LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
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LAWRENCE M. REIFURTH
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RONALD BOYER
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON JUDICIARY

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Tuesday, February 24, 2009
2:05 p.m.

TESTIMONY ON HOUSE BILL NO. 1514, H.D. 1 – RELATING TO MEDICAL TORTS.

TO THE HONORABLE JON RIKI KARAMATSU, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Insurance Division ("Insurance Division") of the Department of Commerce and Consumer Affairs ("Department"). The Insurance Division supports the intent of this bill, which is to reduce the costs of medical malpractice insurance. The Insurance Division limits its comments to Parts I and IV of this version of the bill.

The purpose of this version of the bill is to: (1) add a new section to Hawaii Revised Statutes ("HRS") chapter 671 which imposes a $1 million limit on noneconomic damages for board-certified neurologists and neurosurgeons; (2) require a 25% rollback on medical malpractice insurance premiums for neurologists and neurosurgeons; (3) require the Department to submit a report to the Legislature on the effects of the cap on noneconomic damages and the rate rollback (Part I); (4) require disclosure to patients of adverse events regarding their medical treatment (Part II); (5) require the Hawaii Medical Board to collect and publish information about state-licensed physicians (Part III); and (6) establish a Medical Malpractice Damages Task Force ("Task Force") to

provide support in implementing provisions of this bill and to study the effects of this bill (Part IV).

With respect to the limit on noneconomic damages and the malpractice insurance rate rollback for neurologists and neurosurgeons (Part I), the Department prefers House Bill No. 1120 which is intended to provide a more rational atmosphere for the practice of medicine in Hawaii and to reduce the cost of medical malpractice insurance for all health care providers.

As to the Task Force, this measure does not contain an appropriation. Therefore, the Department would incur the costs in supporting the Task Force and would be required to re-direct resources from its core mission. Given the current fiscal challenges facing the state, it may not be prudent to attach the Task Force to the Department.

We thank this Committee for the opportunity to present testimony on this matter.

LINDA LINGLE
GOVERNOR

DARWIN L. D. CHING
DIRECTOR

COLLEEN Y. LaCLAIR
DEPUTY DIRECTOR

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TO: Honorable Jon Riki Karamatsu, Chair
Honorable Ken Ito, Vice Chair
Members of the Committee on Judiciary

FROM: Serafin "Jun" Colmenares, Executive Director, Office of Language Access

RE: **Testimony in Support of the Intent of HB1514 HD1**
Hearing: Tuesday, February 24, 2009, 2:05 p.m., Conference Room 325

I. OVERVIEW OF CURRENT PROPOSED LEGISLATION

HB1514 HD1 proposes to improve health care by limiting damages for medical torts and allowing consumers to make informed decisions when selecting a health care provider. Specifically, the measure places a ceiling on non-economic damages in medical torts involving neurologists and neurosurgeons and reduces insurance premiums for malpractice liability coverage. In addition, to protect consumers, this measure requires health care providers to disclose to patients adverse events relating to their experience in providing medical treatment and requires the Hawaii Medical Board to collect and publish information (including information about language access) about physicians licensed in the state. Finally, a Medical Malpractice Damages Task Force is established to provide support in implementing the provisions of this measure.

II. CURRENT LAW

Chapter 671, HRS, does not address placing a limit on non-economic damages for medical torts involving neurologists and neurosurgeons. In addition, although Chapter 453, HRS, addresses medical licensing and discipline, there is no requirement on the development and disclosure of physician profiles as proposed here. The Hawaii Medical Board Newsletter describes Board actions taken against physicians over the past year. While the Board collects information about physicians, this does not include the extensive physician profile, including addressing language access.

III. HB1514 HD1

The Office of Language Access (OLA) supports the intent of HB1514 HD1, particularly Part III.

The physician profile may include information on language access. The availability of language access through an interpreter or bilingual medical staff is a vital component for consumers seeking medical assistance. The OLA supports the intent of this measure to the extent that it furthers the goals of the state Language Access Law (enacted by the Legislature in 2006) to ensure meaningful access to state-funded services, programs and activities by persons with limited English proficiency.

LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME LEINAALA FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

WRITTEN TESTIMONY

House Committee on Judiciary

H.B. 1514, H.D. 1 RELATING TO MEDICAL TORTS

Testimony of Chiyome Leinaala Fukino, M.D.
Director of Health

February 24, 2009; 2:05 p.m.

Department's Position: The Department of Health (DOH) supports this bill, but respectfully provides a recommendation to Part II of the current draft. Similarly, this suggested amendment also applies to H.B. 1784, H.D.1, Relating to Medical Torts.

Fiscal Implications: The inefficiencies of the medical tort system are costly– only about 40 cents of every dollar spent on malpractice insurance goes to compensate injured patients while the rest goes to legal fees, court costs, and insurance company administration (RWJF Research Highlights, Oct. 2006). The associated rise in medical malpractice insurance premiums has economically inhibited the ability of doctors to provide necessary services in rural areas and on the neighboring islands.

Purpose and Justification: Part II amends Chapter 321, Hawaii Revised Statutes, requiring health care providers to provide notification of harmful or life threatening adverse events to the patient or family. We suggest that the Hawaii Medical Board, charged with the development of rules and oversight, does not fall under the purview of the Department of Health and thus, the statutory citation should be reconsidered.

The Department of Health strongly supports the Legislature in its efforts to comprehensively consider the many related measures put forth this session to address this critical issue in health care.

The shortcomings of the medical tort system are widely acknowledged. First, few who sustain medical injuries actually receive compensation. Second, malpractice cases are lengthy and awarded compensation amounts are inconsistent. Indeed, the current medical tort system does not seem to effectively promote patient safety and may actually discourage accurate medical error reporting among health care providers. The Department of Health joins with the Office of the Governor, the Department of Commerce and Consumer Affairs and the Hawaii State Legislature as we work towards successfully realizing comprehensive medical tort reform this session.

Thank you for the opportunity to testify.

THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • Fax: (808) 547-4646

Representative Jon Riki Karamatsu, Chair
Representative Ken Ito, Vice Chair

Tuesday, February 24, 2009 – 2:05 p.m.
State Capitol, House Conference Room 325
HOUSE JUDICIARY COMMITTEE

HB1514 HD1 Relating to Medical Torts

Chair Karamatsu, Vice Chair Ito and Members of the Committee,

My name is Robin Fried. I am the Director of Risk Management at The Queen's Medical Center, the largest private tertiary care hospital in the State of Hawaii. I am testifying for The Queen's Medical Center **in opposition to Part II of HB1514 HD1, mandatory disclosure of adverse events.**

Queen's is committed to ensuring the safety and quality of care for its patients 24 hours a day, 7 days a week. While we support open communication and appropriate disclosure to patients and/or patient's personal representatives, we find this section of the bill to be unnecessary and duplicative of existing law and accreditation standards, as well as ambiguous in key aspects.

The proposed language is duplicative of existing law and accreditation standards as follows:

- HRS § 671-3(5) and longstanding case law holds that the treating physician has the duty to obtain informed consent. It follows that the physician has the duty of disclosure of any actual complications and is in the best position to address the medical issues.
- The Joint Commission currently requires accredited hospitals to ensure that the patient or surrogate decision-maker is notified about "unanticipated outcomes of care, treatment and services related to sentinel (major adverse) events".

The proposed language is ambiguous with regard to the following:

- The definition of provider includes both physicians and health care facilities. In situations where the physician is an independent practitioner, not a hospital employee, it is unclear who bears the responsibility for notification – the hospital or the physician.
- The definition of "adverse event" is overbroad and could include almost any complication that may occur.
- The bill provides that failure to comply may subject a health care provider to penalties, yet provides no clear standards for compliance, raising issues of due process.

The Queen's Medical Center urges you to delete Part II of HB1514 HD1. Thank you for the opportunity to testify.

Robin Fried, JD, MS

Tuesday, February 24, 2009, 2:05 p.m. CR 325

To: COMMITTEE ON JUDICIARY
Rep. Jon Riki Karamatsu, Chair
Rep. Ken Ito, Vice Chair

From: Hawaii Medical Association
Gary A. Okamoto, MD, President
Philip Hellreich, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Richard C. Botti, Government Affairs
Lauren Zirbel, Government Affairs

Re: HB 1514 RELATING TO MEDICAL TORTS

Chairs & Committee Members:

In support of HB 1514.

While this measure does is not as broad in scope as is HB 1784, it does address the subject matter, and would be a good vehicle to allow continued discussion on the issue it is intended to address.

Thank you for the opportunity to provide this testimony.

Hawaii Medical Association
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(808) 528-2376 fax
www.hmaonline.net

NFIB
The Voice of Small Business®

Before the House Committee on Judiciary

DATE: February 24, 2009

TIME: 2:05 p.m.

PLACE: Conference Room 325

Re: HB 1514, HD1
Relating to Medical Torts
Testimony of Melissa Pavlicek for NFIB Hawaii

Thank you for the opportunity to testify in support of HB 1514, HD1. NFIB supports this measure.

The National Federation of Independent Business is the largest advocacy organization representing small and independent businesses in Washington, D.C., and all 50 state capitals. In Hawaii, NFIB represents more than 1,000 members. NFIB's purpose is to impact public policy at the state and federal level and be a key business resource for small and independent business in America. NFIB also provides timely information designed to help small businesses succeed.

NFIB agrees that limiting non-economic damages in medical tort actions is an important issue, with the potential to affect many businesses. We have long supported legislation that would tend to reduce additional financial or administrative burden on business, particularly small businesses.

841 Bishop Street, Suite 2100 Honolulu, Hawaii 96813

PRESENTATION OF THE
HAWAII MEDICAL BOARD

TO THE HOUSE COMMITTEE ON JUDICIARY

TWENTY-FIFTH STATE LEGISLATURE
REGULAR SESSION of 2009

Tuesday, February 24, 2009
2:05 p.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON HOUSE BILL NO. 1514, H.D. 1, RELATING TO MEDICAL TORTS.

TO THE HONORABLE JON RIKI KARAMATSU, CHAIR,
AND MEMBERS OF THE COMMITTEE:

The Hawaii Medical Board ("Board") thanks you for the opportunity to provide written testimony on H.B. No. 1514, H.D. 1, Relating to Medical Torts. The purpose of this bill is to place a ceiling on non-economic damages in medical torts involving neurologists and neurosurgeons; reduce insurance premiums for malpractice liability coverage; require a health care provider to disclose to patients adverse events relating to their medical treatment; require the Hawaii medical board to collect and publish information about physicians licensed in the state to allow consumers to make informed decisions in selecting physicians; and establish a medical malpractice damages task force to provide support in implementing provisions of this Act.

While the Board takes no position on the issues relating to medical torts, we do have strong concerns with respect to collecting and publishing information. Although we support and continue to strive, within the capabilities of our resources, to provide information to consumers to make informed decisions, for the reasons stated below we oppose this bill as it places data collecting and publishing responsibilities that we cannot

bear without additional resources, and it requires collection of information that is not related to licensing. It further, inappropriately and harshly, authorizes sanctions against a licensee if the physician fails to comply with furnishing information as well as failing to timely report updates to information.

We first would like to point out that DCCA's web sites already furnish a significant amount of information required by H.B. No. 1514, H.D. 1.

H.B. No. 1514, H.D. 1, however, proposes substantially more data be published and the effect of this is that it will require us to input information that we currently do not post to our database but is otherwise available in hard copy form (for any online publishing, the source of information must come from a database), and to collect and publish information for licensure that we currently do not collect.

On the matter of requiring us to publish information that will result in inputting information that we currently do not post to our database but is otherwise available in hard copy form, this is a workload issue. To manage this task would require additional staff and funding which, in the current economic situation, appears unlikely.

On the matter of requiring us to collect and publish information that we currently do not collect, we object to collecting information which does not have a direct nexus to a physician's competence and qualifications to practice medicine. We license in order to protect the public. Section 26H-2, Hawaii Revised Statutes, relating to policy, states in part that "the purpose of regulation shall be the protection of the public welfare..." To this end, information required of a physician should have (and currently does have) a

direct nexus to the physician's competence and qualifications to practice medicine safely.

On the other hand, some of the information required of physicians by this bill has no nexus to qualifications, is not required to obtain or maintain a license, and is not currently collected.

To facilitate discussion and to help understand which enumerated items contained in H.B. 1514, H.D. 1 (PART III, pages 4 -8) fall into the categories described above, we set forth below by subject matter and the corresponding enumerated items from the bill, what information is currently posted on our web sites, what information we collect but is not in our database and thus is not information that can be extracted to post on an online system and to do so would require additional resources, and what information we do not currently collect (because it has no nexus to licensing purposes).

Information currently posted on our web sites:

(1) The full name of the physician; *This information is in the form of first name, middle initial (if provided), and last name.*

(3) A description of any final disciplinary action by the board against the physician, including fines, penalties, probation, suspension, or revocation of license;

(12) Status of compliance with continuing education requirements; *This information is not posted in our database but if a licensee has a current and active status as disclosed on our online service, that would mean compliance with continuing education requirements have been met.*

For the Committee's information, we also publish the license number of the physician, current license status, original date of licensure, expiration date of the license, any conditions and restrictions placed on the license, prior license name (in the case of name changes), complaint history (the Regulated Industries Complaints Office website), and final disciplinary actions, including settlement agreements (the Office of Administrative hearings website).

Information we collect but is not posted to our database (additional resources needed to do so):

(2) A description of any criminal convictions for felonies and serious misdemeanors, as determined by the board, including convictions reported to the board pursuant to section 329-44;

(4) A description of any final disciplinary action taken by any other licensing jurisdiction in other states against the physician within the last five years;

(5) A description of revocation or involuntary restriction of hospital privileges for reasons related to competence, character, or substance abuse that have been taken by the hospital's governing board or administrative officer, or resignation from or nonrenewal of medical staff membership or restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary action. Adverse decisions reported to the board pursuant to section 663-1.7 shall be included in the profile;

(6) All medical malpractice court judgments or awards in which a payment was awarded to a complainant, including those reported to the board pursuant to sections 453-8.7, 671-5, and 671-15;

(7) Name of medical school attended, dates of attendance, and date of graduation;

(8) Name of graduate medical education program, dates of attendance, and date of completion; *We have this information for the majority of licensees. The exception would be those residents applying for licensure after their first year of residency training. As they would not have completed residency training, we would only have information with respect to the first year.*

(10) State or jurisdiction in which the physician is licensed, date of licensure; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

(11) Names of hospitals where the physician has privileges; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

SECTION 8, amendments to Section 453-7.5, Hawaii Revised Statutes relating to: (3) The board shall include in the physician profile under section 453- a statement that an adverse decision has been reported to the board.

For the Committee's information, enumerated items 2, 4, 5, 6, and the last item relating to amendments to Section 453-7.5 are the bases for complaints against licensees through the Regulated Industries Complaints Office of DCCA or as complaints initiated by the Board's Office. Therefore, underlying reasons for such actions by a physician do

result in a complaint that would be available through the web site on complaint history on a licensee.

Information we do not currently collect (no nexus to licensing):

(1) The address and telephone number of primary practice office, and electronic mail address;

(9) Specialty board certification. The toll free number of the American Board of Medical Specialties shall be included to verify current board certification status;

(10) Current status of licensure of the State or jurisdiction in which the physician is licensed; *This information is disclosed only with the application for licensure but is not collected at any point thereafter.*

(13) Name of the professional liability insurance carrier or whether the physician is self-insured and the status of compliance with financial responsibility provisions;

(14) Whether the physician participates in the medicaid program, health plans, or accepts workers' compensation cases;

(b) The physician may elect to include the following information: professional and community memberships, community activities, publications in peer reviewed medical literature, appointments to medical school faculty, language access, and any specialized areas of treatment.

In light of the above, we cannot support PART III (pages 4-8) of this bill should it move forward with requiring collection and publication of information unrelated to licensing. Should the Committees want us to publish information that is collected but not posted to our data base, it will require support of positions and funding. If the

funding mechanism is to be by way of increased fees to physicians to subsidize the additional staffing, we would have concerns on increasing fees.

Thank you for the opportunity to provide written testimony on H.B. No. 1514, H.D. 1.

Memo

Trecker & Fritz
Attorneys At Law

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To: Chair, Judiciary Committee

From: Marty Fritz

Date: February 24, 2009, Tuesday at 2:05 p.m.

Re: **HB 1514, HD1 (HSCR447)**

Honorable Chair and Committee Members. My name is Marty Fritz. I am a lawyer who represents a limited number of medical malpractice victims who suffer horrific injuries or death from doctors errs.

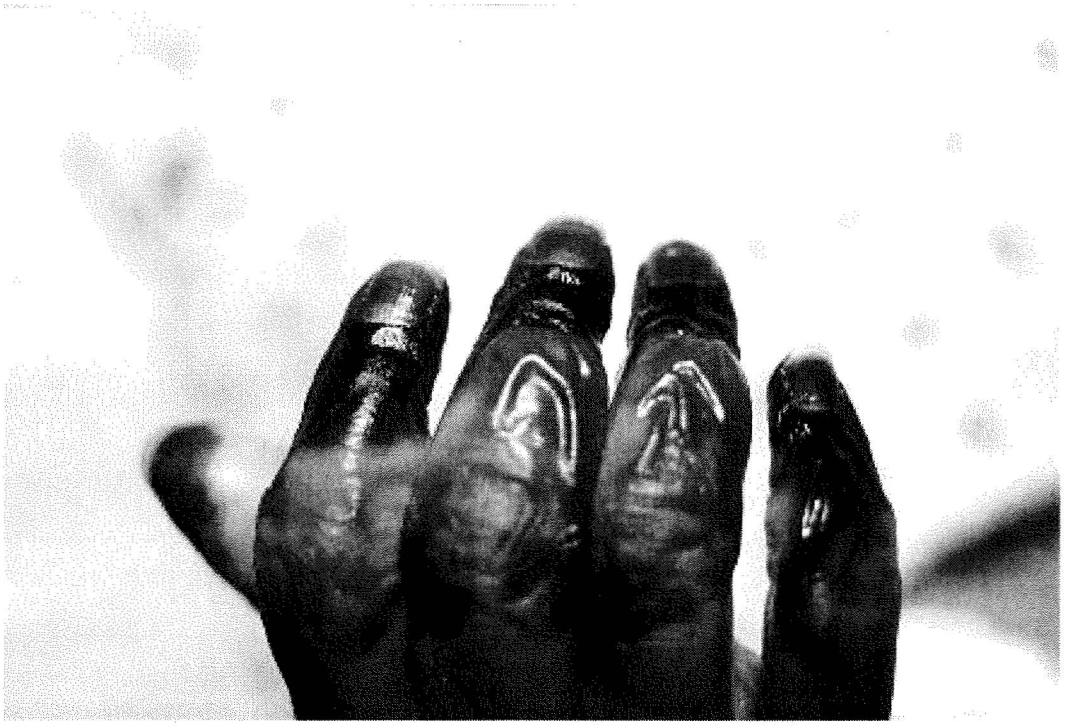
The bills your committee is hearing relating to tort reform have one basic assumption-- there is a need for some change. The arguments I have heard supporting these bills are primarily that there is an explosion in medical malpractice verdicts in the State of Hawaii which is leading large numbers of physicians to leave the state. There are no specifics presented, rather emotional non specific allegations of the negative effects of the current system. The reason why these arguments are non specific is because they are unable to be supported by relating on evidence and analysis.

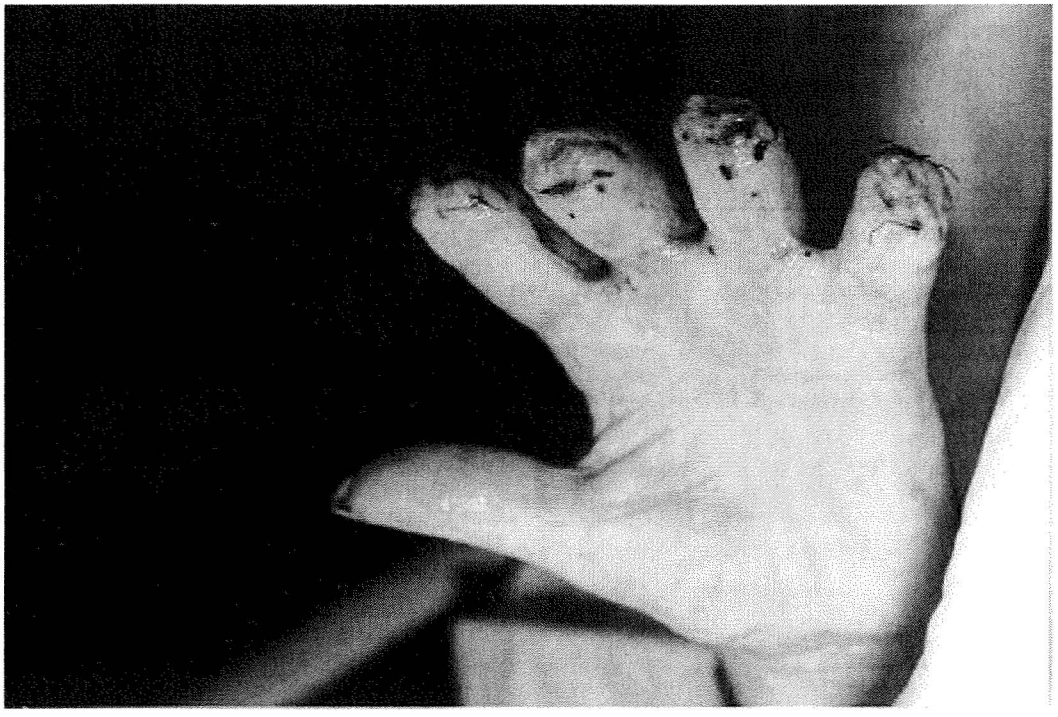
As a former member of the bipartisan committee appointed by the legislature in the late 1990's to make a two year study of the tort system, I am quite aware of how faulty perceptions combined with emotions and publicity can powerfully impact the legislative process. In the 1990's there was a perception that the costs of the tort system were out of control. The study, which thoroughly reviewed actual cases and filings, found to nearly everyone's surprise that just the opposite was true i.e. *there had been a significant drop in accidents and court filings.*

Un-needed restrictions like those proposed including caps on non-economic damages can have devastating impacts on people injured as a result of medical negligence. Although arguments are made that economic damages are sufficient to ensure adequate awards this is clearly incorrect in my experience, especially for specific groups such as housewives and non-working women, retirees, and youngsters, and those with little or no wage earning history or capacity. With caps as those proposed many of these people will obtain tiny awards for injuries that are crippling and literally make their lives hell on earth.

I have enclosed pictures of a person who have been injured by medical errs. This person had her fingers and toes amputated. She was of retirement age and there was no treatment for injuries so she therefore, had little or no economic damages for a life changing, painful, crippling conditions.

Of Counsel:
Steven J. Trecker





February 24, 2009

The Honorable Jon Riki Karamatsu, Chair
The Honorable Ken Ito, Vice Chair

House Committee on Judiciary

Re: HB 1514 HD1 – Relating to Medical Torts

Dear Chair Karamatsu, Vice Chair Ito 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 on HB 1514 HD1 which seeks to lower medical malpractice insurance premiums by adopting legislation that directly affects elements impacting medical malpractice insurance rates. While HAHP supports the overall intent of this bill as a good first step toward helping to contain the spiraling cost of medical malpractice insurance, we would like to express our concerns with Section 3.

We do 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 such as neurology. 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.

We believe, however, that the language in Section 3 could set a dangerous precedent for entities providing any type of insurance coverage. This section would legislatively mandate a 25% "rollback" of premium rates for a specific provider type. Entities providing insurance coverage take many factors into account when setting rates and legislatively mandating a premium in statute may prevent carriers from being able to offer coverage at all. This could have the unintended

consequence of limiting choices for coverage rather than expanding it. Therefore, we would respectfully request the removal of this language from the measure.

Thank you for the opportunity to offer comments today.

Sincerely,

Rick Jackson
President

TESTIMONY OF RUTH ALONI IN OPPOSITION TO HB 1514 HD1 AND HB1784 HD1

February 24, 2009 Hearing
Committee on Judiciary
House of Representatives

Chair Jon Riki Karamatsu and Members of the House Judiciary Committee:

My name is Ruth Aloni and I am a victim of medical malpractice. I oppose HB 1514 HD1 and HB 1784 HD1 that sets caps for noneconomic damages for persons injured by medical malpractice. My doctor failed to diagnose my cancer for two years. Since then, I have suffered through many medical procedures as I have fought against the cancer that has spread through my body. The process of compensating persons injured by malpractice must be fair and not restricted by an arbitrary amount.

Thank you for allowing me the opportunity to testify.

Ruth Aloni
Honolulu, HI

TO	:	**Jon Riki Karamatsu, Chairperson** **House Committee on Judiciary**
FROM	:	**Michael K. Livingston**
SUBJECT	:	**H.B. 1514 H.D.1; H.B. 1636; H.B. 1784 H.D.1**
HEARING DATE	:	**Tuesday, February 24, 2009, 2:05 p.m.** **Room 325**

TESTIMONY OF MICHAEL LIVINGSTON IN OPPOSITION TO
H.B. 1514 H.D. 1; H.B. 1636; H.B. 1784 H.D. 1

To the House Committee on Judiciary:

My name is Michael Livingston. I represent patients who are injured through the negligence of health care providers and failures in our health care delivery system.

I would like to bring to your attention a case handled by my law firm involving an orthopedic surgeon, Dr. Ricketson, who was permitted to perform spinal surgery on our client, Arturo Iturralde, in 2001, despite having had his medical license suspended by Oklahoma in 1999 and revoked by Texas in 2000 (with a finding that he engaged in unprofessional conduct that is likely to deceive or defraud the public or injure the public). This doctor implanted a steel screwdriver in our client's spine instead of a titanium surgical rod. The screwdriver broke inside his back only days after the surgery, requiring three more surgeries and leaving our client completely disabled and in constant pain until his death from related complications several years later.

Dr. Ricketson stopped practicing medicine in Hawai'i after we filed suit against him in 2003. Our investigation discovered that, in addition to having had his medical license suspended in Oklahoma and revoked in Texas, he had been denied a medical license in Kansas in 2002, he had been sued for malpractice at least seven times in several states, and he had admitted to addiction to narcotics and use of crack cocaine. Yet it was not until July 17, 2007, more than six years after Dr. Ricketson implanted a screwdriver in our client's back, that the State of Hawai'i finally revoked Dr. Ricketson's Hawai'i Medical license.

This case demonstrates that neither the hospital credentialing process nor the State medical licensing and review process is capable of providing adequate protection to the public against incompetent practitioners. Simply put, the Hawai'i public was only protected from Dr. Ricketson by Arturo Iturralde's malpractice lawsuit. This case also highlights the commonsense notion that our efforts should be addressed at preventing malpractice instead of limiting recoveries of those who are injured. Efforts to limit recoveries unfairly penalize the injured patient, detract from the real solution of preventing malpractice, and have unintended and undesired consequences. Reduce malpractice and you reduce malpractice claims, while preventing unnecessary injury and improving patient safety.

Michael K. Livingston

Testimony of Bert Sakuda
In Opposition to H.B. No. 1514, H.D. 1

Chair Jon Riki Karamatsu and Members of the House Committee on Judiciary:

Thank you for the opportunity to testify in Opposition to H.B. No. 1514, H.D. 1.

The limitation on patients' recoveries is opposed because it is fundamentally unfair and poor public policy to shift the burden of medical errors from the health system to the injured patient. Insurance now spreads the cost of medical errors among participants in our health care system. No single doctor, hospital, nurse, pharmaceutical company, medical device manufacturer or patient pays the entire cost of major medical errors. Everyone shares in the cost through insurance, including the patient who pays for health insurance (the cost of which reflects the cost of providing medical services including malpractice insurance). The measure would cap damages and shift the entire burden on any amount in excess of the cap solely to the patient.

There is no data to support the claim that capping non-economic damages will cause doctors to remain in Hawaii, let alone move to a neighbor island, take call at hospitals, or significantly reduce the cost of malpractice insurance. The recent LRB study completed in 2006, at the legislature's request, concluded that data regarding the connection between limiting damages and significantly reducing premiums were "at best inconclusive."

The Texas experience is now offered as conclusive proof that a $250,000 cap on non-economic damages will solve the neighbor island and on-call doctor shortage, significantly reduce malpractice premiums and keep doctors from leaving Hawaii. The data and facts, however, do not support the claim of a Texas miracle.

Texas Has Not Solved Its Rural Doctor Shortage

The Texas Medical Board maintains and publishes data on the number of physicians (by specialty) for each of the 215 counties in Texas. It is therefore a simple matter of comparing the data from years before Texas adopted a limitation in damages with the data from subsequent years. The data plainly show that there is no increase in doctors moving to rural Texas.

Texas Medical Board reports for 2003 and 2008 show the following:

	Counties with No OB/GYN	Counties with No Orthopedic
2003	57%	63%
2008	57%	63%

The Texas Academy of Family Physicians reported on the Texas rural physician shortage in its journal, Texas Family Physician Vol. 59 No.3 Fall 2008, stating:

> "The national average for direct-care physicians to every 100,000 people is 220, but Texas averages 157 for every 100,000 people. In primary care, 114 Texas counties are Considered full primary care health professional shortage areas (HPSA designated by the U.S. Department of Health and Human Services) and 47 counties are considered partial HPSAs. Twenty-five counties have no physician."

The number of Texas HPSAs increased to 117 by the end of 2008 according to the Texas Department of State Health Services which publishes a county by county listing of Texas HPSAs. There were 116 Texas HPSAs in 2006, so the supply of physicians in rural and underserved Texas counties has not increased significantly over the past several years.

The Texas Department of State Health Services published a report in June 2007 confirming that Texas had a "persistent geographic maldistribution of the supply of pediatricians in rural and inner city communities." The study confirmed that the rural pediatrician supply increased from 16.9 per 100,000 children to 17.9 - - an increase of just 1. Urban counties however saw a pediatrician increase of 42.5 per 100,000 children to 47.4 - - an increase of 5. The Texas department of Health data proves 1) Texas has an overwhelming maldistribution of pediatricians in urban areas with 47.4 per 100,000 versus just 17.9 in rural counties, and 2) the increase in Texas pediatricians was going to urban not to rural counties.

Texas Has Not Experienced a Dramatic Increase in Physicians

The Texas Medical Board publishes data on licensed physicians annually. Unlike Hawaii, however, the Texas Medical Board keeps separate data for doctors practicing in Texas and doctors licensed in Texas, but practicing elsewhere. The data shows that there was no dramatic increase in the number of doctors practicing in Texas after tort reform went into effect. Instead, the data shows that the increase in Texas doctors has been steady and consistent from well before tort reform to the present.

Here is the data from the Texas Medical Board for the years May 1997 through May 2008:

Texas Doctors
(In State)

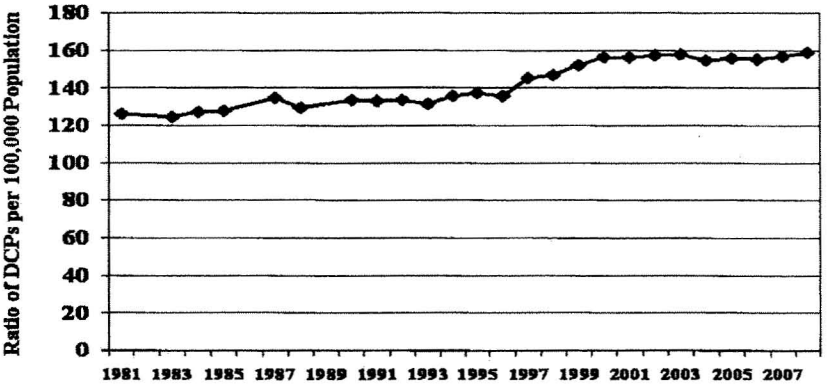
Year	Number	Increase Over Prior Year	Percent Change
1997	29,360		
1998	30,115	755	2.6%
1999	31,164	1,049	3.5%
2000	32,082	918	2.9%
2001	32,946	864	2.7%
2002	34,556	1,610	4.9%
2003	35,723	1,167	3.4%
2004	37,420	1,697	4.8%
2005	38,461	1,041	2.9%
2006	39,605	1,144	3.0%
2007	41,227	1,622	4.1%
2008	42,608	1,381	3.3%

Annual increases before tort reform ranged between 2.6% to 4.9%; while they varied between 2.9% to 4.8% after tort reform. The single largest increase of 4.9% occurred in 2001 well before tort reform. The second largest increase of 4.8% took place between May 2003 and May 2004. Because tort reform did not even take effect until September 2003, it is unlikely that it was the reason for that year's increase given the time required to move to Texas and take the licensing examination. If anything, the following year of 2005 should have seen a big increase, but instead the increase dropped to 2.9%, then increased marginally to 3.0% in 2006. The rate of increases both before and after tort reform is essentially the same.

In addition to keeping separate data for doctors practicing in-state and out-of-state, Texas also maintains separate data for doctors that actually treat patients in contrast to those who do not. Texas refers to treating doctors as "direct patient care physicians." This does not include researchers, administrators, teachers or others who do not treat patients.

In December 2008, the Texas Department of State Health Services published data on physician trends for the years 1981 through 2007, including a graph charting the supply of direct patient care doctors.

Direct Patient Care Physician Trends



Data Source: Texas Medical Board
Prepared By: Health Professions Resource Center
Center for Health Statistics, Texas Department of State Health Services
December 11, 2008

The Texas Department of Health data shows a steady supply of 130 to 140 doctors per 100,000 residents between 1987 through 1996. The supply increases significantly between 1997 and 2000 when the supply jumps from about 140 to 160 doctors per 100,000. This increase all occurs well before tort reform then holds steady to the present with no increase at all after tort reform. The data plainly does not support the claim of a dramatic increase in the supply of doctors that treat patients in Texas after tort reform.

The Increase in the Number of Texas Doctors is Primarily Due to the Large Medical School Enrollment in Texas

Texas embarked on an expansion of medical school facilities and student slots in the mid-90s that has resulted in a current medical school enrollment of approximately 6,029 students.

Texas has eight (8) traditional medical schools and one (1) osteopathic medical school.

School	Enrollment
Baylor	750
Texas A&M	423
Texas Tech	584
UT Galveston	929
UT Houston	939
UT San Antonio	897
UT Southwestern	976
Texas College of Osteopathic Medicine	630

These 6,029 first through fourth year medical students are graduating at a rate of over 1,300 per year. As the Texas Academy of Family Physicians explains, this is important because "if you go to medical school here, you do your residency here, you have more than an 80-percent chance of retaining that person as a professional in Texas." Indeed, "Sixty to 70 percent of residents will stay within 60 miles of where they trained." It is obvious, therefore, that the most significant factor in the increase in doctors in Texas is due to the presence of its large medical school enrollment, not tort reform.

Texas implemented its Joint Admission Medical Program in 2003. This program provides students from rural and underserved communities who are economically disadvantaged with special admissions consideration, scholarships and stipends to pursue a medical education. All eight Texas medical schools participate in the program.

Six of the eight Texas medical schools have also implemented rural track programs that focus on skills needed for rural medical practices that are not necessary for urban practices and not included in traditional medical programs. The scope of rural practice is greater than urban practice because of a lack of specialists in rural areas. Medical school and residency rural track programs prepare doctors for the additional skills they will need and encourage them to establish rural practices.

Texas has an established loan repayment program for medical students who practice in rural communities. Loan repayment programs are proven incentives for encouraging the establishment of rural medical practices.

Texas Malpractice Premiums on Average Are Higher Than Hawaii's

The average malpractice insurance premiums for major Texas insurers reporting their rates are higher than premiums for Hawaii doctors in similar specialties. The average 2008 premiums for Texas insurers Medical Assurance Co. (ProAssurance), Texas Medical Liability Trust, and the Doctors Company for OB/GYNs is $76,790 compared to $61,684 for Hawaii insurer MIEC (Medical Insurance Exchange of California). The Hawaii premiums for doctors insured by HAPI is said to be about 40% lower than MIEC premiums.

Texas premiums vary widely by county. The Medical Assurance Co. (ProAssurance) OB/GYN premiums range from $82,677 for most counties to $97,682 for 40 counties and a high of $151,699 for 14 counties. The Texas Medical Liability Trust premiums vary from $33,744 to $63,432. Premiums for the Doctors Company range between $64,714 and $102,054.

The Texas Malpractice Crisis Was Caused By Insurance Market Dynamics, Not By Malpractice Claims

The Texas Insurance Department maintained a comprehensive database of medical malpractice claims. Professors at the University of Texas, University of Illinois and Columbia University conducted an extensive study of Texas medical malpractice data for the 15 years before Texas enacted medical tort reform based on the alleged explosion in malpractice claims that was blamed for skyrocketing insurance premiums.

The Texas database included "all closed claims, and provides detailed information about payments, defendants, trial outcomes, defense costs, and other matters" for the years 1988 through 2002. The study, entitled, "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988 -2002," states:

> "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."

The research article concludes, "**the more likely explanation is that the rise in premiums reflects insurance market dynamics, and not litigation dynamics**."

The fact that Texas insurance premiums are now decreasing is therefore due to the fact that the enormous increases in premiums before tort reform were not justified by any increase in claims and is now returning to a lower level more appropriate to the level of claims.

Texas Still has More Malpractice Claims Paid Than Hawaii

The Texas Insurance Department no longer maintains the comprehensive database of closed claims. Federal law however requires the reporting of paid malpractice claims to the National Practitioner Data Bank (NPDB). NPDB data published in September 2008 for the year 2007 reports that Texas had the fifth most malpractice claims paid in the nation with 538. Hawaii on the other hand had the ninth fewest with 25. Adjusted for the difference in population, Hawaii still had a significantly lower rate of claims paid than Texas (or California for that matter).

The Effect of Other Texas Reforms Are Ignored

While the Texas law is touted most for its limitation on non-economic damages, there are other aspects of Texas law that have the potential for greater effect that are ignored by the proponents. These include a requirement similar to Hawaii's certificate of merit and an apology exclusion from evidence.

Hawaii has experienced a significant drop in both the number of claims filed at the Medical Claims Conciliation Panel and the amounts of payments since claimants were required to consult with a doctor in the same specialty to determine whether the claim was meritorious before pursuing the claim. Texas instituted a similar requirement that claimants retain the services of a qualified doctor to review and certify the claim for merit at the outset before the case is permitted to proceed. Texas Civil Practice and Remedies Code section 74.351 requires that this consultation and certification occur within 120 days. There is no data that studies and separates the effects of this provision on the Texas experience from the effect, if any, of the damages cap. Absent any data to indicate otherwise, there is no reason to expect that this screening process does not have a similar effect on lowering claims in Texas as it did in Hawaii.

Texas also adopted an apology law similar to Hawaii's that makes apologies inadmissible in evidence in the event of any subsequent litigation. According to the Sorry Works Coalition, Texas physicians have apparently embraced the apology concept with greater enthusiasm than Hawaii's doctors. Sorry Works programs are proven to reduce the number of claims, reduce the amounts paid on claims that are made, and improve patient safety by allowing errors to be freely discussed and become lessons learned for the profession. There is no reason to expect that apology programs in Texas are any less successful than elsewhere.

Finally, Texas raised its Medicaid reimbursement rates significantly several times beginning in 2001. A Council of State Governments report, Physician Shortages and the Medically Underserved (Aug. 2008), suggests: "the most effective incentive to lure physicians to rural underserved areas might be for states to increase Medicaid reimbursement rates." This is because "rural practitioners tend to depend on Medicaid as payment for services more than their suburban and urban counterparts. Consequently, increasing Medicaid reimbursement rates is frequently cited as one of the most promising incentives to encourage physicians to locate in underserved areas.

There is no data on the impact that increased Texas Medicaid rates have had on the supply of rural doctors. This is an important factor in Texas because of the low percentage of rural residents covered by private insurance. The Texas Academy of Family Physicians reports that only one-third of rural citizens are covered by private insurance. Two-thirds are covered by Medicaid/Medicare or are uninsured. The impact of Medicaid rate increases is therefore significant in Texas.

It's the Economy, Stupid

Also ignored is the effect of the energy crisis in fueling the boom in the Texas economy since tort reform was passed in Texas. As the price of oil skyrocketed, so went the Texas economy. At its peak, the Texas economy became the seventh largest in the world with a gross state product in 2006 of $1.1 trillion, it had the most Fortune 500 company headquarters in the nation and was home to 33 billionaires.

The soaring economy was good for doctors as well. It still is in comparison to Hawaii. An HMA representative has testified on numerous occasions that Hawaii orthopedic surgeons make only $125,000 to $150,000 annually, but can easily make three to five times as much on the mainland. A review of Texas doctor want ads will easily confirm that the income of doctors there far surpass incomes of Hawaii doctors. A review of want ads for Texas orthopedic surgeons show numerous positions offering annual compensation of $400,000 to $1,000,000. It should come as no surprise to anyone that a state like Texas with high pay, cheap housing, low cost of living and no state income tax should attract doctors, while Hawaii with low pay, unaffordable housing, high cost of living, and high tax burden should lose doctors (and teachers, police officers, nurses, and all other types of workers).

There Is No Data From Texas (or elsewhere) That Shows That Capping Non-Economic Damages Had A Cause And Effect Relationship On Any Of The Claimed Events That Have Occurred In Texas Since 2003. The Actual Data Shows That Capping Non-

Economic Damages Will Not Cause Doctors To Move To The Neighbor Islands, Take Call or Remain In Hawaii.

Thank you very much for this opportunity to testify.

Testimony of John Yamane
In Opposition to HB No. 1514, HD1

To the House Committee on Judiciary:

There has been much said in the media about the shortage of doctors on the neighbor islands and the supposed need to cap damages to solve the shortage. The Hawaii Medical Association claims that capping damages will cause doctors to move to the neighbor islands. As a person who grew up on a neighbor island, I wish to comment on the reasons capping damages will not solve the problem and offer suggestions on better solutions.

If a doctor wanted to live on a neighbor island, they would already live there. Capping damages will not make the difference. Here's why. There aren't as many opportunities for better paying jobs. The population and economy is just too small to support expanding opportunities. It is harder to find a good job. When you find a job, you get paid less for the same work compared to Honolulu or the mainland. The cost of buying a house and the cost of living is much higher. Everything costs more.

I grew up on Lanai. Almost all of my classmates left as soon as they graduated from high school. I know of only a couple that went back and still live there. The only jobs available were in the pineapple plantation and later the hotels. There were no opportunities for my classmates who became dentists, lawyers and construction workers.

The quality of education is lower on the neighbor islands. Why is it lower? It's lower because it's hard to get good teachers to move to the neighbor islands. Many of those that try it leave after a short time for the same reasons as doctors. If you want a good education for your children, so they can go to a good college, you pretty much have to live in Honolulu. That is what happened to me. My parents realized that there were better opportunities for their children's education and moved us back to Honolulu at the first opportunity.

Unless you marry someone from a neighbor island who wants to go back home, your spouse is not likely to want to live on a neighbor island. There are very few good jobs for them. There are fewer cultural and educational events. Almost all of the musical performances, stage shows and cultural exhibits come only to Honolulu. There is a shortage of good restaurants, shopping, activities for the kids and entertainment options. The fact is that unless you really want to live there, it's just too expensive and boring. Costs more - - pays less.

Every summer my mom would bring my sister and I to Honolulu so we could see other things like plays and museums and go to summer school.

So what has a realistic chance of working? First, you need to target the people who really want to live there. Not the city folks who think they want to live the simple country life, but the students who grew up there, have family and roots there, and know they want to live there because they don't like the city life. The medical school needs sufficient slots dedicated to students from the neighbor islands.

Second, becoming a neighbor island doctor has to be economically feasible. Neighbor island students tend to come from families with modest means so grants and loan repayments for those who actually return home are needed. Tax credits and higher medicaid fees for neighbor island doctors will help.

Those are the kinds of solutions that work. You can't do anything about the quality of life factors to attract people who don't really want to live the neighbor island lifestyle so don't waste time and money trying.

Hawaii has had a difficult time recruiting and retaining doctors, teachers, policemen, nurses, and many other kinds of jobs for the same reasons. Living in Hawaii costs more and pays less. The main reasons doctors leave Hawaii is the same as everyone else. This goes double for the neighbor islands. It has nothing to do with capping damages.

Thank you for letting me testify.