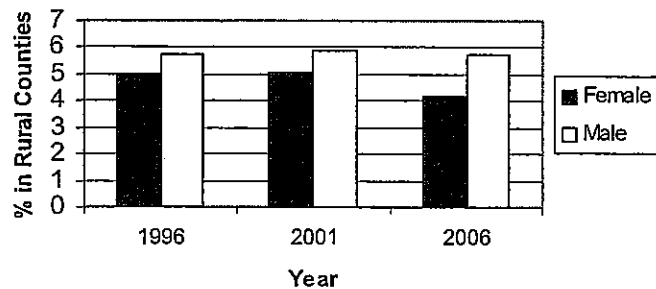
The majority of female general pediatricians in Texas were younger than 45 years old while the majority of males were older than 45 in 2006 (Figure 2). The median age of female general pediatricians (42 years) was much lower than their male counterparts (50 years) reflecting the recent increase of women entering the practice.

Figure 2. Age Distribution of Female and Male General Pediatricians in Texas 2006



Over the past 10 years, the proportion of general pediatricians practicing in rural areas in Texas decreased slightly for women (5% to 4.2%) while staying constant for men (5.7%) (Figure 3).

Figure 3. Percentage of General Pediatricians Practicing in Rural Counties by Gender, 1996-2006



In 2006, the proportion of female general pediatricians in Texas who worked either 20-39 hours or fewer than 20 hours per week was more than twice that of male general pediatricians (Table 8). Studies have shown that the female pediatrician's interest in part-time employment is expected to continue and may periodically alternate between full-time and part-time status.²⁶ With female pediatricians constituting the majority of the pediatrician workforce, there is increased likelihood of more pediatricians in part-time employment. This may in turn, result in a need for additional pediatricians.¹

Table 8. Percentage of general pediatricians by number of hours worked and gender: 2006

Number of hours worked	Female (%)	Male (%)
40+ hours per week	66.9	84.2
20-39 hours per week	26.8	13.3
<20 hours per week	6.3	2.6

Source: 2006 Texas Medical Board's licensing file.

Note: Totals may not equal 100 due to rounding of percentages.

Several studies have noted differences in practice characteristics between male and female physicians. Patient visits with female PCPs are more likely to be longer.²⁷ Female PCPs are also more likely to be engaged in a communication style that fosters collaborative relationships and encourages their patients to be active partners in their care.^{22,27,28} In a 1993 national survey of

pediatricians, it was found that all pediatricians spent similar amounts of time with patients aged 0-2 years, 3-5 years, and 6-11 years, while female pediatricians spent more time with patients in the 12-17 and older-than-18 age groups, compared with male pediatricians.²⁴ A 1997 national survey of 6,748 students grades 5-12 found that 50% of female adolescents prefer a female clinician while only 23% of boys prefer a male clinician.²⁹ These findings emphasize the importance of promoting a diverse pediatrician workforce in order to better serve the needs of the community.

Studies have shown that interest is shifting away from uncontrollable lifestyle specialties among US medical students. The movement away from primary care careers can be attributed to the desire of both men and women to balance professional and personal activities prompting them to choose “controllable lifestyle” medical careers.^{24,25,28,30} Controllable lifestyle specialties have been defined as specialties “with practice styles that allow for more control over the timing and number of hours worked, and more personal time for leisure, family, and avocational pursuits.”^{24,28,30} Anesthesiology, dermatology, emergency medicine, neurology, ophthalmology, otolaryngology, pathology, psychiatry, and radiology are classified as controllable lifestyle specialties, while pediatrics, along with family practice, internal medicine, general surgery, obstetrics-gynecology, orthopedic surgery, and urology fall under the uncontrollable lifestyle specialty category as defined by Schwartz et al.³¹ Contrary to this trend and studies showing women tend to choose specialties that allow for more flexibility and a balanced life,³² female medical students still favor primary care specialties more often than males.³⁰ This further stresses the important roles women physicians fill especially in primary care.

Despite the dramatic increase of women in medicine, they still face substantial difficulties in advancing in the medical profession. In addition to gender bias, they might face negative perceptions exacerbated by the need to work part-time, work flexible hours, or take time off from work (maternity, caring for family) due to family responsibilities.³³ Efforts promoting women’s progress in medicine should continue to be encouraged; this not only allows women to realize their full potential but also allows the field of medicine and the public to reap the benefits from the contributions they could and do make.³³ This underscores the need for changes to ameliorate the difficulties women face including providing flexible work schedules in education, practice, and academia, more part-time employment opportunities, promoting networking opportunities, and addressing other barriers to leadership advancement.²⁴

Pediatric Subspecialists in Texas

Pediatric subspecialists have completed additional years of training and experience in the specialized care of pediatric patients after completion of their general pediatric residencies. They include a broad range of subspecialists such as age-specific generalists (neonatology and adolescent medicine), organ-specific subspecialists (pediatric cardiology), and non-organ-specific subspecialists (infectious disease); they play particularly important roles as more children with chronic conditions live longer due to scientific and technological advances.³⁴

Licensing data on DPC physicians who reported a pediatric subspecialty as their primary specialty of practice were analyzed to describe the pediatric subspecialty workforce in Texas. In 2006, there were 688 pediatric subspecialists in Texas (Table 9) – up from 442 in 1996. There were approximately 10.2 pediatric subspecialists per 100,000 pediatric population. Women comprised only 32.1% (221) of pediatric subspecialists - of which 35.7% and 26.7% practiced in child and adolescent psychiatry and neonatal-perinatal medicine, respectively. Among male

pediatric subspecialists, the majority practiced in child and adolescent psychiatry, neonatal-perinatal medicine, and pediatric cardiology (24.4%, 24.8%, and 14.1%). Since most women entering pediatrics tend to practice as a generalist, this may result in an undersupply of pediatric subspecialists,³⁵ unless this trend changes. Newly imposed caps on resident duty hours during residency training may serve to make subspecialty training more feasible for women.⁸

Table 9. Pediatrician Subspecialty Distribution in Texas 2006

Pediatrician Subspecialty	Number	Percent of Total
Child and Adolescent Psychiatry	193	28.1
Neonatal-Perinatal Medicine	175	25.4
Pediatrics, Cardiology	87	12.6
Pediatric Hematology/Oncology	51	7.4
Pediatric Surgery	48	7.0
Child Neurology	47	6.8
Other subspecialty	87	12.7
Total	688	

Source: 2006 Texas Medical Board's licensing file

Of the pediatric subspecialists practicing in Texas in 2006, only 33% graduated from Texas medical schools, 39.5% graduated from US medical schools outside of Texas, and 27.5% were IMGs. More than 90% of the IMGs were foreign-born. Among foreign-born IMGs, 26.5% were born in India, 7.4% in Mexico, and 5.8% in the Philippines.

In summary:

- There was substantial growth in the supply of general pediatricians in Texas in the past decade. Both urban and rural areas saw improved general pediatrician-to-pediatric population supply ratios.
- Due to disproportionate distribution of general pediatricians, rural and underserved areas continue to suffer severe shortages despite a 45% increase in the supply ratio in Texas.
- Family physicians/general practitioners, internists, and non-physician clinicians, mainly PAs and NPs, serve as safety net providers for pediatric health care especially in rural and urban underserved areas.
- Promoting a diverse and culturally competent workforce will be essential to meet the needs of an increasingly diverse Texas population.
- The increasing number of females in pediatrics brings unique challenges that will impact the generalist and subspecialist supply in Texas, including the need for flexible work schedules, income differences between men and women, barriers to advancement for women, and the recent tendency for women to choose general pediatrics over subspecialties.
- In order to improve pediatric care in rural settings, steps such as maintaining state funded preceptorships for medical students in pediatric offices to promote exposure to pediatric practice in rural areas, providing financial incentives, including loan repayment, and providing arrangements targeting the needs of female pediatricians could be taken to increase the supply of pediatricians in rural areas. Utilization of technology and increased use of non-pediatrician providers are also significant ways to better the provision of medical care in rural settings.^{13,36}

References

1. Goodman DC, American Academy of Pediatrics, Committee on Pediatric Workforce. *The pediatrician workforce: Current status and future prospects*. Pediatrics. 2005 July 1;116(1):e156-173.
2. Shipman SA, Lurie JD, Goodman DC. *The general pediatrician: Projecting future workforce supply and requirements*. Pediatrics. 2004 March;113:435-42.
3. American Academy of Pediatrics, Committee on Pediatric Workforce. *Pediatrician workforce statement*. Pediatrics. 2005 July;116:263-9.
4. Phillips RL, Jr, Bazemore AW, Dadoo MS, Shipman SA, Green LA. *Family physicians in the child health care workforce: Opportunities for collaboration in improving the health of children*. Pediatrics. 2006 September 1;118(3):1200-6.
5. American Academy of Pediatrics, Committee on Pediatric Workforce. *Enhancing the diversity of the pediatrician workforce*. Pediatrics. 2007 April 1;119(4):833-7.
6. American Academy of Pediatrics, Committee on Pediatric Workforce. *Ensuring culturally effective pediatric care: Implications for education and health policy*. Pediatrics. 2004 December 1;114(6):1677-85.
7. Pediatrician workforce data 2005. American Academy of Pediatrics Committee on Pediatric Workforce. 2005 August. Available from: http://www.aap.org/workforce/workforce_data805.ppt
8. Collins M. Texas Medical Association.
9. Council on Graduate Medical Education. *Physician distribution and health care challenges in rural and inner-city areas. Tenth Report*. Rockville, MD: US Department of Health and Human Services; 1998 February. Available from: <http://www.cogme.gov/rpt10.htm>
10. Center for Public Policy Priorities. *The State of Texas Children 2006*. Available from: http://www.cppp.org/factbook06/pdf/sotc_full.pdf
11. State Health Access Data Assistance Center. *Whose kids are covered? A state-by-state look at uninsured children*. 2007 March. Available from: <http://www.rwjf.org/files/publications/other/shadaacschip07.pdf>
12. Texas Medical Association. *Patient care preserved*. 2007 June. Available from: http://www.texmed.org/uploadedFiles/Governmental_Affairs/Texas_Legislature/PatientCarePreserv.pdf
13. Randolph GD, Pathman DE. *Trends in the rural-urban distribution of general pediatricians*. Pediatrics. 2001 February 1;107(2):e18.
14. Texas Pediatric Society. 2007 January 9. Available from: http://www.txpeds.org/preceptorship_program/About_Preceptorship.php
15. U.S. Congress, Office of Technology Assessment. *Nurse practitioners, physician assistants and certified nurse-midwives: A policy analysis (health technology case study 37)*. Washington, DC: U.S. Government Printing Office; 1986 December. Report No.: OTA-HCS-37.
16. Hooker RS, McCaig LF. *Use of physician assistants and nurse practitioners in primary care, 1995-1999*. Health Aff. 2001 July 1;20(4):231-8.
17. Gott S, Furino A, Miller D. *Changes in the scope of practice and the supply of non-physician clinicians in Texas*. San Antonio, TX: University of Texas Health Science Center at San Antonio; 2003 June.
18. Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, et al. *The role of black and Hispanic physicians in providing health care for underserved populations*. N Engl J Med. 1996 May 16;334(20):1305-10.

19. Council on Graduate Medical Education. *Minorities in medicine: An ethnic and cultural challenge for physician training, an update. Seventeenth Report*. Rockville, MD: US Department of Health and Human Services; 2005 April. Available from: <http://www.cogme.gov/17thReport/17.htm>
20. Moy E, Bartman BA. *Physician race and care of minority and medically indigent patients*. JAMA. 1995 May 17;273(19):1515-20.
21. Stoddard JJ, Back MR, Brotherton SE. *The respective racial and ethnic diversity of US pediatricians and American children*. Pediatrics. 2000 January 1;105(1):27-31.
22. Cooper LA, Powe NR. *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance*. 2004 [cited April 11, 2007].
23. Summary of trends in Texas State Data Center 2006 population projections. Available from: <http://txsdc.utsa.edu/tpepp/2006projections/summary/>
24. Brotherton SE, Mulvey HJ, O'Connor KG. *Women in pediatric practice: Trends and implications*. Pediatr Ann. 1999 Mar;28(3):177-83.
25. Council on Graduate Medical Education. *Physician workforce policy guidelines for the United States, 2000-2020. Sixteenth Report*. Rockville, MD: US Department of Health and Human Services; 2005 January. Available from: <http://www.cogme.gov/report16.htm>
26. Cull WL, Mulvey HJ, O'Connor KG, Sowell DR, Berkowitz CD, Britton CV. *Pediatricians working part-time: Past, present, and future*. Pediatrics. 2002 June;109:1015.
27. Roter DL, Hall JA, Aoki Y. *Physician gender effects in medical communication: A meta-analytic review*. JAMA. 2002 August 14;288(6):756-64.
28. King B, Gunn B. *The feminization of the health care workforce: Implications for Texas*. Austin, Texas: Texas Department of State Health Services; 2006 October. Report No.: Publication # 25-12508. Available from: <http://www.dshs.state.tx.us/chs/hprc/femrep.pdf>
29. Kapphahn CJ, Wilson KM, Klein JD. *Adolescent girls' and boys' preferences for provider gender and confidentiality in their health care*. J Adolesc Health. 1999 Aug;25(2):131-42.
30. Lambert EM, Holmboe ES. *The relationship between specialty choice and gender of U.S. medical students, 1990-2003*. Acad Med. 2005 Sep;80(9):797-802.
31. Schwartz RW, Haley JV, Williams C, Jarecky RK, Strodel WE, Young B, et al. *The controllable lifestyle factor and students' attitudes about specialty selection*. Acad Med. 1990 Mar;65(3):207-10.
32. Ross S. *The feminization of medicine*. Medicine and Society. 2003 September; Volume 5, Number 9. Available from: <http://www.ama-assn.org/ama/pub/category/10967.html>
33. Council on Graduate Medical Education. *Women and medicine. Fifth Report*. Rockville, MD: U.S. Department of Health and Human Services; 1995. Available from: <http://www.cogme.gov/rpt5.htm>
34. Gruskin A, Williams RG, McCabe ERB, Stein F, Strickler J, Chesney RW, et al. *Final report of the FOPE II pediatric subspecialists of the future workgroup*. Pediatrics. 2000 November 1;106(5):e1224.
35. DeAngelis C, Feigin R, DeWitt T, First LR, Jewett EA, Kelch R, et al. *Final report of the FOPE II pediatric workforce workgroup*. Pediatrics. 2000 November 1;106(5):e1245.
36. Chang RR, Halfon N. *Geographic distribution of pediatricians in the United States: An analysis of the fifty states and Washington, DC*. Pediatrics. 1997 August 1;100(2):172-9.

For more information on health provider supply statistics, see the Health Professions Resource Center's website at <http://www.dshs.state.tx.us/CHS/hprc/>

This report was prepared by:

Rosemary Ang, MS, Research Specialist, Health Professions Resource Center

Brian King, Program Director, Health Professions Resource Center

Bruce Gunn, Ph.D., Manager, Health Provider Resources Branch

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Baby, I Lied

RURAL TEXAS IS STILL WAITING FOR THE DOCTORS TORT REFORM WAS SUPPOSED TO DELIVER.

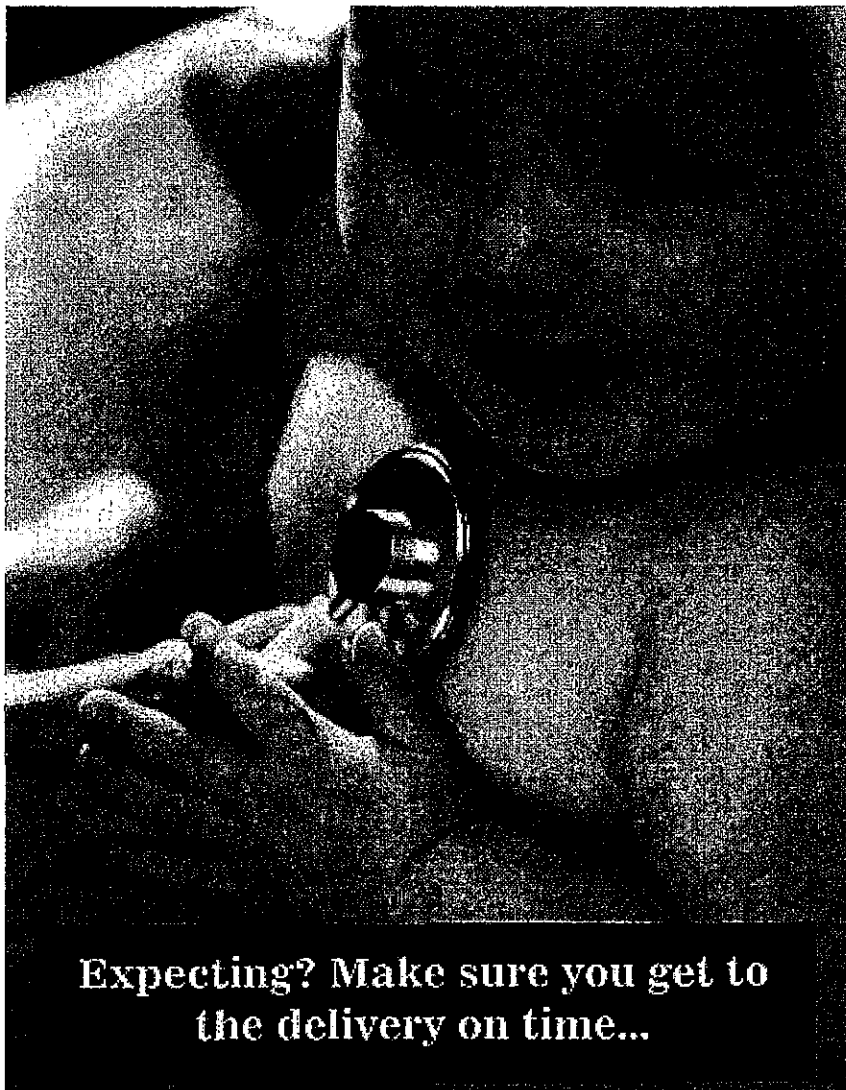
Suzanne Batchelor | October 19, 2007 | Features

The flood of beguiling baby photographs began cascading into mailboxes across Texas as the 2003 fall election drew near. Gracing the cover of a slick brochure, the infant smiled as a stethoscope—held by an unseen but presumably kind physician—was pressed to its chest. “Who Will Deliver Your Baby?” the mailer asked.

The direct-mail pitch was one of many churned out by insurance and medical interests as they spent millions urging voters to pass Proposition 12, a constitutional amendment that would limit the amount of money patients or their survivors could recover in medical malpractice lawsuits.

Swaddled in the glossy brochures was a dire threat. Greedy lawyers were besieging doctors with unwarranted lawsuits that were making malpractice insurance rates skyrocket. Doctors were fleeing Texas, leaving scores of counties with no obstetricians to deliver babies, no neurologists or orthopedic surgeons to tend to the ill. Without Proposition 12, the ad campaign warned, vast swaths of rural Texas would go begging for health care.

EXHIBIT 6



Choosing between greedy trial lawyers and cuddly babies was no contest for most Texas voters. Proposition 12 passed. Four years later, vast swaths of rural Texas are going begging for health care.

Proposition 12, and the far-reaching changes in Texas civil law that it dragged behind it, was built on a foundation of mistruths and sketchy assumptions. The number of doctors in the state was not falling, it was steadily rising, according to Texas Medical Board data. There was little statistical evidence showing that frivolous lawsuits were a significant force driving increases in malpractice premiums.

Perhaps the most insidious sleight of hand employed by Proposition 12 backers was their repeated insistence that medical malpractice insurance rates were somehow responsible for doctor shortages in rural Texas.

“Women in three out of five Texas counties do not have access to obstetricians. Imagine the hardship this creates for many pregnant women in our state,” Gov. Rick Perry told a New York audience in October 2003 at the pro-tort-reform Manhattan Institute for Policy Research.

“The problem has not been a lack of compassion among our medical community, but a lack of protection from abusive lawsuits.”

The campaign’s promise, that tort reform would cause doctors to begin returning to the state’s sparsely populated regions, has now been tested for four years. It has not proven to be true.

Since Proposition 12 passed, insurance companies—many grudgingly—have lowered their rates. More doctors are coming to Texas, as a recent *New York Times* article trumpeted. That is proof, say Proposition 12’s backers, that so-called tort reform is working.

“Texas has seen a tremendous success in luring doctors to practice in our state thanks to tort reform passed in 2003,” says Krista Moody, Perry’s deputy press secretary. Moody noted that the Texas Medical Board is having to add staff to handle a backlog of doctors applying for state licenses.

Those doctors are following the Willie Sutton model: They’re going, understandably, where the better-paying jobs and career opportunities are, to the wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities.

On a Texas map inside the beguiling-baby mailer, blood red marked the 152 counties in Texas that did not have obstetricians in 2003. Rural doctor shortages were kept front and center as the state’s physicians, led by the Texas Medical Association and the Texas Association of Obstetricians and Gynecologists, campaigned for Proposition 12.

A flier printed by the TMA in English and Spanish and posted in waiting rooms across the state told patients that “152 counties in Texas now have no obstetrician. Wide swaths of Texas have no neurosurgeon or orthopedic surgeon. ... The primary culprit for this crisis is an explosion in awards for non-economic (pain and suffering) damages in liability lawsuits. ... vote “YES!” on 12!”

As of September 2007, the number of counties without obstetricians is unchanged—152 counties still have none, according to the *Observer*’s examination of county-by-county data at the state Medical Board.

Nearly half of Texas counties—124, or 49 percent—have no obstetrician, neurosurgeon, or orthopedic surgeon. Those specialists aside, 21 Texas counties have no physician of any kind. That’s one county worse than before Proposition 12 passed, when 20 counties had no doctor.

The TMA counts 186 new obstetricians in Texas since Proposition 12 passed, and President Dr. William Hinchey offers that as proof of tort reform’s effectiveness.

No independent study has shown what caused the increase, though Texas medical schools have graduated increasing numbers, by the hundreds, of physicians every year since 1997, the earliest year for which TMB posts data. And the state’s growth probably played some part. According to the U.S. Census Bureau, Texas’ population grew 12.7 percent between 2000 and 2006, compared with 6.4 percent for the country as a whole. The number of obstetricians in Texas increased only 4.27 percent over the same six years, including three years under tort reform.

More telling is where the new obstetricians—and neurosurgeons and orthopedic surgeons—decided to go.

The Medical Board's latest obstetrician data for the 254 Texas counties reveals that several counties led the gains.

Collin County, the Dallas suburb that is the wealthiest in Texas in terms of per capita income, gained the most obstetricians. Its 34 new ones increased its obstetrician ranks by an impressive 45 percent since Proposition 12 passed.

In second place is Montgomery County, Houston's northern neighbor along the booming Interstate 45 corridor, and the state's fourth-fastest growing county, according to the U.S. Census 2006 estimate. Montgomery gained 19 obstetricians. Tarrant County followed with 17.

Next, at 12 each, are Galveston and Hidalgo counties. Among the rest, a few counties gained in single digits, a few lost, and the majority of counties—two thirds—remained the same.

With well-equipped, well-staffed hospitals, plenty of colleagues, and insured patients, it's not hard to see why Collin County would attract the most obstetricians or offer them the most jobs. Collin's population grew 42.1 percent from 2000 to 2006; the county encompasses Plano, Carrollton, and a small part of Dallas.

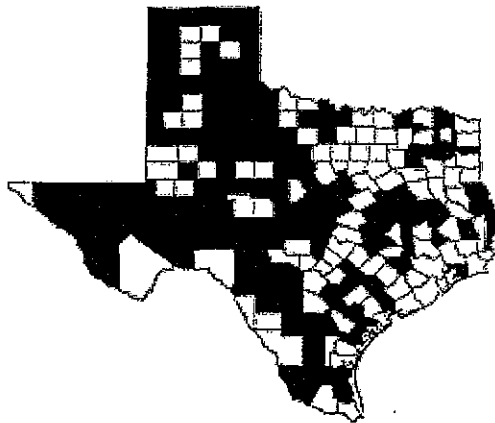
The county's Presbyterian Hospital of Plano alone has 73 obstetricians and 30 neonatologists for newborns. Two allied hospitals serve nearby Allen and Dallas, and the three are far from Collin's only hospitals.

Margot and Ross Perot gave \$6 million last October to the Presbyterian Hospital of Plano for maternal and infant care. The Margot Perot Center for Women and Infants has been named "Best Place to Have a Baby" by *DallasChild* magazine 11 years in a row. The Presbyterian system has even been honored locally for its baby sign-language classes.

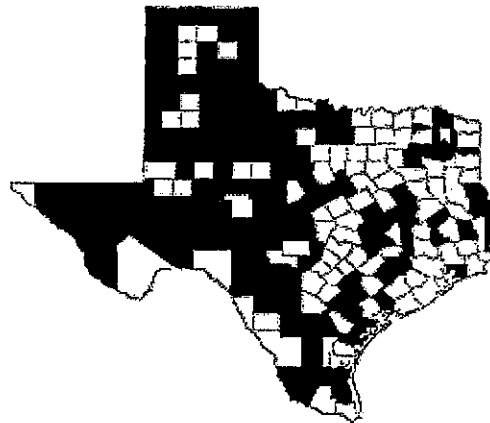
The pattern of doctors' opting to practice in more affluent, urban areas holds true for Texas' overall gains in neurosurgeons (36) and orthopedic surgeons (185) since 2003.

The number of neurosurgeons statewide increased 8.8 percent in the past four years. The biggest share, again, went to Collin County, which gained seven. Bexar and Harris counties each gained five, while Lubbock gained four, and Tarrant, three. At last count 216 counties, or 85 percent, have no neurosurgeon.

Texas has added 185 orthopedic surgeons since 2003, a 10.3 percent increase. Harris County gained the most with 25, followed by Dallas County with 21, Tarrant County with 19, Travis County with 16, and Collin County with 15. There are no orthopedic surgeons in 169 Texas counties.



Texas counties without obstetricians in 2003 before Proposition 12 passed.



Texas counties without obstetricians four years after Proposition 12 passed.

*Source: Texas Medical Board
Dallas, Houston, Austin*

Surely, state leaders and the TMA knew that tort reform wouldn't deliver doctors and specialists to rural Texas.

The persistent struggle to get rural, underserved Texans care by obstetricians, brain surgeons—any specialists—has little to do with lawsuits or high premiums.

Rural health care has been strained by a steady, decades-long migration of Texans from rural to urban areas. Rural areas have fewer hospitals and facilities, and tend to have higher concentrations of patients on Medicaid. "The enormity of Texas ... can serve as a great obstacle for those seeking and providing health care," TMA's own Web site notes. "Approximately 15 percent of Texas' population lives in rural counties, yet only 9 percent of primary care physicians practice there."

It's hard for an obstetrician to make a living in Deaf Smith County in the Panhandle, or Pecos County out west. Understandably, most specialists choose financial security over scraping anxiously by—if for no other reason than to pay back medical school loans. They like to practice near a large community of colleagues, have access to more elaborately equipped hospitals, and treat patients with private insurance coverage.

Yet some of those who pitched Proposition 12 as a cure for rural health care woes now seem surprised that doctors aren't surging into the countryside.

"You limited your line of questioning to a single issue we have not yet revisited," said an e-mail sent by Jon Opelt, spokesman for the pro-Proposition 12 Texas Alliance for Patient Access, when asked about the rural obstetrician situation. The alliance represents more than 200 insurance companies, hospitals, medical clinics, doctors' associations, and nursing homes. It donated \$500,000 to the political action committee, Yes on 12, in 2003, according to the *Houston Chronicle*.

Dr. Charles W. Bailey Jr., a plastic surgeon who was TMA president during the Proposition 12 campaign, said he wonders if perhaps new doctors aren't out there and the Medical Board

simply hasn't been able to keep up its count. "They have a lot of stuff to do, and maybe they haven't really reassessed all the counties," Bailey said. "We have to realize that many of these counties have so few people in them, they won't support a specialist. They'll have family practice physicians delivering babies. Like many towns won't support a neurosurgeon or plastic surgeon or cardiologist. I would just, I don't know if they've really, with all the applications they're processing, if they have the time and manpower to really determine, to do another head count. From all I've heard, they can be hard pressed to keep their head above water."

Medical Board spokeswoman Jill Wiggins expressed confidence in the agency's count. Fortunately, she said, the 2003 Legislature boosted its funding and allowed the agency to add staff. When the board's license applications became backlogged in 2006, Wiggins said, the agency received even more new funding and now has about 142 full-time employees, compared with 101 seven years ago, a 41 percent increase.

Dr. Ralph Anderson, a University of North Texas obstetrics and gynecology professor and legislative adviser in 2003 with the obstetricians and gynecologists association, said the overall statewide increase in obstetricians might still yield a trickle-down effect in rural areas.

"If you bring more obstetricians to the state, a portion of those are going to go into the underserved areas, the Rio Grande Valley. If you have a lot of personalities coming in, they will disperse themselves to the area where they feel comfortable," he said. "The more people interested, the more chance you'll find somebody who's looking for that kind of opportunity. Those communities have benefited because of the increased numbers of people coming into the state."

So how did doctors become poster children for the sweeping tort-reform agenda pushed by the business and insurance lobbies in 2003?

Former TMA lobbyist Kim Ross recalled his firing just before the 2003 legislative session. Ross, who now runs his own public relations firm for national and regional medical clients, said he was canned in December 2002 by the TMA under pressure from Perry.

"There was a strongly held belief that I was personally responsible for TMA endorsing (Democratic nominee) Tony Sanchez over Rick Perry," said Ross. "I definitely took the fall on that."

The doctors' Democratic endorsement had resulted from Perry's earlier, unexpected veto of a bill they had supported requiring prompt payment from health maintenance organizations. "Perry vetoed that in an ambush without any warning. There was a huge response from physicians," Ross said. The governor also was unhappy, Ross said, because he and other TMA staff were then negotiating with trial lawyers over what they would and would not support in 2003 tort-reform legislation.

Though they fired him under political pressure, Ross said, he doesn't believe TMA supported tort reform's claims of bringing health care to rural areas just to gain Perry's favor. "There's always been an article of faith, even among OB-GYNs themselves and family practitioners, who are the mainstay of rural practice, that if we just had some liability relief and less fear of lawsuits, that would translate into a restoration of access," Ross said. He characterized that belief as an "urban myth."

Yet “the cost of liability is a relative fraction of rural healthcare cost—it’s a high part of trauma [emergency] costs—but access is driven by reimbursement,” Ross said. “Reimbursement from Medicare, Medicaid, commercial managed care ... You need some liability stability, but the primary driver is the economics of reimbursement. For all its emotional charge of fairness, liability cost for the most part is not the issue.”

Why did physicians readily believe it when insurance companies blamed greedy, out-of-control plaintiff’s lawyers for high liability rates in 2003? One reason may be that the largest malpractice insurer in Texas is their own.

The TMA and the Legislature created the Texas Medical Liability Trust in 1978 as a self-insured trust solely for TMA members. The trust’s doctor-insureds elect a board of directors via mail-in ballot every three years. Besides insurance, the trust provides defense attorneys to doctors who are sued, and pays doctors’ expenses when the investigators of the Medical Board fine them.

The trust is not regulated by the Texas Department of Insurance. As former Insurance Department Associate Commissioner Birnie Birnbaum noted, the trust can charge what it chooses, while regulated companies must charge the rates they file with the department. (The trust isn’t Texas’ only unregulated malpractice insurer; “risk retention” insurers are also free of state oversight. There’s no federal regulation of insurance companies.)

Since 2003, the trust has reduced its insurance premiums: 12 percent in 2004; 5 percent in 2005; 5 percent in 2006; 7.5 percent this year; and 6.5 percent for 2008. In 2008, the trust will charge doctors 68.7 percent of the charge before tort reform.

Dr. Donald A. Behr, head of TMA’s rural physician group, speaks enthusiastically about his rural practice in Graham, seat of Young County in North Central Texas. Behr and his wife, a nurse, left Fort Worth six years ago and say they love treating the smaller community of neighbors and friends, “not just insurance cards.”

Graham’s hospital is better off than most rural facilities, said Behr, a general surgeon. An old oil town, Graham was flush with millionaires 25 years ago; their philanthropy keeps the hospital afloat.

Of the five counties bordering Young, only one has an obstetrician. Graham has one, but no neurosurgeon, orthopedic surgeon, or cardiologist. Specialists ride in weekly or monthly, like pioneer circuit riders, from Wichita Falls, Mineral Wells, and Abilene.

Graham Regional Medical Center draws from Jack, Stevens, Throckmorton, and Archer counties. “Part of that is because of our obstetrician, part probably because of me,” Behr said.

A frantic edge comes to Behr’s otherwise confident voice when he describes the hospital’s financial fragility despite philanthropy.

“Most of the obstetrics patients in rural Texas are Medicaid,” which pays rural physicians less than urban ones, he said. Just to offer obstetrics, Graham’s hospital has to jump through a few hoops.

First, the hospital has to have a minimum of two doctors who deliver babies and accept

Medicaid, Behr said. Fortunately, Graham has three family practice physicians who also provide obstetrics to back up its lone obstetrician.

“A little hospital with one doctor doesn’t fly,” Behr said. “You’ve got to have anesthesia, and if you don’t have enough volume for a full-time anesthetist, you can’t have obstetrics, basically.”

Graham’s hardworking obstetrician sees patients six days a week, traveling to five towns, and his nurse-practitioner sees the women at other times.

In an interview, Behr scarcely mentions liability insurance as a factor facing rural health care. Adequate reimbursement—getting paid—by Medicare, Medicaid, and private insurers to cover costs topped Behr’s concerns, expressed in a long conversation.

“The only way to keep doctors in rural Texas and anyplace is, somehow we have to find a way to practice medicine cheaper,” he said. “We spend too much, yet there’s a lot of doctors who can’t make a living.”

Tort reform may have failed to brighten health care for rural Texans, but two state agencies are trying to lure physicians and other health care professionals to underserved areas.

The seven-year-old Office of Rural Community Affairs gives doctors stipends of up to \$15,000 a year for residency practice after medical school in underserved areas. A separate program in the state office uses \$112,500 a year in interest from the state’s share of the massive tobacco lawsuit settlement to recruit and retain licensed nonphysicians, such as nurses and physical therapists, in underserved areas. Another \$2 million in tobacco money is distributed by the office to small rural hospitals.

The 2007 Legislature increased funding for a doctor education-loan repayment program administered by the Texas Higher Education Coordinating Board. For the current biennium, the program will hand doctors \$1 million annually.

Loan program Director Lesa Moller said doctors willing to practice in underserved areas can receive up to \$9,000 for each year they complete. After two years, the doctor becomes eligible for federal matching funds of up to \$18,000.

“Unfortunately, there’s been way more applicants than there’s been dollars,” said TMA lobbyist Helen Kent Davis of the assistance programs, adding that the TMA has advocated for the rural programs at the Legislature for many years.

TMA does not fund any rural doctor programs, Davis said.

The irony that tobacco-settlement money is put to work year after year sustaining rural health care professionals and hospitals should not be lost on Texas physicians who campaigned for Proposition 12.

The massive tobacco settlement was the work of trial lawyers, the very folks TMA leaders demonized in their quest for cheaper insurance and fewer lawsuits.

Suzanne Batchelor is a freelance writer in Austin.

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Need for rural doctors critical

By Enrique Rangel
Globe-News Austin Bureau

Kent County has not had a doctor in 53 years.

"The last one we had died in 1954," County Judge Jim C. White said matter-of-factly. "When we need medical care we go to Lubbock or Abilene or to the district county hospital in (neighboring) Fisher County."

The community of 734 residents, down from 859 in the 2000 Census, is not the only county in West Texas without a physician.

Twenty-seven other counties in the region do not have a physician, said Dr. Steven Berk, dean of the School of Medicine at Texas Tech University Health Sciences Center.

"It is definitely a very critical problem," said Berk, who is interim vice president of the F. Marie Hall Institute for Rural and Community Health at Health Sciences Center. "We have a shortage of doctors in the United States but it is more severe in West Texas."

The Office of Rural Community Affairs is aware of the severity of the physician shortage. That's why ORCA is offering stipends of up to \$15,000 to physicians willing to work in a rural community for at least a year.

"We hope to get some doctors interested," said Theresa Cruz, director of the rural health division at ORCA. "We are seeing a downward trend of applicants. Most doctors, especially those just out of medical school, are not all that interested in moving to rural areas."

The Texas Health Service Corps Program has been around since 2001 and on average, the agency gets about five applicants a year, Cruz said. The deadline to apply for the stipends is May 28.

Berk said there are several reasons for the growing shortage of doctors everywhere.

First, the medical profession didn't recognize that a shortage was on the horizon until about five years ago.

In addition, young physicians don't want to work as many hours as their older peers.

And for rural areas, there is an additional problem. Fewer and fewer medical students are going into family medicine because they don't make as much money as they can in specialized medicine, Berk said.

In all, the federal government estimates that at least 35 million Americans live in medically underserved areas, mainly in rural communities or small towns.

Nationwide, there are 280 doctors per every 100,000 people, Berk said. In West Texas there are 45 doctors per every 100,000 people.

The shortage is expected to get worse. A report by the Association of American Colleges found less than 3 percent of medical school graduates want to set up practice in rural areas or small towns.

Equally worrisome is the upcoming retirement of baby boom physicians, the association reported.

Rep. Joe Heflin, D-Crosbyton, whose House District 85 is largely rural, said five of the 16 counties he represents don't have a doctor.

The lack of medical care is one of the main reasons some of those counties keep losing residents, Heflin said.

"A lot of old people who were born and raised in rural areas have had to move to Lubbock, Abilene or another city," he said. "They need medical care and they can't get it where they live."

Berk is hopeful the rural doctor shortage can be alleviated with the 2009 opening of Tech's medical school in El Paso. The school will have a class of 80 students a year, he said. In addition, Texas A & M is looking at opening two additional medical schools.

However, "the only way to solve this problem is to find medical students from small towns," he said. "They are the most likely to go back to their small towns."

Another critical area medical schools are trying to address is to increase their diversity of students, particularly of Hispanic and black students

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willing to go back to their communities once they graduate.

White said he would like to get excited about the prospect that maybe some day Kent County could get a doctor, but he is not optimistic.

"I've been hearing that for more than 20 years," he said.

Globe-News Austin Bureau Chief Enrique Rangel can be reached at enrique.rangel@morris.com or by mail at P.O. Box 12457, Austin, TX 78711-2457. His column appears weekly.

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EMPLOYMENT/CONTRACT WORK: Employment

REPLY SENT: NO

VISA WAIVER AVAILABLE: Not specified

DESCRIPTION:

Are you a board certified, residency trained Neurosurgeon not earning to your full potential? Are you looking for a quality opportunity in a Level I Trauma Center? If your answer is yes, to one or both of these questions, Arthur / Marshall, the most trusted name in physician search, invites you to investigate the following neurosurgery practice opportunity.

SOUTHWESTERN PARADISE

SMALL TOWN FAMILY VALUES

This charming southwestern paradise will afford you and your family the ability to enjoy a number of cultural amenities in town, as well as having access to a Division I University and NCAA sporting events. In this culturally diverse community you will have access to a number of museums, as well as four local wineries. Not to mention, having the ability to enjoy downhill skiing just a short 3-hour drive away. This community boasts above-average schools, which are evidenced by the high average SAT scores from graduating seniors. Combine all this with a cost of living where the average home lists for \$125,000 and you have an ideal location to live and raise your family.

LEVEL I TRAUMA CENTER

UNIVERSITY MEDICAL CENTER

This Level I Trauma Center is the finest in the region currently treating approximately 65,000 patients annually in the Emergency Department. You will join a multiple specialty group with two other neurosurgeons. This opportunity will afford you the ability to earn in the 90th percentile of your specialty while enjoying the administrative support of a well-established group. This state-of-the-art teaching hospital provides the opportunity to practice at the highest level of your profession.

CONTACT:

COLT BEWLEY

ARTHUR MARSHALL INC.

866-414-6077

cbewley@arthurmarshall.com

Close

**\$1 Million Potential in Tort Reform State / Metro Area with Low Cost of Liv
Merritt, Hawkins & Associates/MHA Group
West Texas, Texas**

JOB DETAILS

Draw Area of 400,000
Large and Loyal Referral Base

TITLE: \$1 Million Potential in Tort Reform State / **JOB #:** 757798

Metro Area with Low Cost of Liv

LOCATION: West Texas, Texas

FULL TIME/PART TIME: Full Time

CLIENT: Merritt, Hawkins & Associates/MHA
Group

PERMANENT/TEMPORARY: Regular

POSTED: 01/15/2008

EMPLOYMENT/CONTRACT WORK: Employment

REPLY SENT: NO

VISA WAIVER AVAILABLE: No

DESCRIPTION:

**ORTHOPEDIC SURGEON NEEDED FOR TOP REIMBURSEMENT AREA IN STATE
\$1 MILLION INCOME POTENTIAL**

Investigate this extraordinary **Orthopedic Surgery** opportunity. With a combination of an income potential well above the 90th percentile, no state income tax and a cost of living 17% below the national average, this is an uncommonly lucrative opportunity that will afford you an enviable lifestyle.

- Verifiable income potential between \$800,000 - \$1,000,000 in private practice
- Tort reform state
- Metro area with population over 250,000 – draw area of 400,000
- One of the most desired destinations in the country for physicians – very physician friendly state
- Large and loyal referral base that will allow you to be busy from day one
- \$10 million recently invested in hospital improvements with more enhancements planned
- Exceptional stability and expertise in hospital's OR staff with a median length of employment of 18 years at same facility
- OR nurses have a combined 40-plus years of Orthopedic experience
- Work with a hospital that has ranked number one in employee and physician satisfaction corporate wide for four straight years - when asked about physicians' relationship with the hospital staff, the response was...

Live in one of the fastest growing metro communities in the Southwest offering all the conveniences and amenities of most major-metro areas, including an international airport. Choose from country club living with lavish custom homes to large ranch estates with acreage. Great schools and friendly neighbors that truly look out for each other make this an ideal place to live and raise a family.

CONTACT:

E-mail: leo.vele@mhaagroup.com or tom.florence@mhaagroup.com

Phone: 800.876.0500

Fax: 972.983.0715

Close

\$500,000 Plus First Year Income!!! NO CALL!!!

Arthur, Marshall Inc.

Texas, Texas

JOB DETAILS

City of over 180,000!! Full Patient Base Awaits You!!

TITLE: \$500,000 Plus First Year Income!!! NO CALL!!! **JOB #:** 766813

LOCATION: Texas, Texas

CLIENT: Arthur, Marshall Inc.

POSTED: 02/06/2008

REPLY SENT: NO

FULL TIME/PART TIME: Full Time

PERMANENT/TEMPORARY: Regular

EMPLOYMENT/CONTRACT WORK: Employment

VISA WAIVER AVAILABLE: No

DESCRIPTION:

\$500,000++ FIRST YEAR INCOME, NO CALL !!!!

NO STATE INCOME TAX !!!!

DERM/\$500K +++

NO OPERATIONAL HASSLES!

HIGHLY PROFITABLE practice. Join (4) dermatologists. State of the art equipment-own office. RECIEVE ALL NEW PATIENTS TO QUICKLY BUILD PRACTICE.

Friendly, smaller sized metro city hosts its own symphony, opera and theatre. Great public and private school facilities. FINEST SKI SLOPES IN COUNTRY, GREAT HUNTING, FISHING, CAMPING AND HIKING within just hours!

CONTACT:

COLT BEWLEY

ARTHUR/MARSHALL

866-414-6077

cbewley@arthurmarshall.com

Close

**Non or Invasive Cardiologist needed in sunny Texas / \$450K Base / Huge Pote
Merritt, Hawkins & Associates/MHA Group
Tort Reform State, Texas**

JOB DETAILS

This is an unusual opportunity due to its high level of autonomy, the quality of care available, and the very competitive and secure financial package.

TITLE: Non or Invasive Cardiologist needed in sunny Texas / \$450K Base / Huge Pote
LOCATION: Tort Reform State, Texas
CLIENT: Merritt, Hawkins & Associates/MHA Group
POSTED: 01/15/2008
REPLY SENT: NO

JOB #: 757812
FULL TIME/PART TIME: Full Time
PERMANENT/TEMPORARY: Regular
EMPLOYMENT/CONTRACT WORK: Employment
VISA WAIVER AVAILABLE: No

DESCRIPTION:

**Non-Invasive or Invasive Cardiologist Needed
Establish a Practice Your Way
\$450,000 to Start / \$25,000 in Sign-On Bonus
Relocation Assistance and Loan Forgiveness
First Rate Payor Mix with No State Tax**

You will enjoy a guaranteed starting package of \$450,000 in net income to start, while working out of just one hospital.

Their facility is located in a tort reform state with a favorable practice climate boasting no capitation and tort reform. They also have the comfort of over 300 days of Southwest sunshine each year. The CEO will personally ensure that you have the staff, the equipment, the input and the schedule you need to enjoy an excellent quality of practice.

Charming Texas Community, Tort Reform and No State Tax

This is a cohesive medical community where physicians enjoy an outstanding quality of life. The community has a solid foundation and will allow you to have private school quality in a public school setting.

The city is set amidst beautiful rolling hills and the people are extremely friendly, welcoming and admiring of their physicians. They enjoy spending time on the lake with their families, a local country club and easy access to all the many sporting and cultural events sponsored by a major Big XII university. All this and more are made easy by having an easy check-in regional airport with most major carriers present.

CONTACT:

Ken Bayles
800.876.0500

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**Internal Medicine
Physician Consultant Group
Dallas/Longview, Texas**

JOB DETAILS

Inpatient or out patient!! Make \$300,000 plus with full benefits

TITLE: Internal Medicine

JOB #: 764437

LOCATION: Dallas/Longview, Texas

FULL TIME/PART TIME: Full Time

CLIENT: Physician Consultant Group

PERMANENT/TEMPORARY: Regular

POSTED: 01/30/2008

EMPLOYMENT/CONTRACT WORK: Either

REPLY SENT: NO

VISA WAIVER AVAILABLE: No

NUMBER OF OPENINGS: 3

DESCRIPTION:

We have openings in Longview and Dallas area. Must be BC or BE.

Please contact for more information!

CONTACT:

Please call Steve at 214-233-7104 or email at: smjnchew@sbcglobal.net

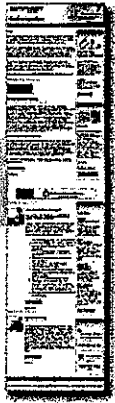
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**Temple, Texas / \$700,000+ Potential
Merritt, Hawkins & Associates/MHA Group
Hill Country, Texas**

JOB DETAILS

Near Austin, TX
No State Income Tax
Two-Year Partnership Track

TITLE: Temple, Texas / \$700,000+ Potential

JOB #: 757801

LOCATION: Hill Country, Texas

FULL TIME/PART TIME: Full Time

CLIENT: Merritt, Hawkins & Associates/MHA Group

PERMANENT/TEMPORARY: Regular

POSTED: 01/15/2008

EMPLOYMENT/CONTRACT WORK: Employment

REPLY SENT: NO

VISA WAIVER AVAILABLE: No

DESCRIPTION:

**\$500K Plus Potential First Two Years
Unlimited Potential After That**

- Well established group 50 minutes north of downtown Austin
- In between Waco and Round Rock, Texas
- Full benefits and malpractice paid for
- No state tax
- Two year partnership track and no buy-in
- Salary plus production bonus
- Town of 65,000 and county of 350,000 people

Please consider an ORS practice opportunity that offers a very rare combination of autonomy, excellent financial security and access to major metropolitan amenities. Be in a practice with two established surgeons with unlimited opportunity. The clinic is a one minute walk across the courtyard to the hospital.

JOIN TWO BUSY ORTHOPEDIC SURGEONS

Enjoy the autonomy of an efficiently run group and the prestige and market clout of being in a facility that offers a spectrum of Orthopedic cases. A salary ensures your financial stability and you will also enjoy a full range of benefits. With partnership in two years, this is an opportunity with a verifiable potential to net \$500,000 a year based on your skills and effort.

SOUTHWESTERN SUNSHINE

This practice offers the best of both worlds. Enjoy a safe family environment, incredible cost of living and little competition while still being within driving distance to world-class restaurants, theatres, art galleries, public aquariums and music venues that host the most popular entertainers. **University of Texas football just a short drive away.**

Experience a vibrant city offering the best in family living and industries, excellent public or private schools, low crime and superb amenities, from fitness centers to shopping. You can drive to several area lakes for boating and water sports within five minutes.

You and your family will benefit from the amenities offered as well as Austin just around the corner, including symphonies, world-class music centers, science and natural history museums, book stores, jazz clubs and more. A great family lifestyle and city excitement when you want, it makes this a great place to live.

Urology / \$425K+ Starting Salary / Sign-on Bonus / Elective Call / State-of-the-Art Facilities
Merritt, Hawkins & Associates/MHA Group
Fast Growing Community, Texas

JOB DETAILS

\$425,000+ Starting Salary / Sign-On Bonus
Top 95% Income Potential
No Required Call / No Buy-In
Tort Reform State / No State Income Tax

TITLE: Urology / \$425K+ Starting Salary /
Sign-on Bonus / Elective Call / State-of-the-Art
Facilities

JOB #: 754149

LOCATION: Fast Growing Community, Texas

FULL TIME/PART TIME: Full Time

CLIENT: Merritt, Hawkins & Associates/MHA
Group

PERMANENT/TEMPORARY: Regular

POSTED: 01/08/2008

EMPLOYMENT/CONTRACT WORK: Employment

REPLY SENT: NO

VISA WAIVER AVAILABLE: No

DESCRIPTION:

Live in one of the fastest growing areas in the nation with the ability to **live in the metro area or in the suburbs**. Be able to access **two international airports within 30 minutes**. Imagine having the autonomy to develop the type of practice you've always wanted, and have the ability to be your own boss. Have all the benefits, resources, of being in a brand new state of the art facility with all the latest technology at your disposal.

- **Earn Top 95th Income in Your Specialty**
- No Buy-In
- **Optional Call Schedule**
- Extremely Competitive Salary + Bonus
- **Perform General Urology or Sub-Specialize**
- New, State-of-the-Art Facility

Come see why this is one of the top 10 Fastest Growing Metros in the United States:

- Immediate Access to Vacation Destination
- **Physician Friendly - Tort Reform State**
- No State Income Tax
- **2 Airports for Easy Regional and International Travel**
- Year-Round Warm Weather - No Snow! No Ice!
- **Excellent Area for Singles, or Raising a Family**
- **#1 in Job Growth in the United States**
- #2 Lowest Cost Area to Live in Texas
- **#4 in Nation for Job Creation and Retention**

CONTACT:

Nolan Smith
800.876.0500

Close

Gastroenterology Private Practice \$400,000+ in Elite Dallas Location**TKG MedStaff****Dallas, Texas****JOB DETAILS**

- 3rd Largest Metro Area in the Country
- Network of over 800 physicians = Immediate referrals
- Largest MSG in the area

TITLE: Gastroenterology Private Practice
\$400,000+ in Elite Dallas Location**JOB #:** 754159**LOCATION:** Dallas, Texas**FULL TIME/PART TIME:** Full Time**CLIENT:** TKG MedStaff**PERMANENT/TEMPORARY:** Regular**POSTED:** 01/08/2008**EMPLOYMENT/CONTRACT WORK:** Contract Work**REPLY SENT:** NO**VISA WAIVER AVAILABLE:** No**DESCRIPTION:**

The Group is currently seeking a BC/BE Gastroenterologist to start a new practice in North Dallas. Existing and established referral base.

Physicians will enjoy an unlimited income potential, ancillary revenues and a comprehensive benefit package including health, life, dental and 401K with match.

- Relocation allowance
- Sign-On Bonus

State of the art Medical Office Building/Surgery Center with endoscopy lab, two nuclear cameras, 4 echo rooms, and a 64 slice PET/CT, MRI and Cyber Knife. In addition to 4 OR/treatment rooms ASC, imaging center, 6 room sleep lab, and physical pulmonary rehab and pain management facility.

Participate in Ancillary Revenue Streams: Physician owned lab, bone density, access to diagnostic imaging center including MRI, PET/CT and more.

The Dallas/Fort Worth area is a thriving and growing area. Easy access to Dallas/Fort Worth International Airport and the Dallas/Fort Worth Metroplex. Family oriented community with plenty of entertainment and excellent school systems. Enjoy all the Southwestern warmth, cosmopolitan flair, Old West charm and modern sophistication "Big D" has to offer.

CONTACT:

Jamie Ward

Director of Resource Development

TKG MedStaff

www.tkamedstaff.com

877-267-4635 Office

214-570-2318 Direct

469-330-8419 Fax

jward@tkamedstaff.com

Ob/Gyn needed in East Texas
Good Shepherd Medical Center- Longview, TX
Longview, Texas

JOB DETAILS

Ob/Gyn needed in East Texas

- \$270,000 Salary plus production
 - Call 1:3
- Excellent Benefits and Retirement
- \$20,000 Sign on bonus and \$10,000 for relocation assistance

TITLE: Ob/Gyn needed in East Texas
LOCATION: Longview, Texas
CLIENT: Good Shepherd Medical Center-
Longview, TX
POSTED: 01/07/2008
REPLY SENT: NO

JOB #: 753661
FULL TIME/PART TIME: Full Time
PERMANENT/TEMPORARY: Regular
EMPLOYMENT/CONTRACT WORK: Employment
VISA WAIVER AVAILABLE: Not specified

DESCRIPTION:

Good Shepherd Health System Administrative Services Organization is currently recruiting two OB/Gyn Surgeons to practice in one of our East Texas hospitals. Excellent salary and benefit package. We are nestled in the lush lake and pine forest region of Northeast Texas. The availability of outdoor activities combined with a growing economy, low cost of living and excellent schools are some of the reasons **people who locate here, love it here!**

Good Shepherd Health System consists of 3 hospitals: Good Shepherd Medical Center - Longview, a 412 bed Level II Trauma center, GSMC - Marshall is a 149 bed Level III hospital and GSMC - Linden is a 21 bed critical care access hospital. For more information about these medical centers, please visit our website at www.goodshepherdhealth.org.

CONTACT:

If this is a position that interests you, please contact:
Bunni Zeilinger, Director of Physician Recruitment at 903-315-2604,
903-237-8129 cell, fax 903-315-5317 or e-mail bzeilinger@gsmc.org .enter>

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In the Grid: Large Firms Pay Many Texas Associates Bigger Bonuses

Brenda Sapino Jeffreys

Texas Lawyer

01-14-2008

Associates with Patton Boggs, which has 57 associates in Texas, may soon feast on two helpings of bonus money under a new system the firm is using this year to reward them for work in 2007.

Patton Boggs will pay deserving associates one bonus in January based purely on their billable hours in 2007 and a second, discretionary bonus in February that's based partly on billable hours but also considers criteria such as pro bono work and participation in firm committees, says Stanley Mayo, managing partner of the firm's 109-lawyer Dallas office.

The cumulative bonuses will range from about \$10,000 to as much as \$70,000, he says.

Mayo says the new bonus plan adopted by the Washington, D.C.-based firm is designed not only to reward associates for their overall effort with the discretionary bonus but also to reward those who racked up an excess of billable hours during the year. Patton Boggs assigns associates to one of three tracks, calling for a minimum of either 1,650, 1,800 or 1,950 hours, depending on practice area, and then rewards associates with bonus money for working 100, 200, 300 or 500 additional hours above those minimums, Mayo says.

"We were doing just a discretionary bonus; however, we felt like some of the associates — certainly in Dallas, New York and New Jersey — were working excess hours, and we felt we should provide a special bonus to them, and bifurcated" the bonus payments, Mayo says.

Patton Boggs associates also are required to put in at least 100 hours on pro bono work during the year, and if they fail to do so for two years in a row, they won't receive a bonus the second year, he says.

EXHIBIT 9

Have associates lost bonus money for neglecting pro bono? "Yes, it's happened," Mayo says.

While Texas associates at Patton Boggs haven't yet received their bonuses rewarding performance in 2007, many other associates in Texas are now a bit richer due to bonus money or, like Patton Boggs associates, will soon receive bonus checks.

Overall, large Texas-based firms and out-of-state firms with large Texas operations paid bonuses roughly equivalent to what they paid associates for 2006 work or a little more than the previous year, according to interviews with lawyers at the firms. The generous bonuses are in addition to base salary raises that many big firms in Texas, although not all of them, gave associates in 2007 as the Texas market-rate base salary for first-year associates increased to \$160,000.

Fifteen of the 25 firms with the most lawyers in Texas as of Jan. 1, 2007, provided information on associate bonuses for 2007. The 25 firms are identified on Texas Lawyer's "The Texas 100" poster, published in April 2007. Jenkins & Gilchrist, the Dallas firm that was 14th on the list but closed its doors on March 31, 2007, is excluded.

While not among the 25 firms with the most lawyers in Texas, litigation firm Susman Godfrey has been a giant among firms due to its hefty bonus payments in recent years.

Partner Stephen Susman says the Houston-based firm paid associate bonuses in December 2007 that ranged from \$60,000 to \$120,000, which is the same range as the previous year. He says it's because the firm's financial performance was roughly equivalent to the prior year.

"We are thrilled to have a great year, and it was like the year before," Susman says.

A number of other large Texas firms paid associate bonuses ranging up to \$60,000, \$70,000 or \$80,000 for high-performing upper-level associates or even a bit more.

Andrews Kurth, for instance, paid a special bonus above the firm's regular performance bonus for a few associates who worked substantially more than 2,300 hours, which was the level on the firm's bonus grid that would qualify an associate for a top bonus.

The firm's bonus payments, according to the grid, ranged from \$5,000 for a lower-level associate working 2,000 hours to as much as \$80,000 for an upper-level associate working 2,300 hours, says Jeffrey Spiers, a partner in Houston who is co-chairman of the firm's associates committee.

"We had several [associates] significantly beyond that workload level, and we wanted to recognize those efforts," Spiers says. "We know that an incremental hour at that level impinges on your other life desires a lot more than the first hour that you bill."

Some of the associates who put in an extraordinarily large number of hours worked on the

corporate and transactional side of the firm, but others were in litigation, he says.

With the extra bonus, a few of the firm's associates received bonus money in the six figures, he says.

A year ago, Andrews Kurth associates could earn up to \$60,000 in bonus, but Spiers says the firm increased the overall level of bonus payments for 2007 work because of market conditions — competitors increased compensation — but also because associates worked hard in 2007.

Baker Botts paid associate bonuses ranging from \$5,000 to \$77,500 in mid-December, says George Lamb, a partner in Dallas who is chairman of the associate compensation committee. A number of associates received the top bonus on the firm's bonus grid, he says.

"It's all discretionary, but guided by three credit-hour levels, one at 2,000, one at 2,150 and one at 2,300," he says.

Lamb says the firm sweetened its bonus grid — bonuses ranged from \$5,000 to \$50,000 in December 2006 — because other firms in the market were paying more.

"There were no complaints, that's for sure," Lamb says in describing how associates with 794-lawyer Baker Botts reacted to their bonus checks.

Fort Worth's Kelly Hart & Hallman, with 106 lawyers, paid associate bonuses in December, but managing partner Dee Kelly Jr. declines to discuss the amounts.

"It's all merit-based and confidential," Kelly says.

Twice as Nice

While many firms pay bonuses before year-end, giving associates cash for the holidays, other large Texas firms hold off until January or later as management figures out how much it will pay associates in bonuses.

At 145-lawyer Brown McCarroll, based in Austin, associates will receive bonuses ranging from \$5,000 to as much as \$65,000 before the end of January, says Robert Werner, the firm's managing partner.

The firm's bonus system is unchanged from the year before, he says.

Akin Gump Strauss Hauer & Feld, which has Texas offices in Dallas, Houston, San Antonio and Austin, pays associate bonuses at the end of January, says Eliot Raffkind, the hiring partner in Dallas.

The 1,023-lawyer firm will pay bonuses similar to those paid a year ago, but "we are still

in the process of figuring that all out," Raffkind says.

He says the bonuses are primarily merit based but have an hours component and take into account pro bono work.

Bracewell & Giuliani, where bonus checks are paid in February, has just begun the evaluation process, says Jennifer Weston, a partner in Houston who is the firm's general counsel for professional development. She says billable hours are considered, along with quality of work and contributions to the firm and the community.

Weston says the upper range of bonuses will increase this year to \$72,500, compared to \$50,000 last year, because some other firms also are paying higher bonuses.

Dallas-based Gardere Wynne Sewell, which has a March 31 year end, will pay bonuses in March, says managing partner Stephen Good. In March 2007, bonuses ranged from \$2,500 to \$50,000, he says.

At Houston-based Vinson & Elkins, the firm plans to pay bonuses on Jan. 15 ranging from \$5,000 to \$45,000, says Keith Fullenweider, a partner in Houston who is chairman of the associate evaluation and compensation committee.

The bonuses are productivity based, Fullenweider says, considering hours for clients or approved firm business. Up to 150 pro bono hours are included in the billable-hour total, he says.

The bonus grid for 2007 work is the same as the previous year, but associates' total compensation improved after the firm increased associate salaries. In July 2007, V&E became the first large Texas-based firm to raise first-year associate base salaries to \$160,000 to match the raises New York-based firms began paying earlier in the year. Other large Texas firms, although not all of them, followed V&E's lead and moved to the new market pay rates for associates.

"We felt that with the substantial increases in base compensation, we were comfortable with leaving our bonus amounts consistent with 2006," Fullenweider says. "We made it clear back in July we were not going to pay more in base and less in bonus."

While a number of Texas firms moved quickly to increase associate compensation in the wake of V&E's market move, some large Texas firms announced they would not raise their associate salary scale in 2007 but would instead put more money into the bonus pool. [See *"Winstead Says Yes to Bonuses, No to Raises," Texas Lawyer, July 30, 2007, page 1.*]

Dallas-based Winstead is one of those firms that gave associates opportunity for more bonus money in 2007 instead of raising the salary scale.

"Since we didn't raise our base in '07, we wanted to make sure the combination of base

plus bonuses was still market competitive for performing associates," says Denis Braham, a shareholder in Houston who is the firm's chairman and chief executive officer. "The majority of our associates were in that market range when the two were totaled together, and some associates exceeded that range and some were a little less."

The 308-lawyer firm paid bonuses in December ranging from \$5,000 to \$65,000, Braham says. That compares to bonuses of as much as \$45,000 a year ago. Braham notes that, in 2008, bonuses will be as much as \$72,000.

He says the firm looks at "intangibles" along with billable hours to determine bonus payments, but to receive \$65,000, a Winstead associate had to be an upper-level associate who billed more than 2,200 hours.

Munsch, Hardt, Kopf & Harr of Dallas also decided to hold the line on associate salaries in 2007. But the firm did enrich bonus payments, says Glenn Callison, the firm's chairman and chief executive officer.

"We actually paid them [bonuses] twice," he says.

Callison says the firm paid regular bonuses on Dec. 15, 2007, that were "probably 50 percent larger than they were last year on the whole." The bonuses ranged from \$2,700 to just under \$50,000.

But due to a "very good year" at the 103-lawyer firm, Munsch, Hardt paid an additional special bonus at year end to associates. The special bonuses, according to Callison, were approximately equivalent to 10 percent of the regular bonus payments.

"People were very excited," Callison says. "The firm enjoyed two back-to-back years of its strongest financial performance ever, and I really felt that people were appreciative that we wanted to share that."

In December, San Antonio-based Cox Smith Matthews paid associates bonuses ranging from \$2,500 to \$55,000, says James "Jamie" Smith, the 135-lawyer firm's managing director. That's up some from last year, when associate bonuses ranged from \$1,500 to about \$40,000, because of associate compensation market conditions, Smith says.

"We didn't adjust base much, if at all, but have a more generous bonus," he says, noting that associates are evaluated on a mix of quantitative and subjective measures, including billable hours and community involvement.

Dallas firm Hughes & Luce paid bonuses to its associates in December, prior to its combination with Kirkpatrick & Lockhart Preston Gates Ellis of New York on Jan. 1. The 149-lawyer firm is now K&L Gates, which has more than 1,500 lawyers with 23 offices in the United States, Europe and Asia. [See "*Hughes & Luce and K&L Gates Partners Agree on Combo Deal*," *Texas Lawyer*, Dec. 24, 2007, page 5.]

Danny Ashby, who was head of the Hughes & Luce compensation committee, says the bonuses ranges from \$2,500 to as much as \$51,000. They were partly based on billable hours and client development, says Ashby, now a partner in K&L Gates.

Jack Cleaveland, chairman of the management committee of 100-lawyer Thompson, Coe, Cousins & Irons, says associates at the Dallas-based firm will receive bonus payments this month. He declines to provide the range of bonus payments, but says, "Individually and in the aggregate, they are better than last year."

David Parham, the partner-in-charge in Dallas for Chicago-based Baker & McKenzie, which has 105 lawyers in Texas, says the firm's associates will receive bonus money in their Jan. 15 paychecks.

"They were substantial bonuses," says Parham, who declines to provide further information on the range of payments.

Seven firms with large Texas operations did not respond to requests for information about associate bonuses: Locke Lord Bissell & Liddell, based in Houston and Dallas; Dallas firms Thompson & Knight, Jackson Walker and Strasburger & Price; Austin's Clark, Thomas & Winters; and Weil, Gotshal & Manges and King & Spalding, both out-of-state firms with large Texas operations.

George Manning, the new partner-in-charge in Dallas for Jones Day, could not be reached for comment before presstime on Jan. 10.

Fulbright & Jaworski of Houston and Dallas-based Haynes and Boone decline to provide associate bonus information.

testimony

From: Cary Rupert [C1@hawaii.rr.com]
Sent: Wednesday, February 13, 2008 11:06 AM
To: testimony
Subject: Please deliver to room 016 for the Senate Health Committee hearing, Wednesday, 2/13/08, 1:15pm.

February 13, 2008

To: Sen. David Ige, Chair
Sen. Carol Fukunaga, Vice Chair
Senate Health Committee

From: Cary Rupert
126 Kaihone Way
Kailua, HI. 96734
(808) 226-2229

Re: SB2412 Relating to Medical Liability
SB2354 Relating to Medical Liability

I am a Hawaii resident and I strongly support SB2412 and SB2354.

Both bills will help to stabilize medical malpractice insurance premiums. I support a \$250,000 cap, on non-economic damages, which has been proven by other states to be effective in stabilizing premiums. I also support limits on attorney fees, so as to give more money to the injured plaintiff. Having been a complainant in a medical injury case, I am sensitive to both the needs and requirements of the complainant as well as that of the "system" we hope to keep in place. I was shocked at the lawyerly activity surrounding my case as well as the costs and profits gained by lawyers for my injury. In the end, I was not fairly compensated and the group I initially filed my complaint against was ABSOLUTELY NOT penalized appropriately. The penalties were excessive and inflated almost solely to provide an obscene profit to the lawyers I WAS REQUIRED to utilize to file my complaint. I also firmly support mediation as opposed to expensive trials and lawyers.

While there is no silver bullet for our healthcare problems, medical liability reform will help to keep Hawaii's physicians in practice and recruit new doctors.

Unless legislators act now, doctors will continue to cut back on their practices or leave the state and Hawaii's residents will not get the care they need when they need it most. I have seen numerous practitioners leave the State of Hawaii, much to their dismay, because the climate for running a practice in the State is so adverse. The loss of high caliber practitioners has negatively impacted my personal well being as well as that of many other people I know.

Medical liability reform is an important part of the solution. Texas and other states have had great success in improving access to care since passing reforms.

Thank you for the opportunity to provide this testimony.

Respectfully,

Cary Rupert
Kailua, HI

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