EXECUTIVE CHAMBERS
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GOVERNOR

Written Testimony of
Linda L. Smith
Senior Policy Advisor to the Governor

Before the
HOUSE COMMITTEE ON HEALTH
Tuesday, February 10, 2009, 8:30 a.m.
Conference Room 329, State Capitol

H.B. 1784 RELATING TO MEDICAL TORTS

Chair Yamane, Vice Chair Nishimoto and Members of the Committee:

Thank you for scheduling this important hearing today on a variety of bills involving the issue of medical malpractice reform. The Lingle-Aiona Administration strongly supports medical malpractice reform as one way to expand access to health care for Hawaii residents. We note that the first bill on your agenda, House Bill 1784, Relating to Medical Torts, is similar to an Administration proposal and we appreciate the Chair's willingness to hold a hearing on this critical legislation.

Hawaii's health care system suffers because of a physician shortage, especially in specialty areas. The Administration strongly believes that the enactment of medical liability reform legislation is one of the best ways to address this issue and to retain and recruit a strong physician workforce in our State. Many health care industry officials are here today who will again articulate this problem and the need for reform. The time is now to come together to address their concerns.

The Administration understands that medical malpractice reform is a complex and emotional issue. Although we may not agree on all the details, we believe we must work together to get a bill passed this year. Again, the Administration extends its gratitude to the Chair for bringing this important issue before the Committee.

LINDA LINGLE
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TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Tuesday, February 10, 2009
8:30 a.m.

TESTIMONY ON HOUSE BILL NO. 1784 – RELATING TO MEDICAL TORTS.

TO THE HONORABLE RYAN I. YAMANE, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). Thank you for hearing this bill. The Department supports this bill.

The purpose of this bill and House Bill No. 1120 is to provide a more rational atmosphere for the practice of medicine in Hawaii and to reduce the cost of medical malpractice insurance for Hawaii's health care providers.

Both bills propose the establishment of limitations on noneconomic damages in medical tort actions, require the trier of fact to consider and assess the negligence of all parties, add a statutory definition of "economic damages", allocate economic and noneconomic damages in proportion to the provider's share of negligence, establish limits on contingency fees, and amend the definitions of "health care provider" and "medical tort" in Hawaii Revised Statutes ("HRS") § 671-1 and "joint tortfeasors" in HRS § 663-11.

Specifically, this bill proposes a $250,000 limit per health care provider, health care institution, and any person who is vicariously liable for an aggregate of $750,000;

where gross negligence is shown, a $3 million limit on noneconomic damages would apply.

This bill also adds definitions for "future damages", "gross negligence", "health care facility", "periodic payments", and "recovered" in HRS § 671-1, and allows judgments for future damages exceeding $50,000 to be made by periodic payment, rather than by lump sum payment

The intent of this measure is to stabilize the medical malpractice insurance market by allowing medical malpractice carriers to better predict the amount of claims and losses. Increased certainty will have the effect of decreasing or moderating premium costs.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) formerly known as the CONSUMER LAWYERS OF HAWAII (CLH) IN OPPOSITION TO H.B. NO. 1784

February 10, 2009

To: Chairman Ryan Yamane and Members of the House Committee on Health:

My name is Bob Toyofuku and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ) in strong opposition to H.B. No. 1784.

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 who are 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

I. Extent of medical errors and malpractice

II. Capping Recoveries will hurt the victims

III. 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

IV. Medical Malpractice "Reform" will not solve these problems

V. The Rollback of Insurance Rates

VI. Attorney's Contingency Fees

VII. 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 HAJ 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, HAJ 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 100 last year – about a 42% 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 eight years.

Year	Claims Filed
2001	**173**
2002	**166**
2003	**132**
2004	**128**
2005	**105**
2006	**123**
2007	**105**
2008	**100**

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 context – out of the millions of instances where Hawaii residents have contact with physicians, hospitals and other medical personnel, only 100 claims were filed in 2008.

With the number of claims going down, the question is: why are premiums supposedly escalating significantly? Proponents say it is because the awards are

increasing. Yet the data confirms that claims payments are significantly declining along with the number of claims. The current Report of the Insurance Commissioner shows a 19% decline in the amount paid for claims. This follows a 53% reduction in claims payments reported by the commissioner last year. The largest insurer for private practice doctors, MIEC, has reported a steady and dramatic drop in claims payments from $8.2 million in 2004 to $2.8 million. Insurance Commissioner reports list MIEC claims payments of $8.2, $4.8, $3.7 and $2.8 million respectively for the past four years since claimants have been required to consult with a doctor to determine the merits of their claims before filing with the MCCP.

While proponents continue to repeat the mantra that a litigation explosion is responsible for escalating premiums and only tort reform can rein in claims, they are unable to explain why both the number of claims and the amounts paid for claims have decreased significantly without any change in tort laws. Neither are proponents able to explain why premiums are so high when claims are so low.

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, the 2008 MCCP report found one frivolous claim filed, and the 2009 MCCP report found no frivolous claims filed.

b. MEDICAL MALPRACTICE INSURANCE IS TOO HIGH

The Hawaii Medical Association (HMA) has always maintained that the premiums of physicians 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 in past legislative sessions 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 2009 are much higher than the highest rates in Hawaii. Here are some examples:

Specialty	Hawaii	Los Angeles
Neurosurgery	$73,248	$107,936
OB/GYN	$58,600	$ 86,348
Orthopedic Surgery	$48,832	$ 71,956
Family Practice	$ 9,768	$ 15,832

Further, the rates in Hawaii are lower in 2009 than in 2007 but the Los Angeles rates remain the same with no reduction. Also, although the rates in Northern California are slightly lower than the rates in Hawaii, the average overall rates in California are higher than in Hawaii.

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 insurance 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.

HAJ 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.

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	3044
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 S.B. 3279, Relating to Medical Liability, a doctor who was leaving for the mainland testified about the high cost of living

in Hawaii and medical malpractice insurance premiums as 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 a 2003 study by the Government Accounting Office (GAO). The Dartmouth study 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? This bill does not solve the problem.

V. THE ROLLBACK OF INSURANCE RATES

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 this committee concludes that reduction in malpractice insurance rates will achieve these goals, then it should include provisions for roll back of insurance rates. The reduction of insurance rates 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 impossible 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. HAJ 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 "[were] 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.

An article by Alex Winslow for the Texas Watch organization, a consumer watchdog, 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.

The Texas Academy of Family Physicians (TAFP) just published a report in its fall 2008 journal that confirms the same results discussed above. The TAFP confirmed that "The national average for direct-care physicians to every 100,000 people is 220, but Texas averages 157 for every 100,000 people." The TAFP reported that fully 141

counties were declared full Health Professional Shortage Areas (HPSA) by the U.S. Department of Health, 47 counties were partial HPSA's and 25 counties had no physicians at all. The TAFP also confirmed the shortage of specialists in Texas, stating, "Many Texas counties suffer from shortages of all sorts of physicians, including some vital specialties like neurosurgery, rheumatology and at one point, obstetrics-gynecology."

A Council of State Governments report on Physician Shortages and the Medically Underserved, published in August 2008, confirmed the results of the article "Baby, I Lied," stating, "At least 150 counties - - more than half the state - - lack an obstetrician, and many medical specialties are likewise limited to more populated areas."

Tort reform did not solve the rural doctor shortage in Texas. In fact Texas is now the second worse state in the nation in the number of HPSA (health professional shortage areas) as determined by the U.S. Department of Health. The real reason Texas has an increasing number of doctors is because of its rapidly expanding medical school programs. The Texas Academy of Family Physicians article reveals: "The Texas Higher Education Coordinating Board reported that the eight Texas medical schools graduated more than 1,300 students in 2006 – 2007, and an additional four-year medical school opening in El Paso in 2009 will boost this number." This factor is critical to understanding the Texas situation 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." Thus the high medical school enrollment alone accounts for the addition of over 1,000 doctors per year in Texas.

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, HAJ strongly opposes this bill and requests that they not pass out of this committee. Thank you for the opportunity to testify.

The Texas Observer

Baby, I Lied

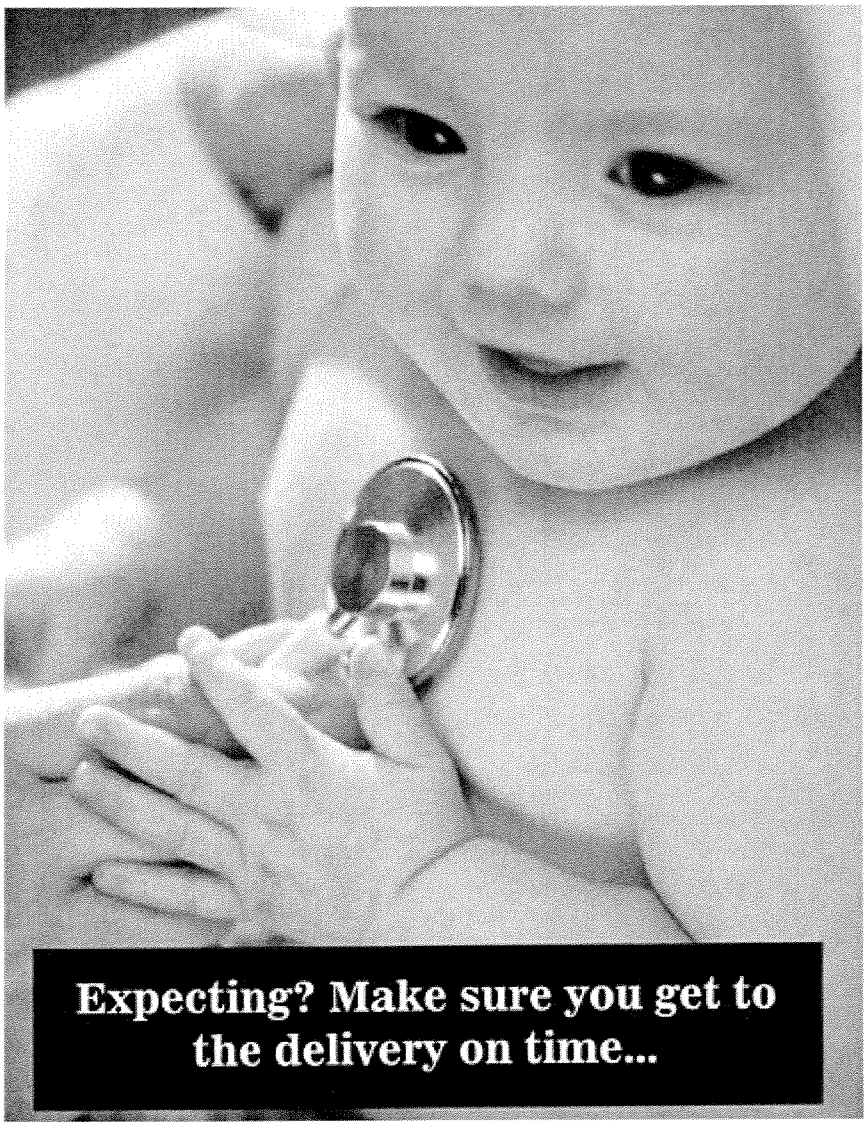
Rural Texas is still waiting for the doctors tort reform was supposed to deliver.

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.

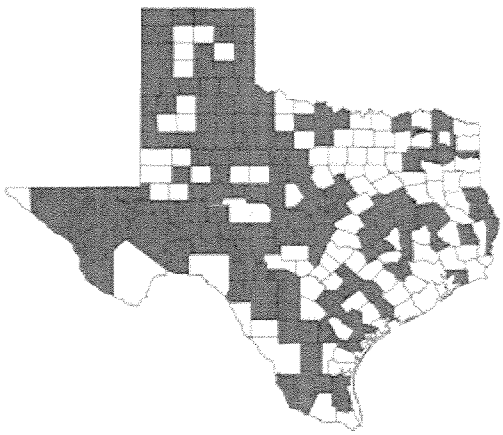
The county's Presbyterian Hospital of Plano alone has 73 obstetricians and 30 neonatologists for newborns. Two allied hospitals serve nearby Allen and Dallas, and the three are far from Collin's only hospitals.

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.

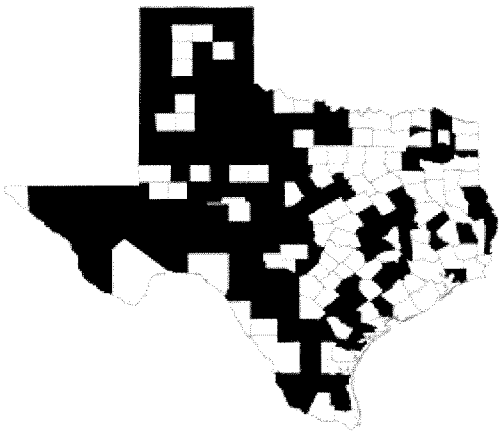
The pattern of doctors' opting to practice in more affluent, urban areas holds true for Texas' overall gains in neurosurgeons (36) and orthopedic surgeons (185) since 2003.

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.

To: House Committee on Health
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

Health Committee

2/10/2009
8:30 a.m.
Room 329

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 1784 RELATING TO MEDICAL TORTS – IN SUPPORT

Chairs & Committee Members:

Hospitals and physicians are teetering on the brink of insolvency because of low reimbursements, high malpractice liability insurance premiums, and their inability, due to prohibitions in their provider agreements, to pass on ever increasing costs. HMSA, Medicare, Health Quest, and the Workers' Compensation fee schedules control physicians' fees. The only way to increase revenues is to see more and more patients with less and less time given to each, resulting in burnout for physicians and a lower quality of care for patients.

Hawai'i Island Health Workforce Assessment of 2008 states that the Big Island would benefit from an additional 45 physicians. This same workforce assessment listed implementation of tort reform legislation to improve the medical malpractice environment as one of the study's conclusions for how to recruit these needed 45 physicians.[1]

One of the major reasons why tort reform will increase reimbursements and lower malpractice premiums is the factor of defensive medicine. Defensive medicine is defined as providing medical services that are not expected to benefit the patient but are undertaken to minimize the risk of a subsequent lawsuit. The study quoted most often is by Daniel P. Kessler and Mark B. McClellan. To really understand actual costs, Kessler and McClellan analyzed the effects of malpractice liability reforms using data on Medicare beneficiaries who were treated for serious heart disease. They found that liability reforms could reduce defensive medicine practices, leading to a 5%-9% reduction in medical expenditures without any effect on mortality or medical complications.

If the Kessler and McClellan estimates were applied to total US healthcare spending in 2005, the defensive medicine costs would total between $100 billion and $178 billion per year. Add to this the cost of defending malpractice cases, paying compensation, and covering additional administrative costs (a total of $29.4 billion) and the average American

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[1] Withy, Kelly, MD PhD. *Hawaii Island Health Workforce Assessment 2008.*

family pays an additional $1,700 to $2,000 per year in healthcare costs simply to cover the costs of defensive medicine.[2]

Also, premium rates are partially based on the amount of malpractice cases in the area and caps on damages coincide with fewer lawsuits.

HB 1784 would enact meaningful tort reforms, extremely similar to those enacted by Texas by Proposition 12, which in 2003 passed a $750,000 aggregate constitutional limit for non-economic damages in professional liability cases and resulted in a 25%-30% drop in premiums with some insurance carriers.[3]

Almost immediately after the Texas model of tort reform passed, companies cancelled planned increases and began slashing rates. Shortly after the passage of Prop. 12, The Doctors Company cancelled a planned 20% increase and in February 2005 announced a 14% cut.[4]

Three years after Prop. 12 every single carrier in Texas had cut its rates, most by double digits. New carriers have started coming to Texas and today insure some 13% of the market. [5]

Many hospital systems have saved $10 million or more on their liability premiums since the passage of Prop. 12. [6]

A dramatic illustration of the reason why can be seen in analyzing the number of medical liability filings in Texas' most populous county, Houston's Harris County. After a mad rush on the part of the trial bar to file before the vote on Prop. 12 in the summer of 2003, the number of filings plummeted to less than half the previous norm: from 550 the year before passage to 204 the year after.[7]

In Texas, hospitals report that they are having greater success in recruiting physicians. And they are now spending the money saved on insurance premiums to update medical equipment, expand emergency departments, improve outpatient services, increase the number of on-call physicians, raise nurses' salaries, launch patient safety programs and expand uncompensated care.

West Virginia Mississippi, Florida, and Missouri have also passed tort reform statutes this decade, which have helped reduce rates by as much as 10%-25% for some physicians.[8]

Although each state is different and Hawaii is comparatively much less litigious than Texas, California and Mississippi, the situation is exasperated because Hawaii is such a small state and by the fact that the number of practitioners in a specific field is extremely limited. Just one or two claims against a few practitioners has a damaging effect on all within the net. The resulting premiums based on actuaries can be staggering.

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[2] Weinstein, Stuart. "The cost of defensive medicine."
3Lewis, Morgan. "Tort reform drives down malpractice premiums in some states." Medical Economics (2009).
[4] "Proposition 12 Produces Healthy Benefits; A Recap: Three Years after Its Passage," Texas Alliance for Patient Access.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Lewis. (2009).

The fact that MIEC rates in Hawaii are in some cases comparable to California with its extremely excessive litigious environment is in and of itself proof of how effective tort reform is. In fact, a 2004 study published by the *Los Angeles Times* showed that California's MICRA savings for Los Angeles County when compared to similarly litigious counties netted malpractice savings of $52,000 per Emergency Medicine physician, $123,000 per General Surgery physician, $180,076 per Neurosurgery physician, $120,000 per OB/GYN physician and $112,686 per Orthopaedic surgeon.[9]

If trial lawyers are still unconvinced, HMA is willing to compromise on a trial period of 5 years where data can be obtained and the case for tort reform can be proven as applicable to Hawaii's unique situation. The only thing anyone can know for sure is that if we continue to do nothing, the system will collapse and people will die as a result. Maybe certain individuals will find it harder to obtain a lawyer if tort reform passes, but all people will find it harder to find a doctor if it does not. This is an uncomfortable choice, but it is a choice many states, when faced with a mounting crisis have chosen to address.

Increasing patient caseloads cannot solve the problem without threatening patient safety. Defensive medicine is practiced daily in all physician offices, emergency rooms, and hospitals, which greatly increases costs to employers, patients, and government.

In a perfect world, injured patients would have no limitations in what they can recover in lawsuits, and this would have no effect on the delivery of vital health care services, or malpractice insurance premiums that physicians, hospitals, and JABSOM have to pay each year. In an imperfect world such as ours, society must impose some limitations on such awards, if the sick and injured are to continue to obtain the obstetrical, neurological, trauma, orthopedic, general surgery and emergency medical care they need.

Thank you for the opportunity to provide this testimony.

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[9] SCPIE Indemnity Co. (Los Angeles, CA); Florida Phycisians Insurance Company (Dade County, FL); Professional Liability Mutual Insurance Company (Long Island, NY); American Physicians Assurance (Wayne County, MI).

February 10, 2009

The Honorable Ryan Yamane, Chair
The Honorable Scott Nishimoto, Vice Chair
House Committee on Health

Re: HB 1784 – Relating to Medical Torts

Dear Chair Yamane, Vice Chair Nishimoto 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 HB 1784 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.

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. 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,

Richard M. Jackson

Rick Jackson
President

NFIB
The Voice of Small Business®

Before the House Committee on Health

DATE: February 10, 2009

TIME: 8:30 a.m.

PLACE: Conference Room 329

Re: HB 1784
Relating to Medical Torts
Testimony of Melissa Pavlicek for NFIB Hawaii

Thank you for the opportunity to testify in support of HB 1784. NFIB supports this measure in its current form.

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

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Toll Free: (800) 237-9300

Memo

To: Chair, House Health Committee

From: Marty Fritz

Date: February 10, 2009, Tuesday at 8:30 a.m.

Re: **HB 1784**

Honorable Chair and Committee Members. My name is Marty Fritz. I am a lawyer who represents a small 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.*

Of Counsel:
Steven J. Trecker

46-3585 Kahana Drive
Honokaa, Hawaii 96727
(808) 640-3181

TO: Rep. Ryan Yamane, Chair; Rep. Scott Nishimoto, Vice-Chair; and Members, House Committee on Health

FROM: Fred C. Holschuh, M.D.

SUBJECT: HB 1784 Relating to Medical Torts

DATE: February 10, 2009

Chair Yamane, Vice-Chair Nishimoto, and Members:

I strongly support HB 1784, Relating to Medical Torts, as it addresses one of the very important issues involved in the physician shortage crisis which is especially troublesome on the neighbor islands. I am a retired emergency physician with 30 years of experience around the state, mostly in Hilo. I am also a past president of the Hawaii Medical Association. However, I am writing as an individual.

As a Hilo Medical Center emergency physician for 29 years, I am very familiar with shortages or absences of certain specialty physicians needed in emergency cases. Frequently, referrals must be made to other hospitals off island. This costs money, often long delays in treatment, discomfort for patients and families, and can put patients at risk.

There are a number of issues leading to physician shortages in our state, but certainly the lack of medical liability reform is one of the significant ones. The reforms passed in Texas are a good example of why this is sorely needed here. Additionally, I wholeheartedly support a $250,000.00 cap on non-economic damages.

I respectfully request passage of HB 1784 and any other legislation that will finally accomplish medical liability reform as quickly as possible. Thank you.

Aloha,

Fred C. Holschuh, M.D.

Yvonne L. Geesey
PO Box 62245
Honolulu, HI 96839
geesey@hawaii.edu

Aloha Chairperson Yamane, Vice-Chair Nishimoto and members of the Health Committee.

Mahalo for the opportunity to offer testimony in opposition to House Bill 1784.

My name is Yvonne Geesey and I am an advanced practice registered nurse—a nurse practitioner and an attorney.

I see patients one day a week and work in the law the other four days. I am here today testifying as an individual.

House Bill 1784 is missing an important aspect—that of the malpractice victim. Health care professionals make mistakes. Health care professionals also practice negligently. We do our utmost to heal, not to harm, however, our patients do suffer harm as the result of our acts or failure to act.

To consider preventing the victims of medical malpractice from recovering the money damages needed to live their lives to the fullest possible following their injury is heinous.

As a nurse I've had occasion to assist in the care of seriously injured persons many times. It is difficult to comprehend the amount of care necessary when we cannot care for ourselves. Can you imagine what you would do if yourself or a family member was seriously injured by malpractice and unable to take care of themself?

The costs of services and supplies are astronomical, however the emotional cost is far greater. To lose your ability to live your life to the fullest—or never even have that chance at all is a tragedy.

It has been said that money cannot buy happiness. But in the case of a seriously injured patient, it can buy the peace of mind that comes from knowing that you have the means to care for yourself.

NON-BILL

SPECIFIC

TORT REFORM

TESTIFIERS

To: House Committee on Health
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

Health Committee

2/10/2009
8:30 a.m.
Room 329

By: 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 1784 RELATING TO MEDICAL TORTS
HB 1514 RELATING TO MEDICAL TORTS
HB 0310 RELATING TO MEDICAL TORTS
HB 1785 RELATING TO MEDICAL TORTS
HB 0575 RELATING TO MEDICAL TORTS

Chairs & Committee Members:

While we will be providing a short testimony on each of these measures during this hearing, HMA would like to provide an overview of our assessment of various options relative to the subject matter of each of these measures. With your permission, this overview will save the committee much time in addressing the various options to our current access to medical care situation.

The first document we present is a list of five options: "Access to Medical Care Crisis – Options." While there are other options available, we believe the two main prescriptions to cure the crisis are either direct payment or tort reform. Both of these are controversial issues that can only be decided by the Legislature, which has to consider what is in the best interest of all the people of Hawaii.

Each option shows the HMA assessment as to what would be accomplished, and the economic impact involved.

The second chart follows the money if contingency fees were capped; and The third chart follows the money if direct payment were to be implemented.

The current MCCP is working well, and has limited frivolous law suits. However, some attorneys use the system as a means of discovery, and then disregard the findings and sue even if the findings are not in their clients' favor. If the Legislature does make amendments to MCCP, we do ask that it not tamper with the basic structure of the MCCP. We will submit more specific testimony as the individual bills are addressed.

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ACCESS TO MEDICAL CARE CRISIS-OPTIONS

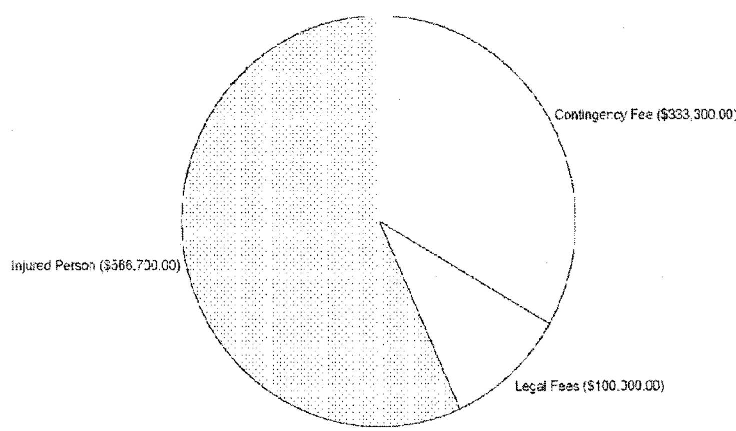
1	2	3	4	5	6
Medical Tort Reform that includes at minimum: • Non-economic caps • Modify Joint & Several Liability to Stage of Liability • Sliding Scale of Attorney Contingency Fees	Direct Payment from Insurance Plans to Physicians so they can recover costs that are not currently allowed to be passed on to patients because of contracts or laws.	Create an allowable surcharge to allow physicians to pass on excessive medical insurance premiums. This would be similar to the fuel surcharge allowed by electric utilities.	Create a Government subsidy with a tax credit for physicians' malpractice insurance to avoid physicians from leaving because they can't pass on legitimate costs of doing business.	Provide Tuition Waivers for Medical Students contracting to stay in Hawaii to practice medicine where needed.	Do Nothing - This is the road to destruction of our health care system as we have known it. Once lost, it will take many years to recreate.
Why?	Why?	Why?	Why?	Why?	Why?
Because the insurance pool is small, a few large claims affect all physicians in the pool, even though they were not a part of the claim. Attorney's Contingency fees (1/3 of the award) and legal fees generally take the first 40% of any award. This is a major incentive for attorneys to accept such fees when their awards can be in the millions.	Physicians are not allowed to pass on their higher costs because their fees are either set by government laws, or by provider contracts. The higher costs of doing business are akin to an unfunded mandate that can't be passed on to patients. The only way they can increase revenue is to accept more patients, which is wearing out many professionals.	The same justification exists as it does for our electric bills. The provider has no control over the costs. The provider does not have to be the one involved in an award to have higher insurance skyrocket. It is simply an uncontrollable cost that is either passed on to the consumer/patient, or the financial burden creates a financial crisis.	Because only Government can resolve this issue. If the Legislature chooses not to address the issue with other options, then the Legislature must address it as an economic issue.	We must prepare for a new generation of physicians, and it must be done while experienced physicians are still here.	Because we already see it happening. The only issue that is questionable is to the extent of the crisis.
Economic Impact?	Economic Impact?	Economic Impact?	Economic Impact?	Economic Impact?	Economic Impact?
The injured individual received full compensation for economic and care costs and/or losses, but is limited on non-economic losses to a designated amount. Designed properly, it will reduce attorney fees while increasing payments to the injured person while reducing costs to physicians, and at the same time reducing the costs involved with defensive medicine	All individuals who now pay a co-pay will have it increased to cover the costs of services. Government may be required to increase fee schedules in order to maintain healthcare needs for those patients covered by government	Those individuals who now pay a co-pay will be required to pay an additional fee if serviced by a high-risk practitioner or facility. A law can be drafted to cover only those physicians in high risk areas of health care, thus providing some controls over the surcharge.	All taxpayers pay, as this would be an indirect subsidy from government. By providing such a tax credit, it keeps physicians in business, creating employment, and protecting all citizens that work and pay taxes. The benefit of protecting the health of our citizens is offset by the savings government will realize from health consumers that can hold jobs and pay taxes rather than draw benefits from government and insurance	All taxpayers pay, while all taxpayers will benefit from having a sustainable health care system statewide.	All citizens, taxpayers. Many will be forced to utilize emergency facilities for emergency care, which will drain the State of far more funds than it would cost to address the crisis head on. Those individuals that can afford to fly to the Mainland for health care will do so, thus depriving Hawaii of tax revenues and health care jobs. Those in need of immediate care may die for lack of immediate care.

Prepared by HMA [illegible]

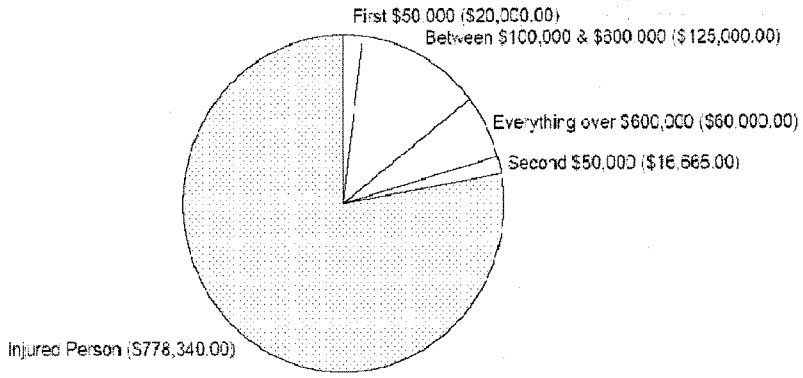
Medical Law Suits – Follow the Money

- **High Attorney contingency fees encourage more and higher rewards for attorneys, with the injured persons getting shortchanged.**
- **On a $5 million dollar jury award, the attorneys for the injured party get $1.6 million plus court costs. Who really pays the bill?**

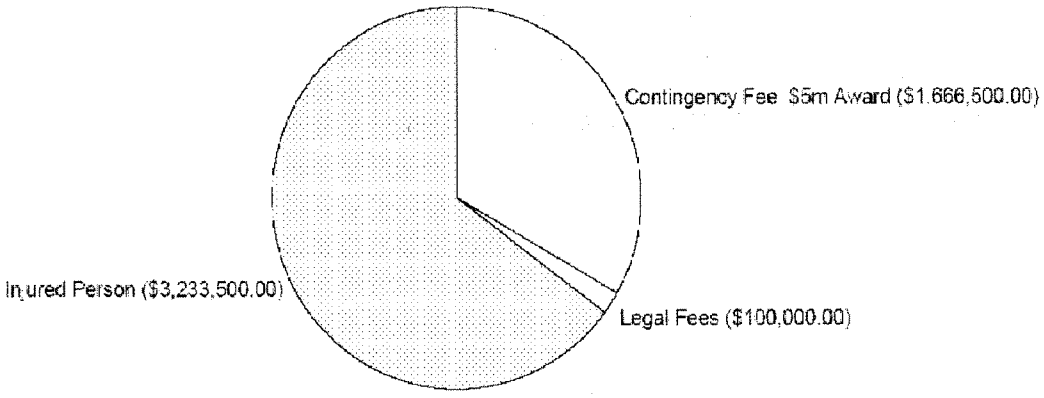
$1 million dollar award under existing contingency fee method:



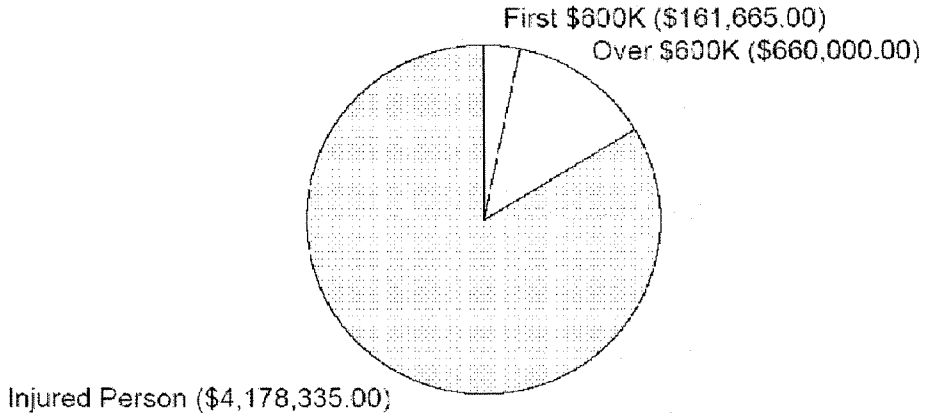
$1 million dollar award under proposed legislation that fails to pass committees chaired by attorneys. (SB3279, SD2, HD1-2006)



$5 million dollar award under existing contingency fees:

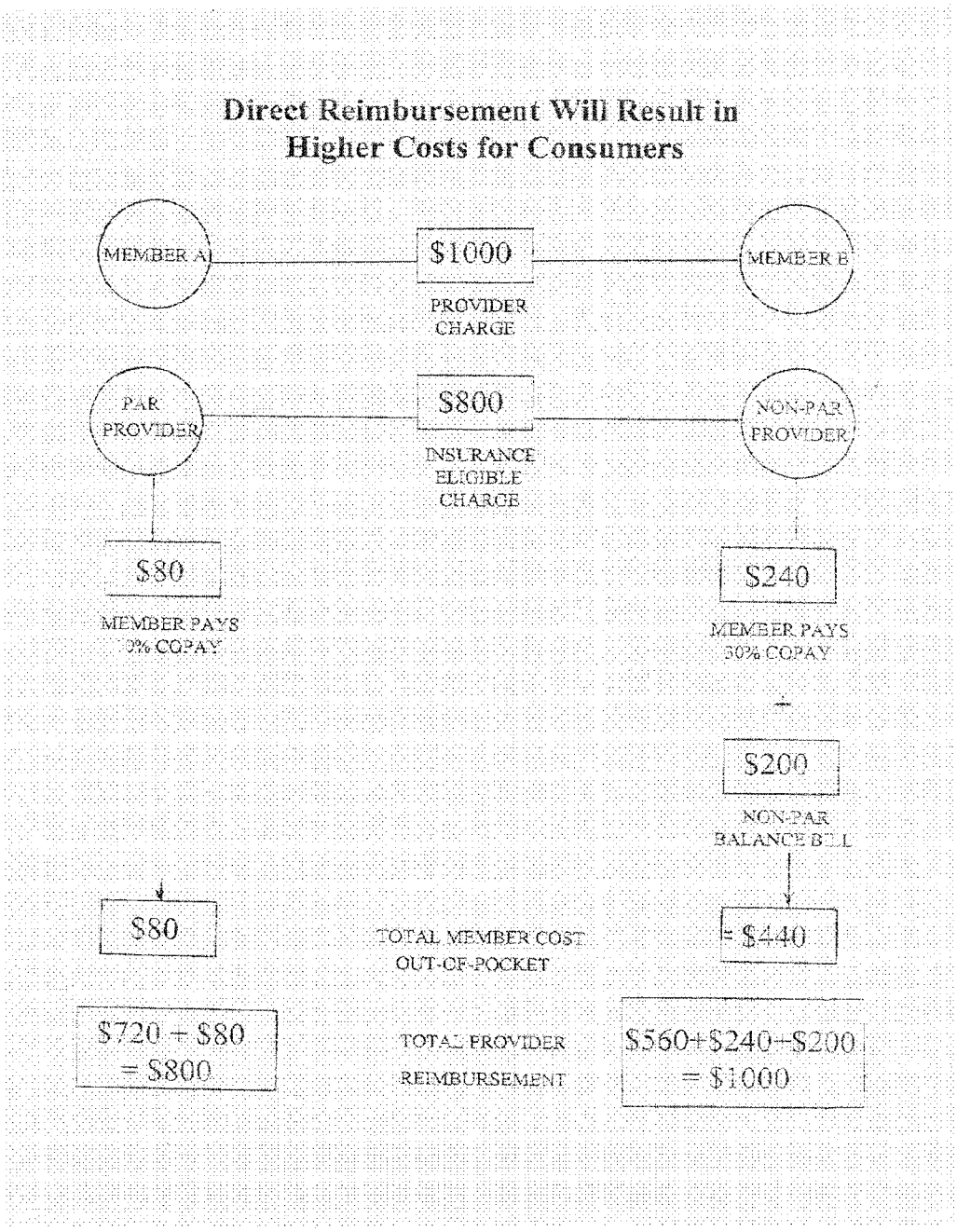


$5 million dollar award under proposed legislation that failed in 2006. (SB3279, SD2, HD1)



<u>Reducing attorney fees increases the award to the injured person.</u>

The following chart was obtained by HMA from an undisclosed source. We believe it was prepared by those that oppose direct reimbursement, but cannot determine its accuracy.



nishimoto2-Bryce

From: John Bellatti [johnbellatti@gmail.com]
Sent: Monday, February 09, 2009 2:47 PM
To: HLTtestimony
Subject: Testimony for Tuesday Feb 10 House Health Committee

COMMITTEE ON HEALTH
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

Dear Sirs,

I have practiced medicine in Hawaii for 21 years, actually 26 if you include my internship and residency at Queens Hospital.

I write in support of Tort Reform. A number of the bill s considered contain exellent parts of this. "Tort Reform" that is not really Tort Reform will be of no use.

I write in support of Bills that Limit the total of non-economic damages to 250,000 per physician, hospital or clinic to be found negligent. I support severability so that if a physician is found negligent, then not necessarily will his employer or affiliate be found liable for same amount. This should not be a rubber stamp. Similarly if the institution (hospital or clinic) be at fault, then the physician shall not be necessarily found negligent also. This is desiged to avoid the plaintiff attorney citing every one who touched the patient, or might have.

I agree with bills which place a penallty on overlooking the Conciliation Panel's decision. BY far the most fair decision for the injured party and for the physician is rendered at the Conciliation panel.. Grand-standing by the plaintiff's attorney is limited in that venue. And the judgement is rendered by a "jury of his peers". A physician is judged by 1 other physician and generally 2 attorneys. I say these are peeers as they are profesionals also.

And finally I write in support of Bills that include a good Samararitan type protection for those in emergency situations where there is limited time for decision making. This would cover care delivered in the emergency room and in any emergency procedures that ensue (including the general surgeon, neurosurgeon, orthopedic surgeon, urologist, otolarynologist) for survival or severe bodily prevention. These procedures may occcur without the ability for careful planning, and occasionally without the ideal equipment. Never the less, the physician is thrown into the situation and does the best possible under the conditions. Arm-chair quarterbacking done two years later is entirely unfair, and leads to unwillingness of surgeons to particiapate.

Th goal of Tort Reform is to return medical care to trained specialists, and to decrease the unnecessary tests and procedures, especially in the emergency room, which are done to prevent potential, unpredictable medical negligence law suits.

The State will benefit greatly with the reduction is cost of care -- which more and more it is being saddled with.

Tort Reform will be good for the citizens, good for the patients, good for physicians and the community of health care providers. Ultimately it will also be good for attorneys who may expect to find better work in other venues.

Sincerely

John Bellatti MD
Orthopedic Surgeion residing in Kona

COMMITTEE ON HEALTH
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

NOTICE OF HEARING
DATE: Tuesday, February 10, 2009
TIME: 8:30 a.m.
Conference Room 329
State Capitol

RE: Support of medical tort reform

Dear Representative Ryan Yamane, Scott Nishimoto and committee members,

The access to health care crisis affects us all. In these rough economic times, passage of medical tort reform is critical. It will not cost the tax payers a dime and will actually decrease the State's financially obligations by decreasing the amount we pay for medical malpractice insurance at the UH medical school and all the state run hospitals, HHSC. In addition, it will decrease the expenses for medical care by decreasing the costs of defensive medicine (ordering tests to avoid being sued).

- The cost of defensive medicine is $1,700-2,000/year for each American family.
- In Mississippi, after passage of medical tort reform, the number of malpractice cases decreased from 1,475 to 192.
- Malpractice premiums dropped 30-50% in Mississippi
- In Texas after passage of medical tort reform in 2003, lawsuits dropped from 745 to 49 and have leveled off at an average of 175.
- Texas has added critical specialists, 24 neurosurgeons, 124 orthopedic surgeons (including one from Hawaii, Dr. Michael Hahn) and 125 ob/gyn physicians.
- Malpractice premiums have also decreased 30-50%. www.protectpatientsnow.org
- The emotional toll that a non-meritorious lawsuit causes for the physician often results in them leaving medicine, leaving the state, depression and sometimes suicide.
- HMSA and other insurers could increase the reimbursement to providers with the money they would save from unnecessary tests not being ordered to avoid being sued.
- The State is paying the cost for trying to find physicians to replace those who leave.

Something needs to be done this year to prevent further physicians from leaving, the decrease the burden on the taxpayers and to improve access to health care for all.

Sincerely,

Linda Rasmussen, MD Past-President, HMA; President, Western Orthopedic Assoc.

The cost of defensive medicine

By Stuart L. Weinstein, MD

TORT REFORM COULD LOWER COSTS, IMPROVE PATIENT CARE

At the recent "America's Health Care at Risk: Finding a Cure" conference, both Republicans and Democrats agreed that bipartisan cooperation and compromise are necessary to solve America's healthcare problems.

In the past, Congress has not addressed the fundamental issues that make the current healthcare system unsustainable. With a clear Democratic majority in both houses, Congress will be challenged to develop a comprehensive solution to America's healthcare problems. The unknown is whether Congress will tackle the issue head-on with a complete overhaul or just adopt a piecemeal approach.

The need for tort reform

The current medical liability system neither effectively compensates persons injured from medical negligence nor encourages the addressing of system errors to improve patient safety. The medical liability crisis has had many unintended consequences, most notably a decrease in access to care in a growing number of states and an increase in healthcare costs.

Access is affected as physicians move their practices to states with lower liability rates and change their practice patterns to reduce or eliminate high-risk services. When one considers that half of all neurosurgeons—as well as one third of all orthopaedic surgeons, one third of all emergency physicians, and one third of all trauma surgeons—are sued each year, is it any wonder that 70 percent of emergency departments are at risk because they lack available on-call specialist coverage?

The impact on the patient-physician relationship

Another unintended consequence of the medical liability crisis is a fundamental change in doctor-patient relationships, with attendant increasing healthcare costs secondary to defensive medicine practices. Many physicians are dissatisfied with the way they think they must practice medicine today. Many now adopt an attitude that "views every patient as a potential lawsuit."

This same attitude is also prevalent among residents. In a recent study of residents across specialties, 81 percent of responding residents said that they view every patient as a potential lawsuit. These protective, fear-of-lawsuit attitudes result in physicians adopting behaviors that increase healthcare costs through the practice of defensive medicine.

The impact on cost

Defensive medicine is defined as providing medical services that are not expected to benefit the patient but that are undertaken to minimize the risk of a subsequent lawsuit. Diagnostic defensive medicine practices have a much greater impact on costs than do therapeutic defensive practices. The quality of the literature on the true costs of defensive medicine and its impact on healthcare costs is poor; few good studies exist, and cost estimates vary widely.

The study quoted most often is by Daniel P. Kessler and Mark B. McClellan. To really understand actual costs, Kessler and McClellan analyzed the effects of malpractice liability reforms using data on Medicare beneficiaries who were treated for serious heart disease. They found that liability reforms could reduce defensive medicine practices, leading to a 5 percent to 9 percent reduction in medical expenditures without any effect on mortality or medical complications.

If the Kessler and McClellan estimates were applied to total U.S. healthcare spending in 2005, the defensive medicine costs would total between $100 billion and $178 billion per year. Add to this the cost of defending malpractice cases, paying compensation, and covering additional administrative costs (a total of $29.4 billion). Thus, the average American family pays an additional $1,700 to $2,000 per year in healthcare costs simply to cover the costs of defensive medicine.

Excessive litigation and waste in the nation's current tort system imposes an estimated yearly tort tax of $9,827 for a family of four and increases healthcare spending in the United States by $124 billion. How does this translate to individuals? The average obstetrician-gynecologist (OB-GYN) delivers 100 babies per year. If that OB-GYN must pay a medical liability premium of $200,000 each year (which is the rate in Florida), $2,000 of the delivery cost for each baby goes to pay the cost of the medical liability premium.

Imaging tests ordered as a defensive medicine measure increase healthcare costs.

The impact on care

Although hard data are difficult to acquire, several studies on physician attitudes indicate that a fear of lawsuits tends to drive providers to adopt behaviors that lead to increased healthcare costs. One study, for example, showed that 93 percent of physician respondents reported engaging in some form of defensive medicine.

Assurance behavior, reported by 92 percent of physician respondents, involves ordering tests (particularly imaging tests), performing diagnostic procedures, and referring patients for consultation. Avoidance behavior, reported by 42 percent of physician respondents, includes restricting their practice, eliminating high-risk procedures and procedures prone to complications, and avoiding patients with complex problems or patients perceived as litigious. A recent unpublished study in Massachusetts showed that 83 percent of physician respondents ordered imaging and laboratory tests or made specialist referrals defensively.

Unfortunately, if these assurance behaviors continue over time, they become the standard of care. Patients also become educated through the Internet and media about this new standard and change their expectations of their care.

On the therapeutic side, defensive therapeutic measures such as Caesarean sections or invasive procedures such as breast lump biopsies are accompanied by significant risks to patients and increased healthcare expenditures, not to mention the issues of patient safety.

Physician practice patterns have clearly changed in response to the liability crisis. With no relief in sight, these defensive behaviors will become engrained in a new standard of care, and healthcare costs will continue to rise unnecessarily. Our only hope is that federal and state legislators will take this key issue into consideration when developing a comprehensive approach to America's healthcare crisis.

Stuart L. Weinstein, MD, is a past president of the AAOS and current chair of the Orthopaedic Political Action Committee.

NOTICE OF HEARING
DATE: Tuesday, February 10, 2009
TIME: 8:30 a.m.
PLACE: Conference Room 329
State Capitol
415 South Beretania Street

Dear Representative Ryan Yamane,

I support tort reform and the bills that are being submitted on Tuesday, February 10th. I am sorry that I can't be there, but I live and practice medicine in Maui.

I have served the cancer patients in Maui for 15 years. I have also been chief of staff of Maui Memorial Hospital in 1999 and 2000. I can honestly say that I have never seen our medical community so stressed and fragile. The number of doctors who are leaving or who are simply not moving here is cripeling our system.

I know there are many factors that contribute to this, including poor reimbursement, but the lack of Medical Tort Reform is a significant reason. States like Texas and Indiana who have passed this type of Tort Reform legislature have seen physician retention improve a great deal. If we are going to save Hawaii from this severe doctor shortage, we need to offer some relief. Medical Tort Reform is a great way to show that you and our legislature really do understand and care about our survival.

Thank you very much for your help.

Sincerely,

Dr. Bobby Baker

Sincerely,

Bobby C. Baker, MD | President
Pacific Cancer Institute of Maui
227 Mahalani Street, Wailuku, Maui, Hawaii 96793
T 808 242 2600 | F 808 242 2626
BB@CancerMD.net | www.CancerMD.net

nishimoto2-Bryce

From: F. Don Parsa [fdparsa@yahoo.com]
Sent: Sunday, February 08, 2009 8:46 PM
To: HLTtestimony
Subject: Tort Reform Attention of Ryan Yamane

To: Ryan Yamane,
Chair, House Health Committee

I fully support Tort Reform as a physician who has practiced in Honolulu since 1981 and has been involved in teaching and voluntary work both in Hawaii and abroad. In fact , I have been the fortunate reciepient of three humanitarian awards from the House of Representatives during the past years.
I do care about the future of the State of Hawaii and I strongly feel and know that Tort Reform is the main step towards improving health care in our state. It is not the only step but it is the major one.
It is becoming increasingly difficult to retain physicians and action must be taken SOON if we want to work together in avoiding a major tragedy. I support a
$250,000 cap on non-economic damages, which has been proven by other
states to be effective in stabilizing premiums. The examples provided by other states such as Texas are most eloquent in demonstrating the important and vital value of Tort Reform.
Sincerely,

F.Don Parsa, M.D.,F.A.C.S.
Professor of Surgery,
Chief,Division of Plastic Surgery,
University of Hawaii,
John A. Burns School of Medicine.
Chief of Plastic Surgery,
Queen's Medical Center.

February 9, 2009

Committee on Health
Hawaii State House of Representatives

Ladies and Gentlemen:

As a practicing physician committed to serving the people of Hawaii, I respectfully ask for your consideration and support on some dangerously neglected critical issues.

Health care providers in our state, from physicians to pharmacies to hospitals, are quickly sinking into a mire of despair. Costs are too high, reimbursements too low, and all the while the Hawaiian people's medical needs continue to grow.

We realize that increased reimbursements are unlikely due to our unwillingness to behave as labor unions and withhold services. However, there are some measures within your purview that could help our medical community continue to care for you, your family and your constituents.

Insurance companies, in particular those private companies providing coverage for our Medicare and Medicaid patients, continue to deny and obstruct payment, even as their reimbursements fail to cover the costs of the services provided. As a private practitioner, their frequent refusal to make timely and reasonable payment creates an additional burden on my office, as we must make significant time and money expenditures to collect on claims.

Before your committee now is the issue of tort reform. The cost of excessive litigation goes far beyond liability insurance premiums.

Defensive medicine has become the norm. It is the performance of unnecessary testing and procedures to protect the provider from potential litigation. By definition, this method of practice adds tremendous costs to the provision of healthcare with very little or no benefit.

Protecting doctors from excessive litigation and predatory insurance companies will protect our health care system with no cost to patients or taxpayers. To continue to tolerate these situations takes us further down the slippery slope we find ourselves on.

Respectfully submitted,

Joseph M. Zobian, M.D.
94-307 Farrington Highway, Waipahu, Hawaii 96797

February 9, 2009

NOTICE OF HEARING DATE: Tuesday, February 10, 2009
TIME: 8:30 a.m.
Conference Room 329 State Capitol

COMMITTEE ON HEALTH
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

Dear Legislators,

Over the years we have seen a steady increase in patients arriving for treatment from the neighbor islands; many are acute or catastrophic, many need treatment for cancer. It would be safe to say that they are not afforded the level and quality of treatment they require on their own islands so they must travel to Oahu. Imagine what it would be like if they are cut off from receiving treatment on Oahu? What will they do then? If you think this is a scenario for the near future, you would be wrong. It is happening now.

What can you do? You can stop delaying what needs to be done and pass some sort of tort reform this session. You can stop draining funds from the health care sector through general excise taxes on medical services, and you can make it possible for the system to have the cash flow it needs to survive by passing a law that says that providers are entitled to direct reimbursement from insurance companies whether or not they participate.

There is no acknowledgement or protection for physicians in Hawaii law for the fact that they must treat patients over an ocean. This poses a higher risk to the patient and the physician should a complication arise after surgery and the patient has returned to his neighbor island. We have also seen an increasing inability of patients to return for follow-up visits to treat their cancers. They simply cannot afford to fly back and stay in a hotel to come see us. This puts pressure on the normal standard of care that patients are supposed to receive and we are supposed to rely on. We are just waiting for the first lawsuit to arise from a tumor that has grown from lack of follow-up care. We have already heard of another lawsuit that has arisen from a patient dying before he was able to have an appointment with a physician. Yes, that's right, due to the shortage; doctors are being sued now, without having even seen the patient! When are we going to start protecting the ones who are staying to take care of our most fragile citizens?

If you think HMSA's online care will address this problem, you would be wrong again. Our malpractice carrier has informed us that they will not be covering us for any claim that arises from participation in that program. So we have not signed up. It is hard

to sleep at night thinking that instead of examining a patient in person, we are now only given a brief description in writing from an untrained individual and we are supposed to guess what is going on. The media campaign touting online care, makes it even harder to convince our neighbor island patients to spend the money to come back to see us for their own good.

This will be the last written testimony I will ever submit. We have tried every year to get help, only to be denied every time. And, while all of you enjoy your pay increases (delayed or otherwise), doctors across the State are providing free medical service to people who can game the system you have created. This letter is being written only because the HMA has requested help, not because it will move any Legislators to do the right thing. We have already begun the process of protecting ourselves from lawsuits because the State will not do anything. This includes terminating anyone from the practice that refuses to come back for follow-up care. High risk and high maintenance patients are still being seen, but only until one of them unfairly sues us. We cannot be responsible for the shortage, do not blame us if we cannot help you in time.

I have been an office manager for my husband's surgical oncology practice for the past fifteen years. Although I speak only for myself, I believe that many in the physician community share my thoughts.

Sincerely yours,

Catherine Morris

Catherine Morris
Patient and Physician Advocate

I would like to submit testimony in favor of Tort Reform. Precedent has shown irrefutably in other states that Tort Reform greatly reduces the costs of medical care both directly and indirectly. In Hawaii we are facing a grave shortage of physicians in multiple specialties. The neighbor islands in particular have been affected the worst.

As an on-call physician in Ophthalmology at Queen's Medical Center, I have personally answered distress calls from outer island emergency rooms unable to find a local Ophthalmologist to care for their patients. Some individuals have waited in the ER for 8 hrs or more while the staff struggle to find a specialist to care for their patient. As a last resort, they contact Queen's for assistance. I have accepted multiple patients on transfer from Maui and Hawaii due to lack of adequate care. These patients must endure not only the pain and suffering during transport, and delay of care, but often times must bear the extra expense of travel and lodging for the duration. Often times, EMS and Air ambulance are utilized for these cases. Many of these patients do not have medical insurance because the premiums are too high. All together, these significant drains on our insurance carriers and public resources drive up health care costs.

Tort Reform is a proven method of reducing healthcare costs. Through the reduction of frivolous litigation and excessive judgement awards, medical malpractice insurance premiums decrease, allowing physicians to stay solvent and to remain in their practices to treat patients. That is what we are here to do. Too many good physicians are lost to the mainland where they can focus on patient care, without the worry of staying solvent and the threat of bankruptcy.

It is long overdue for Hawaii to initiate Tort Reform and evolve with the rest of the nation in order to provide our citizens with adequate healthcare.

Respectfully submitted.

William K. Wong, Jr. MD

Testimony Submission

To:
COMMITTEE ON HEALTH
Rep. Ryan I. Yamane, Chair
Rep. Scott Y. Nishimoto, Vice Chair

NOTICE OF HEARING
DATE: Tuesday, February 10, 2009
TIME: 8:30 a.m.
PLACE: Conference Room 329
State Capitol
415 South Beretania Street

From:
William K. Wong, Jr. MD
President, Hawaii Vision Clinic, Inc.
99-128 Aiea Heights Drive Suite 703
Aiea, HI 96701
808 487-7938

Re:
HB 1784 RELATING TO MEDICAL TORTS.
Limits the amount awarded for non-economic damages in medical tort cases to $750,000 aggregate and $250,000 per physician, healthcare provider, healthcare facility, and any other involved parties. Sets the award limit for non-economic damages in cases of gross negligence at $3,000,000.
HB 1514 RELATING TO MEDICAL TORTS.
Places a ceiling on non-economic damages in medical torts involving neurologists and neurosurgeons.
HB 1636 RELATING TO EMERGENCY MEDICAL PHYSICIANS.
Provides additional protection for physicians who render medical services in genuine emergency situations involving an immediate threat of death or serious bodily injury.
HB 1785 RELATING TO MEDICAL MALPRACTICE CLAIMS.
Establishes a medical malpractice damages task force to develop a strategic plan to address the high costs of medical malpractice insurance rates and make recommendations on damage award ranges and guidelines for medical malpractice claims.
HB 310 RELATING TO MEDICAL TORTS.
In medical tort litigation authorizes the court to impose sanctions on a party whose rejection of the Medical Claim Conciliation Panel decision resulted

in the trial and who at trial fails to improve on the panel's award by increasing or decreasing it by at least 30 percent.

HB 575 RELATING TO MEDICAL TORTS.

Requires claimants who reject the medical claim conciliation panel's award of damages and pursue litigation to pay the health care provider's attorneys' fees, costs, and cost of the provider's time, unless the litigation results in an award of more than 200% of the panel's award. Requires claimants who reject the panel's finding of no negligence and pursue litigation to pay the attorneys' fees and costs of all defendants, unless the result of litigation is a judgment in favor of the claimant.