LATE

Testimony of Bert Sakuda
In Opposition to S.B. No. 1074

Chair David Y. Ige and Members of the Senate Health Committee:

Thank you for the opportunity to testify in Opposition to S.B. No. 1074. We OPPOSE arbitrary limitations on patient recoveries.

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

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

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

Texas Has Not Solved Its Rural Doctor Shortage

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

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

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

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

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

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

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

Texas Has Not Experienced a Dramatic Increase in Physicians

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

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

Texas Doctors
(In State)

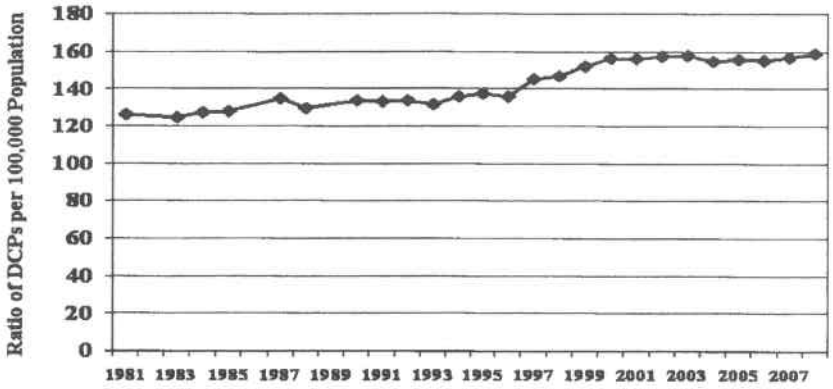
Year	Number	Increase Over Prior Year	Percent Change
1997	29,360		
1998	30,115	755	2.6%
1999	31,164	1,049	3.5%
2000	32,082	918	2.9%
2001	32,946	864	2.7%
2002	34,556	1,610	4.9%
2003	35,723	1,167	3.4%
2004	37,420	1,697	4.8%
2005	38,461	1,041	2.9%
2006	39,605	1,144	3.0%
2007	41,227	1,622	4.1%
2008	42,608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

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

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

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

Direct Patient Care Physician Trends



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

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

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

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

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

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

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

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

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

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

Texas Malpractice Premiums on Average Are Higher Than Hawaii's

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

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

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

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

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

> "This **evidence suggests that no crisis involving malpractice claim outcomes occurred**. It thus also suggests a weak connection between claims-related costs and short-to-medium term fluctuations in insurance premiums. If so, litigation reforms may not prevent future insurance crises."

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

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

Texas Still has More Malpractice Claims Paid Than Hawaii

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

The Effect of Other Texas Reforms Are Ignored

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

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

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

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

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

It's the Economy, Stupid

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

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

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

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

Thank you very much for this opportunity to testify.

LEAVITT, YAMANE & SOLDNER

LATE

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Testimony of John Yamane
In Opposition to SB No. 1074

To the Senate Committee on Health:

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

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

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

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

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

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

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

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

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

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

Thank you for letting me testify.