HEALTH CARE REFORM ISSUES: ANTITRUST, MEDICAL MALPRACTICE LIABILITY, AND VOLUNTEER LIABILITY

HEARINGS

BEFORE THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

ON

H.R. 911, H.R. 2925, and H.R. 2938

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FEBRUARY 27 AND 28, 1996

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U.S. GOVERNMENT PRINTING OFFICE

24-740 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052906-9

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TUESDAY, FEBRUARY 27, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room 2141, Rayburn House Office Building, Hon. Henry J. Hyde (chairman of the committee) presiding.

Present: Representatives Henry J. Hyde, Carlos J. Moorhead, F. James Sensenbrenner, Jr., Bill McCollum, George W. Gekas, Steven Schiff, Bob Goodlatte, Stephen E. Buyer, Fred Heineman, Steve Chabot, John Conyers, Jr., Patricia Schroeder, Jack Reed, Sheila Jackson Lee, and Robert C. Scott.

Also present: Alan F. Coffey, Jr., general counsel/staff director; Diana L. Schacht, counsel; and Kenneth Prater, clerk.

OPENING STATEMENT OF CHAIRMAN HYDE

Mr. HYDE. The committee will come to order.

This morning, we begin 2 days of hearings on issues specifically within the jurisdiction of the Judiciary Committee which relate to health care reform. We will consider the appropriate antitrust enforcement standards for physician networks, the need for reform of the medical liability system, and how a relaxation on the liability of volunteers could encourage more people to donate their time to nonprofit organizations.

This morning, the committee will first hear—actually second hear—from Robert Pitofsky, Chairman of the Federal Trade Commission, on the Antitrust Health Care Advancement Act of 1996. That is H.R. 2925, legislation which I have introduced to ensure that the conduct of certain provider networks receives rule of reason consideration for purposes of the antitrust laws.

In contrast to previous legislative proposals on this subject, my bill is narrowly tailored so as to encourage and enhance competition in the health care marketplace. H.R. 2925 does not grant an exemption from the antitrust laws, nor does it in any way require the enforcement agencies to approve conduct which they believe would have an anticompetitive effect. It merely requires that there not be an automatic assumption that such networks would be per se illegal.

I am pleased to note that H.R. 2925 has been cosponsored by 33 of my colleagues, including Bill Archer, chairman of the Ways and

Means Committee, and several of the members of this committee: Mr. McCollum, Mr. Gekas, Mr. Coble, Mr. Smith of Texas, Mr. Schiff, Mr. Canady, Mr. Inglis, Mr. Goodlatte, and Mr. Buyer. Further, it has been strongly endorsed by the American Medical Association as a necessary mechanism if its members are to be allowed thoroughly to compete against insurers and HMO's.

The committee will then hear from a panel of witnesses on the subject of medical malpractice liability reform. Our health care system is being burdened by a number of cost-based pressures. One of these costs is the threat of liability suits facing medical practitioners and health care providers and the large dollar amounts they are forced to spend to protect themselves against these legal actions.

Many liability cases brought against doctors are frivolous. In fact, two out of three medical liability claims are closed without any payment to the claimant, but only after large legal and administrative costs have been incurred. On the other hand, there is evidence that our liability system is not compensating patients who have valid claims for malpractice. At least one study has shown that only 1 in 16 persons injured by negligent doctors receive compensation. Clearly, our tort system is not achieving its goal of making injured plaintiffs whole and deterring substandard medical care.

Last session the House of Representatives passed a medical malpractice liability reform package as part of the Medicare bill. That initiative failed because of the operation of the Byrd rule in the Senate, but that does not mean that our attempts to address the very real deficiencies of the medical malpractice liability system are over. Today we renew our efforts to find a measured and fair way to bring back into balance the legitimate needs of both doctors and patients.

Finally, both today and tomorrow, we will also take up the subject of volunteer liability. My good friend and colleague from Illinois, Congressman John Porter, has done excellent work in this area, and we will hear from him this morning.

Whether imagined or real, the fear of being subject to personal liability for services donated to nonprofit organizations and governmental organizations has erected a barrier to many to donate their talents. The committee will hear about a variety of proposed mechanisms directed at eliminating this fear, thereby encouraging citizens to give back to their communities by volunteering their expertise.

I look forward to an interesting and an illuminative 2 days of testimony.

[The memorandum of Mr. Hyde follows:]

February 23, 1996

MEMORANDUM

TO: Members, Committee on the Judiciary

FROM: Henry J. Hyde, Chairman

RE: Hearings on Health Care Reform

On February 27 and 28, the full Committee will hold hearings on issues relating to health care reform. Specifically, the hearings will focus on (1) H.R. 2925, the "Antitrust Health Care Advancement Act of 1996," (2) medical malpractice liability reform, and (3) limitations on the liability of volunteers.

1. **THE ANTITRUST HEALTH CARE ADVANCEMENT ACT OF 1996**

On February 1, I introduced the "Antitrust Health Care Advancement Act of 1996" (H.R. 2925), which would apply rule of reason treatment to the conduct of certain health care provider networks. The bill is intended to prevent antitrust enforcement policies from imposing an artificial barrier to the utilization of private cooperative initiatives which can make our health care system more efficient. H.R. 2925 enjoys bi-partisan support and is co-sponsored by 30 of my colleagues.

Health care provider networks, or "HCPNs," -- those composed of doctors, hospitals, and other entities who actually deliver health care services -- are potentially vigorous competitors in the health care market. Their formation leads to lower health care costs and higher quality of care. Costs are lower because contracting directly with health care providers eliminates an intermediate layer of overhead and profit. Quality is higher because providers, and particularly physicians, have direct control over medical decision-making. Physicians and other health care professionals are better qualified than insurers to strike the proper balance between conserving costs and meeting the needs of the patient.

Concern has been raised, however, that the application of current antitrust enforcement guidelines is discouraging providers from forming networks which would have a positive effect on competition. These networks would most likely be found legal under the antitrust laws, but physicians -- who are understandably concerned about potential treble damage liability -- are unwilling to create them in the absence of pre-conduct approval from the enforcement agencies. H.R. 2925 removes this artificial barrier to entry, by conforming agency enforcement practices to the manner in which courts have interpreted and applied antitrust law.

A. Applicable Antitrust Law

Antitrust law prohibits agreements among competitors that fix prices or allocate markets. Such agreements are per se illegal. Where competitors economically integrate in a joint venture, however, agreements on prices or other terms of competition that are

reasonably necessary to accomplish to procompetitive benefits of the integration are not unlawful. See, e.g., Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 19-20 (1979). Price setting conduct by these joint ventures is evaluated under the "rule of reason," that is, on the basis of its reasonableness, taking into account all relevant factors affecting competition.

The antitrust laws treat individual physicians as separate competitors. Thus, networks composed of physicians which set prices for their services as a group will be considered per se illegal under the antitrust laws if they are not economically integrated joint ventures. In the typical provider network, competing physicians relinquish some of their independence to permit the venture to win the business of health care purchasers, such as large employers. These networks promise to provide services to plan subscribers at reduced rates. The ventures also achieve another central goal of health care reform: careful, common sense controls on the provision of unnecessary care.

However, agreements among physicians who retain a great deal of independence but set fees for their services as part of a network bear a striking resemblance to horizontal price fixing agreements. These are the most disfavored and most quickly condemned restraints in antitrust jurisprudence. The key factual question which would distinguish a network that is per se unlawful from one which, upon consideration of the circumstances, is acceptable because it is not anticompetitive in nature, is the degree of integration of the individuals who form the network.

While the antitrust laws provide substantial latitude in the context of collaboration among health care professionals, there is an understandable degree of uncertainty associated with their enforcement. Because each network involves unique facts -- differences not only in the structure of the network, but also in the market in which it will compete -- the ability of providers to prospectively determine whether their arrangement will be considered legal is limited.

B. Current Enforcement Standards

In order to eliminate this uncertainty, and to encourage procompetitive behavior that would otherwise be chilled, the Department of Justice and Federal Trade Commission have established a mechanism for prospective review of proposed HCPNs. In 1993, the antitrust enforcement agencies jointly issued "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust." These guidelines, which were amended in 1994, contain safety zones which describe provider network joint ventures that will not be challenged by the agencies under the antitrust laws, along with principles for analysis of joint ventures that fall outside the safety zones. A group of providers wishing to embark on a joint venture may request an advisory opinion from the agencies. The agencies, after reviewing the particulars of the proposed venture, then determine whether the network would fall within a safety zone, or otherwise not be challenged under the antitrust laws.

The problem is that these enforcement guidelines articulate standards that are more restrictive than the realities of the agencies' enforcement practices and the current state of the

law. They treat as per se illegal many more networks than the antitrust laws would require, because case law does not single out integration exhibited by the sharing of financial risk as carrying special weight.

The guidelines promise rule of reason treatment to ventures where the competitors involved are "sufficiently integrated through the network." This is consistent with judicial interpretations of the law. See, e.g., Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 19-20 (1979). Where the guidelines diverge significantly from current law, however, is in defining integration solely as the sharing of "substantial financial risk." A network which integrates in any other way -- regardless of the extent of that integration, or whether a court interpreting the antitrust laws would find it to be integrated -- cannot qualify as a legitimate joint venture. This means that the agencies would not proceed to examine the specific facts of these joint ventures to determine their likely impact on competition; the arrangement would be viewed as per se illegal.

This restrictive notion of what constitutes a legitimate joint venture discourages procompetitive ventures from entering the health care marketplace, under the guise of antitrust enforcement. It excludes potential provider networks which would mean an expanded set of consumer choices and increased competition (and thereby, lower costs) for health care services.

C. Scope of H.R. 2925

H.R. 2925 overcomes this barrier by requiring that the conduct of an organization meeting the criteria of a Health Care Provider Network be judged under the rule of reason. The result will be to permit a case-by-case determination as to whether the conduct of that HCPN would be procompetitive, and thus permissible under the antitrust laws. It is important to emphasize, however, that this is not an exemption from the antitrust laws. In no event would providers be allowed to set prices or control markets if, in doing so, they have an anticompetitive effect on the market. The normal principles of antitrust law will continue to apply. There could just be no automatic assumption that such networks would be per se illegal.

Only an organization meeting specified criteria would qualify for the more liberal, rule of reason consideration. The network must have in place written programs for quality assurance, utilization review, coordination of care and resolution of patient grievances and complaints. It must contract as a group, and mandate that all providers forming part of the group be accountable for provision of the services for which the organization has contracted. If these criteria are not met, the entity could still be considered per se illegal.

Rule of reason consideration would be extended not only to the actual performance of a contract to provide health care services, but also to the exchange of information necessary to establish a HCPN. An important limitation on the exchange of information is that it must be reasonably required in order to create a HCPN. Further, information obtained in that context may not be used for any other purpose.

H.R. 2925 delegates to the Department of Justice and the Federal Trade Commission authority to specify how rule of reason consideration would be implemented under these circumstances.

The provisions of H.R. 2925 are similar to those contained in the Medicare/ reconciliation package approved by the House last December. But, H.R. 2925 extends beyond Medicare products and would include contracts with private insurance groups. Thus, under H.R. 2925, a provider group seeking to contract with an HMO, or Blue Cross/Blue Shield, would be eligible for its protections.

D. Witnesses

The Committee will hear from two panels of witnesses on the subject of antitrust law. Robert Pitofsky, Chairman of the Federal Trade Commission, will testify on Tuesday as to the FTC's enforcement experience and the its current efforts to expand its guidelines. On Wednesday, the Committee will hear testimony from a panel composed of Nancy Dickey, M.D., on behalf of the American Medical Association; Gayle McKay, on behalf of the American Association of Nurse Anesthetists; Margaret Metzger, Senior Vice President and Corporate General Counsel, Tufts Associated Health Plan, on behalf of the Group Health Association of America/American Managed Care and Review Association; and Professor Clark C. Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law.

II. MEDICAL MALPRACTICE LIABILITY REFORM

The proper functioning of the medical malpractice system is one of the most important safeguards against substandard medical care. The ability of victims to bring lawsuits in cases of medical malpractice achieves three important goals: It permits victims to receive just and adequate compensation for harm suffered, it deters poor quality health care, and it penalizes negligent providers.

At least two factors have prompted calls for medical liability reform. First, some research suggests that the medical tort system is not achieving its goals. For example, one study[1] reported that only a fraction of malpractice injuries result in claims, that compensation is often unrelated to the existence of medical malpractice, that the legal system is slow at resolving claims, and that legal fees and administrative costs consume almost half of the compensation awarded.

From 1960 to 1984, medical malpractice awards in the United States increased by more than 1,000 percent. A 1988 study showed that the average U.S. physician has a 37 percent chance of being sued for professional liability in his/her lifetime, and that surgeons and obstetricians have a 52 percent and 78 percent change respectively. Furthermore, once sued for malpractice, physicians and their patients/claimants can expect lengthy court battles. On average, it takes more than two years to resolve a medical liability case from the time it

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[1] Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report of the Harvard Medical Practice Study to the State of New York (Cambridge, Mass.: President and Fellows of Harvard College, 1990).

is filed and almost 5-1/2 years for a complex case. For obstetrical claims, the average litigation time frame is 5 years, but 7 years for cases involving brain-damaged infants.

Studies indicate that 60 to 75 percent of medical malpractice cases have no merit and nearly 60 percent of malpractice insurers' defense costs are spent defending cases that ultimately are closed without any compensation being paid to the plaintiff.[2] Of those cases that merit litigation and result in verdicts favorable to plaintiffs, the Rand Corporation estimates that only 43 cents of every dollar spent on the litigation actually reaches the injured patient. The majority of each dollar spent goes towards attorney fees, expert witnesses and insurance company overhead.[3]

The second factor militating toward reform is the perception that the current tort system places an unreasonable burden on hospitals and physicians. There is evidence suggesting that liability-related costs are too high and unduly influence the way hospitals and doctors practice medicine.[4] The burden imposed on the health care system by medical malpractice litigation is not limited to the cost of malpractice insurance. The practice of defensive medicine, both in an affirmative and negative sense, takes a real toll on the system.

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[2] Medical Malpractice, Characteristics of Claims Closed in 1984, U.S. General Accounting Office, 1987.

[3] Deborah R. Hensler and Mary E. Vaiana, Trends in Tort Litigation, the Story Behind the Statistics, Rand Corporation, Institute for Civil Justice.

[4] A CBO study reported the cost of medical liability associated with purchased insurance in 1990 at $5 billion, which represents 0.74 percent of national health care expenditures. Other studies have set that figure at over $8.2 billion. These amounts do not include the cost of self-insurance, which is estimated at 20 to 30 percent of premiums.

When our legal system induces physicians to order additional or more complex diagnostic tests and procedures than they would otherwise, or leads them to schedule additional patient visits and to spend more time with the patient, the system bears the burden of these unnecessary expenditures. Negative defensive medicine is just as damaging to the health care system: by inducing doctors to restrict the scope of their practices to low risk patients or procedures, or to exit certain practice areas altogether, it reduces the availability of care and choice in the health care marketplace.

There are many ways in which the system might be reformed to provide incentives for the better attainment of its goal. Some of the measures that have been adopted or considered by the various states include caps on non-economic and/or punitive damages, limitations on contingency fees, use of periodic payments, institution of shortened statutes of limitation, admission into evidence of collateral source payments, elimination of joint and several liability, and alternatives to litigation. The precise contours of each of these individual reforms is susceptible to endless permutations, and the combinations in which they might be packaged adds increased choice in crafting an effective reform package.

Medical malpractice actions are governed largely by a patchwork of state laws (the exception being claims which must be brought under ERISA or the Federal Tort Claims Act). This leads to widely divergent outcomes depending on the locus of the lawsuit. The purpose of these hearings is discuss the advisability of enacting legislation at the Federal level which would address the problems of the medical liability system uniformly, and what reforms might be appropriate.

The third panel on Tuesday will address medical liability issues. It will include testimony from Frederic J. Entin, Senior Vice President and General Counsel of the American Hospital Association; Philip H. Corboy, Esquire, Immediate Past Chair, American Bar Association Special Committee on Medical Professional Liability, on behalf of the Committee; George D. Dikeou, on behalf of the Physician Insurers Association of America; Robert T. Clarke, President and CEO, Memorial Health System, on behalf of the Health Care Liability Alliance; Joseph W. Hanss, Jr., M.D., on behalf of the American College of Obstetricians and Gynecologists; Mark Hiepler, Esquire, Hiepler & Hiepler; and Linda Ross. The American Medical Association is also prepared to comment on this issue when it appears on the antitrust panel.

III. LIMITATIONS ON VOLUNTEER LIABILITY

The final goal of these hearings will be to address the peculiar liability issues raised in the context of volunteerism. Many believe that the fear of personal liability discourages many people from volunteering their time and services. Whether this fear is justified or imagined, it nevertheless is creating impediments to the provision of services, including health care services, through non-governmental sources.

Many approaches have been considered by which to ameliorate this problem. Today, we will specifically consider the proposals set forth in legislation pending before the House:

A. The "Volunteer Protection Act of 1995" (H.R. 911)

Introduced by Congressman John Porter, and now carrying 201 co-sponsors, this bill provides incentives for states to enact limitations on liability for volunteers working for non-profit organizations and governmental entities. It provides a one percent increase in the fiscal year allotment received by a state under the Social Services Block Grant Program if the state enacts immunity legislation which complies with the criteria set forth in the bill.

The immunity envisioned under H.R. 911 would only apply to volunteers acting in good faith and within the scope of his or her official functions and duties. Injuries caused by willful and wanton misconduct would not be covered. States would have the flexibility to enact certain further specific exceptions to the coverage of their acts.

B. The "Charitable Medical Care Act of 1996" (H.R. 2938)

The "Charitable Medical Care Act of 1996," introduced by Congressman Bob Goodlatte, would make it easier for free medical clinics to recruit medical professionals to volunteer their services for the poor. It would exempt from liability those persons who provide services through free clinics, to the extent they commit simple negligence. No protection would be granted from suits alleging gross negligence or willful misconduct.

Witnesses on the subject of volunteer liability limitation will be John H. Graham, IV, CEO, American Diabetes Foundation, on behalf of the National Coalition for Volunteer Protection; Sister Christine Bowman, O.S.F., for the Catholic Health Association; and Chris Franklin, Vice President, National Office of Volunteers, American Red Cross.

Attached is a copy of the witness list as well as copies of the bills under consideration.

[The bills, H.R. 911, 2925, and H.R. 2938, follows:]

104TH CONGRESS
1ST SESSION

H.R. 911

To encourage the States to enact legislation to grant immunity from personal civil liability, under certain circumstances, to volunteers working on behalf of nonprofit organizations and governmental entities.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 13, 1995

Mr. PORTER (for himself, Mr. ACKERMAN, Mr. ALLARD, Mr. BAKER of California, Mr. BALLENGER, Mr. BARRETT of Nebraska, Mr. BARTLETT of Maryland, Mr. BEREUTER, Mr. BEVILL, Mr. BOEHLERT, Mr. BONILLA, Mr. BONO, Mr. BROWDER, Mr. BUNNING of Kentucky, Mr. CALLAHAN, Mr. CALVERT, Mr. CANADY of Florida, Mrs. CLAYTON, Mr. COBURN, Mr. CONDIT, Mr. COX of California, Mr. DAVIS, Ms. DELAURO, Mr. DOOLEY, Mr. DOYLE, Mr. EHLERS, Mr. EMERSON, Mr. ENGEL, Mr. ENGLISH of Pennsylvania, Mr. EVANS, Mr. FALEOMAVAEGA, Mr. FARR, Mr. FATTAH, Mr. FAWELL, Mr. FIELDS of Texas, Mr. FILNER, Mr. FLANAGAN, Mr. FORBES, Mr. FOX of Pennsylvania, Mr. FRANK of Massachusetts, Mr. FROST, Ms. FURSE, Mr. GEJDENSON, Mr. GEKAS, Mr. GORDON, Mr. GENE GREEN of Texas, Mr. GREENWOOD, Mr. GUNDERSON, Mr. HALL of Ohio, Mr. HANCOCK, Mr. HASTERT, Mr. HEFLEY, Mr. HEFNER, Mr. JACOBS, Mrs. KELLY, Mr. KIM, Mr. KING, Mr. KLECZKA, Mr. KLUG, Mr. KNOLLENBERG, Mr. LAHOOD, Mr. LANTOS, Mr. LARGENT, Mr. LEACH, Mr. LEWIS of California, Mr. LIGHTFOOT, Mr. LIPINSKI, Mr. LIVINGSTON, Ms. LOFGREN, Mrs. LOWEY, Mr. MARTINEZ, Mr. MCCOLLUM, Mr. MCHALE, Mr. MCHUGH, Mr. MCKEON, Mr. MEEHAN, Mrs. MEYERS of Kansas, Mr. MILLER of Florida, Ms. MOLINARI, Mr. MONTGOMERY, Mr. MOORHEAD, Mr. MORAN, Mrs. MORELLA, Mr. MURTHA, Mr. NEY, Mr. OLVER, Mr. OWENS, Mr. PACKARD, Mr. PARKER, Mr. PAXON, Mr. PAYNE of Virginia, Mr. PETRI, Ms. PRYCE, Mr. QUINN, Mr. RADANOVICH, Mr. RIGGS, Mr. ROYCE, Mr. SANDERS, Mr. SANFORD, Mr. SAXTON, Mr. SCHAEFER, Mr. SCHIFF, Mr. SCHUMER, Mrs. SEASTRAND, Mr. SENSENBRENNER, Mr. SERRANO, Mr. SHAYS, Mr. SKEEN, Ms. SLAUGHTER, Mr. SMITH of Texas, Mr. SOLOMON, Mr. STARK, Mr. STEARNS, Mr. STUMP, Mr. THOMPSON, Mr. TORKILDSEN, Mr. UNDERWOOD, Mr. UPTON, Mr. VISCLOSKY, Mrs. VUCANOVICH, Mrs. WALDHOLTZ, Mr. WALSH, Mr. WELDON of Pennsylvania, Mr. WELLER, Mr. WILSON, Mr. WOLF, Mr. ZELIFF, and Mr. ZIMMER) introduced the following bill; which was referred to the Committee on the Judiciary and, in addition, to the Committee on Ways and Means, for a period to be

subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To encourage the States to enact legislation to grant immunity from personal civil liability, under certain circumstances, to volunteers working on behalf of nonprofit organizations and governmental entities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Volunteer Protection Act of 1995".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds and declares that—

(1) the willingness of volunteers to o · their services is deterred by potential personal liability for simple mistakes made in the course of volunteer service;

(2) as a result, many nonprofit public and private organizations and governmental entities, including voluntary associations, social service agencies, educational institutions, local governments, foundations, and other civic programs, have been adversely

affected through the withdrawal of volunteers from boards of directors and service in other capacities;

(3) the contribution of these programs to their communities is thereby diminished, resulting in fewer and higher cost programs than would be obtainable if volunteers were participating; and

(4) because Federal funds are expended on useful and cost-effective social service programs which depend heavily on volunteer participation, protection of voluntarism through clarification and limitation of the personal liability risks assumed by the volunteer in connection with such participation is an appropriate subject for Federal encouragement of State reform.

(b) PURPOSE.—It is the purpose of this Act to promote the interests of social service program beneficiaries and taxpayers and to sustain the availability of programs and nonprofit organizations and governmental entities which depend on volunteer contributions by encouraging reasonable reform of State laws to provide protection from personal financial liability to volunteers serving with nonprofit organizations and governmental entities for actions undertaken in good faith on behalf of such organizations.

SEC. 3. NO PREEMPTION OF STATE TORT LAW.

Nothing in this Act shall be construed to preempt the laws of any State governing tort liability actions.

SEC. 4. LIMITATION ON LIABILITY FOR VOLUNTEERS.

(a) LIABILITY PROTECTION FOR VOLUNTEERS.—Except as provided in subsections (b) and (d), any volunteer of a nonprofit organization or governmental entity shall incur no personal financial liability for any tort claim alleging damage or injury from any act or omission of the volunteer on behalf of the organization or entity if—

(1) such volunteer was acting in good faith and within the scope of such volunteer's official functions and duties with the organization or entity; and

(2) such damage or injury was not caused by willful and wanton misconduct by such volunteer.

(b) CONCERNING RESPONSIBILITY OF VOLUNTEERS WITH RESPECT TO ORGANIZATIONS.—Nothing in this section shall be construed to affect any civil action brought by any nonprofit organization or any governmental entity against any volunteer of such organization or entity.

(c) NO EFFECT ON LIABILITY OF ORGANIZATION.—Nothing in this section shall be construed to affect the liability of any nonprofit organization or governmental entity with respect to injury caused to any person.

(d) EXCEPTIONS TO VOLUNTEER LIABILITY PROTECTION.—A State may impose one or more of the follow-

ing conditions on and exceptions to the granting of liability protection to any volunteer of an organization or entity required by subsection (a):

(1) The organization or entity must adhere to risk management procedures, including mandatory training of volunteers, as defined by the Secretary of Health and Human Services by regulation.

(2) The organization or entity shall be liable for the acts or omissions of its volunteers to the same extent as an employer is liable, under the laws of that State, for the acts or omissions of its employees.

(3) The protection from liability does not apply—

(A) if the volunteer was operating a motor vehicle, vessel, aircraft, or other vehicle for which the State involved requires the operator or vehicle owner to maintain insurance;

(B) in the case of a suit brought by an appropriate officer of a State or local government to enforce a Federal, State, or local law; and

(C) to the extent the claim would be covered under any insurance policy.

(4) The protection from liability shall apply only if the organization or entity provides a finan-

cially secure source of recovery for individuals who suffer injury as a result of actions taken by a volunteer on behalf of the organization or entity. A financially secure source of recovery may be an insurance policy within specified limits, comparable coverage from a risk pooling mechanism, equivalent assets, or alternative arrangements that satisfy the State that the entity will be able to pay for losses up to a specified amount. Separate standards for different types of liability exposure may be specified.

SEC. 5. CERTIFICATION REQUIREMENT AND ADJUSTMENT OF SOCIAL SERVICES BLOCK GRANT ALLOTMENTS.

(a) CERTIFICATION AND BLOCK GRANT ALLOTMENTS.—In the case of any State which certifies, not later than 2 years after the date of the enactment of this Act, to the Secretary of Health and Human Services that it has enacted, adopted, or otherwise has in effect State law which substantially complies with section 4(a), the Secretary shall increase by 1 percent the fiscal year allotment which would otherwise be made to such State to carry out the Social Services Block Grant Program under title XX of the Social Security Act.

(b) CONTINUATION OF INCREASE.—Any increase made under subsection (a) in an allotment to a State shall

remain in effect only if the State makes a certification to the Secretary of Health and Human Services, not later than the end of each 1-year period occurring successively after the end of the 2-year period described in subsection (a), that it has in effect State law which substantially complies with section 4(a).

SEC. 6. DEFINITIONS.

For purposes of this Act—

(1) the term "volunteer" means an individual performing services for a nonprofit organization or a governmental entity who does not receive—

(A) compensation (including reimbursement or allowance for expenses), or

(B) any other thing of value in lieu of compensation,

in excess of $300, and such term includes a volunteer serving as a director, officer, trustee, or direct service volunteer;

(2) the term "nonprofit organization" means any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(3) the term "damage or injury" includes physical, nonphysical, economic, and noneconomic damage; and

(4) the term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any other territory or possession of the United States, or any political subdivision of any such State, territory, or possession.

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104TH CONGRESS
2D SESSION

H. R. 2925

To modify the application of the antitrust laws to health care provider networks that provide health care services; and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 1996

Mr. HYDE (for himself, Mr. ARCHER, Mr. WELDON of Florida, Mr. MCCOLLUM, Mr. GEKAS, Mr. COBLE, Mr. SMITH of Texas, Mr. HASTERT, Mr. SCHIFF, Mr. THOMAS, Mr. CANADY of Florida, Mr. INGLIS of South Carolina, Mr. GOODLATTE, Mr. BOUCHER, Mr. CRANE, Mr. SHAW, Mrs. JOHNSON of Connecticut, Mr. MCCRERY, Mr. CAMP, Mr. CAMPBELL, Mr. SAM JOHNSON of Texas, Mr. CHRISTENSEN, Mr. GANSKE, Mr. LIPINSKI, and Mr. HANCOCK) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To modify the application of the antitrust laws to health care provider networks that provide health care services; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Antitrust Health Care Advancement Act of 1996".

SEC. 2. APPLICATION OF ANTITRUST RULE OF REASON TO HEALTH CARE PROVIDER NETWORKS.

(a) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any State law similar to the antitrust laws—

(1) the conduct of a health care provider in exchanging with 1 or more other health care providers information relating to costs, sales, profitability, marketing, prices, or fees of any health care service if—

(A) the exchange of such information is solely for the purpose of establishing a health care provider network and is reasonably required for such purpose, and

(B) such information is not used for any other purpose,

(2) the conduct of a health care provider network (including any health care provider who is a member of such network and who is acting on behalf of such network) in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a health benefit plan, and

(3) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH BENEFIT PLAN.—The term "health benefit plan" means—

(A) a hospital or medical expense-incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a multiple employer welfare arrangement or employee benefit plan (as defined

under the Employee Retirement Income Security Act of 1974).

Such term includes a contract to provide health care services under section 1876 or 1903(m) of the Social Security Act.

(3) HEALTH CARE PROVIDER.—The term "health care provider" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(4) HEALTH CARE SERVICE.—The term "health care service" means any health care service for which payment may be made under a health benefit plan, including services related to the delivery or administration of such service.

(5) HEALTH CARE PROVIDER NETWORK.—The term "health care provider network" means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a health benefit plan—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such health benefit plan, along with internal proce-

dures to correct identified deficiencies relating to such methods and such services,

(E) has established a program to monitor and control utilization of health care services provided under such health benefit plan, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such health benefit plan, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

(6) STATE.—The term "State" has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

SEC. 3. ISSUANCE OF GUIDELINES.

Not later than 180 days after the date of the enactment of this Act, the Attorney General and the Federal

Trade Commission jointly shall issue guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of section 2.

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24-740 96 – 2

104TH CONGRESS
2D SESSION

H. R. 2938

To encourage the furnishing of health care services to low-income individuals by exempting health care professionals from liability for negligence for certain health care services provided without charge except in cases of gross negligence or willful misconduct, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 1, 1996

Mr. GOODLATTE (for himself, Mr. MOORHEAD, Mr. MCCOLLUM, Mr. SMITH of Texas, Mr. HOKE, and Mr. BRYANT of Tennessee) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To encourage the furnishing of health care services to low-income individuals by exempting health care professionals from liability for negligence for certain health care services provided without charge except in cases of gross negligence or willful misconduct, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Charitable Medical Care Act of 1996".

SEC. 2. EXEMPTION OF HEALTH CARE PROFESSIONALS FROM NEGLIGENCE LIABILITY IN THE PROVISION OF CERTAIN HEALTH CARE SERVICES WITHOUT CHARGE.

(a) LIMITED LIABILITY.—

(1) IN GENERAL.—Subject to subsection (b), a health care professional who is licensed or certified to furnish health care services by the appropriate authorities for practice in a State shall not be liable for any civil damages for any act or omission resulting from the rendering of a health care service described in paragraph (2) unless the act or omission was the result of gross negligence or willful misconduct.

(2) HEALTH CARE SERVICE DESCRIBED.—

(A) IN GENERAL.—A health care service described in this paragraph is a health care service which is—

(i) voluntarily rendered by a health care professional—

(I) within the scope of the health care professional's license or certification; and

(II) without charge to the recipient of such service (or any health in-

surance plan or program under which the recipient is covered); and

(ii) offered and rendered in, or upon referral from, a free medical clinic.

(B) FREE MEDICAL CLINIC.—

(i) IN GENERAL.—For purposes of subparagraph (A)(iii), a free medical clinic is a private, not-for-profit entity which—

(I) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a);

(II) is licensed if required by the State in which it is located; and

(III) provides free outpatient health care services, a majority of which are rendered to individuals whose income does not exceed 200 percent of the poverty line.

(ii) POVERTY LINE.—For purposes of clause (i)(III), the term "poverty line" has the same meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

(b) REQUIREMENTS PRIOR TO FURNISHING THE SERVICE.—Subsection (a)(1) shall apply only if a health care professional before furnishing a health care service—

(1) agrees to furnish the health care service voluntarily and without charge to the recipient of such service (or any health insurance plan or program under which the recipient is covered); and

(2) provides the recipient of the health care service with adequate notice, as determined by the Secretary of Health and Human Services, of the health care professional's limited liability with respect to the service.

(c) PREEMPTION.—The provisions of this section shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this section shall not preempt any State law that provides greater incentives or protections to a health care professional rendering a health care service described in subsection (a)(2).

(d) EFFECTIVE DATE.—This section shall apply with respect to health care services furnished on or after the date of the enactment of this Act.

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Mr. HYDE. I will now recognize the distinguished ranking minority member for the minority, Mr. John Conyers, for purposes of an opening statement.

Mr. CONYERS. Good morning, Mr. Chairman, and members of the committee.

Mr. HYDE. Good morning.

Mr. CONYERS. I have a few comments, but I would prefer to defer them until after our colleagues have spoken and before the witnesses begin. I might bring them up then.

Mr. HYDE. Very well. I trust there are no other opening statements, because we have a full panel, and if anyone has something they wish to say, we can put it in the record by unanimous consent.

Good morning, Mr. Scott.

Mr. SCOTT. Good morning.

Mr. HYDE. We have a very distinguished panel of Members of Congress before us today. One of the Congressmen who is to testify, John Porter, has not arrived as yet. No, that is not John Porter. Whoever did that just got a copy of his testimony, that is all.

In any event, John Porter is from Illinois, and he is the principal sponsor of the Volunteer Protection Act, H.R. 911, which he has introduced in many Congresses. His bill has now over 200 cosponsors, an indication of his hard work and dedication on the issue of protecting volunteers.

We also are pleased to have with us a gentleman who is here, Congressman Dave Weldon from Florida, who as a practicing physician is very knowledgeable about both the liability and the antitrust problems faced by doctors.

We look forward to hearing the views of these two distinguished Members on these subjects. Because we have a large number of witnesses today, I would ask that members of this committee refrain from questioning our congressional panel, and note that members will have the opportunity to question the witnesses on the remaining panel.

So the Chair is delighted to recognize the Honorable Dave Weldon, a Member of Congress. Dave.

STATEMENT OF HON. DAVE WELDON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. WELDON. Thank you, Mr. Chairman. It is a pleasure to be here, and to be a lead sponsor of the Antitrust Health Care Advancement Act of 1996. As a physician who has and was involved in trying to form a provider-sponsored network, I am very much aware of the hurdles that providers face when attempting to set up these networks.

One may ask, why do we want to establish provider networks? I believe it is because it is good for patients and it is good for our communities. We wanted to establish a provider-sponsored managed care system that was based on patient needs. We wanted to make health insurance less expensive for the individuals and businesses in our community.

We live in the same community where we practice. Our patients are our neighbors. They are our friends. They play with our children. They go to the same churches we go to. We, therefore, have a vested interest in making sure that these businesses in our com-

munity are able to have access to quality health care at a reasonable cost so that they can be competitive in the emerging global marketplace.

Today, we have corporations making decisions about health care for folks in our communities based on annual reports or profit decisions. If I were a patient, I would rather that decisions about my health care be made by someone in my own community rather than in a corporate office in another State.

Passage of antitrust relief is essential if we are to allow provider groups to compete with insurance companies. This competition will give patients more choices and, I believe, bring the price of health care down. Such networks will enhance the free market, increase competition and make health care more affordable, and allow more people to be covered with health insurance. It is also good for patients and providers, because decisions can be based on what is good for the patient, not what an insurance company or a third party tells us we must do.

When my medical colleagues and I began working to establish a network in our community, we discovered we had significant hurdles.

In the late 1980's and early 1990's, our community, as many other communities in the Nation, experienced significant health care inflation. We decided that we would try to get together to see how we could work to develop managed care provider delivery systems that would help our businesses be more competitive. I canceled some of my patients to go to such a meeting, to sit down with other providers in our community, and the discussion was led off by legal counsel that told us that basically we could not discuss anything that relates to costs, sales, overhead, profit margin, marketing, et cetera.

Indeed, we were actually told that even though we were together in the room for the purpose of developing a system that would reduce costs and save money for businesses in our community, that the very act of discussing it would be construed by the Justice Department as collusion. Indeed, we were told that we would be guilty until proven innocent.

The net result of all of this was that no provider networks were developed in the community that I practice in. This is the Melbourne-Palm Bay area, the south end of Brevard County, FL, a population of about 200,000 people. What has emerged over the past 5 years is, two of the largest medical groups in the community have slowly, in a very, very expensive and arduous fashion, pursued a path of merger and acquisition with other smaller groups in the community so that they could some day be able to engage in managed care delivery systems.

This, to me, is the problem with the climate the way it exists today, and why I think legislation such as that which we have proposed is very much needed. I think it will enhance quality and it will enhance competition, specifically global competition. We are involved in a global marketplace, and for our businesses and our communities to be competitive, they need to be able to provide health care to their employees at a reasonable cost.

Finally, in closing, I would just like to mention briefly the Volunteer Protection Act. I very much support this legislation. I have en-

gaged in volunteer work as a physician. After the hurricane that hit south Florida, Hurricane Andrew, I went into this devastated area to provide health care to the victims of that disaster. I believe more physicians and more health care providers would have gotten involved if we had this type of legislation to protect providers engaging in volunteer work.

Again, I thank you, Mr. Chairman and members of the committee. I apologize for not being able to stay for questions, but I very much support these efforts you are pursuing. Thank you.

Mr. HYDE. Thank you, Congressman Weldon. I might note for the record you have been one of the moving forces on the antitrust legislation, for which I am personally grateful.

Mr. WELDON. Thank you. Thank you very much.

Mr. HYDE. The distinguished gentleman from Illinois is here, and we already have introduced you appropriately, John. So, if you will, provide us with your statement.

STATEMENT OF HON. JOHN EDWARD PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. PORTER. Mr. Chairman, let me say first how very appreciative I am of the fact that you are holding this hearing and allowing me to testify on the Volunteer Protection Act. It is legislation that has been introduced in the last five Congresses. In each one of them it has had about half of the House of Representatives as cosponsors, and yet it has never received a hearing prior to this time. I can't tell you how much I appreciate the opportunity to testify this morning.

This country, like no other country on earth perhaps, depends upon volunteers for much of what it does. If we shut down volunteer activities in America, our economy, our society would shut down also. It is a tremendously important area and it is particularly important, Mr. Chairman and members of the committee, in regard to health care in our country. Many of our hospitals are manned by women and men who volunteer to help. Much of our health care services depend upon volunteers, and it is an area where we have to continue to encourage people to come forward and serve in a volunteer capacity.

Is there a problem in this society regarding volunteers' willingness to come forward? I think the answer to that is, definitely there is. I am talking not only about direct service volunteers, people who are on the ground and doing the work that is needed to be done, but I am talking about the willingness of people who come forward also to serve as members of boards of directors of volunteer organizations all across our country.

What is the problem? They fear in this overly litigious society of ours that they will end up being named as a defendant in a lawsuit. In fact, volunteer directors and direct service volunteers are named often in lawsuits. It is not that recoveries are often taken against them, Mr. Chairman. It is the fact that they have to hire an attorney and defend themselves through at least a portion of that litigation, and that does have a very chilling effect upon the willingness of people to come forward and offer their services as volunteers. We need them to continue to come forward.

I proposed legislation in 1986, and in each Congress since that time, a very simple bill called the Volunteer Protection Act. It has in each Congress had the designation of H.R. 911. It was an emergency 10 years ago, Mr. Chairman. It is still an emergency.

It would recognize, as we do, that tort law is primarily the province of our States and not the Federal Government. It would encourage the States to take action to provide volunteers immunity from most lawsuits, and leave the organization for which they are providing their volunteer activities the liability in each case, so that any volunteer acting within the scope of their volunteer activities and not in a willful and wanton manner would be exempt from tort liability. The organization for which they are volunteering would remain liable. States are encouraged to enact a volunteer protection law, the incentive, originally a stick and later a carrot, is a small adjustment in the amount of money that they would receive from the social services block grant.

As I said before, Mr. Chairman, the supporters of this legislation are very strong. A number of members of this committee are themselves cosponsors of this legislation. In this Congress we already have 204 cosponsors, almost half the House, and I have to say that this legislation is supported by practically every volunteer organization in America. From the Girl Scouts and Boy Scouts to the American Association of University Women to the Red Cross, you can name practically any organization in America, they have been and are very, very strong supporters of this legislation.

I would commend it to this committee. You are in the process of looking at the liability question, particularly on the medical side, but I believe that this broader issue of volunteer liability is a very, very important one to our country and can easily be addressed by encouragements in the law for the States to take action. Many of the States, I might say, since we introduced the legislation, have already taken action in this area, although often it is spotty.

Mr. Chairman, I would suggest that this committee can, by including this legislation, encourage States to do the right thing and protect volunteers, keeping them coming forward and offering their services to our society, as we must have them.

[The prepared statement of Mr. Porter follows:]

PREPARED STATEMENT OF HON. JOHN EDWARD PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. Chairman, I thank you for the opportunity to testify on behalf of America's volunteers. Over 90 million Americans devote their time and energy to our community organizations, our hospitals and nursing homes, and our local governments. The talents of these individuals are absolutely vital to American society. Without volunteers' dedication and commitment to service, many of our nation's educational, health care, and social service needs would go unmet. I believe that the spirit of altruism should be encouraged, and it is my hope that every American would be motivated to engage in community service.

Unfortunately, in this litigious age, volunteers and the organizations they serve face liability problems. One of the most widely reported horror stories involved Little League coaches in Runnymeade, New Jersey, who were sued when a fly ball injured a young player in the outfield. The central allegation in the cause of action was that the boy was a born infielder, not an outfielder, and the coaches knew it. This case was settled for $125,000. A few highly publicized cases, such as this one, has forced individuals to weigh liability risks against their desire to serve.

However, direct service volunteers, like Little League coaches or Red Cross nurses, are not the only ones being drawn into litigation. More common, perhaps, are suits against volunteers serving on boards of directors of non-profit organiza-

tions. Frequently, charitable organizations will seek out established and esteemed members of the community to serve on their boards. Such individuals help to lend visibility to the good works of the charity and, quite frankly, can be very helpful in the fundraising so vital to any non-profit organization. As a result, however, they are also easy targets for a lawsuit.

More serious perhaps than these individual suits and the problems they have created for the particular defendants involved, is the public perception of volunteering as a risky undertaking. Even though volunteers have not been sued successfully in large numbers, volunteers have been named in many lawsuits and the costs of legal defense can be staggering. This fear of lawsuits has affected volunteer programs nationwide by discouraging individuals from coming forward to pledge their time for good causes.

Our nation is becoming increasingly dependent on volunteer services. As our government becomes more streamlined, many of our nation's needs must be met be private citizens. Unfortunately, many would-be volunteers are simply turning away. Our society needs volunteers too desperately to allow this to continue.

In 1986 I introduced legislation which would encourage states to enact laws to provide civil liability immunity for individual volunteers except in extraordinary circumstances. I have reintroduced my bill, the Volunteer Protection Act (with the signature bill number H.R. 911), in each subsequent Congress. My bill would prevent the individual volunteer, whether board member or direct service volunteer, from being forced to defend him or herself for liability action related to their unpaid service to any not-for-profit organization.

H.R. 911 outlines a model law and provides states with the guidelines for effective volunteer protection laws. Under my legislation, states may require volunteer organizations to undertake "risk management" training or procedures, may stipulate that the protection does not apply to anyone driving a vehicle, and they may require that qualifying organizations demonstrate sufficient assets or insurance to compensate an injured person. However, the individual volunteer, acting in good faith, would not be liable.

To encourage these reforms, after a state has enacted volunteer protection measures outlined in H.R. 911, it would qualify for a one percent increase in the Social Services Block Grant funding it receives.

Of course, volunteer protection does not provide immunity to drunk drivers and other bad actors. Volunteers who behave willfully or wantonly would continue to be held liable for their misdeeds. Only "simple negligence" is protected.

It is also important to remember that the organization utilizing the volunteer would continue to be held liable. Legal action would be channeled away from the individual to the organization. The not-for-profit organization would be encouraged to behave in a safe and careful manner because it would remain responsible for its conduct.

Over the years, the Volunteer Protection Act has gained widespread support from hundreds of non-profit and volunteer dependent organizations, including those as diverse as the Big Brothers/Big Sisters of America, the American Red Cross, the General Federation of Womens' Clubs, and the Air Force Association. The level of attention received by the legislation has also helped to promote state action on volunteer protection laws in 36 states. In the last four Congresses, it has enjoyed the bipartisan support of over 200 Members of Congress.

The advancement of volunteer protection statutes is a goal shared by hundreds of nonprofit and volunteer-dependent organizations. Volunteers are central to our way of life, and they must be encouraged, not deterred from their devotion to service. I do not pretend to believe that H.R. 911 will solve the liability crisis, but I do believe that it will encourage Americans to continue volunteering and will assure them that they can do so without the fear of ending up in court.

Mr. HYDE. Well, I thank the gentleman for his helpful testimony. I might suggest you contact the Governor of Tennessee, Don Sundquist. A letter from him supporting your bill would be helpful because that is the Volunteer State.

Mr. PORTER. Gee, I never thought of that.

Mr. HYDE. Thank you. Thank you, Congressman Weldon and Congressman Porter.

Mr. HYDE. Our next witness is Chairman Robert Pitofsky of the Federal Trade Commission. This is Chairman Pitofsky's first appearance as a witness before the Judiciary Committee since he was

appointed Chairman of the FTC, and we are very honored to have him.

Chairman Pitofsky previously served as a Commissioner of the FTC from 1978 to 1981. Prior to that, he served as the first Director of the Bureau of Consumer Protection. A former professor at the Georgetown University Law Center, Chairman Pitofsky, taught, among other subjects, antitrust law. Later, he became dean of the Georgetown Law Center. He has also written extensively on trade regulation and antitrust law, and has been a member of the council of the Antitrust Section of the American Bar Association.

We are very pleased to have Chairman Pitofsky with us today, and look forward to hearing his testimony.

Chairman Pitofsky.

Mr. CONYERS. Mr. Chairman.

Mr. HYDE. The gentleman from Michigan.

Mr. CONYERS. Thank you. Pardon the interruption, but I did have a few comments before the Chairman began that I would like to put in the record.

Mr. HYDE. By all means.

Mr. CONYERS. If you, Mr. Chairman, would allow me to intrude.

This has been a very good meeting so far. We are all in good humor, and this is an important subject matter. It is my responsibility here to bring up a little bit of recent history about how these measures came before the Judiciary Committee at this point in time.

The New York Times, on October 15 of last year, gave us a clue. Since I only have a few minutes, I will just quote a couple of operative sentences that have put me on alert, and maybe it will put you as well on some kind of awareness as to what might be going on here.

"The Speaker of the House brought the American Medical Association behind his Medicare reform program last week by handing out three concessions, and they regret it very much. The first was a concession to soften proposed cuts in fees that doctors can charge for patients to stay in fee-for-service. The second was an agreement extracted to ease antitrust laws for the ostensible purpose of permitting doctors and hospitals to create their own health plans in competition with traditional insurance companies. And the final concession was to cap malpractice awards at ridiculously low levels."

This is not from the Democratic National Committee. This is from the New York Times editorial dated October 15.

Another point you might want to be aware of, especially after our good friend John Porter, who has the enormous respect of the Members of Congress, is that these volunteer liability proposals constitute an effort to unilaterally federalize an area of law traditionally left to the States, a rather curious notion coming from the members of the party that have dumped more States rights nonsense on this Judiciary Committee in the 104th Congress than any time in my career here.

So with that alert, I would like to have this hearing go on, because as far as the antitrust proposal is concerned, it represents to me—and I am here for the hearing, so I am open to being persuaded—a classic solution in search of a problem.

Now, most doctors know that they are fully authorized under the existing antitrust laws to join together to compete against HMO's and PPO's. All they need to do is show that their combination allows for some form of economic efficiency. The Department of Justice and, indeed, the FTC have also laid out special guidelines to clarify the antitrust treatment of physician joint ventures, and have even offered to preclear any proposed arrangement to the extent that there is lingering uncertainty.

Ladies and gentlemen, this problem, I think, is in the process of being resolved even as we meet.

Finally, a word on the malpractice proposals, because they are a clear effort to placate the medical special interests at the expense of the American people. Caps on damages and other limitations on plaintiffs' rights will do little more than shift accountability from those few medical providers who are negligent, and there aren't many, but to shift the accountability from them to innocent victims is a little bit disturbing to me this morning.

So I thank you, Mr. Chairman, for allowing me to make these few observations, and I would like to welcome those people that are here in the audience that are apparently people concerned about this subject matter because they may have been inappropriately involved in it at one time or the other.

I thank the Chair.

Mr. HYDE. Well, I thank the gentleman for his always illuminating comment. I just would say that I would hope he would go recheck the Porter bill. He would find that it provides incentives for the States to change their laws. It is not an imposition on the States. So I just—I hesitate to correct the gentleman.

Mr. CONYERS. Well, you should, because they provide cash payments and you are not entirely correct. Or do we want to have a debate between ourselves—want to have it——

Mr. HYDE. Cash payments as incentives between the States to change their laws.

Mr. CONYERS. Why don't we hear the witnesses. I know you are a very good instructor in this subject.

Mr. HYDE. Well, I just want to correct erroneous statements made even by the distinguished gentleman from Michigan.

Mr. CONYERS. Well, we are going to have a busy 2 days, I will tell you that.

Mr. HYDE. I have had a busy lifetime doing that.

The Chairman of the Federal Trade Commission.

STATEMENT OF ROBERT PITOFSKY, CHAIRMAN, FEDERAL TRADE COMMISSION

Mr. PITOFSKY. Mr. Chairman, members of the committee, thank you very much. I am delighted to be here and have this opportunity to testify, on behalf of the Federal Trade Commission, on the application of the antitrust laws to the health care market. I will try to summarize my testimony briefly this morning.

The occasion for the hearing is H.R. 2925, a bill that would extend rule of reason treatment, and by that we mean more generous, more extended analysis, to certain types of physician networks by which doctors get together to market their services in the health care market.

Let me start by saying that we agree with the goals of this legislation. Specifically, we accept that there may be a wider range of physician joint ventures that are efficient and that pass along their benefits to consumers and, therefore, deserve more extended antitrust treatment. The question, then, is not whether the law deserves to be clarified but how it ought to be done and what timing ought to apply.

While the bill is carefully drafted and narrowly focused, as the chairman said, we believe, for reasons that I will come to later this morning, that this legislation is not the right way to go.

Let me try to establish some background facts about this issue and then discuss the merits of the legislation. Antitrust, over a long period of time, most people would say antitrust enforcement has been very successful in preserving the ability of new forms of health care systems to come into existence. Professor Havighurst will testify tomorrow. He refers to the antitrust role in the health care market as one of its greatest triumphs.

I should say immediately that the goal of the antitrust laws, the appropriate role, is not to decide what kind of health care system is adopted but, rather, to preserve the opportunity of health care systems to play a role in the market. We do not want to drive the health care market in one way or the other. We want to keep it open.

However, when arrangements arise that are highly anticompetitive and have no redeeming virtues, and I have in mind particularly price-fixing arrangements, we condemn those as illegal per se. We don't stop to examine purpose or power or effect. In doing so, incidentally, we are treating doctors and doctor networks the same way we treat all the rest of the American economy where price fixing is involved.

The issue addressed by the legislation has to do with an exception to this per se, that is this tough rule, against price fixing. If price fixing occurs through a network and if the network is integrated, that is, it is knit together in a way that provides efficiencies likely to be to the advantage of consumers, that avoids per se treatment and we move over to this more extended, more generous rule of reason.

The Federal Trade Commission and the Department of Justice, recognizing this distinction, have put out guidelines several times, first in 1993, then in 1994, in which we tried to indicate to those organizing doctor networks which kinds of networks would escape this abbreviated per se treatment. We said in these guidelines that if the network is financially integrated, that is to say if the doctors share risk which leads to cost containment, or if the network produces a new product that would not exist in the marketplace but for the network, that avoids per se treatment and brings the arrangement over to a rule of reason.

Incidentally, in adopting that approach, the agencies didn't make it up. The approach reflects language in a leading Supreme Court opinion on the subject, the *Maricopa* case, and we are tracking the *Maricopa* decision.

But the agencies also were clear in both of these guidelines that these were not necessarily the only ways to escape per se treatment. There might, the guidelines said, be all sorts of other effi-

ciencies that one might want to take into account, particularly in light of the fact that health care is such a dynamic market. Buyer organizations are changing. Insurance arrangements are changing. Provider organizations are changing. So we said all along there could be other ways to escape this more drastic antitrust treatment.

The issue today, and the issue addressed by the proposed bill, is what is this wider range of efficiencies that would justify more lenient treatment? Recognizing that the market is dynamic, the Federal Trade Commission's Bureau of Competition announced late last year an effort to gather information from all the players in this market, from self-insurers, employers, buyer coalitions, providers, and so forth. We started down the road of asking them, what are these other efficiencies? What are these other justifications for doctor networks?

I should add that I have met with many of the players in this market myself, with the AMA, with representatives of insurance coalitions and others. We also tried to involve the States in our review of this, and there is a task force now, Department of Justice, Federal Trade Commission and State AG's, that is looking at the very question that the legislation addresses. I believe in a matter of months we will be able to revisit our guidelines, perhaps clarify them, and come up with an answer to the question of whether there is this wider range of efficiencies sufficient to avoid per se treatment.

I can't speak for the Commission this morning, we haven't completed our analysis of this question. But my own personal view is it is highly likely that a wider range of efficiencies will justify rule of reason treatment.

Given that background, one might ask, why not support the bill, since that is what the bill is looking toward? I think there are many reasons why it would be better to allow us to continue our process of clarifying our guidelines—remember, the guidelines all along said other efficiencies might be relevant—rather than address this problem through legislation.

What the legislation does to set up a series of factors and provides, if a physician network satisfies these various factors, then it is entitled to rule of reason treatment. The factors include whether the doctors are funding the network, whether or not there is contract administration, whether there is quality of care control, and whether there is utilization review by the network; very reasonable factors. One would expect that an integrated, efficient network would have some or all of these factors involved.

Nevertheless, I think the legislation has problems to it. First of all, one could probably satisfy every one of the factors in the legislation and nevertheless set up a network that is primarily designed to raise prices to consumers and to exclude new forms of care.

Partial funding, well, I could set up a physician network in which the funding consists of just about enough money to run the cartel, to run the price-fixing conspiracy. Quality of care and utilization review, that could be done once a year at the end of the year, just to satisfy the legislation. In other words, there is a qualitative aspect to all of this. It is not just that the participants contribute

some money, but what is the money used for? How is it used? How is the network integrated with these capital contributions?

Second, and perhaps more important, this is an extremely dynamic market, in my experience one of the most fast-changing markets I have ever seen. One of the problems with the legislation is, it is going to set up a box; that is, a list of factions, and it is going to say to physicians, "Now, look, if you can manage to get inside the box, we are going to give you more lenient, more generous, more flexible treatment." The result of that is that networks will be designed to fall within the box; that is, satisfy the faction, rather than designed to serve patients, to serve the health care market to the best extent possible.

If we do it by guidelines, the guidelines are adjustable on fairly short notice. We have already adjusted the guidelines once and we are in the process of doing so again, whereas legislation is more difficult to adjust. So my suggestion would be to allow the guideline process to proceed rather than to create what I think might be an artificial set of factors that networks will try to satisfy.

Also, I would point out to the committee that a bill like this which specifies which behavior, which joint ventures should be treated under the per se rule and the more lenient rule of reason approach, is almost unprecedented in 105 years of Sherman Act enforcement. The only example I can think of, of Congress telling the enforcement agencies and the courts when the per se rule is inappropriate, is in the joint research venture statute passed about 10 years ago. Even that statute backed away from allowing rule of reason treatment where price fixing was involved.

So to the extent that this bill covers the negotiation of prices by doctors, it would be unprecedented in 105 years. Generally speaking, the per se rule and the rule of reason construct is judge-made, and Congress has left it to the enforcement agencies and judges to deal with this question.

Finally, I would mention briefly that, as is always the case with legislation, there are some questions that arise as to what the terms mean. One example is, the legislation says that under a rule of reason all factors in a properly defined relative market would have to be considered.

The Supreme Court has directed us to back away from this "all factors" approach and, rather, move toward what they call a truncated or abbreviated rule of reason. I doubt this is the intent of the legislation, but the strict language of the legislation might be read to back away from that trend in the Supreme Court, in the direction of narrower, more focused rule of reason treatment.

Let me conclude by saying this: It seems to me there are two possibilities here. One is to let the agencies complete their review, their clarification, come up with what may well be revised guidelines, submit them to the committee, make them public. If the thought is that the adjustment is not adequate, the committee can then consider legislation. We can do that in a matter of months. We started several months ago and we are roughly halfway or a third of the way through the process.

The alternative is to pass the legislation and then, as the legislation provides give us 6 months to write guidelines. But the disadvantage of that is that once the legislation is there, we are boxed

in with respect to the kind of guidelines we can write. I therefore would urge the committee and the Congress to allow us to complete our review and our clarification process.

Thank you very much.

Mr. HYDE. Thank you, Chairman Pitofsky.

[The prepared statement of Mr. Pitofsky follows:]

PREPARED STATEMENT OF ROBERT PITOFSKY, CHAIRMAN, FEDERAL TRADE COMMISSION

Mr. Chairman and members of the Committee, I am pleased to appear before you today to present the testimony of the Federal Trade Commission concerning H.R. 2925, and the application of the antitrust laws to health care provider networks.[1] This testimony will discuss what the Commission believes to be the proper role of antitrust law enforcement in the health care area, and how antitrust enforcement has been vital to maintaining competitive health care markets. It will also discuss the steps we have taken and will continue to take under existing law to assure that antitrust analysis appropriately addresses the rapid changes that characterize health care markets today, and surely will in the future. It will then offer some observations on the proposed legislation under consideration by the Committee.

Introduction

We think you will find many areas of agreement between the Commission and the other witnesses who will testify today concerning the issues that are being considered by this Committee. Clearly, health care markets are undergoing rapid and far-reaching changes. New methods of coordinating the delivery and financing of health care services are emerging and competing for consumer acceptance. Health plans developed and controlled by providers of health care services can offer attractive options for consumers. Indeed, many such plans currently are operating

[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

in the market, and are doing so successfully, in conformity with current understandings of the requirements of antitrust law.

Nonetheless, the Commission agrees with the goal of this legislation: to assure that antitrust law does not impose unnecessary burdens on the development or operation of provider-directed plans that may have significant procompetitive potential.

In the past, cases brought by the Commission have declared illegal without extended review some physician networks that had a direct and substantial effect on price but lacked compensating consumer benefits that occur when there is financial integration. In adopting that position in two sets of guidelines issued jointly by the Commission and the Department of Justice and in numerous enforcement actions and advisory opinions, we indicated that other forms of efficiency might justify avoidance of per se rules in appropriate circumstances. Beginning several months ago, we initiated a review to determine whether there now are such efficiencies other than financial integration that justify rule of reason treatment. The Commission staff is actively engaged in discussions with all segments of the health care industry to continue to inform and update our antitrust analysis.

We believe it would be advisable to allow us to complete that review rather than enact H.R. 2925. A legislative directive as to what price related conduct deserves per se versus rule of reason treatment would be almost unprecedented, might allow certain clearly anticompetitive behavior to escape per se

treatment, and would rigidify the development of physician networks in the sense that organizers would seek to establish networks that fall within the technical requirements of the legislation rather than those networks that insure maximum patient benefit. Indeed, the legislation could create the same chilling effect on new forms of provider networks that some say has resulted from the current guidelines -- forcing new provider arrangements into inflexible categories.

The Commission, in consultation with the Department of Justice, plans to make further guidance available to the health care industry and to this Committee at the conclusion of our own review which will be within a matter of months.

The Role of Antitrust

A key function of the antitrust laws in the operation of health care markets is to keep those markets open and competitive, so that new ways of delivering and financing health care services can compete for acceptance by purchasers. Because the development of these new arrangements depends on vigorous competition among market participants -- including providers, insurers, and others -- it is important to prevent price fixing and market allocation agreements among competitors that are not reasonably related to cooperative activity that can produce countervailing advantages to consumers.

Over the past two decades, federal antitrust enforcement has succeeded exceptionally well in facilitating the emergence of new and more efficient health care delivery systems by vigorously challenging anticompetitive efforts by health care providers to impede those innovations. This enforcement activity has been one crucial factor in the emergence of vigorous competition among health plans for the patronage of consumers and employers. The prospect of effective antitrust enforcement remains critical to the ability of the marketplace to develop better methods of responding to the demand for high-quality and cost-effective health care services. Let me emphasize that it is not the Commission's role -- and neither is it our desire -- to drive market developments in any particular direction. Rather, our goal is to deter private restraints that limit the range of options available, or raise prices, to consumers.

Although health care markets have changed dramatically, collective action by health care providers to obstruct cost-containment efforts by purchasers unfortunately remains a significant threat to consumers. In the past five years, the Commission, the Department of Justice, and state attorneys general have brought numerous enforcement actions challenging price fixing and boycotts by groups of physicians or other providers that banded together to resist innovative efforts at cost-conscious purchasing.[2] When this kind of egregiously

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[2] See, e.g., Southbank IPA, 114 F.T.C. 783 (1991) (consent order); Trauma Associates of North Broward, Inc., C-3541 (continued...)

anticompetitive conduct is uncovered, antitrust enforcers have been able to condemn it quickly. These groups have often portrayed themselves as "networks," "independent practice associations," or other such potentially procompetitive ventures (even including utilization review or quality assurance programs) -- but in fact often have turned out to be nothing but sham efforts to forestall or undermine new forms of health care.

For example, last year the Commission entered into a consent agreement settling charges that a group of physicians in Danville, Virginia agreed on reimbursement rates and other terms of dealing with third-party payers, agreed to boycott payers that did not meet those terms, and thereby succeeded in preventing any managed care plan from entering the area.[3] While the group held itself out as a network, the facts uncovered by the Commission's investigation indicated -- and the Commission's complaint alleged -- that the group was formed in order to block the entry of managed care. The Commonwealth of Virginia, whose state employee health plan was a victim of the boycott, entered into a joint

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[2](...continued)
(FTC consent order), 59 Fed. Reg. 63,805 (December 9, 1994); Puerto Rican Physiatrists (La Associacion Medica de Puerto Rico), C-3583 (FTC consent order), 60 Fed. Reg. 35,907 (July 12, 1995); Physicians Group, Inc., C-3610 (FTC consent order), 60 Fed. Reg. 25,223 (May 11, 1995) (final order issued August 11, 1995); U.S. v. Health Choice of Northwest Missouri, Inc., No. 95-6171-CV-SJ-6 (W.D. Mo. filed September 13, 1995); U.S. and State of Connecticut v. Healthcare Partners, Inc., No. 395CV01946RNC (D. Conn. filed September 13, 1995); U.S. v. Classic Care Network, Inc., 1995-1 Trade Cas. (CCH) ¶ 70,997 (E.D.N.Y. 1995); Commonwealth of Virginia v. Physicians Group, Inc., No. 95-0015-D (W.D Va. filed May 16, 1995).

[3] Physicians Group, Inc. C-3610, supra note 2.

investigation with FTC staff, and collected money damages for the harm to its employee health plan.[4]

Similarly, the Commission in 1994 challenged a group of surgeons in Broward County, Florida, who held themselves out as a corporation offering hospitals a host of services, including quality assurance and utilization review. But, as alleged in the Commission's complaint, the group was found to be nothing more than a vehicle for the surgeons collectively to set the price of their services. These surgeons provided trauma services in the emergency rooms of two hospitals for some time, but when the hospitals refused to accede to all of the terms they demanded, the surgeons collectively refused to deal with the hospitals. Although the group consisted of only fourteen surgeons, the walkout forced one of the hospitals to close its trauma center for a period of months, denying patients in the area access to these important lifesaving services.[5]

The Role of the Agencies in Providing Guidance

Beyond our role as enforcers of the antitrust laws, the Commission and the Department of Justice have long recognized the importance of providing antitrust guidance to the healthcare industry in order to facilitate competition in the market. Because of the dynamic nature of this industry, we have made

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[4] Commonwealth v. Physicians Group, Inc., supra note 2.

[5] Trauma Associates of North Broward, Inc., C-3541, supra note 2.

unprecedented efforts to provide meaningful guidance in healthcare. Indeed, we have provided more guidance in a wider variety of forms to the healthcare industry than to any other. For example, in 1993, after months of careful study and consultation with industry representatives, the agencies issued a set of six policy statements concerning a variety of cooperative activities of concern to healthcare providers.[6] At that time, the agencies also promised that they would respond to requests for advisory opinions or business review letters concerning matters addressed by the guidelines, as well as other healthcare issues, within strict time deadlines.

While the initial healthcare guidelines were widely praised as an important first step, feedback from a variety of sources indicated a need for more detailed guidance in some of the guideline areas, as well as for guidance in additional areas. Within a year, the agencies responded with a new, expanded, set of guidelines. The 1994 Guidelines,[7] which were significantly more extensive than the initial set, addressed several additional

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[6] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in the Health Care Area, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (September 15, 1993). These policy statements addressed: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.

[7] U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152 (September 27, 1994).

areas of concern to the healthcare industry, provided a more comprehensive explanation of how the agencies apply antitrust standards and analyze cooperative arrangements under the law, and provided numerous detailed examples concerning a variety of factual situations to demonstrate how the antitrust laws would apply. Provider networks were the subject receiving -- by far -- the most extensive elaboration and additional guidance in the revised Guidelines.

The 1994 Guidelines' treatment of potential collaboration among providers in rural areas shows how the enforcement agencies' antitrust analysis adapts to existing market conditions. Because of the scarcity of many types of providers in most rural areas, collaboration may require the participation of a proportion of competing providers that would raise serious questions in other geographic markets. Several examples in the Guidelines illustrate how antitrust analysis takes account of competitive conditions such as the need for a certain level of provider participation in order for a joint venture to operate efficiently. For example, the discussion of physician network joint ventures indicates that a hypothetical independent practice association including more than half of the general practitioners and all of the specialists practicing in a rural area would be acceptable under the facts set forth in the example.[8] Similarly, the discussion of other types of provider

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[8] 1994 Guidelines at 81-84 (4 Trade Reg. Rep. (CCH), at pp. 20,791-92).

collaboration indicates that a hypothetical joint venture among the only two hospitals in a rural area for the operation of expensive medical equipment, or for the joint operation of a specialized clinical service, would be permissible in the circumstances described.[9]

We also have actively met the industry's individual requests for guidance in specific factual situations. Since the Guidelines were issued in 1993, both the Commission staff and the Department of Justice have issued a large number of letters approving physician network joint ventures. The Commission staff issued 11 favorable opinions during that period, while the Department of Justice issued 18 business review letters approving proposed provider networks. Commission staff has issued only one letter that failed to approve a proposed network.

Despite the agencies' favorable treatment of most provider-sponsored networks, we appreciate that the proposed legislation and these hearings grew out of a concern that the Guidelines are too restrictive in their treatment of such networks. Chairman Hyde's statement introducing this legislation clearly underscores the point. The Commission is giving this issue serious attention in ways that will presently be described. It is important, however, to put those concerns in perspective.

First, many provider-controlled managed care plans are operating right now in the marketplace. Industry statistics

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[9] Id., at 29-33 (4 Trade Reg. Rep. (CCH), at pp. 20,778-79, 20,781).

indicate that 20% of all preferred provider organizations (PPOs) and 15% of all health maintenance organizations are provider-owned.[10] A 1994 survey showed 9.31 million people were enrolled in provider-owned PPOs.[11] Many other provider-sponsored managed care plans are being developed or planned. For example, press reports indicate that "three-fourths of state medical societies are either contemplating or are actually in the process of establishing physician-sponsored networks."[12]

Indeed, various knowledgeable observers have concluded that the antitrust laws cannot be said to have interfered significantly with the development of efficient physician-directed plans. For example, the American College of Physicians and the Physician Payment Review Commission have each issued recent reports that examined criticism of antitrust law and concluded that the evidence did not support the charge that provider-sponsored plans were being prevented from forming under current law.[13]

Second, those expressing concerns about the federal antitrust agencies' healthcare Guidelines have not criticized the cases that the agencies have brought. The enforcement actions

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[10] American Medical News, November 6, 1995, p. 30.

[11] Modern Healthcare, May 1, 1995, p. 41.

[12] See press reports cited in Physician Payment Review Commission, Annual Report to Congress, p. 295 (1995).

[13] See, e.g., American College of Physicians, Physician-Run Health Plans and Antitrust 16-17 (1995); Physician Payment Review Commission, Annual Report to Congress (1995).

relating to provider networks have been predicated on the presence of clearly anticompetitive conduct, not a rigid application of the per se rule. These actions demonstrate the critical importance of continuing active enforcement of the antitrust laws in health care markets in order to ensure that consumers enjoy the benefits that competition can offer.

Application of Antitrust Law to Provider Networks

The central inquiry of antitrust analysis is to understand the likely competitive effects of particular conduct. In the century since the enactment of the Sherman Act, antitrust jurisprudence has developed a number of analytical tools to guide this inquiry. The fundamental tool is called the rule of reason, under which we examine in a comprehensive fashion the purpose of an activity, the market power of the participants involved, and the likely adverse and beneficial market effects of the conduct, in an effort to reach an overall judgment on the net competitive effects of the activity.

On the basis of judicial experience, however, certain types of conduct have been found to be so inherently detrimental to competition that they are conclusively presumed to restrain competition unreasonably, and are treated as per se violations of the antitrust laws. Price fixing and market allocation agreements among competing sellers, and certain kinds of

boycotts, fall into this category.[14] While the per se rule needs to be applied carefully, in its proper place it continues to play an important role in antitrust enforcement. It sends a strong message to market participants that certain kinds of conduct inherently inimical to competition will not be tolerated. It establishes a bright line for all the parties in predicting the legal consequences of their behavior. In addition, by eliminating the need for proof of market power and actual market effects, the per se rule makes prosecution of such conduct less difficult, time consuming, and expensive.

In recent years, the courts have recognized a type of rule of reason analysis known as the "truncated" or "quick look" approach. In appropriate cases, the courts have been willing to dispense with the need for elaborate proof of market power regarding conduct that, while not traditionally in a per se category, nonetheless has an obvious potential to restrain competition seriously. This type of analysis can be a very important tool in dealing with efficiency arguments in some cases, without the cumbersome and very expensive proceedings that often attend extended rule of reason inquiries.[15]

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[14] See, e.g., *Palmer* v. *B.R.G. of Georgia*, 498 U.S. 46 (1990) (per curiam); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

[15] An example of truncated analysis is FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986), where the Supreme Court found that dentists' collective refusal to submit x-rays to insurers amounted to "[a] concerted and effective effort to withhold (or make more costly) information desired by consumers," id. at 461-62. The Court stated:

(continued...)

The availability of truncated analysis, however, does not diminish the value of the per se rule in defining and deterring clearly anticompetitive conduct. The bright lines established by the per se rule provide greater predictability for market participants than truncated analysis, and thereby help reduce uncertainty about the applicability of antitrust law to certain almost invariably anticompetitive conduct. In addition, because it greatly facilitates prosecution of such conduct, the per se rule is an effective deterrent to activity that is likely to harm consumers.

Even where a provider network's operation has the potential to cause competitive harm, the conduct is not condemned as per se illegal if the restraint on competition is reasonably related ("ancillary") to the attainment of efficiencies by the network. Such situations will be evaluated under the rule of reason, not under the per se rule.

Under the Health Care Antitrust Guidelines issued by the Commission and the Department of Justice, a network joint venture that involves price agreements among otherwise competing health

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[15](...continued)
Application of the Rule of Reason to these facts is not a matter of any great difficulty. . . . [N]o elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement. . . . Absent some countervailing procompetitive virtue -- such as, for example the creation of efficiencies in the operation of the market or the provision of goods and services, . . . such an agreement limiting consumer choice by impeding the ordinary give and take of the market place . . . cannot be sustained under the Rule of Reason." Id. at 459 (citations omitted)(emphasis added).

care providers is subject to rule of reason analysis if it involves the sharing of substantial financial risk among the participants to the venture, or if the venture creates a new product producing substantial efficiencies.[16] While the language of the current Guidelines is broad enough to capture a wide range of efficiencies, the focus of the agencies' analysis has been on financial risk sharing by network participants as a means of distinguishing between cartels and legitimate, potentially procompetitive, joint ventures. Marketplace experience confirms that substantial financial risk-sharing among providers of the type discussed in the Guidelines generally encourages providers to act together to produce efficiencies that can benefit consumers. Capitation and other systems involving financial risk-sharing by providers were developed in response to payers' demands that providers of services assume some responsibility for the total expenditures incurred on behalf of a particular population of patients. These mechanisms provide direct incentives for providers, as a group, to manage the quality, setting, type, and amount of services provided by each individual member of the group in a cost-effective manner. The Guidelines, however, also state that the agencies would consider forms of economic integration that may occur in a network other

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[16] U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust (September 27, 1994) at 71 (4 Trade Reg. Rep. (CCH), at p. 20,788).

than those specifically listed in the Guidelines as types of risk-sharing.[17]

Moreover, one theme that has emerged consistently in our discussion with employers who provide health benefits to their employees is the demand for "accountability" by providers for the quality and cost of services provided. What this means is that employers want value for their money, and they want providers to be able to demonstrate that value. Financial risk sharing is one way to structure a health benefit plan so that it encourages this kind of accountability, but it is not necessarily the only way. Indeed, health care purchasers and providers are experimenting with a variety of creative ways to promote high quality, cost-effective health care. The rapid development of improved systems for gathering, interpreting, and disseminating data about costs, services, quality, and effectiveness of treatments, for example, likely will facilitate the development of new mechanisms for evaluating the effectiveness of care rendered by particular networks or other provider groups.

As our experience with the Guidelines shows, we have been open to information suggesting that other types of arrangements may produce efficiencies that can benefit consumers. We recognize the development of new health care arrangements,

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[17] "In addition, the Agencies will consider other forms of economic integration that amount to the sharing of substantial financial risk; the enumeration of . . . [capitation and fee withholds] is not meant to foreclose the possibility that substantial financial risk can be shared in other ways." Id. at 70 (4 Trade Reg. Rep. (CCH), at p. 20,788).

bringing with them a broader range of potential efficiencies that may justify rule of reason treatment. In response, as mentioned earlier, the Bureau of Competition announced late last year an effort to gather information from many segments of the industry concerning alternative products and the efficiencies that may flow from various types of health care provider networks.[18] Staff members have talked to self-insured employers, buyer coalitions, provider representatives, and other industry participants about a range of issues, including what products buyers seek in the market and the impact of existing interpretations of antitrust law on the availability of those products. This inquiry is designed to support consideration by the Commission and the Department of Justice of any additional guidance that may be appropriate. Such guidance will be most useful to the extent that it has a strong factual grounding based on the actual experience of a broad range of participants in the market.

The proper antitrust analysis of joint ventures has been explored through a variety of efforts. In addition to the aforementioned ongoing process, analysis of joint ventures was one of the topics addressed in the Commission's recently-completed Global Competition hearings. It also is a subject currently being discussed with appropriate state officials. The

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[18] "Antitrust, Medicare Reform and Health Care Competition," Prepared Remarks of Mark D. Whitener, Deputy Director, Bureau of Competition, Federal Trade Commission, Before the American Enterprise Institute for Public Policy Research (December 5, 1995).

states have a vital interest in these matters, both as significant purchasers of health care services and as enforcers of their own antitrust laws, which would be affected by the proposed legislation. We therefore feel it is critical to obtain input from the states on this issue. We think it vital to allow these information gathering and consultation activities that already are underway to proceed over the next few months before further specific guidance is offered.

The Legislation

The legislation being considered by this Committee provides that (1) the sharing among health care providers of information relating to costs, sales, and price, among other things, for the purpose of establishing a health care provider network; and (2) the negotiation and performance of a contract for providing healthcare services under the terms of a health benefit plan, including specifically the establishments of fees, shall not be deemed per se illegal under any state or federal antitrust law. Rather, such conduct would be judged "on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets." Under the proposed legislation, health care provider networks are organizations operated by and composed of providers for the purpose of providing health care services. They exhibit certain characteristics including partial funding by the members of the network, contract administration,

and programs for review of quality, effectiveness, and appropriateness of treatment, and for managing utilization and coordination of care.

While we support the goals of the legislation, the Commission believes that the proposed legislation is not the best way to promote provider networks that will benefit consumers. Formally establishing certain factors in legislation may retard innovation in a rapidly changing market, by driving the market in the direction of plans that meet the statutory test, regardless of whether it makes independent business sense for ventures to be structured this way. While features identified in this bill are likely to be present in an efficient network venture, they may not be sufficient to ensure that efficiencies will be achieved.[19] But more importantly, even if they were sound standards for today's market, they may well fail to measure up in just a few years' time, as health care markets continue their rapid evolution.

Our experience persuades us that health care markets are changing far too quickly to assess the potential efficiencies of provider collaboration on the basis of any single set of fixed criteria. Indeed, Commission staff's ongoing discussions show that industry participants hold divergent views on where the

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[19] For example, the presence of credential review and utilization review programs does not necessarily indicate that the network is designed to promote competition. Some of the Commission's cases involved situations in which such programs merely served as a vehicle to thwart efforts by purchasers to introduce their own standards to achieve quality or cost-reduction goals.

health care industry is headed, and different parts of the country appear tc be developing in significantly different ways. What we can all agree on is that these markets will continue to change rapidly. The Commission believes that meaningful guidance based on current market realities is needed. Such guidance, however, must have sufficient flexibility to accommodate the innovative arrangements that may emerge tomorrow. A legislative solution risks discouraging innovation in a market that needs creative solutions to the challenge of containing health care costs.[20]

In addition, the proposed legislation presents a risk of immediate consumer harm from anticompetitive conduct. Ventures designed to meet the letter of the law, but that in fact are designed to retard rather than to further competition, would

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[20] In another context, this Committee has recognized the problems with enumerating specific criteria for antitrust analysis:

> In 1984, an earlier version of the NCRA had included language attempting to provide increased specificity to the rule of reason provision. Eventually, the Committee withdrew the language because of concerns that such detailed criteria might be incomplete, therefore requiring continual refinement in the future and perhaps creating a negative inference that any factor not listed was inapplicable. . . . . The Committee recognized in 1984, as it does now, that antitrust cases require an economic consideration of highly complex facts, and that appropriate antitrust rules and presumptions evolve gradually as judicial experience with particular types of transactions accumulates. Moreover, each new concept or phrasing of a concept, introduced into a broad statutory standard might itself become the source of extended debate and uncertain application.

House Report on National Cooperative Production Amendments of 1993, H.R. No. 103-94, 103rd Cong., 2nd Sess. 187-88 (1993)

escape per se condemnation. As mentioned earlier, a number of our recent cases have involved sham networks that probably satisfied some of the factors set forth in the legislation. We suspect that such groups could easily have set up an organization that also nominally met the other criteria of H.R. 2925. Thus, the Commission is concerned about the possibility that this legislation may encourage the development of groups that threaten very real harm to competition and offer little or no efficiency benefits.

There are likely to be substantial costs to eliminating the applicability of the per se rule to all groups meeting the criteria in the proposed legislation. The per se prohibition on certain forms of highly anticompetitive conduct -- such as price fixing and market division -- is an important tool for the efficient enforcement of the antitrust laws. Created by the Supreme Court, the per se rule has functioned effectively for over half a century as an instrument of judicial economy that seeks to avoid unnecessary, complex, prolonged, and costly inquiries concerning conduct where the potential harm to competition is clear, and the conduct has, at best, only limited potential to create substantial efficiency benefits for consumers.[21] These categories have evolved through judicial

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[21] Antitrust scholars recognize the importance of the per se rule in the protection of competition. See, e.g., R. Bork, The Antitrust Paradox 267, 269 (1978) ("Price-fixing and market division agreements . . . should be illegal per se when they do not accompany a contract integration or are not capable of contributing to its efficiency." "The per se rule against naked (continued...)

experience, and it has been left to enforcers and judges to adjust them when appropriate.

Legislative directives requiring application of the rule of reason as opposed to per se treatment have been extremely rare. To our knowledge, the only statute that does so is the National Cooperative Research and Production Act, which specifies that rule of reason treatment will be accorded certain types of joint ventures. That law, however, specifically excludes from its coverage pricing agreements involving the marketing of products or services.[22]

We all agree, it would appear, that market-based health care delivery is the most desirable alternative to comprehensive government regulation of health care provision, and that the market model depends upon active competition among delivery systems. Physicians and other health care providers are essential inputs into these competing delivery systems, and competition among providers is a necessary condition of competition among delivery systems. Provider conduct that is highly anticompetitive and does not produce countervailing efficiencies should be subject to swift and effective condemnation.

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[21](...continued)
price-fixing and market division agreements is thus justified not only on economic grounds but also because of the rule's clarity and ease of enforcement.").

[22] 15 U.S.C. § 4301(b)(2). The House Committee Report on the bill specifically noted that the "marketing exclusion" encompassed pricing conduct. H.R. No. 103-94, 103rd Cong., 2nd Sess. 190 (1993).

Conclusion

For the reasons discussed above, the Commission opposes enactment of H.R. 2925. The Commission intends to complete its current inquiry into these issues expeditiously, and to provide additional guidance concerning the application of the antitrust laws to provider networks within less than 6 months.[23] In that process, we will not only clarify the appropriate scope of per se treatment, but will offer additional guidance as to how provider networks will be analyzed under a full or truncated rule of reason. We will of course work with the Department of Justice in this effort. It is our firm belief that this is the way for antitrust policy to evolve and adapt to changing market conditions in health care. Adoption of legislation granting favored status under the antitrust laws to certain kinds of networks risks impeding future innovative responses to market forces that could offer significant benefits to consumers.

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[23] The staff has sought to complete most of its current information gathering project by the end of February, but it will continue to receive information from the public after that time.

Mr. HYDE. The gentleman from Wisconsin, Mr. Sensenbrenner.

Mr. SENSENBRENNER. Mr. Chairman, I would just ask, wouldn't it be better, so that everybody would know what the parameters were, that there be legislation? That way it is set and everybody knows what is in bounds and out of bounds, rather than having your agency and the Antitrust Division of the Justice Department have an evolving case law where you respond to specific complaints or specific instances?

Mr. PITOFSKY. In many areas, sir, I would agree with you. I think this is an exceptional area, and the reason I think guidelines rather than legislation is the better idea—and other witnesses can testify to this after me—is that the health care provider market is changing at such a rapid pace that what we think is efficient and meritorious now is almost certain to change a year from now, 2 years from now, 5 years from now. Therefore, you get the advantage of certainty with respect to legislation, but in this market I think flexibility is more important than certainty.

Mr. SENSENBRENNER. Well, we are going to be around. We can always amend a statute if there is a consensus, but at least there is accountability amongst the people in their elected representatives, and if we make mistakes there are ways to replace us.

Mr. PITOFSKY. I understand, but I do think that guidelines adjusted fairly regularly are a lot easier to manage than legislative amendments.

Mr. SENSENBRENNER. Well, I guess the difference of opinion depends upon which side of the table one sits on here.

Thank you very much, Mr. Chairman.

Mr. HYDE. Thank you.

The gentleman from Michigan.

Mr. CONYERS. Thank you, Mr. Chairman.

I want to welcome Chairman Pitofsky. He has got a large set of responsibilities as mergers go on in America at record pace. I have been urging our Committee on the Judiciary to begin to examine the incredible number of mergers and concentrations and reformations that are going on, and I also urge that your organization do as well, sir.

Have you been looking at that area?

Mr. PITOFSKY. In our antitrust function, it is the majority of what we do. Almost two-thirds of our resources today are devoted to merger review.

Mr. CONYERS. Now, I am not teaching any courses here today, but on the constitutional question there is just a little lingering, nagging notion that I have got to get out here. This legislation appears that it might limit State antitrust laws as well as Federal considerations, and that it might, might, raise a constitutional issue involving the commerce clause, particularly in light of *Lopez*. Your response?

Mr. PITOFSKY. In light of *Lopez?*

Mr. CONYERS. Yes.

Mr. PITOFSKY. Let's see. I have to think about this for a minute. The question is whether or not doctor networks are really in interstate commerce. *Lopez* was the case involving the gun in the schoolyard?

Well, I perhaps ought to come back with a more considered response, but it seems to me that the health care market is sufficiently connected to interstate commerce, in terms of the purchase of equipment, in terms of the integration of doctor networks with hospitals and with other networks. I would be surprised if the courts were to conclude that doctor networks—except in very unusual circumstances, there might be unusual circumstances—but ordinarily I would think that they are in interstate commerce in a way that the record in the *Lopez* case could not demonstrate.

Mr. CONYERS. Thank you. How would paring back the per se rule of antitrust liability impact on the ability of the FTC to challenge price fixing and other anticompetitive activity by health care providers?

Mr. PITOFSKY. It would be a problem for us. It would be a problem. The idea of the per se rule is when you review a transaction that is highly anticompetitive, that is to say it fixes or raises prices to patients with no justification at all, the idea of the per se rule—and this has been true for 60 years and it is true throughout our economy—is that we can handle those cases expeditiously.

Antitrust, unfortunately, is famous, when it gets into a rule of reason, for 2- and 3- and 4-year trials. A per se rule allows us very efficient ways to dispose of the matter. Remember, the practice has no justification. Also, it is a bright line for people out there in the marketplace to know where legality ends and illegality begins.

Certainly we have made no exceptions for oil companies, steel companies, lawyers, accountants and so forth. We have applied the per se rule in those areas, and as much as I recognize that the health care market is special, I would not think we ought to have a special deal for doctors with respect to the per se rule.

Mr. CONYERS. Well, finally, Chairman, have physician networks experienced any difficulty in obtaining guidance under the antitrust rules?

Mr. PITOFSKY. No difficulty obtaining guidance. They have asked us for 28 or 30 advisory opinions. We have cleared all but one proposed physician network. Also, there are many physician networks now, that is, physician-owned networks, that are now in the marketplace. Twenty percent of PPO's, 15 percent of HMO's are physician-owned, and the number is growing. So I don't think antitrust has been a great impediment in doctor networks becoming established in the marketplace.

Mr. CONYERS. Thank you very much, sir.

Mr. HYDE. The gentleman from Pennsylvania, Mr. Gekas.

Mr. GEKAS. I thank the Chair. Mr. Chairman, I have been in the self-described vanguard of trying to bring about a loosening of the noose of antitrust with respect to health care for a long, long time, as a matter of fact, way before the current debate began to simmer. So the next question I ask, which now comes because of a matter of conscience, I ask unanimous consent that it be regarded that I have one, that there is an objection.

Mr. HYDE. Objection.

Mr. GEKAS. There is an objection.

Mr. HYDE. An objection has been heard.

Mr. GEKAS. I knew it.

It appears that on the one hand while I am pressing for a mitigation of the antitrust laws, that I have heard from, in the health care industry, from sole practitioners who believe that all of this activity, of allowing the formation of the entities in particular communities that could lead to price fixing or other kinds of incorporation of procedures, et cetera, would cut them out. Is there any validity, or have you heard anything like this at all during the deliberations on these issues?

Mr. PITOFSKY. Well, there are two aspects of this. One is, I heard your colleague before I spoke talk about the fact that if doctors exchanged information about prices and fees in the process of setting up a physician network, they would be in some risk of violating the antitrust laws. They were told by their lawyers that the presumption of guilt would apply instead of innocence.

My recommendation is that they ought to get different lawyers because that is just not right. That is simply not right. The per se rule has not been applied to an exchange of information among doctors to set up a network and, in my opinion, it could not be applied. So the exchange of information is not a problem.

The other issue is whether the doctors can set up these networks and whether they are at a disadvantage compared to insurance companies setting up networks, and I have heard that claim. I don't believe they are, but to the extent that they have overreacted to the DOJ/FR guidelines, and they feel that only financial integration is the way to ensure the safety of their arrangement, we are going to address that question. We started addressing that question several months ago, and to the extent you are saying that you think that the antitrust laws have been a little too restrictive in setting up these arrangements, I am not sure I disagree with you.

That is why we are conducting this review, and that is why we are looking at modification, clarification, really, because we said all along other efficiencies count, clarification of our guidelines which will give doctors a little more running room in setting up these networks.

Mr. GEKAS. If the Congress and the Members feel that moving toward relaxation of antitrust and the adoption of this legislation would lead to more quick formation of some of these entities, so that the competitive factors worldwide would enter into the picture and prices would lower and costs would be mitigated, shouldn't you be advocating quick passage of this legislation instead of opposing it, with the idea that the gentleman from Wisconsin was advocating, that we then revisit it when and if necessary, and work with you on the guidelines and amendments and whatever? But at least we would be getting the world community in health care set on a policy which would say that the Congress at least is worried about the strangulation of antitrust.

Mr. PITOFSKY. Two responses to that: First of all, on the timing, we can probably adjust our guidelines more quickly than Congress can deal with this in terms of legislation. So in terms of speed, we can move this along very promptly, and we are almost halfway down that road already.

The second question is whether the legislation has the right factors. As I said, I believe that one could touch every base in that legislation and still have a physician network that is highly anti-

competitive, and therefore I would like the opportunity to present to the committee our views on what the right factors ought to be.

Mr. GEKAS. I ask unanimous consent for 30 seconds.

Mr. HYDE. Granted.

Mr. GEKAS. Then I would suggest—and a nod of the head will end this part of the discourse—going both ways. Let's proceed with our legislation here, while you proceed with the latest set of guidelines, and maybe the two will converge. Can you nod your head either way?

Mr. HYDE. You can verbalize an answer too.

Mr. CONYERS. You can jump off the roof, too.

Mr. PITOFSKY. I think the thinking on this subject is converging, as a matter of fact. But I want to repeat the point I made earlier: Once you set up legislation and you say you have got to go from A to B to C to D and you have got to connect all of those dots and so forth, the market is going to produce networks not that serve the best interests of cost containment and consumers, but get to A, to B, to C and D. We can do guidelines that are more flexible than that.

Mr. HYDE. I thank the gentleman.

The gentlewoman from Colorado, Mrs. Schroeder.

Mrs. SCHROEDER. Thank you, Mr. Chairman. Thank you for having the hearings, and I thank you for joining us this morning, Chairman.

I just want to go back through this. It is very interesting, the language we are hearing about "the noose" of antitrust and "the strangulation." I mean these are really heavy words.

Mr. GEKAS. I admit that.

Mrs. SCHROEDER. You are saying that there is a preclearance procedure and almost any doctor group that has applied has gotten through, except for one. So what is this noose about? How long does this take? Where do you think we are getting this language about nooses and strangulation and so forth, if you have had every provider group approved except one?

Mr. PITOFSKY. To go just to the people who are complaining about the present situation, I think they would say that the guidelines indicated that without financial integration, these physician networks would be less likely to be accepted. And that is to say, capitation, withholds. That is to say the doctor has an interest in seeing at the end of the year that their expenses came down.

I think that was something of an overreaction to what the guidelines say, but some people out there may honestly feel that the only way they can get out of this noose, this tough per se rule, is through financial integration. I don't believe that ever was true, and if it is true, we can clarify that situation and demonstrate to people there are other ways to get outside of the noose.

Mrs. SCHROEDER. So what you are saying is that in your review that you are now undertaking, you are really determining whether efficiencies other than financial integration will justify the rule of reason? Is that what you are telling us?

Mr. PITOFSKY. Exactly right.

Mrs. SCHROEDER. I take it by what you are saying that you are apt to come down on the side of financial integration plus other things. Would that be fair?

Mr. PITOFSKY. That is my present view. I can't speak for the Department of Justice or the other Commissioners, but we started down this road because we thought that might be the case.

Mrs. SCHROEDER. Then I hear Members also saying, well, the reason you want to go on with your review is that you sit in the executive branch or you sit on the regulatory side, and we are over here on the legislative side and we want to legislate ours instead. I think we need to have a little sharper focus of what the difference is. I mean, you will proceed with the review. The review will be done by?

Mr. PITOFSKY. My guess, it will certainly be less than the 6 months indicated in the statute to allow us to write guidelines. I would hope that we could do it in 3 or 4 months, but less than 6.

Mrs. SCHROEDER. You also said that if this legislation passed, you really thought that there was a way that these groups could go through all the gates the legislation set up and still be anticompetitive?

Mr. PITOFSKY. Absolutely. That is my principal concern here. I think a clever lawyer could set a physician network up that satisfies the legislation and yet is highly anticompetitive.

Mrs. SCHROEDER. Some of those clever lawyers that you trained in law school, you know they are out there because you trained them.

Mr. PITOFSKY. Right, I know they are out there somewhere.

Mrs. SCHROEDER. I think all of this is terribly important. I know the great joke going around my city where we are watching two or three megagroups come in and just crowd everybody out, the consumer is feeling very much like they are getting crowded out.

Everybody is telling the joke about the three guys that arrive before St. Peter at the gates to heaven, the pediatrician, the gerontologist, and the one who worked for the HMO. St. Peter says to the pediatrician, "You can come in. You worked for babies." He says to the gerontologist, "You can come in. You worked for old people." And to the one who worked for the HMO he says, "You can come in for 48 hours."

For people who are going through this, this is kind of how this feels. It may feel like it is in the stratosphere, but in Denver, CO, we are concerned about how this works out and how this feels for the patient and the user too. I think there is a good reason for antitrust, and I thank you very much for working so hard on it.

Mr. MOORHEAD [presiding]. The gentleman from New Mexico is recognized.

Mr. SCHIFF. Mr. Chairman, I would pass.

Mr. MOORHEAD. The gentleman from Florida.

Mr. MCCOLLUM. At the present time I will pass. I just walked in, unfortunately, Mr. Chairman.

Mr. MOORHEAD. The gentleman from Rhode Island.

Mr. REED. Thank you, Mr. Chairman.

Mr. Chairman, in your review of this whole area, have you encountered situations where physician networks were frustrated by other entities who would threaten them with civil antitrust actions or anything like that, where they would need a statutory clarification for them to go forward even though your mechanism is available?

Mr. PITOFSKY. It is hard to say what would have happened had our guidelines been different. I really do not think that the antitrust laws have been a major barrier to the establishment of physician networks. I am sorry to say there is a long history of some physician groups using this network excuse as a device to boycott new forms of health care.

So I think most people think that antitrust has done a good job in keeping the market open. As far as preventing the most efficient forms of network from being created, I don't see much of a record that that has happened, although it is possible that the guidelines, I think because there was an overreaction to them, may have straightened the gate, narrowed the range of joint ventures that have occurred. I doubt it, but it is possible.

Mr. REED. One of the objections, Mr. Chairman, is that any statute that we propose will be circumvented by clever attorneys. Isn't that the same case with policies that you promulgate?

Mr. PITOFSKY. Yes, but I think we can adjust our policies more rapidly, more frequently; we can be more flexible in guidelines than I think legislation can. For example, in our previous guidelines, not only did we put out explanations of what the points of concern were, but we put out fairly lengthy hypotheticals. We would put out lengthy commentary on what the guidelines were intended to achieve. I think that is easier to do in guidelines than it is in legislation.

Mr. REED. Let me just ask another question, which would be if the Congress adopted legislation, wouldn't you still have the opportunity through policy statements to supplement and explain, clarify the legislation? Is that appropriate?

Mr. PITOFSKY. Yes, that is in the legislation, actually. It gives us 6 months to produce guidelines, but our guidelines would then be anchored, be keyed to the elements of the legislation. Sitting here at this moment, while I have said several times now I think the legislation looks in the right direction, I am not sure the specific elements in that legislation are the ones that we would recommend after we have a full opportunity to talk to all the players in the field.

Mr. REED. As we go forward, is it conceivable in your mind that you could, in fact, present or be in favor of certain statutory guidelines or posts that would anchor your efforts, and you could help us to do that and support it?

Mr. PITOFSKY. That is a possibility.

Mr. REED. Thank you, Mr. Chairman.

Mr. SCHIFF. Mr. Chairman.

Mr. MOORHEAD. The gentleman from Virginia, Mr. Goodlatte.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. Pitofsky, thank you for testifying before us today. Could you identify the areas in which the FTC and Justice are considering issuing additional statements of health care enforcement policy, and could you tell us when we might expect them to be issued?

Mr. PITOFSKY. It is primarily on the question addressed by this legislation. We were thinking of clarification of our guidelines to indicate that there are efficiencies, other than financial integration and the creation of a new product, which would justify more extended antitrust treatment.

Some of the factors that we have looked at are mentioned in the guidelines, like utilization review and quality of care review. But we think there may be other factors, as well, that ought to be taken into account.

But it is the range of efficiencies that justify less stringent, more extended antitrust analysis, and I can only say that I believe we will have our review completed in less than 6 months. My hope is that we could do it more promptly than that.

Mr. GOODLATTE. Some of these changes in the health care field, some of the new organizations and so on that are developing, are very innovative but they also involve very substantial changes in relationships, in some instances capital investment and so on. How can physicians and other health care providers rely upon guidelines that don't have the full force of law in making that kind of a commitment?

Mr. PITOFSKY. The truth is, in the antitrust field Congress legislates very broadly and then usually leaves it to guidelines to try to explain to people who are affected by the legislation what they ought and ought not to do. It is very rare, in fact, it is virtually unprecedented that Congress would decide where a rule of reason as opposed to per se treatment applies.

The health care market is a very large percentage of our gross national product, but the other 85 percent of our economy is governed by broad antitrust provisions and then rather specific guidelines. So it is common to do it through the guideline approach.

Mr. GOODLATTE. Well, in that same vein, I think you would agree with me that this market is changing very rapidly, and a lot of these innovative delivery systems are emerging on a very fast basis. It has been alleged that your enforcement guidelines have the effect of funneling all physician networks through the same mold. Isn't the role of antitrust enforcement to preclude anticompetitive conduct, rather than to require that competitive activities be constructed in a certain way?

Mr. PITOFSKY. Absolutely. Let me emphasize all the things that I agree with in what you said. It is an extremely dynamic market, more so than almost any that I have seen. It is very important for the role of antitrust to be to protect access, not to decide which forms of transaction or network are to be preferred.

One of the things that I am concerned about is, I don't believe that criticism of the guidelines is right, but assume it is. Assume it is, and that we funneled transactions in a particular way. My concern is that that same criticism will be directed toward the legislation, because it will funnel transactions in a particular way. What I would hope that we can come up with is a set of guidelines that will clarify the point that we intended to be more flexible.

Mr. GOODLATTE. One last question. In your testimony you indicated that the FTC has issued only one letter that failed to approve a proposed network.

Mr. PITOFSKY. I think that is right.

Mr. GOODLATTE. Do you know the facts of that particular request and what the grounds were?

Mr. PITOFSKY. I don't know, but I can submit that to the committee. I don't recall the particular case. These were advisory opinions.

We have also brought some cases that challenged transactions, but I don't know about the advisory opinion.

Mr. GOODLATTE. If you would do that, I certainly would like to have the benefit of that.

[The information follows:]

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
THE CHAIRMAN

April 11, 1996

The Honorable Bob Goodlatte
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Goodlatte:

During my testimony before the Judiciary Committee on H.R. 2925, you asked me to provide information about the one health care provider network that did not receive a favorable advisory opinion from the Federal Trade Commission staff. This letter responds to that request, and I ask that it be made part of the hearing record.

Since the 1993 Health Care Policy Statements were issued, Commission staff has declined to approve only one physician network. The proposal involved a preferred provider organization (PPO) to be sponsored by the Montana Medical Society. All members of the Society were eligible to participate in the PPO, and it was anticipated that more than half of the doctors in the state would participate. The plan proposed to pay doctors at the 88th percentile of fees regularly charged by the participating doctors. As a result, except for the 12 per cent of physicians charging the very highest prices, doctors would be paid their usual fees. The plan intended to use a 15% risk withhold, which means that 15% of fees would be held in reserve by the PPO, and would be paid to the doctors only if a predetermined savings target was met. According to the information submitted with the request, the PPO would face little competition from other managed care plans in the state.

Based on the facts presented to them, the staff could not reach the conclusion necessary for advance approval, that is, that the arrangement would be unlikely to injure competition and consumers. In particular, the staff found that there was a substantial possibility that the PPO could attain market power. Among other things, it was noted that even though physicians were not required to affiliate with the PPO on an exclusive basis, they might have little incentive to participate in other plans that might attempt to enter the market in competition with the medical society plan, or to discount their fees, because the medical society plan would pay most doctors their full regular fees.

The staff letter also pointed out that it was unclear whether the arrangement was designed to offer the kind of benefit to competition and consumers that would justify permitting competitors to agree on their prices -- a type of agreement that normally would raise serious questions under the antitrust laws. Use of a withhold arrangement is one way to foster such a benefit, because it can create incentives for a group of doctors to take steps to ensure that the group as a whole practices cost-effective medicine. The Commission staff, and the

Department of Justice as well, have approved many networks that employ this mechanism. Indeed, on the same day that the Montana PPO letter was released, the staff issued a favorable opinion letter to a Jackson, Mississippi physician network that proposed to operate with use of a withhold arrangement.[1]

In the case of the Montana Medical Society however, the circumstances raised significant questions about whether the arrangement was likely to lead to more efficient behavior. In particular, (1) the vast majority of physicians would have had their normal charges allowed in full, and (2) the large number of physicians expected to participate in the PPO made it likely that many doctors would have only a small number of PPO patients in their practices. These facts suggested that the possible loss of the withhold might not create any real economic incentive for the members of the network to modify their individual behavior in order to permit the group as a whole to compete more effectively with other physicians or groups of physicians. In reaching this conclusion, the staff relied in part on published studies regarding the effect of withhold arrangements.

All of these circumstances taken together meant that the Commission staff could not conclude that the venture was unlikely to cause anticompetitive harm. As a result, advance approval for the proposal could not be given. As the opinion letter expressly states, the staff did not conclude that the proposed network would necessarily violate the antitrust laws. Rather, the staff could not assure the requesting party in advance that the operation of the proposed network would not be unlawful.

I hope this information is helpful. I am enclosing copies of both the Montana advisory opinion letter and the approval letter to the Jackson, Mississippi venture.

Sincerely,

Robert Pitofsky
Chairman

cc: The Honorable Henry Hyde
Chairman, House Judiciary Committee

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[1] Letter from Mark Horoschak to George Q. Evans (SEMCO/JMC) (July 5, 1994)

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition

July 5, 1994

George Q. Evans, Esquire
Wise Carter Child & Caraway
Post Office Box 651
Jackson, Miss. 39205

Dear Mr. Evans:

This is in response to your request for an advisory opinion on the legality under the antitrust laws of a method of operation proposed to be undertaken by your clients, Southeast Managed Care, Inc. ("SEMCO") and Jackson Medical Cooperative, Inc. ("JMC"). SEMCO is a predominantly physician-owned, for-profit corporation that will operate managed care plans serving a three-county area around Jackson, Mississippi. JMC is composed of physicians who will provide the medical services to enrollees and beneficiaries of SEMCO's managed care plans. As is explained more fully below, it does not appear that operation of SEMCO and JMC, as proposed, is likely to violate any law enforced by the Federal Trade Commission.

Semco is a for-profit stock corporation that will operate managed care plans in Hinds, Madison and Rankin Counties, Mississippi (the "Tri-County area").[1] It is intended to be a "physician-directed" organization, and stock was offered first to physicians practicing in the Tri-County area. Any unpurchased stock will be offered to area employers and third-party payers and to the public. SEMCO anticipates that approximately 60 doctors practicing in the area have or will purchase stock. Five of the six members of its board of directors are physicians.

SEMCO intends to market to local employers and to third-party payers a package of alternative managed care products that will include a health maintenance organization, a point of service plan, and a preferred provider organization. SEMCO will receive from the payer an administrative fee per employee. In addition, it will share in cost savings realized by the payer pursuant to the risk-sharing arrangement discussed below. SEMCO will contract with JMC for physician services and with hospitals and other ancillary service providers at specified fees and rates for services to be rendered under contracts entered into between SEMCO and each payer.

JMC is a nonprofit membership corporation consisting of primary care and specialist physicians who will provide medical services pursuant to SEMCO's managed care contracts. JMC has at

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[1] According to the submission, this three-county area is a single market for physician and hospital services.

least 174 members, and a number of other physicians in the community have expressed an interest in joining. JMC expects the number of members to reach approximately 270, at which point JMC intends to limit membership.[2] JMC as an entity will be required to contract exclusively with SEMCO. Individual members of JMC, however, will be free to join other physician network joint ventures, to contract individually with health insurance plans, and to continue to see non-plan patients on a fee-for-service basis.[3] Each JMC member is required to pay an initial membership fee of $185.

JMC is authorized to enter into contracts with SEMCO that will bind JMC members, subject to a limited right of the physicians to opt out of particular contracts. SEMCO is authorized to market the services of JMC members to payers and to enter into binding contracts with purchasers on terms that have been approved by JMC's board of directors.

Under SEMCO's HMO plan, JMC will be paid a capitated rate per enrollee. For the PPO product, JMC members will be paid on a discounted fee-for-service basis, with the fee withhold described below. SEMCO will use a fee schedule based on the McGraw-Hill Relative Value Units, and the multiplier has been set so that fees are approximately at the 50th percentile of national rates as determined by Medical Research Data, and about the 60th percentile for prevailing fees in the Tri-County area.

Under PPO contracts, SEMCO will withhold 15% of the amount due each physician for a risk pool. The amounts withheld will paid at the end of the contract year if a predetermined targeted cost saving from the previous year is met.[4] In addition, a payer will be able, if it so desires, to negotiate a second cost savings target, with the resulting savings, if realized, to be divided between the purchaser and SEMCO/JMC. JMC also will use utilization management techniques, including preadmission certification, concurrent hospital review, retrospective review, and individual case management.

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[2] There were approximately 1400 non-federal physicians practicing in the Tri-County area in 1993. Thus, JMC's membership will not exceed 20% of the physicians in practice in the area.

[3] However, JMC members are not permitted, during the term of their membership in JMC or for one year thereafter, to solicit any person covered by a SEMCO contract to enroll in a competing managed care organization.

[4] SEMCO anticipates that with a gatekeeper system, a payer can realize a 10-15% savings the first year.

There are seven general acute care hospitals within the Tri-County area. SEMCO has contracts in place or under negotiation with four of these hospitals, and does not presently intend to contract with the others.

A number of competing managed care plans are operating or are being developed in the Tri-County area. These include a physician-hospital organization, another PPO, and a Blue Cross-Blue Shield PPO that operates statewide. A number of JMC members currently participate in one or more of these plans.

Based on the description of the proposed operation of SEMCO and JMC that you have provided, and is summarized above, it appears that the proposed course of action is unlikely to violate the antitrust laws. While the proposal clearly involves a horizontal agreement on price and the other terms of dealing among members of JMC, this agreement is ancillary to the partial integration of the members' practices through JMC. Accordingly, the arrangement will be evaluated under the rule of reason. It does not appear that the venture is likely to be able to attain or exercise market power. Thus, the proposed operation of SEMCO and JMC does not appear likely to restrain competition unreasonably.

Agreements on price and other terms of sale, made by otherwise competing physicians through joint marketing arrangements such as PPOs, raise serious antitrust issues and may amount to per se illegal price fixing where the physicians have not substantially integrated their medical practices or do not share substantial financial risk through the joint venture. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). By contrast, physicians who do substantially integrate their practices or financial arrangements normally will not have their agreements on prices or other related terms of doing business through the joint venture subject to per se condemnation. Rather, these determinations will be subject to rule-of-reason analysis, which weighs their procompetitive and anticompetitive impact. See, e.g., Hassan v. Independent Practice Associates, P.C., 698 F. Supp. 679, 689-691 (E.D. Mich. 1988).

The FTC and the Department of Justice recently jointly issued an enforcement policy statement that establishes an antitrust "safety zone" for physician network joint ventures, such as PPOs, that involve the sharing of substantial financial risk and do not include as participants more than 20% of the area physicians in any specialty with active hospital privileges.[5]

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[5] United States Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in the Health Care Area at 33-46 (September 15, 1993), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,150 (1993).

The statement also explains how joint ventures that do not fall within the safety zone will be analyzed by the antitrust enforcement agencies. Such physician network joint ventures will not be deemed inherently illegal, but instead will be reviewed under a rule-of-reason analysis if the physician members share substantial financial risk or if the combining of the physicians into a joint venture provides substantial efficiencies that enable them to offer a new product. The analysis will seek to determine, considering all the characteristics of the joint venture and of the market in which it operates, whether the venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture.

The SEMCO/JMC arrangement satisfies most but not all of the requirements of the safety zone. First, it appears to involve substantial risk sharing among the participants to the venture. The enforcement policy statement identifies two examples of substantial financial risk sharing:

> when there is an agreement to provide services to a health insurance plan at a "capitated" (or per subscriber) rate; or
>
> provision by a [PPO] of financial incentives for its members to achieve cost-containment goals, such as withholding a substantial amount of the compensation due to its members, with distribution of that amount to members only if cost-containment goals are met.

(p. 35). Through such arrangements, the risk of loss from higher-than-expected use of services is borne at least in part by the physician group. This helps to ensure that each member of the group has a direct interest in the competitive success of the group as a whole that vitiates the normal incentive of each member to maximize his or her income by increasing the number of services provided to enrolled patients. Thus, the risk-sharing mechanism must be designed to provide participating physicians with sufficient incentives to modify their behavior in accordance with the established cost-containment goals, and to assure cost-effective behavior by the other physicians in the program.

The risk-sharing features of the SEMCO-JMC proposal appear to be designed to provide such incentives. Under HMO contracts, JMC will accept capitation payment. For PPO contracts, SEMCO intends to use a 15% risk withhold in conjunction with a fee schedule that already provides for substantial discounts from prevailing fees in the community. Although the discounted fee schedule by itself does not establish risk-sharing among the members of JMC, the payment system as a whole appears to provide the necessary risk-sharing. While some physicians might consider a 15% withhold from their regular fees simply to be a discount or

cost of doing business and disregard it,[6] physicians who already have agreed to a substantial discount from their regular fees are likely to have a greater incentive to recover the withheld funds. Thus, it appears that physician members of JMC would have a strong incentive to meet the cost targets in the contracts.[7]

In terms of its overall membership, JMC also falls within the 20% parameter of the safety zone. It does not fully meet the safety zone requirements, however, because in several important medical specialties its membership exceeds the 20% limit.[8] In the context of the facts presented to us, however, the size of the provider panel does not appear to pose a significant threat to competition.

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[6] See, e.g., Milstein, Bergthold & Selbovitz, In Pursuit of Value: American Utilization Management at the Fifteen-Year Mark at 374, in Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions (P. Boland ed. 1991) (a 10% withhold applicable to only a small number of patients was not enough to change physician behavior); Gordon & Herman, Appropriate Reimbursement Methodologies for Managed Care Systems at 337-39, in Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions (P. Boland ed. 1991) (if physicians do not expect a return of the withhold, they may view it as a discount and increase the volume of services in order to increase total reimbursement).

[7] Because JMC will have a limited provider panel, it is more likely that JMC members will have a significant number of patients in their practices who are covered by SEMCO contracts. This factor may also increase the effectiveness of JMC's cost-containment efforts. See Hillman, Pauly, & Kerstein, How Do Financial Incentives Affect Physician's Clinical Decision and the Financial Performance of Health Maintenance Organizations?, 321 N. Eng. J. Med. 86, 90 (1989) (presence of a higher proportion of HMO patients in a physician's practice may increase his or her awareness of the HMO's imperatives).

[8] For example, JMC members include 45% of obstetrician-gynecologists and about half of the pediatricians in the market. A number of the pediatricians, however, appear to be subspecialists who may be the only practitioner of that kind in the area. JMC also includes all of the nephrologists in the area. Since all these doctors are in one practice, their participation in JMC does not add to whatever power they may already possess in the market. However, serious antitrust questions would be raised if this group or another sole practitioner in a particular specialty affiliated on an exclusive basis with JMC or SEMCO.

"Market power" is generally defined as "the power to control prices [or restrict output] or exclude competition." United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956). Market power may be exercised either unilaterally or in combination with others. The most likely way that a PPO could attain market power would be if: (1) it included a high percentage of physicians in the market; and (2) those physicians -- or a sufficient number of other physicians (either currently in the market, or new entrants) -- were not available either to form competing arrangements to offer services to payers, or to individually offer their services to payers. This situation could occur, for example, if the PPO had a high percentage of physicians in a market and expressly required its members to market their services to payers exclusively through the PPO. Similarly, a PPO could have market power if it had a high percentage of physicians in a market, and its physician members tacitly agreed to deal only through the PPO or only on the terms that the PPO offers. This situation could have anticompetitive effects by requiring those payers to deal with the PPO and its physicians on terms dictated by the physicians. The reduction of competition in the market for physicians' services also could permit the PPO to raise prices to consumers or reduce output in the market for physician services and, in turn, in the market for prepaid health care plans.

Based on the facts described above, there does not appear to be a significant danger that SEMCO/JMC will attain market power through coercive or exclusionary means.[9] The provider panel as a whole is only a small proportion of doctors available in the community, so other plans should not be foreclosed from access to sufficient doctors to compete effectively. While JMC has a higher proportion of members in some specialties, the available information provides no reason to believe that these members will be able to impede entry or operation of other plans. A number of other managed care plans are already in operation in the Tri-County area, and others are in the planning stage. Of course, if the high representation of some specialties in JMC did in fact impede the ability of other plans to compete effectively, an antitrust concern would arise.

On balance, the development of SEMCO/JMC appears to be designed to further rather than to restrict competition. JMC's provider panel as a whole will not be overinclusive; the physicians appear to be bearing genuine risk, both through the fee withhold in the PPO plan and through capitation in the HMO plan; and local market forces are prompting the development of other physician groups with which JMC will be in competition.

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[9] Nor does there appear to be any basis for concern about coordinated interaction between SEMCO/JMC and other physician networks.

For these reasons, the formation and operation of the plan as proposed would not appear to violate any law enforced by the Federal Trade Commission.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's Rules. Under the Commission's Rules of Practice §1.3(c), the Commission is not bound by this staff opinion and reserves the right to rescind it at a later time. In addition, this office retains the right to reconsider the questions involved and, with notice to the requesting party, to rescind or revoke the opinion if implementation of the proposed program results in substantial anticompetitive effects, if the program is used for improper purposes, or if it would be in the public interest to do so.

Sincerely yours,

Mark Horoschak

Mark J. Horoschak
Assistant Director

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition

July 5, 1994

Paul W. McVay
President
ACMG, Inc.
2570 Technical Drive
Miamisburg, Ohio 45342-6100

Dear Mr. McVay:

This is in response to your letter requesting an advisory opinion from the Federal Trade Commission staff on the legality under the federal antitrust laws of a proposed method of operation to be undertaken by ACMG, Inc. According to the information contained in your letter, ACMG is involved in the development and management of health maintenance organizations, preferred provider organizations, physician-hospital organizations, and other managed health care programs. Since 1984, ACMG has worked with groups of health care providers in establishing managed care programs. ACMG is not owned or controlled by providers of health care services.

ACMG intends to propose to a state medical society a program for establishing a state-wide PPO in Montana. The PPO will be sponsored by the medical association, and operated pursuant to a contract between ACMG and the association. Physicians licensed to practice within the state who are members of the medical society will be eligible to participate. Participating physicians are free to participate in other PPOs.

Under the proposed program, the physician organization would agree, as a condition of contracting for ACMG's services, to adopt all the elements of the program, including its fee compensation plan. ACMG determines the maximum payment for each service, which is set at the 88th percentile of the fees regularly charged by the participating physicians. Each physician who elects to participate in the plan submits current fees for review by ACMG personnel, who notify the doctor of any fees that exceed the maximum allowable charge. The physician is obligated to accept ACMG's allowance as payment in full for covered patients. In addition, the physician must agree that the PPO will retain 15% of the allowable charge in a "risk pool" for each payer in the program.

ACMG will market the PPO only to employers who self-fund their health benefits programs. ACMG will review each employer's past claims experience, and actuarially determine expected health care costs for the coming year based on the employer's current benefit design without the PPO option. Certain costs above that amount will be insured through a stoploss carrier. The employer

and ACMG will then establish a target amount from the projected claims expense that the employer can expect to save through use of the PPO. The amount of the expected savings will be based in part on the employer's willingness to establish financial incentives for employees to use the PPO network for health care services.

The physician risk pool for each payer is distributed to the providers in proportion to their contributions to the pool if that payer's annual health plan costs, adjusted for any stoploss recoveries, do not exceed the targeted cost for that year. If costs do exceed the target, all or a portion of the risk pool is used to defray those costs. If costs are less than the target amount, a portion of the surplus is shared with the network providers.

Financial penalties are also imposed on health plan beneficiaries for inappropriate use of medical facilities, such as use of emergency rooms for non-emergency services. ACMG recommends that employers adopt an incentive arrangement that shares with employees any savings greater than the targeted amount.

ACMG also provides a management information system that tracks utilization and a utilization review program in which all participating physicians and hospitals must agree to participate. The program includes sanctions for providers who do not adhere to established utilization criteria, procedures and protocols. Individual providers are at risk for all costs attributable to services which are determined to be medically unnecessary or inappropriate.

ACMG had not yet negotiated contracts with hospitals. It does not intend to limit the number of hospitals that participate in the program.

You have informed us that there currently is only one managed care program operating in Montana, a full-risk HMO. The medical organization does not intend to offer an HMO or any managed care product other than the PPO that is the subject of this advisory opinion. Since the PPO will be marketed only to employers with self-funded health benefit plans, ACMG does not anticipate that the PPO will compete directly with the HMO for the same payers.

Based on my understanding of ACMG's proposal, as summarized above, I believe that the establishment of a PPO sponsored by a state medical society, under the conditions that ACMG contemplates, poses a substantial risk of violating the federal antitrust laws. As is explained in more detail below, the structure proposed by ACMG appears to involve a horizontal agreement on price among competing physicians, and it is not

clear that the agreement can be justified as ancillary to a partial integration of the participating physicians' practices. Moreover, there appears to be a substantial possibility that the PPO would attain market power that could be exercised to the detriment of consumers.

Agreements on price and other terms of sale, made by otherwise competing physicians through joint marketing arrangements such as PPOs, raise serious antitrust concerns and may amount to per se illegal price fixing where the physicians have not substantially integrated their medical practices or do not share substantial financial risk through the joint venture. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). The antitrust laws treat price agreements among competing sellers of a product or service as inherently suspect because of the significant danger that such agreements will injure consumers by raising prices above the competitive level. The PPO arrangement described in your letter does not involve an explicit agreement among participating physicians on the prices to be charged to patients covered by the plan, since fees are determined by ACMG and each physician will decide unilaterally whether to join the PPO. Your letter makes it clear, however, that the sponsoring medical association must agree in advance to accept the price parameters that ACMG establishes: that is, that fees will be set at the 88th percentile of charges and that the withhold will be set at 15%. While this does not necessarily establish an agreement among the medical society's members not to deal with payers on other price terms, it does constitute an agreement among at least some of the members that they will deal collectively on those particular terms.

Physicians who do substantially integrate their practices or financial arrangements normally do not have their agreements concerning prices or other related terms of doing business through the joint venture subjected to per se condemnation. Rather, these determinations typically are subject to rule-of-reason analysis, which weighs the actual or potential procompetitive benefits of the agreement against its actual or potential anticompetitive effects. See, e.g., Hassan v. Independent Practice Associates, P.C., 698 F. Supp. 679, 689-691 (E.D. Mich. 1988). Price agreements among the participating providers in a PPO or other physician network joint venture are permitted if the group has adopted significant economic incentives for the members to compete as a group with other physicians or groups of physicians, and it appears that the group as a whole is at least potentially subject to sufficient competition from other providers or managed care plans that they will be forced by the market to behave competitively, with respect to both price and utilization.

The FTC and the Department of Justice have jointly issued an enforcement policy statement that establishes an antitrust

"safety zone" for physician network joint ventures, such as PPOs, that involve substantial financial integration of the physicians' practices through the joint venture and do not include as participants more than 20% of the area physicians in any specialty with active hospital privileges.[1] The statement also explains how joint ventures that do not fall within the safety zone will be analyzed by the antitrust enforcement agencies. Such physician network joint ventures will not be deemed inherently illegal, but instead will be reviewed under a rule-of-reason analysis if the physician members share substantial financial risk or if the combining of the physicians into a joint venture provides substantial efficiencies that enables them to offer a new product. The analysis will seek to determine, considering all the characteristics of the joint venture and of the market in which it operates, whether the venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture.

The PPO described in your letter does not fall within the antitrust safety zone for two reasons. First, there is no commitment that the participating physicians will constitute no more that 20% of the physicians overall or in any particular specialty with active hospital privileges in any geographic market. On the contrary, participation in the PPO will be open to all physicians who are members of the state medical society. You state that approximately 65% of physicians practicing in the state are state medical society members, and that you anticipate that approximately 80% of that membership would elect to participate. This would amount to more than 50% of all physicians practicing in the state. In local markets, of course, the proportion of participating physicians could be higher or lower. In addition, the PPO could have as participants a substantial proportion of practitioners in particular specialties, either within local markets or statewide.

Second, it is not clear from the information you have provided that the participants in the PPO will share substantial financial risk. The enforcement policy statement identifies as one example of sharing substantial financial risk

> the provision by a [PPO] of financial incentives for its members to achieve cost-containment goals, such as withholding a substantial amount of the compensation due to its members, with distribution of that amount to members only if cost-containment goals are met.

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[1] United States Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in the Health Care Area at 33-46 (September 15, 1993), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,150 (1993).

(p. 35). Accordingly, the withhold arrangement that your proposal contemplates is of the type that could constitute substantial risk sharing within the terms of the policy statement. We cannot determine from the information currently available, however, whether the compensation arrangement in your proposal, taken as a whole, is likely to provide participating physicians with a direct interest in the competitive success of the group as a whole, thus providing incentives for each physician to modify his or her behavior in accordance with the established cost-containment goals and to assure cost-effective behavior by the other physicians in the program.

Under the proposal described in your letter, fees paid to the PPO's members would be based on the 88th percentile of regular charges of the participating physicians. Thus, almost all participating physicians would have their charges allowed in full. Moreover, given the large number of physicians who are likely to participate in the PPO, it is likely that many physicians will have only a small number of PPO patients in their practices. Under these circumstances, a 15% withhold from charges may not be enough to affect each physician's normal incentive to maximize his or her income by increasing the number of services provided to enrolled patients.[2] In that case, the withhold would not be a sufficient form of risk sharing to render a price agreement among PPO members permissible under the antitrust laws.

Even if the physician compensation arrangement were deemed, on fuller review, to constitute significant sharing of risk among

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[2] See, e.g., Milstein, Bergthold & Selbovitz, In Pursuit of Value: American Utilization Management at the Fifteen-Year Mark at 374, in Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions (P. Boland ed. 1991) (a 10% withhold applicable to only a small number of patients was not enough to change physician behavior); Gordon & Herman, Appropriate Reimbursement Methodologies for Managed Care Systems at 337-39, in Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions (P. Boland ed. 1991) (if physicians do not expect a return of the withhold, they may view it as a discount and increase the volume of services in order to increase total reimbursement); Hillman, Pauly, & Kerstein, How Do Financial Incentives Affect Physician's Clinical Decision and the Financial Performance of Health Maintenance Organizations?, 321 N. Eng. J. Med. 86, 90 (1989) (presence of a higher proportion of HMO patients in a physician's practice may increase his or her awareness of the HMO's imperatives); Does the Primary-Care Gatekeeper Control the Costs of Health Care?, 309 N. Eng. J. Med. 1400 (1983) (a small financial incentive, especially if applied to a small proportion of total charges, is ineffective to change physicians' behavior).

the participating physicians, there still appears to be a significant possibility that the PPO could attain and exercise market power. "Market power" is generally defined as "the power to control prices [or restrict output] or exclude competition." United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956). Market power may be exercised either unilaterally or in combination with others. If a PPO attains market power, a price agreement among its members will not survive antitrust scrutiny under the rule of reason.

The most likely way that a PPO could attain market power would be if: (1) it included a high percentage of physicians in the market; and (2) those physicians -- or a sufficient number of other physicians (either currently in the market, or new entrants) -- were not available either to form competing arrangements to offer services to payers, or to individually offer their services to payers. This situation could occur, for example, if the PPO had a high percentage of physicians in a market and expressly required its members to market their services to payers exclusively through the PPO. Similarly, a PPO could have market power if it had a high percentage of physicians in a market, and its physician members tacitly agreed to deal only through the PPO or only on the terms offered by the PPO. This situation could have anticompetitive effects by requiring payers to deal with the PPO and its physicians on terms dictated by the physicians. The reduction of competition in the market for physicians' services could permit the PPO to raise prices to consumers or reduce output in the market for physician services and, in turn, in the market for prepaid health care plans.

PPOs sponsored by state medical associations or other organizations with highly inclusive physician membership often have as participants a very high percentage of physicians practicing in the area served by the PPO. ACMG anticipates a high level of physician participation in this instance. Moreover, the PPO here would have the official sponsorship of the medical society, and would face little competition from other managed care plans. In such circumstances, there is a significant possibility that the plan will attain market power.[3]

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[3] In a different context, it was found that the UCR reimbursement limits on fees paid by Blue Shield plans to physicians were significantly higher where the Blue Shield plan's board includes members who have been nominated, elected, or approved by a local medical society or other organized group of physicians. Kass, David I. and Paul A. Pautler. "Physician and Medical Society Influence on Blue Shield Plans: Effects on Physician Reimbursement." in A New Approach to the Economics of Health Care, edited by Mancur Olson. American Enterprise for Public Policy Research. Washington, D.C. 1981. p. 321-338.

Anticompetitive effects are less likely to flow from the operation of a PPO if participating physicians are free to, and do, participate in competing PPOs or other managed care plans. I understand that ACMG does not contemplate prohibiting physicians from participating in other managed care plans. Nonetheless, if a PPO has a very inclusive membership, particularly where it has the sanction of the state medical society, there may be little incentive for participating physicians to market their services to other plans. Instead, physicians may tacitly agree among themselves to offer their services to payers only through that PPO, or to decide independently that it is not in their financial interest to support the development of other plans by participating in them. Where, as here, the medical society plan pays to most participating physicians their full charges, physicians have even less incentive to discount their fees and join other plans. Under these circumstances, the non-exclusive physician participation provision could effectively be negated, and the market could be deprived of competition that otherwise would be offered by other plans.

For the reasons discussed above, the proposal presented in your letter appears to raise serious questions under the antitrust laws. This does not, of course, mean that this office has concluded that the operation of a PPO established in the manner described would violate the antitrust laws. It does, however, mean that we cannot assure you in advance that the operation of such an organization would not violate the law.

The concerns we have identified flow from the agreement between ACMG and the medical society on the basis on which physicians will be paid for their services. Another approach might accomplish your objectives without presenting the same antitrust risk.[4] For example, ACMG might wish to consider offering a PPO without prior agreement with physicians collectively on price terms, or operating as an independent intermediary between a physician-organized PPO and payers. In either case, ACMG could provide payers with price and other information about participating physicians, and transmit proposed contracts from payers, including fee schedules to be used under such contracts, directly to individual physicians for their independent consideration.

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[4] See, e.g., Health Care Committee, Section of Antitrust Law, American Bar Association, Managed Care and Antitrust: The PPO Experience at 27-28 (1990); Lerner and Narrow, PPO Programs and the Antitrust Laws at 858, in The New Healthcare Market: A Guide to PPOs for Purchasers, Payers and Providers (P. Boland ed. 1985); Health Care Management Associates, 101 F.T.C. 1014 (1983) (advisory opinion); Letter from Mark J. Horoschak to J. Bert Morgan (Nov. 17, 1993) (advisory opinion).

This approach would avoid an agreement between ACMG and the medical society or its members collectively on terms of doing business, including price, and therefore would not appear to raise price-fixing concerns under the antitrust laws. Of course, the organization must take care to ensure that the decisions by the physicians on whether or not to accept the proposed contracts in fact are made individually, and do not involve any tacit or explicit agreement among the physicians not to deal, or to deal only on certain jointly agreed-upon terms. Similarly, care should be taken in transmitting information to payers to assure that they understand that such information is merely to help the payers to formulate their proposals; that the payers are free to propose whatever contractual terms and offers they wish to those physicians; that payers remain free to deal individually with some or all of the PPO's physician members and are not required to deal through the PPO; and that the PPO's agent has no power or authority to make offers, negotiate, agree for, or bind, members. Under this approach, ACMG would still be able to contract with the physician organization for participation in a utilization review system, if it chose to do so.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's Rules. Under the Commission's Rules of Practice §1.3(c), the Commission is not bound by this staff opinion and reserves the right to rescind it at a later time. In addition, this office retains the right to reconsider the questions involved and, with notice to the requesting party, to rescind or revoke the opinion if implementation of the proposed program results in substantial anticompetitive effects, if the program is used for improper purposes, or if it would be in the public interest to do so.

Sincerely yours,

Mark Horoschak

Mark J. Horoschak
Assistant Director

Mr. HYDE [presiding]. I thank the gentleman.

The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

I think most of the questions I had, have either been answered or probably will be answered by some subsequent speakers. Let me just ask, the ills that might occur if this legislation might pass would include price fixing. What other ills might take place?

Mr. PITOFSKY. That is the main concern, that it would prevent us from bringing cases on a per se theory where they justifiably ought to be brought. The other ill is what I was just talking about with Mr. Goodlatte, and that is that it will set up parameters, and instead of letting the market decide the best kind of physician network, the legislation will influence the market more than it should.

Mr. SCOTT. Another question: Are any other professional groups seeking similar exemptions, like lawyers?

Mr. PITOFSKY. They may be seeking it but they haven't received it.

Mr. SCOTT. Would there be any justification?

Mr. PITOFSKY. I really don't think—some people might disagree about this—I don't think that doctors under the antitrust laws should be treated differently than lawyers, accountants, architects, chemists, scientists, law professors, and so forth. One could argue that the health care market is so unusual and so dynamic that the doctors deserve some kind of special treatment. I don't think that is right.

Mr. SCOTT. Thank you.

Mr. HYDE. I thank the gentleman.

The gentleman from Indiana, Mr. Buyer.

Mr. BUYER. Let me pick up right where you left off. I can agree with a lot of that statement you just made, but I almost have this sense that we are in a period of correction. I don't like to treat one sector any differently than anyone else. I don't like Congress coming down with mandates and that type of thing.

But I have this strong sense that in health care, when we talk about the dynamics of it, it is so large and there is so much happening in the market place. We have a hybrid health care system in this country, Medicare, Medicaid, the VA medical system, private health care; costs are being driven by research, by consumers' demand for the highest quality of care.

I agree exactly with what you are saying, but my overall sense—I have served now 3 years on the Republican Health Care Task Force, I did my battles with the White House before this session of Congress—I just wanted to share with you, I strongly sense we are in a period of correction here.

My concern has been for the rural areas, and we can talk about moving, whether it is PPO's or HMO's, and greater integration with those types of networks. Maybe they will be able to compete with each other better in the big urban areas, but what about the rural sectors, that is my largest concern. That is what I represent. Would you please comment about what the impact would be in rural areas?

Mr. PITOFSKY. Well, I agree with you that treating networks in urban areas the same as in rural areas is a real mistake, and the second set of guidelines put out by the Department of Justice and

the FTC made it clear that rural areas will be treated differently and specially. There is some discussion of that very fact, and there are some examples of physician networks that would not be acceptable in an urban area which these guidelines say are acceptable in a rural area.

We are aware of that distinction. We have already taken that into account. We could be even clearer about it in another set of guidelines.

Mr. BUYER. The marketplace, we all recognize that yes, it is changing, but a lot of it is changing by not only downward pressures of cost containment by government, but also by businesses and corporations. Would you agree with that?

Mr. PITOFSKY. Absolutely.

Mr. BUYER. That is part of the innovation by health providers, whether they are doctors or whether they are HMO's or whether they are insurance companies or hospitals. In order for them to survive, they must also change in these dynamics.

Mr. PITOFSKY. Absolutely.

Mr. BUYER. You testified that there was one proposed network that did not meet your guidelines and failed. Would you please tell me what that was and what was the basis of your opinion?

Mr. PITOFSKY. Well, I don't know about the one advisory opinion where we denied clearance. There were several cases, one in Virginia and another in Florida. Danville, VA, and Broward County, FL. In both cases, what the allegation was was that the doctors were not so much involved in setting up a network designed to be more efficient as they were involved in setting up a network designed to preclude managed care, that is HMO's, from coming into their market.

In other words, their purpose was not efficiency, it was exclusion, and the Federal Trade Commission brought those two cases. The parties didn't want to litigate. They settled. I am not sure they admitted guilt, but they didn't litigate and an order was entered in both cases.

There is a history, I might say, going back to a rather famous Supreme Court case in 1942, of doctors getting together, banding together in what they call networks, what they call provider associations, where their main goal is to frustrate managed care.

Mr. BUYER. You made a comment, if legislation passes, clever lawyers will create networks that can get around the law. Congress passes laws all the time for which clever lawyers try to do certain things. FTC, the responsibilities of the Department of Justice, antitrust, are not going away; correct?

Mr. PITOFSKY. Absolutely. Right.

Mr. BUYER. When you said you prefer your guidelines have more flexibility, obviously the freedom that you have in being able to make these guideline changes easily also creates uncertainty out there in the marketplace, does it not?

Mr. PITOFSKY. Well, I think of the comparative advantage of guidelines over legislation as follows: Either one today could do the right thing or the wrong thing. We could do it right or make mistakes. The difference is, in a fast changing market like this, I assume this committee doesn't want to address legislation each and every year for the next 5 years.

But an administrative agency's responsibility is to make sure that the regulations that it enforces are consistent with the way the market is operating, so we can much more easily adapt to changes in the market than I think legislation can. That is what the Federal Trade Commission has been about in recent years. We have held very extensive hearings to make sure that the antitrust laws that we enforce are consistent with the way the world does business.

Mr. BUYER. Thank you, Mr. Chairman. That is why I see us in a period of correction and not a period of permanency. Thank you.

Mr. HYDE. I thank the gentleman.

The gentlewoman from Texas.

Ms. JACKSON LEE. Mr. Chairman, I thank you, and certainly I view the opportunity to review many aspects of health care and the regulation of such as a very important responsibility.

Mr. Chairman, I thank you for your presence, as well, the Federal Trade Commission acknowledging the role that the Trade Commission has played both as a factfinder, and you made a very vital point, I believe, and that is the difficulty of changing legislation every 5 years or maybe every year, as opposed to the role that the Federal Trade Commission can play in its monitoring and assessing capacity.

Mr. Hyde, I have an opening statement that I would just ask unanimous consent to have submitted to the record at this time.

Mr. HYDE. Without objection, it will be entered in the record.

Ms. JACKSON LEE. Thank you.

[The prepared statement of Ms. Jackson Lee follows:]

PREPARED STATEMENT OF HON. SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

The hearing today is an important opportunity for us to gain insight on new developments in the management of health care, to gain a working knowledge of antitrust law as it is applied to health care provider networks and review issues relating to medical malpractice. We have an excellent group of witnesses who are well-respected in their professions and will be able to enlighten us on these important issues.

Even though the Congress did not adopt comprehensive health care reform in 1994, technological advancements and different approaches to health care management have continued unabated. I do believe that it is important that we periodically review our laws to ensure that they are applicable to these changing circumstances.

Antitrust law principles, such as the per se rule and the rule of reason, are deeply embedded in case law and in agency interpretation. These principles reasonably give business firms a sense of whether there actions are permissible under antitrust

law. The Justice Department and the Federal Trade Commission have considerable expertise in this area and it is important for us to focus particular attention to their experiences.

During this hearing , we must carefully examine H.R. 2925, the Antitrust Health Care Advancement Act of 1996, to determine whether it is the appropriate manner in which to proceed on clarifying the types of actions and behavior that are permissible for health care provider networks.

This hearing's focus on Medical malpractice liability reform is a very controversial issue because we touched on this subject when we debated product liability reform. None of us can deny the seriousness of medical malpractice lawsuits and the chilling effect on physicians. We, however, have a duty to protect the American consumer and make them whole when physician and hospital negligence does occur.

While this hearing is not the appropriate forum to revisit all of the issues surrounding comprehensive health care reform, I believe that some of those issues should be resolved before making significant changes in malpractice liability.

I am also concerned about this hearing today because we are trying to solve these set of problems while Congress is still debating the issue of Medicare and Medicaid reform. The future

of these programs have become entangled in the budget debate. Congress must move forward on strengthening Medicaid and Medicare before we implement changes regarding health care service delivery.

Even though I have some concerns about the timing of examining some of these issues, I will keep an open mind and pay careful attention to the witness testimony. There are many powerful interests on both sides of these issues. Congress must move very carefully in the areas of antitrust and health care reform since these areas are extremely complex and do not lend themselves to simplistic solutions.

Ms. JACKSON LEE. The concern I would have as we review these very important aspects of our business is the whole question of health care reform. There has been certainly some mirth and some humor. I think it was a very serious effort that was made over the last 2 years, that did not end in the kind of fruition that many of us would have liked to have seen. I think we realize that the task is still at hand.

With that in mind, I am concerned that we look at these issues in the shadow of not having a complete response to Medicare and Medicaid, and at the same time looking more at the business of health care than the service of health care.

I would raise these questions, and not want to put any words in your mouth as to whether or not you oppose this legislation. But I am interested in determining how competent and well-prepared the Federal Trade Commission would be over the next years to monitor the new formation of joint ventures by the medical profession.

Particularly, this is new to us, it is new to physicians. I talked to them at home, and in actuality they are responding to what they think is necessary to survive. They have come to me and have suggested that they are not abandoning the private practice concept. They loved that life, but they are doing these joint ventures in order to survive.

Do you have the tools that can continue to monitor whether or not these joint ventures and other type associations are effectively working? Will you be able to provide us with maybe more indepth data that would then give us the sufficient basis to correct what some people seem to think is an injury?

If you would answer that first question, because I know how these lights go, let me get my other questions on the table, if you don't mind. I hope you will include in that how large your enforcement staff is on these issues; what kind of data you have on complaints from these groups under the per se rule; and I would want you to give your comments as to whether or not H.R. 2925 needs minor overhaul or whether or not it needs complete readjustment, or whether or not this is a point to put sort of a hold on this legislation in order for you to gather the data.

As I finish my questions, let me just emphasize in your responses I don't mind you commenting on the fact that we may be putting the cart before the horse in light of the fact that we are still looking at health care reform in this country, which should be one of our chief responsibilities. Certainly your agency looks at it from a different perspective, but are we getting ahead of ours?

I thank you, Mr. Chairman.

Mr. PITOFSKY. Thank you for those questions. First of all, can we monitor this changing marketplace? I suppose this is an opportunity for me to discuss our budget, but you probably don't want to hear about it.

We are—what shall I say?—we are strapped to a certain extent in our ability to do all the things that we have been assigned to do by law. But I will say this: Antitrust application to the health care market is a very high priority. I am not sure there is any higher priority within the agency.

I mentioned that we spend two-thirds of our resources on mergers, and that includes the health care market. In the nonmerger area of antitrust we probably spend more time and effort on health care than any other area of the economy. So that is not something that we would allow to slip.

Enforcement staff, ours is an agency of about 950 people, probably half are in the enforcement staff. I am not sure, sitting here right now, how many people are involved in health care review. Let me get that data for the committee, including the complaints that we have received from people claiming that certain kinds of physician networks deserve per se treatment. I suspect that there are rather common kinds of complaints that we receive.

Finally, on your last point, minor overhaul/major overhaul, I would like to agree with your last thought. I don't know the answer to that. I certainly believe that some of the elements of the proposed legislation do reflect efficiencies that should be taken into account, but I would like the opportunity to complete our analysis. We are talking to everybody in this field, all the players in this market, and if the legislation were put on hold briefly, we would be able to report back to the committee both in the form of responding about the legislation but, more importantly, clarifying our guidelines.

Ms. JACKSON LEE. Thank you, Mr. Chairman. I yield back.

Mr. HYDE. I thank the gentlewoman.

The gentleman from North Carolina, Mr. Heineman.

Mr. HEINEMAN. Thank you, Mr. Chairman.

Welcome, Mr. Chairman Pitofsky. We are really talking here about something that is really probably one of the most vital issues in America today. Certainly the medical industry has created within itself a revolution, and I applaud them for getting ahead of the curve. What we are talking about here today is part of the development of that revolution.

Whether we go the congressional way, whether we go the deductive way, so to speak, they are both important. But what really is important is that we get the finest, the best bottom line, not only for the Medicare people in this country but for the rest of the people in this country. It is extremely important.

We have been debating this, not me, but the 103d Congress had been debating the health care plan that the President and his wife came in with back in 1993. You state that your process will take less than 6 months, so this seems not to be a lot of problem with that. The Congress looks to set guidelines for the next 6 months.

Could we not have you come back with your process, your deductive process, so to speak, prior to the 6-month period, and perhaps increase your positions as it relates to working your way to a final product, and perhaps recommend obviating congressional recommendations? Would that not be the best way? Because the bottom line is not who is preeminent, how we go about this inductive or deductive process, but that the bottom line is the bottom line we can get.

Mr. PITOFSKY. I think we could come in with something in the nature of an interim report. We have other Commissioners to be considered, plus the Department of Justice, but I think we are well along on that path. Even if we don't do an interim report, my hope

is that we would be here in well less than 6 months with a final adjustment of our guidelines.

Mr. HEINEMAN. As I sat here early on in the hearings, I kept seeing "FDA, FDA" flashing before my face, and wondering how that got off the ground to the point where it took us 10 years and 7 years and 5 years, where we approve not only medical devices but pharmaceuticals and the like. So I wish you luck. I wish we could put together the best health care system in the world, because we certainly have the resources here to do it.

Thank you, Mr. Chairman.

Mr. HYDE. Thank you.

The gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Thank you.

I will be one of the last to welcome you here this morning, Mr. Chairman.

Mr. PITOFSKY. Thank you, sir.

Mr. MOORHEAD. I think the thing that concerns all of us—and our doctors come to us who are in rather serious trouble right now—is that the economic pressures that can come from the HMO's and the Federal Government and others who have much stronger economic power than the individual doctor may have, have totally changed the situation out there. Most of my M.D.'s. are telling me their incomes are down 25, 35 percent over what they were a few years ago, and they cannot compete with the ability of the HMO's to drive down the prices in the hospitals and other places.

There has to be some way for them to defend themselves, and what we are talking about here is providing some kind of ability for them to defend themselves. If we do not do that, a lot of doctors, like my own doctor and his doctor wife, are just going to leave the profession. They are going to say, "We are not going to do it anymore," and I think that would be a terrible thing for our country, if we see too many of the qualified people who have practiced medicine for many years deciding they can't do it anymore.

I hope that you or this legislation or something does something to protect the quality of health care that we have, with the individual practitioners that care about an individual person. They are your friend, your neighbor, and they really care what happens to people they treat. So many times when you get in these big, big organizations, they care all right, but they don't care that much.

Mr. PITOFSKY. Mr. Moorhead, I take your statement very seriously, and I recognize that we are dealing here partly with the ability of doctors to function effectively in the marketplace, but also at the same time the quality of care. I would hate to think that antitrust law, by being out of step with the way the market is developing, is a burden. I don't think it has been over the years.

On the contrary, I think we have succeeded in keeping the market open for new forms of health care. I also want to mention something I said earlier, that there are many doctor networks that are functioning right now in the marketplace. Fifteen and 20 percent of different categories are doctor-organized networks. However, if we can clarify our guidelines and make it possible for other efficient joint ventures to be established, I think we are all on the same page here in trying to facilitate that occurring.

Mr. MOORHEAD. You know, what happens if you have to go into a hospital and you are in an HMO, the HMO's drive the prices down that the hospitals charge. The Federal Government does exactly the same thing. But if you go into the hospital outside of one of those plans, your bill is going to be double at least what those other bills are.

We hear these stories about exorbitant bills in the hospitals, but it is because it is the only way they can survive. They charge where they can charge. If these doctors don't have some kind of an organization they can go into where they can have some of that economic power, they get left out in the cold.

Mr. PITOFSKY. Well, we are all thinking of the same issue, which is whether there are other forms of organization that they ought to go into, and that antitrust not impair their ability to do so if their goal is really, as you put it, to practice their profession in the most efficient way possible.

If their goal is to get together and drive out new forms of health care, then it seems to me that is inconsistent with a free market and that we have an obligation to make sure that doesn't happen.

Mr. MOORHEAD. Thank you.

Mr. HYDE. I thank the gentleman.

The gentleman from Florida, Mr. McCollum.

Mr. MCCOLLUM. Thank you, Mr. Chairman.

I just have a couple of questions based on your testimony, now that I have had an opportunity to review it. I apologize for coming in late.

In the bill itself that you criticized, which is H.R. 2925, there are two aspects to that bill. One of them deals with the conduct of a health care provider in exchanging with one or more health care providers information relating to cost, sales, profitability, marketplaces, et cetera, strictly dealing with the exchange of the information.

Do you have any objection to our eliminating the per se rule pertaining to it and, in other words, freeing up the exchange itself of information? That doesn't seem to be the heartburn in your testimony.

Mr. PITOFSKY. No, it is not. There is no objection to it. I would alert the committee that that is already the law. It would be legislation that affirms what is presently the law, that the rule of reason applies to those exchanges and not the per se rule, but of course I have no objection to it.

Mr. MCCOLLUM. We have a lot of people complain to me, and other Members do, all the time, hospitals particularly, saying, "Hey, we can't do that. Our lawyers tell us that may be the law, but we will not talk about it with the other people because we are afraid to. Our lawyers tell us that we will get in trouble." That is the kind of thing I think we sometimes legislate that you may perceive as unnecessary, but maybe it is needed to calm things down.

Mr. PITOFSKY. Mr. McCollum, I said earlier maybe they ought to get new lawyers. They probably are being poorly advised.

Mr. MCCOLLUM. There are a lot of them getting that advice.

Secondly, with regard to the network issue, it seems to me that your major concerns fall into two categories, one of which is obvious, we can't do much about it, and that is the complex moving of

the whole area, and perhaps the potential for various organizations to try to conform to the law that we would draft, to meet certain requirements that would not necessarily be good public policy. That may well be true generically, whether it affects price fixing or anti-competitive measures or not.

But the other one, it seems to me, narrows down to primarily a concern on your part that by putting this networking provision in, we will be somehow protecting some price fixing. The shams, the illustrations that you gave in Broward County in my State, are an example of that.

You said in your testimony that the only legislative directive that eliminates the per se treatment that is currently in law, that you were able to find, is the National Cooperative Research and Production Act, and I say that that law specifically excludes pricing agreements involving the marketing of products or services. Suppose we did that to this paragraph dealing with the health care provider network. I realize that would not overcome all of your concerns, but would that go significantly to overcoming them if we put a clause like that in?

Mr. PITOFSKY. Let me see if I understand. The legislation would say that doctor networks can be formulated, but the doctors would not be permitted jointly to negotiate the price of their services with the insurance companies or other buyers?

Mr. MCCOLLUM. Without the per se rule being adopted.

Mr. PITOFSKY. In other words, the per se rule would still apply there? To be candid with you, I don't think the people who are complaining about the present situation would think they had gained very much if the bill were to exempt the negotiation of price. That is really the heart of the matter, allowing the joint venture—if doctors want to get together and jointly buy a CAT scan machine, I don't believe anybody thinks that is a problem. If they want to get together and engage in joint research or exchange information about the way certain patients are treated, that is not really much of a problem either. That is what is permitted——

Mr. MCCOLLUM. Let me ask you this last question related to hospital experience. Granted, we are talking about networks and doctors, but in Orlando there are two major hospitals, big ones, and I have had them say to me, "We don't even talk to each other about it, but what we would like to do, instead of both of us building cancer centers and both of us building cardiology centers"—and they are doing that, duplicating everything—"we would like to be able to say to the other, you build the cardiology center and we will refer the patients over there for a fee, and we will build the cancer center and you refer your patients over here for a fee."

Now, that probably would violate today's antitrust laws, but maybe that would be good policy, because that could drive prices down if there were a price-fixing mechanism so that you could go over them on fixing prices instead of discussing the efficiencies, and that gray area in the big picture is a problem. That is what I think we want to get at. We want to try to do something about that and drive the cost of medicine down, not up. Nobody wants to drive it up.

But I think you see where we are dealing with this. Granted, it is just networking here, but it is similar. I don't want to take more

time with that, but I don't know if you have a response to that. If you want to respond and the chairman will let you, I would be glad for you to.

Mr. PITOFSKY. Very briefly, you have really raised a new question here? This is what we call division of markets. That is to say, "You take the heart cases and we will take the lung cases." There is no integration there at all. There is no merging and there is no joint venture. Antitrust would no more allow that than if General Motors said to Ford, "You build the small cars and we will build the big cars." That might drive the price down, but that is not the free market. We want the market to decide who builds big cars and who builds small cars.

The issue addressed by the proposed legislation is a tougher question because there is integration. There is combination. There are some efficiencies. The question is, at what point do those efficiencies become so significant that we allow more lenient treatment, and that is what the bill addresses and that is what we are trying to address.

Mr. HYDE. The gentleman from New Mexico, Mr. Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. Chairman, thank you for being here. I want to just follow up on a bit on what Congressman Moorhead talked about, and that is the idea of where physicians are in the marketplace now with the emergence of managed care. I am not trying to make this an evaluation overall of managed care. I think it is beyond the scope of what we are doing, and if I were to, I would point out some positive accomplishments of managed care and some problems. I think most people would.

But specifically in the area of marketplace, it seems to me that managed care reduces ultimately the total amount of competition because the large managed care conglomerates, if you will, have enormous economic weight all through the system to tell physicians, "This is what we are going to pay. If you don't like it, don't take it, and you are not going to work;" tell hospitals, "If you want us to fill your hospital beds, these are our terms;" and to tell patients ultimately, "This is what you pay and this is what you are going to get."

It seems to me that promoting the ability of physicians to create and promote networks of providers for the appropriate reasons, ultimately will have more competition in the marketplace because there may be one, two, three, maybe four HMO's. If there are other types of operations, then there is that much more competition in the marketplace, which I think is ultimately good. As a general premise, do you agree with that or do you take exception to that?

Mr. PITOFSKY. I do, I do.

Mr. SCHIFF. Pardon me, but I do what?

Mr. PITOFSKY. I do agree that the more networks that are in the market, the more likely there is to be competition, and patients will profit. I also want to emphasize we are not on the side of managed care or fee-for-service. That is not our role. Our role is to make sure the market allows all of those to operate without one group precluding the other.

Mr. SCHIFF. Well, that is my point. It just seems to me, as I look at the medical marketplace now, that managed care has the pre-

ponderance of economic force. It just seems to me that some balance there is ultimately in the interests of physicians and consumers. That is the point I am making.

Otherwise, I don't own stock in any managed care. You know, I don't make any money from the health care profession one way or the other. I have the same goal you do, to have the maximum amount of legitimate competition that ultimately benefits the consumers. I think that should include managed care but also other areas.

I am going to take one more half minute to say that I appreciate this hearing on this important subject. Managed care is growing so fast that we do need to stay on top of it as Congress, so that we can discuss these issues in fairness to managed care as well as to other types of health care providers.

I also want to say that because of other commitments I will not be here for the total extent of this hearing, but I want to say that I think you have picked some very important subjects in the legal system. I just want to say, because we have had other hearings on these subjects such as malpractice reform and charitable provisions, that I don't believe for a minute that the legal system is beyond reproach. I don't believe for a minute that the legal system does everything perfectly and we shouldn't examine it.

I personally supported the legislation which passed over the President's veto recently, that dealt with certain stockholder suits that I felt have reached the point of becoming abusive. I think some very good questions are raised by Mr. Goodlatte's legislation that talked about whether the legal system prevents certain people from getting service, but I oppose things which I regard as arbitrary.

For example, caps on noneconomic damages sound good and they could lower the bottom line, there is no doubt about that, but I think at the expense of certain individuals not receiving compensation that they are justly entitled to in appropriate cases. But I think it is good that we have the ongoing debate and discussion.

Thank you, Mr. Chairman.

Mr. HYDE. I thank the gentleman very much.

On page 3 of your testimony you state a legislative directive contained in the bill, H.R. 2925, would rigidify the position of physician networks, in the sense that organizers would seek to establish networks that fall within the technical requirements of the legislation rather than those that would ensure maximum patient benefit. But isn't this just what the guidelines have done? Don't the guidelines artificially induce physicians to structure their networks to fit within the guidelines? Six of one and half dozen of another?

Mr. PITOFSKY. That is a criticism of the guidelines that we are trying to respond to, but I can only come back to the point that I have made earlier. We think that we should keep an eye on this market and possibly adjust the guidelines year in and year out. I don't think legislation can do that. This committee doesn't want to sit and review this question each year.

Mr. HYDE. Well, what you are saying is that guidelines are more pliable, more flexible, more manipulable, and we can keep adjusting them, fine-tuning them, whereas legislation is a pretty tough shot to do, as we all know. That is really what you are saying.

Mr. PITOFSKY. That is exactly right.

Mr. HYDE. The other side of that coin is predictability, certitude. People in the world like to know what the law is, especially people who have tax problems. They would like to know that next month, and when they make commitments, they make investments, there is something to be said for certitude and predictability. That is diminished when we have these flexible, amorphous, changeable guidelines. So that is the tradeoff, right?

Mr. PITOFSKY. Mr. Chairman, that is a very accurate statement of the tradeoff.

Mr. HYDE. Thank you. In contrast to a doctor's own network where each doctor is sort of a medical entrepreneur or considered as such, how is the consumer served by allowing large insurers to take over the health care marketplace? I understand that their behavior is unilateral, one company, Travelers or whatever have you, but if they sign up 40, 60, 70 percent of the doctors in an area, where is the consumer choice and how will prices be limited under that circumstance?

Mr. PITOFSKY. Well, if the insurance companies really have a dominant position in the market, and if the insurance companies act in such a way as to preclude competition——

Mr. HYDE. Let's just say one company in a region, let's say in Orlando one company signs up 60 percent of the physicians.

Mr. PITOFSKY. Well, if in fact—well, one reason they might sign up 60 percent of the physicians is because they are performing efficiently and the market allows them to do that. If they are the only company in Orlando, and if they use their market power to preclude other forms of health care from entering that market, we would stand ready to challenge that kind of behavior under the antitrust laws.

Mr. CONYERS. Would the Chairman yield?

Mr. HYDE. Sure.

Mr. CONYERS. I thank the chairman for yielding on that point. Let me just extend this hypothetical. Suppose that an insurance company under discussion sends a letter saying also to the doctors in the area that if you don't join, this is your last chance and you can kiss your opportunity to join this operation goodbye? How does that affect your response to Chairman Hyde?

Mr. PITOFSKY. I am not sure how that would play. One preliminary point: We are getting into complicated areas because of McCarran-Ferguson and the extent to which antitrust laws apply to insurance. But the kind of conduct the chairman was describing it seems to me falls within exemptions to McCarran-Ferguson, and if it were called to our attention we could do something about it.

Mr. Conyers, on your point, I am not sure. I would have to know more about the facts there.

Mr. CONYERS. Let's just be general enough, to the extent that the doctors get the word that this is it, my friend, you join this one, or you can figure out how you are going to survive in a market where one big player exists and is driving out all the individual private practitioners.

Mr. PITOFSKY. It could be, depending on all the facts, it could be hard negotiating, hard bargaining, or it could be some kind of ar-

rangement among the members of that insurance coalition to drive out other forms of health care.

Mr. CONYERS. It could be coercion that comes from size.

Mr. PITOFSKY. Right.

Mr. CONYERS. Now, how does the Commission react to that sort of situation?

Mr. PITOFSKY. Size, in itself, is not a——

Mr. CONYERS. No, not in itself. That the coercion results because of the size.

Mr. PITOFSKY. So far we haven't got an antitrust violation. But if they use techniques resulting from their size to preclude others from coming into the market, then we begin to have problems.

Mr. CONYERS. Well, that ought to scare the beans out of every doctor with a medical certificate in the United States of America. He can get threatened, he can have—it can be a polite threat, you know. They can write very artfully a long letter explaining that "This is it, buddy. You join this Great Lakes Region Association between now and May 1, or that wonderful opportunity will not exist for you anymore, and you can figure out where you will be practicing from now on."

Now, if you are telling me that that is all free and wonderful in this great enterprise of practicing medicine, I think any medical person hearing this ought to be even more afraid than he or she could be right now without the hearing.

Mr. PITOFSKY. Let me expand on what I said before, because I realize now what you are driving at and I perhaps was misleading. I was focusing on what the bill was focusing on, which is where per se ends and rule of reason ends. The hypothetical that you gave me where 60 percent of a specialty in a certain area join under a rule of reason, that would be a problem, and that is true under our present guidelines.

Mr. CONYERS. I would just feel a little happier, Mr. Chairman, if you could give me some assurance to take back to the doctors in the Midwest that they don't have to be up against the wall every time somebody big comes along in the area and says, "It is us. We are it. We are signing up people a mile a minute. We are going to be the biggest thing in the area. You can see our advertising. You know we have got connections with certain other groups here that we are going to pool everybody in, and here is the deal," and it is not a very good deal. Then they say, "And, by the way, you have got 30 days to let us know whether you are interested or not, and after that it is closed."

Now tell me, Mr. Chairman, that that is OK, then I have got to get a notice out to all of my doctor friends that, listen to me, that you are right, you ought to be scared, because I just got it from the main man in Washington. Talk to me, Mr. Chairman.

Mr. PITOFSKY. You present a kind of a gray area case——

Mr. CONYERS. Gray?

Mr. PITOFSKY [continuing]. In which the challenge is that if you do not join our network now, the boat is going to leave, the train is going to leave, and you will not get a chance later on. At that point, I don't think you have an antitrust problem.

Mr. CONYERS. Well, that is beautiful. That takes care of every doctor that I know, because you might as well think about the rest

of it. Just what does he or she do, then, since there is a gray area that doesn't present a problem?

Mr. PITOFSKY. You know, as a practical matter——

Mr. CONYERS. Yes, as a practical matter they go out of business. That is the practical part.

Mr. PITOFSKY. No. Usually, in almost every market that I am aware of, they are not going to be put to that choice because there are going to be competing networks.

Mr. HYDE. Well, if I may reclaim my time, Mr. Chairman, I don't want to take an oversimplistic view of antitrust law, but as I understand it, it takes two or more competing entities or separate entities to combine to create an antitrust violation. That being so, my concern is that single entities, insurance companies, are increasingly controlling the health care marketplace and antitrust doesn't reach that problem.

We are talking about doctors who, as I say, are individual medical entrepreneurs coming together in a network with an HMO to provide service, and that raises questions of the Federal Trade Commission and the rest of us. But a single insurance company can come in, sign up 60, 75 percent of the doctors, and I don't see that as a good trend. It doesn't serve competition.

So I would simply point that out, that that is something that can happen and does not advance competition. I think we can agree on that. We just don't have a remedy for that under the present legislation.

Sort of to summarize, this bill is about providing health care professionals with some degree of certainty, legal standards they can rely on. Many have charged that the guidelines that the Chairman is defending don't provide the needed certainty.

Now, we know that one of its virtues may be one of its vices. That is, the guidelines are easily changed. No public comment or notice is required, no judicial review. Regardless of whether a network gets approved under a guideline, there is no assurance that a private suit won't be successfully brought to challenge its conduct. Those suits subject defendants to treble damages. Don't we need to give doctors some incentives to try innovative networks by giving them assurances they won't be found per se illegal?

Mr. PITOFSKY. I am not aware of a private suit in this area. I mean, I think that is theoretically a problem, but I am not aware of any private suits in this area. In terms of clarifying the line between per se and rule of reason, I have said several times I agree that clarification in that area would be useful, and that is what we started the end of last year and that is what we are about.

Mr. HYDE. Well, I thank you.

Mr. CONYERS. Mr. Chairman, could you allow one final intrusion, and I apologize. I don't do this often.

Mr. HYDE. Surely.

Mr. CONYERS. Chairman Pitofsky, what if the letter goes out about this one giant that Chairman Hyde referred to in the area, and they just happened to leave out African-American medical practitioners and the letter happens to not go to African-American practitioners in the area? So the black doctors end up finding out at the hospital that there is some new wonderful, big, efficient, highly-supported medical group coming on, but they didn't happen

to get a letter. Does that raise any problems, antitrust or otherwise, in your mind, sir?

Mr. PITOFSKY. I don't think it raises antitrust problems. It may raise other problems in other areas of the law. Could I clarify an answer I gave you earlier, because I think I may have misspoken.

Mr. CONYERS. I am waiting with bated breath.

Mr. PITOFSKY. Here it is. I should have distinguished between exclusive and nonexclusive doctor networks. If the letter goes to all the doctors in town and says, "The boat's leaving, you must join our network, and in joining our network you must be committed to us and no one else," that may have been what your question was. That is an antitrust problem.

On the other hand, if the letter says, "Here is an opportunity for you to join a network, join us," but it doesn't preclude you from operating on your own with some other network, I guess that is what I was thinking of, and at that point it is not an antitrust problem. I should have been clearer when I answered you earlier.

Mr. CONYERS. I thank you very much, and we will continue this discussion.

I thank the chairman for allowing the intervention.

Mr. HYDE. I thank the gentleman.

Mr. Chabot of Ohio has come in. If the gentleman wishes we would recognize him.

Mr. CHABOT. Thank you, Mr. Chairman. I appreciate that. I have no questions at this time.

Mr. HYDE. I appreciate that.

Thank you, Mr. Chairman. You have survived the ordeal by fire very successfully. We thank you so much.

Mr. PITOFSKY. Thank you, Mr. Chairman, for this opportunity to testify.

Mr. HYDE. We are going to proceed. It is 11:30, and I have the high hope and expectation that we can finish with panel 3, if you can let the hunger pangs exist, we can finish and not have to come back after lunch. We will try it and see how far we can get.

Our final panel consists of several public witnesses who have varying perspectives on medical malpractice. First we have Mr. Fredric Entin, senior vice president and general counsel of the American Hospital Association. Under Mr. Entin's direction, the AHA's Office of General Counsel addresses a variety of legal issues for member hospitals, including antitrust and tort reform.

We also have my good friend, Mr. Philip Corboy, who is with us here today. Phil is the immediate past chair of the American Bar Association Special Committee on Medical Professional Liability, and will testify here today on behalf of the American Bar Association. He is also a former president of the Chicago Bar Association and has authored numerous bar journal articles, as well as a frequent lecturer and panelist at bar association meetings and medical seminars.

We also have Mr. George Dikeou. I hope I am pronouncing that correctly. Am I in the ballpark?

Mr. DIKEOU. Dikeou.

Mr. HYDE. Thank you. On behalf of the Physician Insurers Association of America. Mr. Dikeou is the chairman of the legal section of the Physician Insurers Association of America.

Also testifying is Mr. Robert Clarke, president and CEO of Memorial Health System of Springfield, IL. Mr. Clarke is representing the Health Care Liability Alliance.

Next, Dr. Joseph Hanss, a board-certified obstetrician and gynecologist who has been practicing for 28 years in Phoenix, AZ. Dr. Hanss is testifying here on behalf of the American College of Obstetricians and Gynecologists. Dr. Hanss is a past president of the Arizona Medical Association, and has been very active at the State level in trying to get medical reform liability passed.

Mark Hiepler is a partner in the California law firm of Hiepler & Hiepler. Mr. Hiepler is a plaintiff's attorney, very familiar with the California medical practice law.

Lastly, we have Ms. Linda Ross. Ms. Ross has brought a claim against a California HMO for wrongful death relating to malpractice, and she will share her personal experiences with us.

We look forward to hearing from all of you on these important issues. Mr. Entin, I will recognize you first for 5 minutes of oral testimony. I would hope that all of the witnesses could confine their statements in chief to 5 minutes. Your full statement will be made a part of the record in its entirety. And so, Mr. Entin.

STATEMENT OF FREDRIC J. ENTIN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION

Mr. ENTIN. Thank you, Mr. Chairman. I am Fred Entin, general counsel for the American Hospital Association. The AHA has over 5,000 members, including hospitals, health care systems, networks and other providers of care. We are pleased to present our views on the reform of the health care liability system.

We have specific proposals in our written testimony, most of which would appear in the bill that passed the House last year. We particularly support provisions to provide for a cap on noneconomic damages and for reform of the—to fair share liability, eliminating the joint and several rule. We commend the chairman and the committee for its leadership in this endeavor.

The health care liability system is seriously flawed. It fails to compensate injured patients fairly or effectively. Some never receive the compensation they are entitled to. Others are compensated excessively.

Before I became general counsel of the AHA, I practiced medical malpractice defense in Cook County, IL. It was my experience that in many cases we were taking to trial cases where the alleged incident occurred 10 to 12 years prior to the time we reached trial. Any system that gets money to those who deserve so delayed is certainly not working very well.

The failures of this system are reason enough to push for reform. But if we put this issue in a larger context, the need for reform becomes even more compelling. It would be a mistake to address the issue of liability reform in a vacuum.

As has been mentioned by members of this committee in this hearing, during the last 3 years Congress has debated indepth the issue of health care reform. During the course of the last year, the issue of the budget has been debated, where Medicare and Medicaid expenditures have been the center piece. No legislation has occurred. There has been no budget agreement, but there is consen-

sus, I believe, that has emerged that the health care system is too costly and that access to care poses a serious threat to the well-being of many Americans.

Let us remember that the health care liability system does not exist by itself. It is part of the American health care system. The costs of the liability system are borne directly by those who engage in the health care system. That means hospitals, physicians and patients. At a time when the system is trying to achieve greater efficiencies to reduce costs and deliver basic services, we cannot ignore the fact that the liability system adds costs and denies to whole communities basic medical services.

This country is demanding reform of the health care system. The liability system, in our opinion, presents a barrier to that change. The threat of lawsuits and the way the current health care liability system handles them has a dramatic impact on access.

Many providers are afraid to fully practice their profession because of potential liability claims, especially in high risk specialities. Some providers are unwilling to practice their specialities at all because of increasing malpractice premiums. A liability system that intimidates the delivery of certain specialities does a disservice to us all.

At the same time the liability system is hurting access to care, it is also increasing the cost of care. Lawyers Weekly USA, a trade publication, reports that health care cases accounted for 5 of the 10 highest awards in liability last year.

Median awards in malpractice increased by 40 percent last year. Over the last 5 years, the annual rate of increase in malpractice cases is three times that in other tort cases. I can suggest that there is no logical explanation for this disparity, except that we have a system that is out of control and awarding those who win lottery-like recoveries.

The costs of the health care system are also artificially bloated due to the cost of defensive medicine. Many physicians and other providers make decisions anticipating what the legal system may require rather than the needs of their patients. It has been estimated that defensive medicine added, in 1991, as much as $25 billion to the cost of health care.

AHA believes that the problems with our current liability system can be addressed through a number of initiatives. Many of those have been shown to be effective in places like California through the MICRA reforms. Prominent among those is the cap on non-economic damages, which after being studied has shown that expenditures have fallen in those States where there is a cap, and no compromise to patient safety has been observed.

We also would urge further development of practice parameters, especially those parameters that would raise a presumption that the standards of care have been met. We would urge a reexamination for fair share liability to protect deep pockets such as hospitals and prevent irresponsible providers from going bare of insurance.

The health care liability system needs a massive overhaul. Provisions as being examined by this Congress are important measures to address the problems of the liability system and to achieve the efforts and the needs of health care reform in general. We urge the

members of this committee and the Congress to continue your important efforts.

Thank you, Mr. Chairman.

Mr. HYDE. Thank you very much, Mr. Entin.

[The prepared statement of Mr. Entin follows:]

PREPARED STATEMENT OF FREDRIC J. ENTIN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Fredric J. Entin, senior vice president and general counsel of the American Hospital Association (AHA), whose membership includes 5,000 hospitals, health care systems, networks and other providers of care. I am pleased to present our view of how and why the current health care liability system should be reformed.

This country's health care system is undergoing rapid change. At AHA, we are working to direct the forces of change toward community-based health networks that integrate the financing and delivery of care. We believe that, by bringing providers together into such networks, we can knit the now-fragmented system together for patients and provide care more efficiently and cost-effectively.

To do this, we must address the high cost, inefficiency and inequity of our health care liability compensation system. The AHA believes that the existing health care liability system fails to meet its goals of compensating injured patients fairly while also deterring bad health care practices. We need health care liability reforms that will encourage physicians and other practitioners to practice high-quality medicine without fear of unfounded or excessive liability

The situation is getting worse. Median jury verdicts increased 17 percent from 1994 to 1995 and the largest increase was in awards for health care liability cases. The median verdicts in those cases rose from $356,000 in 1994 to $500,000 in 1995, an increase of 40 percent. The news is especially bad for hospitals. According to *Lawyer's Weekly USA*, a trade publication, health care cases accounted for five of the ten highest awards in all jury verdicts last year. Four of the awards were against hospital defendants; the fifth was against a health plan. Those awards ranged from $40 million to $98.5 million each.

Clearly, the time for health care liability reform is ripe. AHA commends Chairman Hyde, the Judiciary Committee and the House of Representatives for recognizing this. We thank those members who worked for reform over the past year, specifically in debating H.R. 956, the "Common Sense Legal Standards Reform Act of 1995." The House passed two amendments important to hospitals and other providers: a $250,000 cap on non-economic damages in health care liability cases; and a "fair share" amendment, which changed some joint and several liability to proportionate liability, no longer allowing a defendant responsible for as little as one percent of total fault to be held responsible for paying an entire award. And, for the first time, health care

liability reform reached the floor of the U.S. Senate. We are encouraged by this progress, and urge you to continue these efforts.

The Need for Change

The U S health care system is unique, both in its strengths and weaknesses We have a wealth of health care facilities and highly trained personnel, and have long been recognized for the high quality of health care we provide Our health system encourages clinical innovation and is known for state-of the-art treatments and technologies At the same time, however, we have created unrealistic expectations. When treatment fails to meet those expectations, very often the result is a lawsuit

The effect of litigation threat -- and of the way our current health care liability system handles lawsuits -- goes far beyond economics. The system today has a dramatic impact on access to care Many health care providers are afraid to fully and freely practice their trade because of potential liability claims, especially in high-risk specialties. Some providers are simply unwilling to practice in their specialty areas because of increasing malpractice premiums and the threat of a lawsuit. Many communities are therefore left underserved, with little or no access to appropriate health care services For example, obstetricians working in Virginia, which has a reasonable limit on total damages, cannot afford to practice here in Washington, where annual malpractice insurance costs are $70,000 -- more than most people earn in a year.

Consequently, patients are often left to patch together services in a variety of settings from unconnected providers, or from providers who are not properly trained in specialty areas. In order for providers to be able and willing to deliver appropriate health care services in all specialty areas, the threat and burden of malpractice suits must be eased.

At the same time that the health liability system is hurting access to care, it also is increasing the cost of care. Many physicians and other providers practice "defensive medicine" in order to shield themselves from lawsuits. In other words, they order tests or provide services not because the services are medically necessary, but because they may protect the provider in case of litigation.

Many opponents of reform fear that quality of care will suffer if reforms are implemented. But a new study shows that in states that have reformed their health care liability laws, lower health care costs have resulted, with no significant impact on health outcomes. The study was performed by researchers at the Stanford University Graduate School of Business (Kessler and McClellan, "Do Doctors Practice Defensive Medicine?" Quarterly Journal of Economics (forthcoming)). In states that implemented caps of $250,000 or $500,000 for non-economic damages like pain and suffering, along with other reforms, the researchers found that hospital expenditures for elderly people with heart disease fell by about 5 percent, without compromising patient safety.

An earlier Lewin-VHI, Inc. study, "Estimating the Costs of Defensive Medicine," indicated that the nation could shave its health care bill by as much as $35.8 billion over five years, if the practice of defensive medicine were reduced.

Other studies of our health care liability system agree that the current system hurts providers' ability to make quality health care available to all Americans while effectively managing health care costs. See, for example: (Saks, Michael J., "Do We Really Know Anything About the Behavior of the Tort Litigation System--and Why Not?," University of Pennsylvania Law Review Vol. 140 (4), April 1992.); (Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York (1990) (Harvard Medical Practice Study)); and (Medical Malpractice: Characteristics of Claims Closed in 1984, General Accounting Office, GAO/HRD 87-55)

People injured by negligent care are entitled to fair and prompt compensation, but all parties should have the right to a fair and cost-effective dispute resolution process. Unfortunately, the current health care liability system:

- costs far too much and works much too slowly;
- threatens access to health care, especially higher-risk services such as obstetrics and emergency room care;
- fails to provide access to the legal system, or fair compensation, to most patients injured by medical malpractice, while providing exorbitant awards to a few;
- cannot promptly or cost-effectively identify unfounded claims;
- fails to adequately promote quality health care or protect patients from avoidable injuries; and

- adds billions of dollars annually to the national health care bill in health care liability premium costs by encouraging doctors and other medical professionals to practice "defensive medicine" as a hedge against potential lawsuits.

Uniform Standards for Health Care Liability

AHA endorses the following health care liability principles as essential to reforming the health care liability system:

A cap on non-economic damages. AHA supports full and fair compensation for all economic "out-of-pocket" losses suffered by patients who are injured as a result of malpractice. Reform should include unlimited economic damages and up to $250,000 for intangible, non-economic damages such as pain and suffering. Such a ceiling would not prevent people from recovering the necessary funds to pay for medical expenses, lost wages, rehabilitation costs, or other losses suffered as the result of a health care injury.

The cap would ensure that plaintiffs are justly compensated for actual economic losses that are incurred, while preventing "runaway" awards for noneconomic damages, and allowing health care dollars to be better spent on patient care. Limits on non-economic damages, according to a report by the Office of Technology Assessment ("Impact of Legal Reforms on Medical Malpractice Costs," OTA report, Sept. 1993), are the single most effective reform in containing health care liability premiums.

Modification of joint and several liability. The "joint and several" rule allows any defendant to be liable for the entire amount of an award, regardless of how small that defendant's share of the fault may be. As a result, the rule generally punishes a co-defendant (or a sole defendant) who is fully insured or has substantial assets -- the so called "deep pocket" defendant. For some providers, this removes any incentive to carry full liability insurance coverage.

Under the current system, some providers can choose to either underinsure themselves or "go bare," by holding no insurance at all. Then, when a large award is made to a plaintiff, the "deep pocket" defendant -- often a hospital -- is made to pay most or even all of the award, beyond its fair share and regardless of whether it has been found substantially at fault. As a matter of fundamental fairness, we strongly urge that the joint and several rule be abolished in favor of proportionate -- or "fair share" -- liability, where liability is commensurate with fault.

Periodic payments. Traditionally, judgments in medical malpractice cases have required lump sum payment of damages for the plaintiff's past and future losses. Periodic payments would allow compensation to be made in intervals rather than a lump sum, permitting settlements to be geared to a plaintiff's needs over the course of his or her life. In addition, because periodic payments can be funded through an annuity, future needs can be fully met at a considerably lower cost to the health care system.

Elimination of the collateral source rule. The collateral source rule prevents a court or jury from taking into account the fact that part of the plaintiff's expenses are already covered by another

source -- such as health insurance, disability compensation, and income protection insurance -- when determining the amount of damages to be awarded. The effect of the rule is to award a double recovery for payments from these other sources.

AHA supports a direct offset of all collateral sources, so that an award made to a plaintiff is automatically reduced by the amount of these other payments. Certain collateral sources such as Social Security and life insurance benefits would be exempt. In addition, credit would be given for premiums or other payments that have been made by the plaintiff to obtain the collateral benefits. This provides appropriate awards without allowing a plaintiff to "double-dip" by collecting duplicate compensation from multiple sources.

Regulation of attorneys' fees. Under the current health care liability system, patients awarded compensation are often shortchanged. Money that should go toward their long-term care goes instead to pay attorneys' fees. This is because, traditionally, attorneys in liability cases are paid through contingent fees, through which a successful attorney receives a percentage of the plaintiff's award.

Under this payment scenario, the amount of the contingency fee reduces the amount of money that goes to the injured plaintiff. It is important to establish a schedule for attorney's fees that ensures adequate compensation for the plaintiff, proper representation for health care liability claimants, and reasonable attorneys' fees. Such a schedule would allow the plaintiff to receive a greater portion of the recovery amount that is awarded.

Additional tort reforms. AHA supports a uniform statute of limitations in health care liability cases. Standard rules should require that claims be filed within one year of the date an injury is discovered, with an outside limit of three years from the date an injury occurred. Extra time would be allowed for claims for children under six, who may not be able to communicate the existence of an injury, and claims where something with no therapeutic purpose is left in a claimant's body and not discovered for years.

AHA also supports the concept of certifying expert witnesses for any claim filed, whether through the civil justice system or a conflict resolution proceeding. An expert witness must be accompanied by an affidavit from a qualified expert, asserting that the claim brought forward has merit. Affidavits of merit that are filed with complaints will help screen out frivolous lawsuits. In addition, AHA supports appropriate limits on punitive damages.

To incorporate these principles, federal preemption of existing state laws is necessary. Many states have been unsuccessful in adopting health care liability reforms, while others have implemented significant reforms. Federal law should create a "floor" by preempting corresponding provisions of state law unless the state law is more effective. This would allow states to implement standards that meet their needs, while providing a minimum level of reform in all health care liability actions. Clearly, because the federal government pays for one-third of all health care provided in this country, federal-level reform is in the best interest of taxpayers.

Essential Provisions for Health Care Liability Reform

We believe that, in addition to the uniform standards mentioned above, the following issues are key to health care liability reform:

Patient safety reforms: Health care liability reform must promote patient safety and quality of care. Adverse outcomes can be reduced through continuous quality management, strengthening public and private systems that gather and analyze risk-factor data, and appropriate follow-up action. To this end, AHA supports requiring states to establish patient safety programs.

And, licensed professionals should be required to participate at least once every three years in programs tailored to their particular profession and specialty area of practice. In addition, each liability insurer should provide or endorse risk-management programs for its insured, and every health care facility or institution should be required to have in effect a risk management program.

Conflict resolution mechanisms (sometimes referred to as ADR -- alternative dispute resolution): Health care liability reforms must do more than rein in damage awards. They must also make the process work more smoothly. Bringing liability claims to court is often inefficient, costly and renders unpredictable results. Nontraditional approaches that either remove claims resolution from the courts altogether, or make court cases move more quickly, can play an important role in reforming the health care liability system. Conflict resolution mechanisms are intended to give patients choices other than going to court, making the resolution of health care liability claims speedier, more fair, and more cost-effective.

AHA supports the continued development of successful conflict resolution programs for health care liability through federal support of demonstration projects. These projects should evaluate the merits of proposals designed to divert claims from the civil justice system and resolve them faster and in a more cost-efficient manner States should maintain the flexibility to design systems that best meet their needs

Practice parameters/guidelines: The development and implementation of medical practice parameters, coupled with other health care liability reforms, is essential to reforming health care liability Medical practice parameters are guidelines for patient treatment, developed to provide a framework for clinical decision making. Practice parameters can help ensure that quality care is provided, and can help reduce the cost of that care. AHA believes that physicians and other providers who can demonstrate compliance with a practice parameter or guideline should be able to present that compliance as an affirmative defense in a lawsuit

Adoption of medical practice parameters, along with other liability system reforms, would help discourage or eliminate spending on unnecessary services by reducing the practice of defensive medicine. With practice parameters to follow, providers would be less likely to furnish services beyond the appropriate treatment called for in the guidelines. Practice parameters would also enhance access to high-risk specialty services by making physicians less inclined to stop providing these services.

Conclusion

Health care liability reform can play a key role in improving health care by helping reduce the high cost, inefficiency, and inequity of our current compensation system. Billions of dollars in health care savings and enhanced access to care can be achieved by changing the liability laws to discourage or eliminate spending on unnecessary services, and to reduce practitioners' fear of providing high-risk services.

Like many other complex issues of health care reform, health care liability demands a federal solution to ensure that all Americans have access to a system that compensates patients adequately and equitably. A package consisting of federal tort reforms for malpractice claims, implementation of patient safety mechanisms, exploration of conflict resolution mechanisms, and the development of effective practice guidelines will go a long way toward improving not just the health care liability system, but the health care system as a whole.

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Mr. HYDE. Dr. Hanss.

STATEMENT OF JOSEPH W. HANSS, JR., M.D., ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. HANSS. Mr. Chairman, members of the committee, I am Joseph Hanss. I am a practicing obstetrician gynecologist from Phoenix, AZ. I am testifying on behalf of the American College of Obstetricians and Gynecologists [ACOG], an organization representing more than 37,000 physicians and other health care professionals dedicated to improving women's health.

I wish to thank Chairman Hyde and the committee members for your interest in this problem and for giving me the opportunity to testify about a problem that demands to be rectified: the adverse effects of the liability crisis on obstetric care. I think the best way to tell you the problem with the current system is through my personal story, that of a primary care obstetrician-gynecologist.

I have been in practice in Arizona for 28 years. During that time, I have been very active in trying to get medical liability reform enacted at the State level. We have been successful in getting three minor reforms passed, only to see each of them struck down by the Arizona State Supreme Court because they were found unconstitutional. Although I normally count myself as one who believes that it is best to have decisions made on the State level, the inaction I have witnessed on liability reform has forced me to appear before Congress today and plead for Federal reform.

Without medical liability reform, I have seen my liability insurance premiums steadily increase to a point where I can no longer absorb the cost. I am forced to increase my patients' fees.

Unlike many of my colleagues, I still practice obstetrics even though my liability premium will be more than $46,000 this year. As of 1985, Arizona lost 21 percent of its rural obstetrical providers because of the problems related to increasing liability costs. This isn't a problem that only affects my State but every State that has underserved populations.

Less obstetric providers means that pregnant women cannot find anyone in their locale to take care of their high-risk pregnancies or even to get prenatal care. Patients, your constituents, are the ones who ultimately suffer from the lack of Federal liability reform. The time has come to enact Federal reform and provide relief for the millions of patients who would benefit from it.

According to a 1992 survey of ACOG, the membership who were polled, 12.3 percent of Ob-Gyn's had quit obstetrics and almost one-quarter had decreased the amount of high-risk obstetric care provided, solely because of the risk of malpractice. The same survey showed that almost 80 percent of my board-certified colleagues, physicians who go through a rigorous certification process to demonstrate indepth knowledge about women's health, had at least one claim filed against them. In New York, nearly 90 percent of Ob-Gyn's have been sued, the average being four times. Clearly, the problem is not the bad doctor. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an obstetrician-gynecologist when I did a rotation in Ob-Gyn as an intern. After 28 years of practice, I still continue to get excited about delivering babies. This joy is diminishing, however, with the delivery suite becoming a battleground and patients and physicians pulled apart by an adversarial tort system. I am beginning to wonder how long I will continue. Every time I deliver a baby or pick up a scalpel, I put my entire practice and my family at risk.

It would be unconscionable if Congress doesn't enact Federal tort reform. With each day of inaction, liability risks and rising insurance premiums will continue to drive out dedicated professionals. We cannot allow this situation to deteriorate further and jeopardize the health of women and their babies in this country. To avoid this, uniform Federal standards of tort reform need to be enacted, as we have detailed in our written statement.

In closing, I urge Congress to seize this opportunity and pass meaningful tort reform. The system is badly broken. Patients are paying for it, and it is time for the Federal Government to step in and fix it once and for all.

On behalf of women seeking obstetric and gynecologic care in this country I beg you to pass legislation that will give them access to care, care they want and so rightfully deserve.

Thank you, Mr. Chairman.

Mr. HYDE. Thank you, Doctor.

[The prepared statement of Dr. Hanss follows:]

PREPARED STATEMENT OF JOSEPH W. HANSS, JR., M.D., ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Chairman Hyde and Members of the Committee, I am Joseph Hanss, Jr., MD, a practicing obstetrician-gynecologist from Phoenix, Arizona. I am testifying on behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 37,000 physicians and other health professionals dedicated to improving women's health. I wish to thank the Chairman of this Committee and the Members for your interest in antitrust and medical liability. While I am taking the opportunity today to focus my testimony on a problem that demands to be rectified – the adverse effects of the liability crisis on obstetric care – I want to say for the record that ACOG supports antitrust reform and urges Congress to enact legislation to allow physicians to deal with insurance companies on a level playing field.

I think the best way to demonstrate the problems associated with the liability system is through my personal story. I have been in practice in Arizona for 28 years and have been very active at the state level in trying to get medical liability reform passed because of its devastating effect on the practice of obstetrics. Since I've been in practice, I've seen my medical liability insurance premiums steadily increase to a point where I can no longer absorb the cost and am forced to increase my patients' fees. This not only affects my Medicaid and Medicare patients, but also my private pay and third party insured patients. Despite Arizona's liability crisis, I still practice obstetrics, even though I will pay more than $46,000 this year for my liability insurance premium. To break this down for illustration's sake, based upon the number of hours I work, more than half of what I receive as reimbursement for an office visit goes to pay my liability insurance premium. However, my liability premium pales in comparison to colleagues of mine who practice in New York and Florida – their yearly premiums can be as high as $121,000 and $130,000, respectively.

Arizona is a case study as to why we need medical liability reform on a federal level. The Arizona state legislature has repeatedly tried to enact tort reforms – limited tort reforms – but has been stymied by a state constitutional provision declaring "no law shall be enacted in this State limiting the amount of damages to be recovered for causing the death or injury of any person." This provision was used by the Arizona Supreme Court to strike down a law that allowed periodic payments of medical malpractice judgments five years after the law was enacted. This was extremely unfortunate.

After having just a minor tort reform for five years, the medical community saw a tangible benefit from the periodic payments law. The proof that this tort reform reduced costs came after the periodic payments bill was enacted in 1989; medical liability malpractice insurance rates immediately decreased by 5% and remained that way for the next five years. Now that the Supreme Court declared periodic payments unconstitutional just one year ago, we expect to see an increase in these insurance premiums sometime this year.

This looming liability insurance increase concerns me because my patients cannot continue to absorb these types of cost increases. However, without medical liability reform, they are going to continue to bear the brunt of a tort system out of control.

In light of what is "not happening" in Arizona, I am here today because I am concerned about my ability to continue to serve my obstetric patients. Some of my colleagues have given up the

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practice of obstetrics; others, the practice of medicine. Close friends have moved to Maine and California to practice because those states have enacted medical liability reform. This problem has hindered Arizona for years; in fact, by 1985 Arizona lost 21% of its rural obstetric providers because of the problems related to increasing liability costs. Unless the federal government begins to address the problems related to medical liability, I am afraid that many other colleagues and I will be forced to make similar choices. Let me briefly describe the problem and suggest what can be done to address effectively the current medical liability situation.

According to a 1992 survey of ACOG's membership, 12.3% of obstetrician-gynecologists nationally had quit obstetrics and almost one-quarter had decreased the amount of high-risk obstetric care they provide because of the risk of malpractice. The same survey showed that almost 80% of my board-certified colleagues -- physicians with demonstrated knowledge in women's health and who have gone through a rigorous certification process -- had at least one claim filed against them. In the state of New York, nearly 90% of obstetrician-gynecologists have been sued, with the average number of suits filed against these New York doctors being four. Clearly, the liability crisis is not primarily due to the "bad doctor," since the current system demonstrates that a physician's chance of being sued for medical malpractice bears little relation to whether the physician has been negligent.

The major problem is neither mine nor even that of the obstetrician-gynecologists who have quit obstetrics because of malpractice concerns. The problem is for our patients who ultimately suffer from the liability situation -- those who have difficulty finding an obstetrician-gynecologist to treat

their high-risk pregnancies, and those for whom obstetric care is unaffordable because of the liability premiums their obstetrician-gynecologists have to pay. The bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. This is certainly true in Arizona. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an obstetrician-gynecologist after I did a rotation in ob-gyn as an internal medicine resident. The first time I helped deliver a baby sealed it in my mind that my calling was to be an ob-gyn. There are few experiences in life that can match the satisfaction and joy of delivering children into this world.

But lately this joy has been diminished. The delivery suite has become a battleground, with patients and physicians pulled apart by an adversarial tort system. Obstetric care will become unaffordable and unavailable if we allow liability risks and insurance premiums to continue to drive out dedicated professionals. We cannot allow the situation to deteriorate further and jeopardize the health of women and their infants in this country.

Although I am pleased and heartened that the Committee is holding these hearings, I remain concerned about Congress' inaction on enacting federal tort reforms. ACOG has testified on the importance of medical liability reform numerous times; yet, we have not seen any medical liability reforms enacted into law. I realize that the House of Representatives has passed significant tort reforms that would help bring medical liability insurance rates down, but no one will benefit from

this action unless the House insists that these reforms make it through the conference report process and get signed into law.

The current system for compensating injured parties is time-consuming, with average delays of almost five years in ob/gyn cases before payment is made. It is also inefficient, with as little as 28% of the malpractice premium dollar going directly to the injured parties. Furthermore, the medical malpractice lawsuit rate has doubled since 1982, even though it has been shown that 60% of these claims have no merit and are closed without payment. The system is broken, patients are paying for it, and it is time for the federal government to step in and fix it, once and for all.

ACOG believes the following reforms are needed in order to ensure our tort system works for all involved parties.

A Cap on Noneconomic Damages

Without a cap on noneconomic damages, real reform to our legal system is in jeopardy. A cap would curtail the rising cost of malpractice insurance, thus ensuring that access to care, particularly maternity care, is available to all women. California's adoption of a $250,000 cap on noneconomic damages more than twenty years ago has allowed the state to control its medical liability insurance costs. Studies have shown that California's cap affects less than 2% of the cases filed, but it has been instrumental in weeding out the "lottery" cases from meritorious suits.

The former Office of Technology Assessment stated in its September 1993 background paper, "Impact of Legal Reforms on Medical Malpractice Costs," that a cap on noneconomic damages "consistently...reduced malpractice cost indicators." Furthermore, the paper suggested that losses for noneconomic damages, such as "pain and suffering," are difficult to quantify. It concluded that "juries are provided no clear standards for determining them," and that the "emotional desire of the jury to do something for the victim often causes unduly high awards." The OTA has been proven correct this year – for the second year in a row, jury verdicts grew – climbing 40% to $500,000 for all medical liability cases, according to Jury Verdict Research, a firm that tracks trials and their awards. This same study reported that the median jury award in liability cases involving childbirth was $1.3 million – more than twice the amount for the next highest category. Clearly, with juries awarding sums like this, liability rates are going to continue to be kept artificially high.

A cap on noneconomic damages does not limit in any way recovery for economic losses, such as medical care expenses, rehabilitation, or lost income. It is a reasonable approach since the plaintiff still receives full compensation for economic damages. ACOG believes $250,000 is a reasonable cap on noneconomic damages.

Periodic Payment of Awards

ACOG also supports periodic payment of awards since they provide another way to reduce the costs of liability actions while assuring that the plaintiff receives a fair recovery. As I mentioned earlier, this reform resulted in a 5% decrease in malpractice insurance during the brief time it was in effect in Arizona. In addition, if the tort award for future damages is paid out over time rather

than all at once, both the plaintiff and defendant benefit. The plaintiff is assured that money will be there when it is needed and the defendant's payout is made more predictable.

Mandatory Collateral Source Offset

ACOG supports elimination of the collateral source rule to allow for a mandatory offset against awards for compensation received from other sources. This reform would require any defendant to introduce evidence of a claimant's receipt or potential receipt of reimbursement from health or disability insurers for losses resulting from an injury. As it stands now, the collateral source rule allows plaintiffs double recoveries since they can recover from government or private insurance companies and also in tort. To the extent that injuries are compensated more than once, insurance costs for all are increased.

Reform of the Statute of Limitations

Reform of the statute of limitations for malpractice claims to be brought to court is greatly needed. This is important to ob-gyns, both for cases involving adults and minors. Specifically, ACOG advocates that a claim must be filed within two years of the date by which an alleged injury should have reasonably been discovered, but in no event more than four years from the time of the alleged injury. In the case of alleged injury to children under four years of age, a claim could be brought until the child's eighth birthday.

Some states' statutes of limitations for medical liability claims permit plaintiffs an extraordinary amount of time within which to bring suit, particularly in the case of minors where some

jurisdictions allow a suit to be brought beyond the age of maturity. For an alleged injury at birth, actions can be brought in some jurisdictions, including my state of Arizona, after more than twenty years. Such cases are obviously difficult to defend. Even good memories fade after twenty years, the whereabouts of all relevant parties may not be known, and medical practices may have changed dramatically. This "long tail" phenomenon presents major problems for insurers in establishing rates and reserves and for defendants in producing evidence and witnesses.

There are also similar problems with a liberal "discovery rule," which may toll the statute until an injury is discovered or reasonably should have been discovered. Our limits would allow a reasonable time for actions to be brought, while providing a point beyond which a suit cannot be brought. This is, in our view, fair to all parties.

Sliding Scale Limits on Plaintiff Attorney's Contingency Fees

Originally, the contingency fee was meant to allow all people, regardless of income, the ability to seek redress in the court system. However, the current contingency fee system is not serving this function well, if at all. Most people with small claims never get access to the civil justice system because the contingency fee causes lawyers primarily to be interested in "lottery" cases. ACOG supports a sliding scale to limit contingency fee to ensure that patients, not lawyers, receive the bulk of awards.

"Clear Use of and Convincing" Evidence as Burden of Proof for "Drop-In Deliveries"

Elevating the burden of proof to "clear and convincing" from the current "preponderance of evi-

dence" would improve access to obstetric care, especially for women who reside in underserved areas. Under what is known as the "special obstetric rule," an obstetric provider, who provides labor and delivery care to a woman he or she has not previously treated during her pregnancy, is given the benefit of a slightly elevated standard of proof – clear and convincing evidence. Deliveries are unpredictable. What begins as a normal delivery can quickly become high risk. During the prenatal period, obstetric providers learn as much as possible about the patient and her pregnancy to limit surprises and anticipate the problems that might occur during labor and delivery. One of the most stressful situations an obstetric provider can face is delivering the baby of a woman whom he or she has not seen before and for whom no medical records are available. However, changing the burden of proof in no way hinders a woman from recovering full damages if she was negligently injured.

During Senate debate on HR 956, the only amendment that passed that body with a filibuster-proof vote was an amendment that allowed for this special obstetric rule. Passing by a margin of 61 to 39, support for such a provision ran the gamut of the political spectrum. Obviously, with this kind of support it would seem natural for the House to support a similar provision.

Grants to States to Set Up Alternative Dispute Resolution (ADR) Systems

Our current medical malpractice system needs innovative mechanisms for determining whether individuals are negligently injured in the course of receiving health care services, and compensating those who are determined to have been negligently injured. ACOG supports

availability of grants to states to develop ADR systems, such as fault-based administrative, defined catastrophic injury compensation, early offer and recovery, or binding arbitration.

Conclusion

I hope today's hearing shows there is a serious interest in federal tort reform and demonstrates this Committee's commitment to passage of real medical liability reform. This issue has been pondered by Congress since the 1980's. Certainly, with the Republican's Contract With America advocating for "common sense legal reform," it only makes sense to enact comprehensive legal reform at once rather than doing it in a piecemeal fashion. Even in the Chairman's home state of Illinois, wide-ranging tort reform was enacted last year that included most of the reforms I have discussed today.

As an advocate for decision-making at the state level, I am convinced that the federal government must intervene on medical liability reform. Otherwise, state-level reforms will continue to be blocked or struck down (as in Arizona's case), and the nation's health care costs will continue to climb. Since the House has taken the lead on the medical liability reform issue by passing a cap on both noneconomic and punitive damages, it is my hope you will finish the job you set out to do in the Contract With America – get real medical liability reform legislation passed and signed into law.

In closing, I urge Congress to seize the opportunity and pass truly meaningful tort reform – today's deplorable liability situation can no longer wait. Without it, you are imposing a disservice for both

those who seek and those who provide health care services. On behalf of the women seeking obstetric and gynecologic care in this country, I beg you to pass legislation that will allow them access to the care they want, need, and deserve.

Mr. HYDE. Mr. Dikeou.

STATEMENT OF GEORGE D. DIKEOU, GENERAL COUNSEL, COPIC INSURANCE CO., ON BEHALF OF PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. DIKEOU. Mr. Chairman, members of the committee, my name is George Dikeou. I am appearing on behalf of the Physician Insurers Association of America, PIAA. PIAA represents 54 companies throughout the United States that provide medical malpractice insurance to physicians and dentists. These companies collectively represent about 235,000 physicians throughout the United States. I am also a board member and general counsel to the Colorado company which is a member of PIAA, and I am here to testify in favor of Federal tort reform.

I thought perhaps it might be of interest to the committee to talk about the Colorado experience. Since 1988, Colorado has had very comprehensive and effective tort reform. Our tort reform was a product of a study done in 1987 and 1988, funded by the National Institutes of Health and conducted by both the University of Colorado School of Medicine and the Colorado Department of Health. The study was published and tendered to the Governor's office and to the legislature in February 1988, and the conclusions of that study sent shock waves, I think, throughout the State.

The conclusions of the study were as follows: That 21 percent of all physicians delivering babies had left that specialty practice during the prior 5 years. The reasons cited for that departure were increases in insurance premiums, uncertainty concerning the availability of insurance, and the fear of lawsuits.

The study went on to find that if a pattern of increased premiums continued—and I might put this in some perspective. In 1986 the Hartford Co. increased premiums in Colorado 473 percent in one year. My own company increased premiums 76 percent in 1986 and 57 percent in 1987. The study concluded if that pattern of increase continued, 63 percent of the physicians doing obstetrics, delivering babies and doing prenatal care, would stop doing that specialty.

The other consequence in Colorado would be that 42 of 63 of our counties would no longer have obstetrical service. It was also predicted that 6,300 women in the State of Colorado would have to drive 52 or more miles each direction in order to secure obstetrical care.

As you might imagine, this study had tremendous impact on what happened in our legislature, and we passed in 1988 very comprehensive tort reform.

Our tort reform contains many of the provisions advocated to you by the Physician Insurers Association of America. We do have a $250,000 cap on noneconomic loss. We have proportionate liability. The jury is instructed to apportion liability among all tort feasors. We have periodic payments. We have some control over collateral source. We have an effective statute of limitations, and we have effective control over punitive damages. We do not have contingent fee limitations.

I think it important, real quickly, to show you the effects of tort reform in Colorado, and I have one chart that I will tender to the

clerk. I know you won't be able to see this, but it is not in our budget to have elaborate displays.

In 1988, when tort reform was passed, an obstetrical physician in Colorado paid $62,000 in premiums. In 1996, the rate is $30,000. So because of tort reform and risk management activities, which we pursue actively, we have reduced premiums for obstetrical physicians by over $30,000.

In addition, since 1990 we have returned to our policyholders in excess of $40 million in premium credits, representing savings that have occurred to the company during that period of time. Therefore, in 1996 an obstetrical physician would pay $26,000 total premiums, versus $62,000 when tort reform was passed.

Thank you.

Mr. HYDE. Thank you very much, Mr. Dikeou.

[The prepared statement of Mr. Dikeou follows:]

PREPARED STATEMENT OF GEORGE D. DIKEOU, GENERAL COUNSEL, COPIC INSURANCE CO., ON BEHALF OF THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. Chairman and distinguished members of the Judiciary Committee, I would like to thank you for providing me with the opportunity to testify on health care liability issues this morning. I congratulate you, Chairman Hyde, for scheduling this two day hearing in order to examine the complex health care reform issues that fall within the Judiciary Committee's jurisdiction. During the first session of the 104th Congress, the Contract with America's Common Sense Legal Standards Reform bill was pending, and the legislative process moved so quickly that it was difficult -- even for those of us who have been working in the health care liability system for many years -- to follow all the tort reform proposals being debated here on Capitol Hill. Because of the quick pace of the tort reform debate in 1995, a lot of misinformation about the potential effects of tort reform was circulated without adequate time for tort reform supporters to correct the record. Today the record can be corrected. The health care liability system is a complex concept for most Americans, and perhaps for many non-attorney members of this Committee and the Congress. Nevertheless, I was very impressed by the significant progress that was made towards enacting health care liability reform in the House, and wanted to express my personal thanks to you Mr. Chairman for your commitment to debating federal health care liability reforms during this Congress. The fact that the building blocks of reform were debated and voted on twice in the House of Representatives is unprecedented, and your continued commitment to thoroughly examining these issues is greatly appreciated. So, I am pleased to have the opportunity to share my professional expertise on health care liability with the Committee and hope that it will contribute to an informed debate.

AN INTRODUCTION TO PIAA

I am testifying today on behalf of the Physician Insurers Association of America (PIAA) which is a national trade association representing 54 physician and dentist owned or directed medical liability insurance companies which together insure over 235,000 physicians and dentists—almost sixty percent of all physicians in private practice—in almost every state. I have been associated with PIAA's member company in Colorado, COPIC Insurance Company, for many years, and I currently serve as COPIC's General Counsel. I would like to add that it is nice to see Congresswoman Patricia Schroeder here this morning. The gentlelady has served the people of Colorado with distinction for many years, and will be missed when she retires at the end of this Congress. I have also been active in PIAA for many years, serving as Chair of its Legal Counsel Section since 1992. It is important to note that PIAA member companies are different from other liability insurers in several key aspects:

- PIAA companies must be owned or managed by physicians or dentists.
- PIAA companies predominantly provide medical professional liability insurance.
- Most PIAA companies operate on a not-for-profit basis, returning any profits accrued to the physicians, dentists or hospitals they insure, thereby decreasing physicians' medical practice expenses.

- PIAA member companies have led the health care industry in emphasizing and investing heavily in risk management and patient safety activities designed to improve medical practice and to limit the occurrence of medical errors.

Most PIAA member companies were formed in the mid-1970s when for-profit, commercial insurers began to withdraw from the medical liability insurance market. During this period, the number and cost of medical malpractice cases began to grow exponentially causing commercial insurers to sustain huge losses. In some states where commercial insurers withdrew in order to stem their losses, physicians were unable to purchase medical liability insurance at all. In other states, premiums were increased so much that physicians couldn't afford to purchase it. So they decided to pool their resources, often in collaboration with the state medical societies, and create physician owned and directed professional liability insurers which ensured the availability of coverage for practicing physicians. The physician founders of PIAA companies understood that the alternative to forming their own companies to provide affordable insurance would be to force many physicians to either practice without any professional liability insurance or to forgo practicing altogether. The physicians who established PIAA member companies found both alternatives to be unacceptable. Our companies believe that patients injured due to medical error should be reimbursed for their medical bills and other appropriate damages. So, for PIAA member companies, the struggle has been, and continues to be, one in which we try to balance physicians' needs for readily-available, affordable liability insurance, with the needs of injured patients who deserve to be reimbursed in a fair, expedient fashion when medical errors or negligence has caused their

injury. Along with our efforts to instill balance in the health care liability system, PIAA has been advocating federal health care liability reform. Based upon what is currently working in many states, California's Medical Injury Compensation Reform Act (MICRA) has become the model for federal reform. MICRA has successfully balanced the competing concerns of plaintiffs and defendants. MICRA has five major provisions. PIAA, in coordination with the Health Care Liability Alliance (HCLA), has adopted MICRA's provisions as a federal model. MICRA's five major provisions are: $250,000 cap on noneconomic damages, periodic payments, contingency fee limits, statute of limitations and a collateral source evidentiary rule. The PIAA and HCLA support two additional very important provisions for a model federal bill: limited federal preemption to protect states like Colorado and California that have strong tort reform laws, and fair share liability so that a defendant in a health care liability case is only responsible for the percentage of the noneconomic damages for which he or she has been determined to be at fault. PIAA is a founding member of the HCLA, which is a group of health care and insurance organizations lobbying for comprehensive health care liability reform based on the MICRA model.

PIAA PROVIDES CONGRESS WITH CREDIBLE MALPRACTICE DATA

In addition to advocating a comprehensive health care liability reform bill, PIAA advocacy efforts include providing our member companies with accurate, timely data through our Data Sharing Project. The PIAA maintains the largest data base of medical malpractice claims information in the country. The Data Sharing Project, which was founded in 1985, contains approximately 133,000 claims in its most recently-reported cycle of June-December 1995. The number of PIAA companies who voluntarily

participate in this PIAA Data Sharing Project has varied over the years with approximately twenty-five currently participating. Consequently, it provides a national sample of the number and type of medical liability claims on a semi-annual basis. Information about the number, cost and the reasons for medical malpractice lawsuits filed against physicians insured by PIAA member companies is collected through the Project. The Data Sharing Project began collecting similar data for dentists in the second half of 1995. This includes, but is not limited to, the following :

- ✓ **Causation information**-the cause(s) of the alleged medical injury.
- ✓ **Indemnity payments**-settlements or awards made directly to the plaintiffs as a result of the claim resolution process.
- ✓ **Expenses**-expenses incurred by the insurer during the claims resolution process, including defense attorney and court costs, expert witness fees and other administrative expenses.
- ✓ **Claim severity**-the severity of the medical injury sustained by the plaintiff on a scale developed by the National Association of Insurance Commissioners.
- ✓ **Demographic features pertaining to the insured physician, the plaintiff and institutions**-background information on the physicians, the plaintiff or claimant, and the institution where the medical injury allegedly occurred.

We believe that PIAA's Data Sharing Project can be a valuable resource for this Committee, as well as other House and Senate Committees with jurisdiction over health

care liability issues. For example, PIAA has prepared an analysis[1] comparing California member companies' premiums for several medical specialties (Family Practitioners, Obstetricians etc....) before tort reforms were enacted with premiums of the same medical specialties after tort reform was enacted in order to evaluate the effectiveness of such reforms. The results of this premium comparison demonstrated that California's physicians' premiums were consistently higher than most other states in 1984, just before MICRA was upheld as constitutional. By 1994, California's physicians premiums were below average when compared with other states. In my home State of Colorado, for example, our legislature enacted a strong law in 1988. It is very useful to track the number and amount of malpractice awards to see if the law is reducing unnecessary malpractice litigation in our state, and compare it to the State of Alabama which has not enacted similar tort reforms. We are able to construct such comparisons through COPIC's participation in the Data Sharing Project.

PIAA'S DATA SHARING PROGRAM CONTRIBUTES TO IMPROVED CARE

Another very important function of the PIAA Data Sharing Project is the publication of an annual freestanding "special report" on a medical issue that has generated, or appears to have the potential for generating, a large number of medical liability lawsuits. Earlier in my testimony, I mentioned that PIAA member companies are unique because they lead the health care community in promoting risk management. Many of you may not be familiar with risk management, so I would like to explain what it is and why it represents such a valuable contribution to the improvement of

[1] Please see Appendix 1- PIAA Member Company Premium Survey Charts

health care. But first I have to note that in the heat of the tort reform battles fought here on Capitol Hill in 1994 and 1995, opponents of tort reform have often claimed that medical liability insurers are pushing for reform only because they want to make more money. That is not the case for most PIAA companies which not only refund excess premiums to physicians, but also dedicate profits to this data collection effort and other risk management activities. COPIC, for example, distributed $34.8 million to policyholders from 1985 through 1995, and has declared a $6 million distribution to policy holders for 1996.[2] Effective health care liability reforms which reduce malpractice costs enable our member companies to finance more of these activities.

In May of 1995, the PIAA special report on Breast Cancer attracted national media attention in USA Today because its findings could help physicians and their female patients detect breast cancer earlier, thereby potentially saving many women's, and particularly younger women's, lives. The Breast Cancer study was drafted after PIAA's Data Sharing Committee, comprised of physicians from PIAA member companies, found that more medical malpractice suits were filed for women with breast cancer than for patients suffering from any other illness or injury. Using the information collected through the Data Sharing Project, the PIAA panel was convened to determine why so many breast cancer claims were being filed, especially since most of the claims involved younger women. By studying the data, the panel was able to report a number of findings which will help women and their doctors do a better job at detecting breast cancer in its earlier, more treatable form. For example, they found that the mammogram reports were negative or equivocal for 80% of the breast cancer

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[2] Please see Appendix 2 -Information from COPIC Insurance Company

patients who later filed malpractice suits. Some of the mammograms in this study must have been misread and some were probably poor quality images, but most mammograms were of high quality and were correctly interpreted by physicians. This means that mammography does not necessarily detect every malignant breast lump. Most importantly, however, our physician panel advised women and their physicians to carefully monitor any breast lump that is detected, regardless of a negative mammogram report which often provides women and their doctors with a false sense of security. Other information which can help both patients and physicians was contained in this report as well. PIAA provides copies of these special reports to all of our member companies. Many of them are distributing copies of this report to each physician they insure, so that all practitioners can learn from these tragic cases and detect future breast cancer cases promptly. The PIAA has already distributed over 50,000 copies of the 1995 Breast Cancer report.

In summary, this information is useful to PIAA member companies and the physicians they insure for several reasons. First and foremost, it is an ongoing proactive effort to identify medical procedures or conditions which need special attention from physicians in the future. Second, by disseminating such data to the physicians they insure, our member companies help improve patient care while simultaneously reducing the risk of lawsuits. The topics for PIAA's other special reports, which are released each May during PIAA's annual meeting, have been: Laparoscopic Procedures-1994, Medication Errors-1993, Lung Cancer-1992, Colon Cancer-1991. The report to be released this May will be on Myocardial Infarctions, more commonly know as heart attacks.

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PIAA SUPPORTS STATE REFORMS WHICH WORK

In developing our legislative platform, PIAA studied what was working at the state level to strike a balance between the need to preserve the rights of injured patients and the need to limit the growing number of million dollar lawsuits, two-thirds of which are dropped without a verdict or settlement. The states have been experimenting for many years with various tort reform laws. For health care liability reform be effective, it must decrease the frequency, or number of medical malpractice cases, as well as the severity, or level of indemnity payments, resulting from the cases. Approximately two-thirds of all cases filed are dismissed without any payment, an indication that many are meritless cases and should be discouraged. It is these frivolous cases which add significant legal and administrative costs to our national health care costs. It's a rather straightforward concept. In order to keep premiums at an affordable level, you must reduce the number of meritless malpractice suits and you need to establish some rational basis for projecting the amount of money insurers must hold in reserve in order to reimburse injured patients in the future. Colorado's tort reform laws, as well as California's MICRA[3], have proven that a limit, or cap on the awards for noneconomic damages works to decrease both the frequency and severity of medical malpractice cases. The Office of Technology Assessment[4] and the American Academy of Actuaries[5] (Academy), in separate analyses of State tort laws both concluded that a cap on noneconomic damages is crucial if reforms are to actually reduce the health care costs attributable to medical liability. A Milliman &

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3 Twenty-two states have placed some limit or cap on damages.

4 *Impact of Legal Reforms on Medical Malpractice Costs*, Office of Technology Assessment, September, 1993. Please see Appendix 3.

5 *Malpractice Reform Work Group's Report: State Comparison of Medical Malpractice Payments/Reforms*, American Academy of Actuaries, March 10, 1995. Please see Appendix 4.

Robertson study[6] in New York estimated that physicians premiums would decline approximately 28% if New York passed a $250,000 cap on noneconomic damages like Colorado's and California's. Colorado, like California, has a $250,000 cap on noneconomic damages. I am here to testify that this law is working and has resulted in substantial premiums savings since 1988 when our strong tort reform law was enacted. I would also like to address another criticism leveled at the federal health care liability reforms which PIAA advocates. The critics say that MICRA's $250,000 cap has not reduced total health care costs in California. It is true, total health care costs in California have continued to rise with inflation, but health care liability costs, as a percentage of the total costs, have declined. Moreover, the Academy[7] advises Congress that:

> "Tort reform effectiveness should be measured by comparing the cost after the reform to what the cost would have been absent the reform. This is particularly important given the significant inflationary trend in the costs of malpractice claims. A tort reform can be effective by reducing or stabilizing this "inflation" even though it may or may not produce an overall year-to-year reduction in costs. Depending on the circumstances, expectations of *absolute* reductions in costs and premiums is unrealistic."

We also know that Colorado's and California's collateral source reform laws are working. These laws are designed to prevent plaintiffs from recovering twice for the same

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6 Projected Effect on New York Professional Liability Costs of Capping Noneconomic Damages, Milliman & Robertson, Inc.- January 1995. Please see Appendix 5.

7 *Malpractice Reform Work Group's Report: State Comparison of Medical Malpractice Payments/Reforms*, American Academy of Actuaries, March 10, 1995.

damages -- often referred to as double recovery. Colorado's collateral source law[8] provides that in an action brought to recover damages for a tort resulting in injury or death, the court shall reduce the amount of damages awarded by the finder of fact by the amount that the person, his estate, or his representative has been indemnified or compensated for the loss by any person, company or fund related to the injury. However, this does not include any amount by which the person, his estate, or representative is indemnified or compensated by a benefit paid out of a contract entered into and paid for by or on behalf of such person. MICRA has an evidentiary rule and bans subrogation. PIAA advocates legislative modification of the collateral source rule, to allow information about payments already made to plaintiffs to be provided to the jury. I understand that the issue of subrogation was of significant concern to you Mr. Chairman, and to several other members of the Committee, during debate on a floor amendment to the Common Sense Legal Standards Reform Act in March 1995. I would be happy to talk with you about how the Colorado approach is working in the cases that COPIC has handled, since this Committee is examining the range of state experiences in order to find out what tort reforms work best. Because of double recovery in the increasing number of lawsuits against health care providers, every American pays more in health care costs. Most concerned citizens probably don't mind paying slightly more in health insurance premiums to make sure that any person injured by medical negligence is fairly compensated, but most citizens object to paying twice. Eliminating double recoveries is a matter of fairness, and once again the OTA and the Academy both determined that collateral source rule reform must be part of any effective tort reform package.

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[8] Please see Appendix 6-Summary of Colorado Tort Reform Law Updated Through 1995.

A third tort reform provision which we see working in California and many other states, is limitations on attorney's contingency fees. Colorado does not limit attorney's fees. In California, attorney fee limits, in combination with the cap on noneconomic damages, has been effective in two ways. Attorneys are less likely to pursue a frivolous lawsuit if they know they will not be able to take a large percentage of the plaintiff's unlimited noneconomic damages, therefore the number of lawsuits decline. The injured plaintiff also benefits by retaining a larger percentage of the award or settlement under MICRA's contingency fee limits.

The fourth reform that is working in Colorado[9], California and other states is periodic payment of damages. This provision mostly benefits injured plaintiffs by ensuring that a steady stream of income is available to them over time in order to pay anticipated medical bills and other expenses the plaintiff may incur due to his or her injury.

Colorado[10], California and many states employ a fifth very effective reform which sets reasonable statutes of limitation. Statutes of limitation effectively reduce the number of lawsuits, and ensure that lawsuits are brought within a fair period of time after the alleged incident.

Reform of joint and several liability is a sixth very important reform supported by the PIAA. Colorado has already enacted this reform.[11] The final reform provision that PIAA strongly supports would protect states which have already enacted strong health care liability reforms like California and Colorado. I cannot overemphasize how

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9 Please see Appendix 6-Summary of Colorado Tort Reform Law Updated Through 1995
10 Please see Appendix 6-Summary of Colorado Tort Reform Law Updated Through 1995
11 Please see Appendix 6-Summary of Colorado Tort Reform Law Updated Through 1995

important it is for the Congress to include carefully drafted preemption language that would permit state laws which are more stringent than the federal law to stand.

PIAA COMMITTED TO WORKING WITH THE COMMITTEE AND THE CONGRESS TO ENACT BALANCED REFORM

The PIAA would like to thank Chairman Hyde and this Committee once again for their leadership on health care liability issues. We are optimistic that the health care liability reforms already approved by the House in March 1995 as part of the Common Sense Legal Standards Reform Act, and those passed in October 1995 as part of the Medicare Preservation Act represent a significant step forward in our efforts to secure a comprehensive federal health care liability reform bill. PIAA was extremely pleased that through our advocacy efforts we worked with Republican leadership to convince the Congressional Budget Office (CBO) that a comprehensive package of health care liability reforms could generate significant federal savings through the Medicare and Medicaid program. Subsequently CBO scored the potential budget impact of health care liability reform for the first time. It is important to note, however, that PIAA believes it has proved that public and private savings could be substantially higher than the CBO's preliminary estimate of $200 million over seven years. We will work with the CBO and with this Committee to provide the data we believe will show a greater federal budget impact than the initial CBO estimate given the fact that reducing the practice of defensive medicine should generate significant savings throughout the health care system.

As you know, health care liability provisions were passed by the House as part of the Medicare Preservation Act. PIAA was gratified to have the opportunity to assist in

providing data which helped the CBO develop the score certifying that these provisions would generate savings needed to shore up the ailing Medicare Trust Funds. While we were disappointed that the health care liability provisions were dropped in the Senate because of concerns that they might be subject to a point of order under the Byrd rule, the Senate Parliamentarian never made an official ruling to that effect. PIAA's so-called "Parliamentarian Dream Team" which included PIAA Counsels Gene Godley and Ed Bethune, HCLA Counsels Peter Leibold and Laura Gogal, and former Senate Parliamentarian Murray Zweben prepared a brief which argued that the health care liability provisions would not be subject to a point of order under the Byrd rule. Before Senate Parliamentarian Bob Dove could respond to the brief, that provision, and others, were dropped in order to expedite consideration of the larger budget measure.

PIAA has member companies in almost every state, and we stand ready to assist the Committee in continuing to evaluate state experiences so that you can fine-tune the health care liability reform provisions being considered by this Congress. COPIC and the other PIAA companies are handling medical malpractice suits every day, and believe that our collective experiences, under the patchwork of state health care liability laws, could be of great assistance to this Committee and the entire Congress. Thank you Mr. Chairman.

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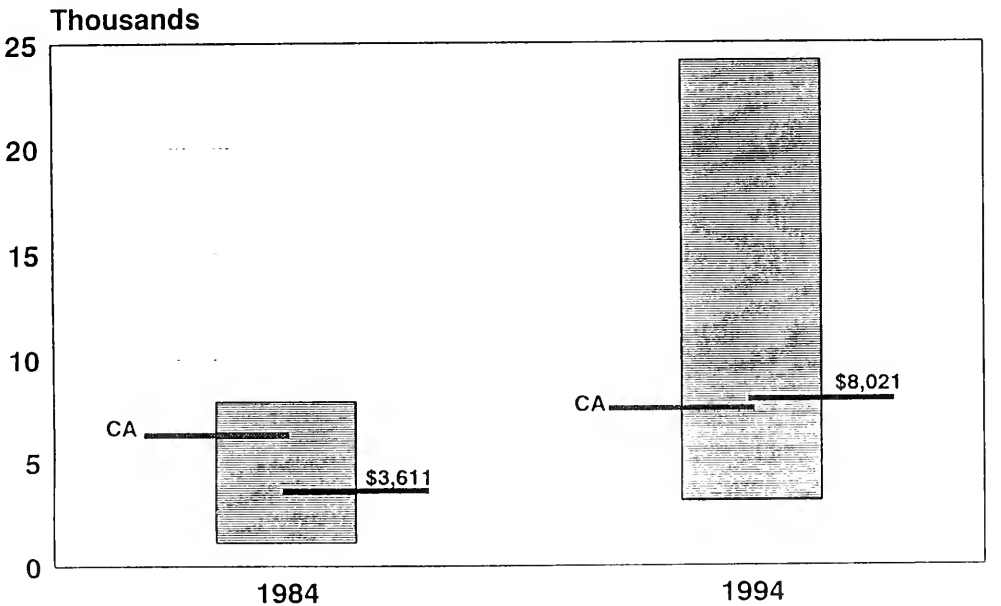
PIAA Member Company Premium Survey

FP/GP - Premium Range & Average

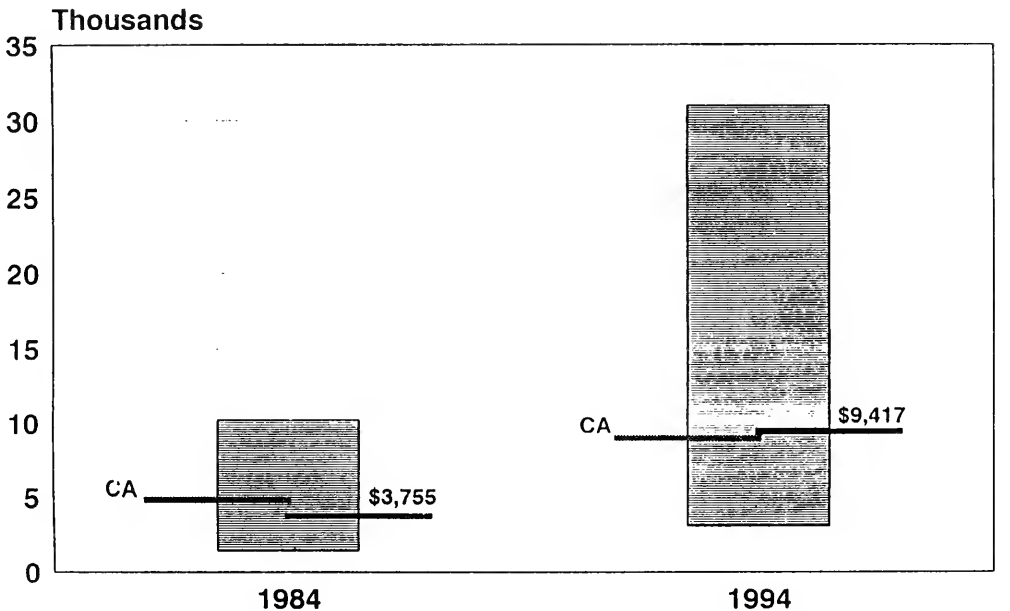


27 company responses

All premiums on mature claims-made basis at $1mil/$3mil policy limits

PIAA Member Company Premium Survey

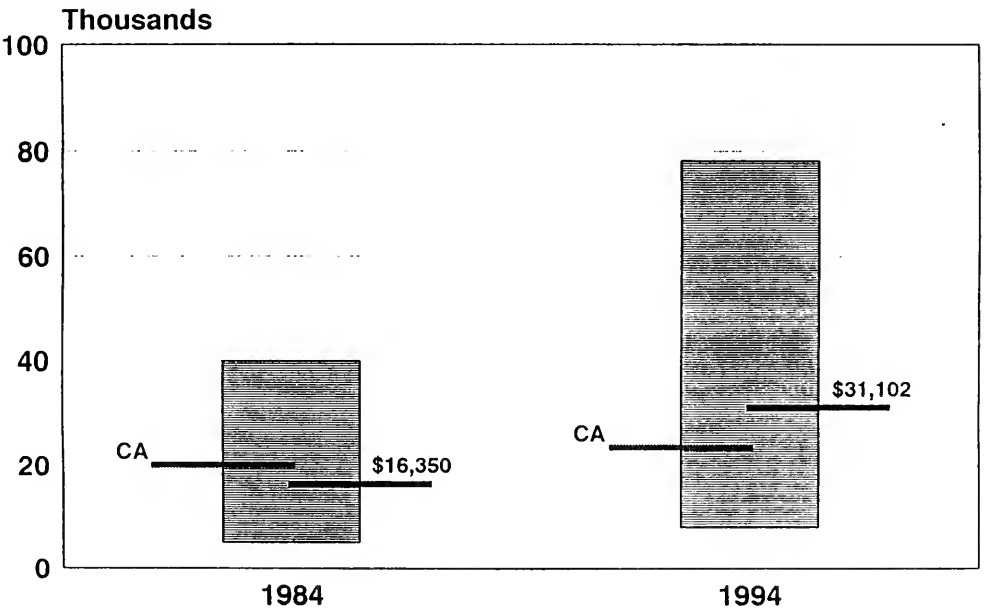
Pediatrics - Premium Range & Average



27 company responses
All premiums on mature claims-made basis at $1mil/$3mil policy limits

PIAA Member Company Premium Survey

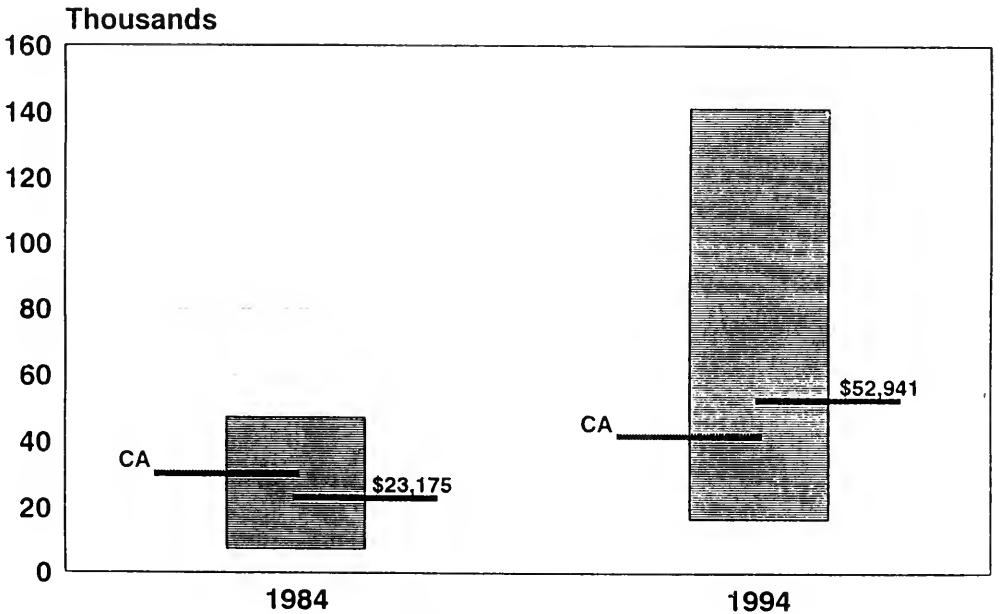
General Surgery - Premium Range & Average



27 company responses
All premiums on mature claims-made basis at $1mil/$3mil policy limits

PIAA Member Company Premium Survey

OB/GYN - Premium Range & Average

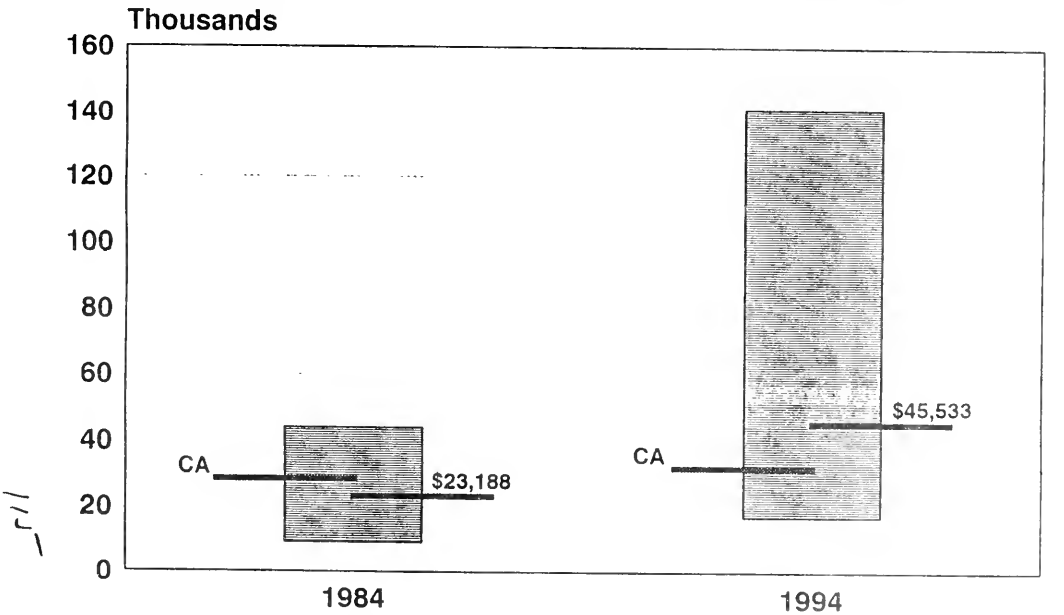


27 company responses

All premiums on mature claims-made basis at $1mil/$3mil policy limits

PIAA Member Company Premium Survey

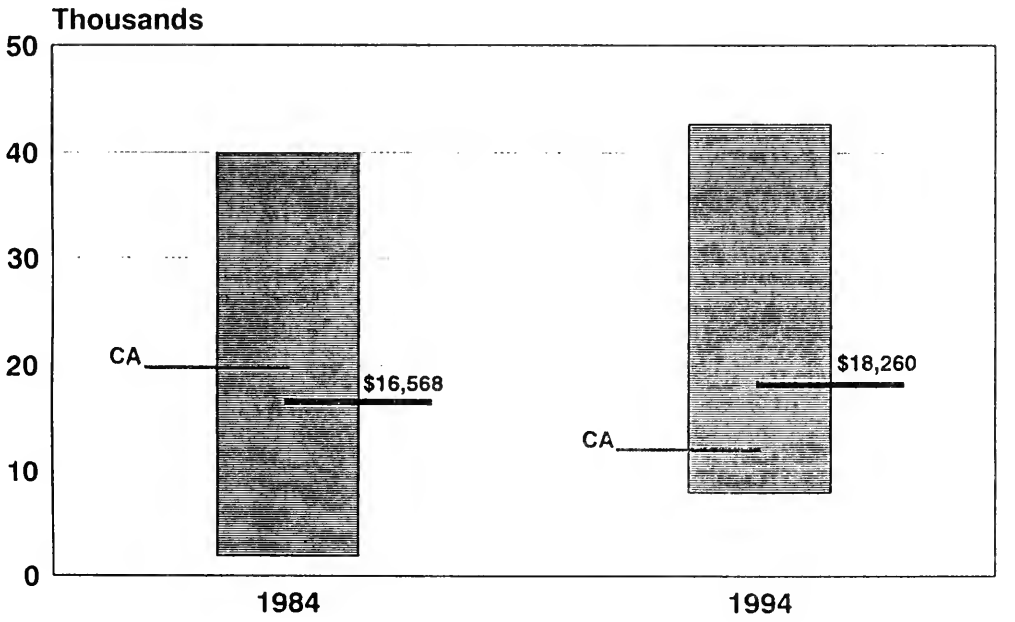
Orthopaedic Surgery - Premium Range & Average



27 company responses
All premiums on mature claims-made basis at $1mil/$3mil policy limits

PIAA Member Company Premium Survey

Anesthesiology - Premium Range & Average



27 company responses
All premiums on mature claims-made basis at $1mil/$3mil policy limits

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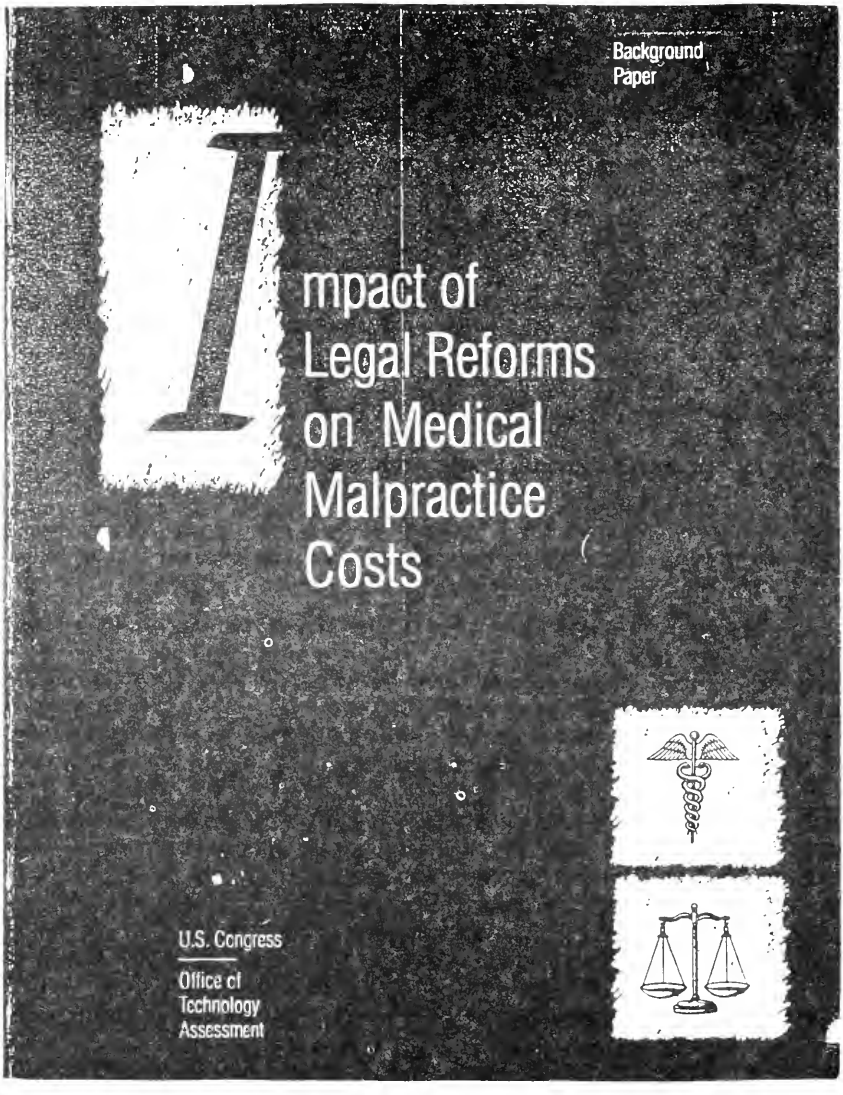
FACT SHEET

- Started June 30, 1981 as Copic Trust -- a self-insurance trust.
- Became fully licensed and regulated Colorado insurance company in September, 1984.
- Began writing medical professional liability policies as Copic Insurance Company on January 1, 1985.
- Copic absorbed 1200+ new insureds as the traditional insurance carriers declared rate increases of up to 473% and/or left Colorado late in 1986 and early 1987.
- Now Colorado's second largest domestic insurance company.
- December 1995 admitted assets of Copic Trust and subsidiaries -- $243.7 million.
- Copic operates on a not for profit basis.
- Distributions returned to policyholders thru 1995 - - $34.8 million.
  Declared distribution to be paid to policyholders in 1996 - - $6 million.
- Insured 4,368 physicians, as of December 31, 1995.
- Controlled by physicians for the benefit of physicians.
  Twelve of fifteen Copic Board Members are physicians.
- Copic writes medical professional liability policies only for Colorado physicians, hospitals and clinics.
- Ratio of expenses to net premium written -- 24% at 12/31/95.
- Received A- rating from A.M. Best on its first application in 1994.

REV. 1/96


Background Paper
Impact of Legal Reforms on Medical Malpractice Costs
U.S. Congress
Office of Technology Assessment

INTRODUCTION

Medical malpractice costs are increasingly being targeted in the political debate on health care reform. The direct costs of medical malpractice, measured by insurance premiums paid by physicians, hospitals, HMOs, and other providers, account for less than 1 percent of the health care budget. However, many physicians and policymakers believe that a potentially large hidden cost of the malpractice liability system is the practice of "defensive medicine." Definitions of defensive medicine differ, but most include the practice of ordering extra tests and procedures primarily in response to a perceived threat of a future medical malpractice claim.

OTA is currently studying defensive medicine, its costs, and the potential impact of medical malpractice reform on defensive medicine. The final report of this study will be published in early 1994. This background paper reviews the medical malpractice reforms that have been implemented in the States and the limited evaluations of their success in reducing three indicators of direct malpractice costs (hereinafter referred to as "malpractice cost indicators"):

- Claim frequency (the number of claims per 100 physicians);
- Payment per paid claim (the average dollar amount awarded to plaintiffs for claims that result in payment); and
- Malpractice insurance premiums.

The paper also provides a summary of the leading new reform proposals, highlighting some of their possible strengths and weaknesses.

Trends in Malpractice Cost Indicators

Malpractice insurance premiums, claim frequency, and average payment per paid claim increased rapidly in the mid-1970s and have since followed a fluctuating and more moderate upward path, marked by a relatively sharp increase during the mid-1980s. Since 1988, premiums and claim frequency have declined. Data on payment per paid claim are difficult to obtain because insurance companies hold most of these data. (Approximately 80 percent of medical malpractice claims are settled through private negotiations between the physician's insurer and the plaintiff.) One measure of malpractice claims payment that captures both actual and projected damages per claim is direct insurance losses, a measure that combines trends in both payment per paid claim and the probability of a claim resulting in payment. Between 1979 and 1985, direct insurance losses increased by 25 percent per year and then declined by 2.7 percent annually from 1985 and 1991, suggesting that either mean payment per paid claim or the probability of payment, or both, have declined in recent years.

It is not known whether these recent declines are part of a cycle or indicate a secular change in the medical malpractice environment. In addition, national averages obscure the sometimes pronounced changes across regions of the country and physician specialties.

Approaches to Medical Malpractice Reform

Over the past 20 years, almost every State has passed some type of medical malpractice reform. Most of the legislative activity occurred during the mid-1970s and mid-1980s in response to two malpractice "crises" marked by rapid increases in medical malpractice insurance premiums (Bovbjerg 1989). The "crisis" during the mid-1970s was more dramatic, because in some States physicians found themselves unable to obtain insurance. Most reforms

have had the goal of limiting the number of malpractice suits and payments per paid claim, in the hope that such limits would lower insurance rates.

Reforms to limit the number of suits or payment per paid claim include:

- Shortening the statute of limitations (i.e., the time period in which a suit can be brought);
- Limiting attorney fees;
- Requiring pretrial screening of suits;
- Setting specific dollar limits on payments per paid claim ("caps on damages");
- Requiring the plaintiff's health or disability insurer be the first payer of medical and related expenses (amending the "collateral source rule"); and
- Permitting the malpractice insurer to pay future damages as they come due, rather than in lump sum ("periodic payment" of damages).

To date, reforms that aim to promote access to the malpractice liability system by injured patients have not been a priority. Some recent reform proposals are designed to increase patients' access to the legal system, either by expanding the scope of injuries for which compensation will be provided or by removing the dispute from the courts and using alternative dispute resolution procedures or an admin-istrative tribunal. With the exception of limited no-fault programs for birth-related injuries in Florida and Virginia, few of these proposals have been adopted by the States or used to any extent in medical malpractice actions.

Finally, clinical practice guidelines have received considerable attention as a potential tool for determining the standard of care in medical malpractice trials. Maine and Minnesota have just begun programs to use clinical practice guidelines in medical malpractice litigation.

Impact of State Medical Malpractice Reforms

During the past decade, a handful of rigorous empirical studies has examined whether the medical malpractice reforms implemented by the States have had their predicted effects of reducing claim frequency, payment per paid claim, or malpractice insurance premiums. These studies have used multi-State data and multiple regression analysis to assess the specific impact of individual medical malpractice reforms after controlling for other factors that might be responsible for such differences.

The one reform consistently shown to reduce malpractice cost indicators is caps on damages. Requiring collateral source payments to be deducted from the plaintiff's malpractice award has also been shown to reduce certain malpractice cost indicators. Pretrial screening panels and limiting the statute of limitations show conflicting results. Finally, statutes that restrict attorney fees, require periodic payment of awards, and codify the standard of care have not been shown to have the intended result of reducing malpractice cost indicators.

Although the finding that both caps on damages and mandatory collateral source offsets reduce certain malpractice cost indicators is strong, one cannot conclude that the other reforms have no impact. Contradictory results in different studies may reflect different models and assumptions. The failure to find an effect may be a result of factors unrelated to the

effectiveness of the reform. Certain reforms have not been studied sufficiently to draw conclusions. In addition, a number of reforms were modest and might not be expected to have large effects. For example, periodic payment of awards is triggered in a very small number of suits with large future damages, so the savings gained by paying awards on a periodic basis may be very modest. Legal challenges to statutory changes may have also delay the actual implementation of the reform. Finally, due to data limitations, no conclusions can be drawn regarding the impact of medical malpractice reform on claim frequency.

Conclusion

Caps on damages and mandatory collateral source offsets should reduce the direct costs of the medical malpractice compensation system. The studies are not detailed enough to conclude anything about the level of the cap necessary to achieve this effect, but caps on noneconomic damages alone appear to reduce direct malpractice costs. It should be noted, however, that these savings are likely to come by reducing the payments per paid claim received by a small number of most severely injured plaintiffs.

The studies did not examine the impact of any of the reforms on access to compensation by patients injured by negligent care. While not addressing the access issue directly, some State courts have found certain medical malpractice reforms, most notably caps on damages, to violate their State constitutions, because they singled out medical malpractice plaintiffs for a reduction in their ability to recover damages. Other kinds of injuries (e.g., those resulting from other types of malpractice accidents) were not covered in the laws that have been struck down

Analysis of the impact of most reforms is limited, especially of reforms that move malpractice disputes outside the civil litigation system. The lack of uniform national data on claim frequency, payment per paid claim, and insurance premiums limit opportunities for strong empirical research on the potential for medical malpractice reforms to reduce malpractice costs.

Even if a given reform reduces direct malpractice costs significantly, the direct savings (i.e., from reductions in malpractice premiums) would represent only a very small portion of the national health care budget. Medical malpractice reform can be expected to generate significant savings in overall health care costs only if it can be shown that physicians order a significant number of extra tests and procedures and that these defensive practices are indeed influenced by the level of malpractice claim activity.

The impact of changes in malpractice cost indicators on physician behavior is not known. Although reducing malpractice cost indicators through medical malpractice reform might encourage physicians to limit defensive ordering of tests and procedures, it may also dampen whatever beneficial effects of the medical malpractice system has in deterring negligent medical practice. The advisability of such changes under a new health care payment regime--particularly one with greater incentives to reduce costs--is a policy issue that deserves careful consideration.

AMERICAN ACADEMY *of* ACTUARIES

March 10, 1995

The Honorable Steven Schiff
United States House of Representatives
Washington, DC 20515

Dear Representative Schiff:

In 1994, the American Academy of Actuaries (Academy) formed a Malpractice Reform Work Group. The Work Group's mission is to provide objective actuarial input on the potential effects of proposed tort reforms associated with changes in the cost of medical malpractice insurance. The group is composed of actuaries with extensive experience in the field of medical malpractice.

To assist lawmakers in the development of effective tort reform legislation, the Work Group has collected and reviewed several studies of medical malpractice tort reform, evaluated them based on their methodologies and actuarial experience, and summarized their contents into key points.

The studies reviewed by the Academy Work Group included all those referenced in work done for Congress by the Office of Technology Assessment (OTA) (Impact of Legal Reforms on Medical Malpractice Crisis, September, 1993). The OTA report addresses the direct savings through lower losses and premium costs associated with tort reform. Neither the 1993 OTA report nor the Academy Work Group have addressed the impact of medical malpractice on defensive medicine.

OBSERVATIONS AND CONCLUSIONS

Based on the studies analyzed, the Academy Work Group has the following observations and conclusions:

- A package of tort reforms is more likely to achieve savings in malpractice losses and insurance premiums (and, to the extent they are related, lower defensive medicine costs) rather than one or two reforms.

- An effective reform package should include two key components: a cap on awards for noneconomic damages, and some form of mandatory recognition of compensation from collateral sources. The 1993 OTA report agrees that these are the most effective reforms.

1100 Seventeenth Street NW Seventh Floor Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948

- Other reforms should be included in a reform package to help assure its effectiveness. Among others, these could include more restrictive statutes of limitations, limitations on expert qualifications, frivolous suit penalties.

  - As the OTA report correctly observes, although there are no significant findings for certain tort reforms studied, it is inappropriate to conclude the reforms have no impact. Study limitations and modest initial expected savings from individual reforms have produced inconclusive findings. The Academy Work Group further notes that findings of specific tort reform studies are subject to significant qualification because of the inability to control for the dynamics of the loss environment and isolate the effect of any single reform. Thus, reforms other than caps should be considered for inclusion in a package to improve the likelihood of achieving savings.

  - California's experience is an example of the stability and improvement in losses and premium costs which can be achieved by a coordinated tort reform package. The Medical Injury Compensation Reform Act (MICRA) tort reform package was implemented in 1975 and continues to be in effect. (Attachment 1 to this letter provides more information comparing California's experience to the experience of two other states.)

- Poorly constructed tort reforms will not result in lower malpractice costs and premiums and may actually increase malpractice costs.

  - Caps on noneconomic damage awards are most effective when set at levels such as $250,000, and applied on a per medical injury (rather than a per claimant) basis. High caps and/or multiple caps may actually increase costs.

  - Alternative Dispute Resolution (ADR) has been discussed as a potential medical malpractice component in health care reform. The OTA report notes that there are many forms of ADR and little is known about the potential impact on medical malpractice costs. However, ADR that is non-binding and/or applicable to lower value claims only, may increase costs.

- Tort reform effectiveness should be measured by comparing the cost after the tort reform to what the cost would have been in the absence of the reform. This is particularly important given the significant inflationary trend in the costs of malpractice claims. A tort reform can be effective by reducing or stabilizing this "inflation" even though it may not produce an overall year-to-year reduction in costs. Depending on the circumstances, expectations of absolute reductions in costs and premiums is unrealistic.

The Academy Work Group would be happy to provide more specific comments regarding individual reforms or issues associated with alternative dispute resolution, administrative compensation or protocol driven systems based on the published studies and our own experience.

Sincerely,

James D. Hurley
Chairperson, Malpractice Reform Work Group

Committee Members:

William E. Burns
Linda A. Dembiec
Timothy L. Graham
Edward M. Wrobel, Jr.

Attachments

STATE COMPARISON OF MEDICA' MALPRACTICE PAYMENTS/REFORMS

In the Academy work group's view, the focus of any tort reform should be on a package of reforms that has exhibited some success in stabilizing medical malpractice costs. The most effective elements of a package, and therefore, key ingredients, appear to be caps on noneconomic damages and some form of offset for collateral payments from other sources. While there are significant limitations on data used to study specific tort reforms, persuasive results can be observed by looking at the experience in certain states over a long period of time and relating that experience to the timing of particular tort reform measures.

Attached are comparisons of cost levels for three specific states, each state having had tort reform measures in place for an extended period of time (the specific tort reforms are described in Attachment 2). In each case, the measure of costs is the individual state's paid losses as a percent of the total U.S. All else being equal, the percent of costs, in terms of paid medical malpractice claims relative to the total U.S., should remain constant over time. The observed changes, or lack thereof, in the state's relative cost level provide an indication of the effectiveness of tort reforms. The three examples are:

- California - The Medical Injury Compensation Reform Act (MICRA) package of reforms was enacted in 1975. Since then, medical malpractice costs have fallen as a percent of the U.S. total.

- New York - Several individual reforms were enacted in 1975, 1981, 1985, and 1986. There has been no observable improvement in the state's relative cost. The New York reforms did not include any cap on damages.

- Ohio - Reforms enacted in 1975 included a cap on damages; however, the cap was overturned in 1985. Costs rose dramatically after the cap was overturned and have remained high.

The California loss data is shown on Exhibit 1. It illustrates that while California has had a relatively stable proportion of the U.S. physician population, it's percentage of loss payments (relative to the U.S. total) has dropped dramatically since the inception of its MICRA package of tort reforms. Prior to tort reform in 1975, California's percentage of loss payments ran significantly higher than their level of physicians. By 1981, California's loss payments had dropped and were about even with their percentage of physicians. Since 1981, California has continued to benefit from their MICRA reforms. Costs continue to drop as a percent of the total U.S. while the level of physicians remains stable. Although other factors affect this data, the timing and relationship provides support for improvements due to the MICRA reforms.

Many opponents of tort reform argue that insurance premiums do not drop after tort reform. It is true that this is difficult to measure since costs and premiums normally go up with inflation and tort reform may only slow down the increases. However, the California data shows that premiums declined as loss levels declined. Exhibit 2 compares the paid loss data from Exhibit 1 with California premiums as a percentage of the total U.S. premiums for medical malpractice.

Year-to-year fluct·ations do occur, but over an extended period, premiums have fallen in a similar proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived.

The New York loss experience is shown in Exhibit 3. It shows that the tort reform measures implemented in New York did not improve its experience relative to other states. New York's percentage of loss payments do not show any observable pattern of decline or improvement over the 16 year period, despite the various tort reform measures adopted. This result supports the merits of a cap on damages, which New York does not have, and the package concept (New York's reforms were put in piece-meal).

The final example is Ohio, with data presented in Exhibit 4. The data shows a gradual decline in the cost level following tort reform, from 1976 through 1982, and a sharp increase during the time the cap was under challenge in the courts with a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no indication of decreasing. Again, this data appears to support the benefits of a tort reform package and the specific benefit from a cap on noneconomic damages, as seen by the increases in costs when the cap was no longer in effect.

EXHIBIT 1

Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975-92

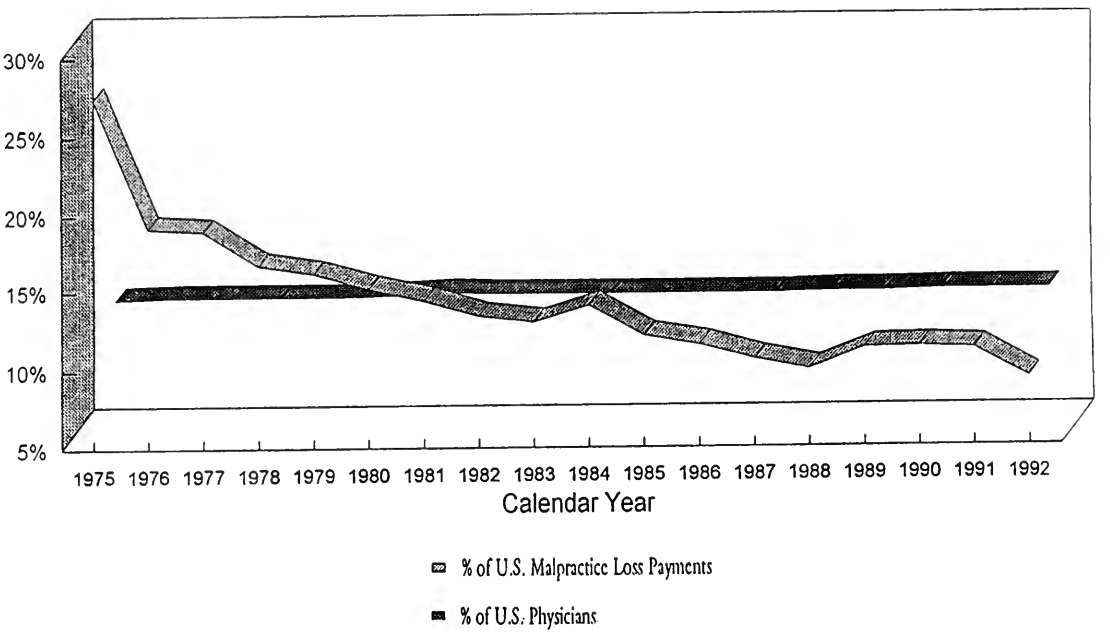


EXHIBIT 2

Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975-92

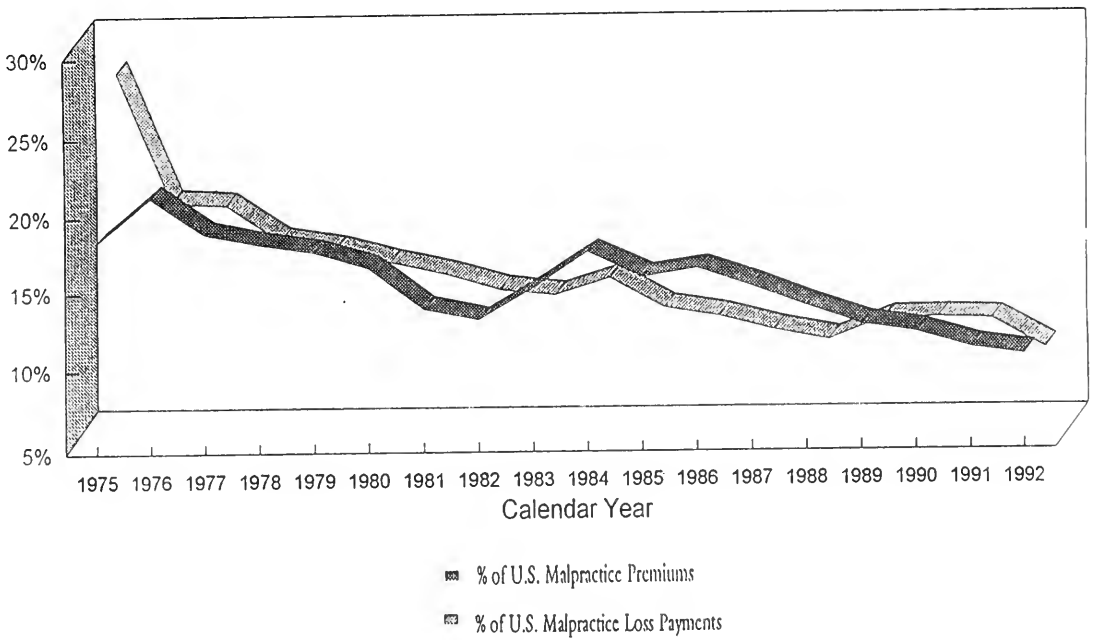


EXHIBIT 3

Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975-92

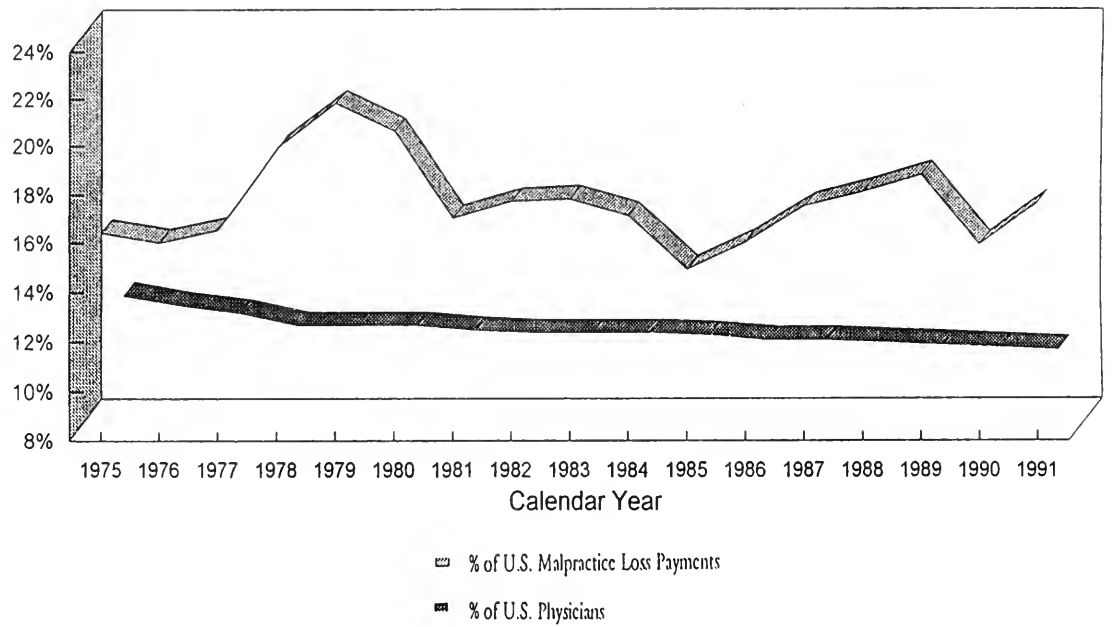
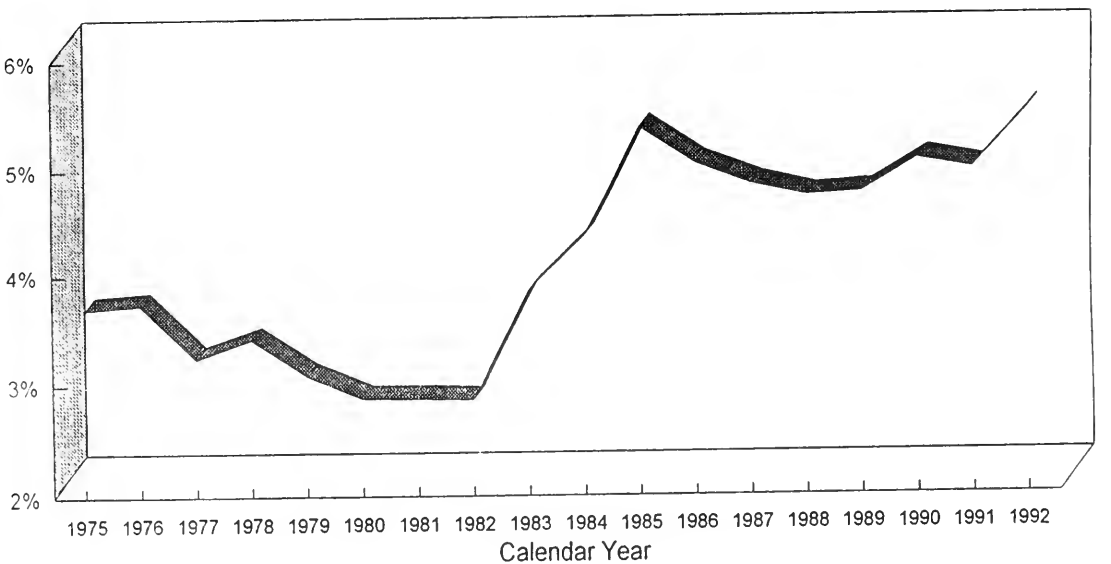


EXHIBIT 4

Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975-92



DESCRIPTION OF MEDICAL MALPRACTICE REFORMS

TYPE OF PROVISION	CALIFORNIA	NEW YORK	OHIO
BARRIERS TO SUIT	ATTORNEY FEES - Enacted 1975; Amended 1987. Sliding Scale -- Fees may not exceed: 40 percent of first $50,000 of plaintiff recovery; 33 1/3 percent of the next $50,000; 25 percent of next $500,000; 15 percent of any amount on which the recovery exceeds $600,000.	ATTORNEY FEES - Enacted 1985. Contingent fees for medical injury action shall be established according to a sliding scale: 30 percent of first $250,000 recovered; 25 percent of the next $250,000; 20 percent of the next $500,000 recovered; 15 percent of the next $250,000; and 10 percent of any amount of $1,250,000.	ATTORNEY FEES - No Statutory limits.
	NOTICE - Enacted 1975. Plaintiff must provide 90 days notice before filing suit.	NOTICE - No statutory provision.	NOTICE - No statutory provision.
	FRIVOLOUS SUIT PENALTY - No statutory provision.	FRIVOLOUS SUIT PENALTY - Enacted 1985; Amended 1986. In a medical injury case, the court shall award prevailing party costs and reasonable attorney fees not exceeding $10,000 if claim or defense is frivolous.	FRIVOLOUS SUIT PENALTY - Enacted 1987. The court may award reasonable attorney fees to any par., adversely affected by frivolous conduct.
	PRETRIAL SCREENING PANELS - No statutory provision.	PRETRIAL SCREENING PANELS - Enacted 1974. Mandatory submission of medical injury claims to a "medical malpractice panel." The unanimous opinion of panel is admissible at any subsequent trial.	PRETRIAL SCREENING PANELS - Enacted 1975; Amended 1987. Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties. Decision is not admissible at any subsequent trial. Prior to 1987 amendment, submission was mandatory and results were admissible.

SOURCE: Compendium of State Systems for Resolution of Medical Injury Claims, Agency for Health Care Policy and Research, U.S. Public Health Service, Department of Health and Human Services, February 1991.

TYPE OF PROVISION	CALIFORNIA	NEW YORK	OHIO
BARRIERS TO SUIT (continued)	IMMUNITY - No statutory provision.	IMMUNITY - No statutory provision.	IMMUNITY - Enacted 1977. No person shall be liable for ordinary negligence for rendering emergency care at the scene of emergency, outside of hospital or doctor's office. - Enacted 1981. No person providing voluntary emergency services to school athletic program shall be liable for ordinary negligence.
	STATUTE OF LIMITATIONS - Enacted 1975. Three years after injury or 1 year after discovery or reasonable discoverability, whichever occurs first; in no event more than 3 years after injury, unless fraud, concealment, or a foreign object. Minor under 6 years must bring suit within 3 years or before 8th birthday, whichever is longer.	STATUTE OF LIMITATIONS - Enacted 1975. Two years and 6 months from act or from last treatment where there is continuous treatment for condition giving rise to claim; if foreign object, one year from discovery or reasonable discovery.	STATUTE OF LIMITATIONS- Enacted 1990. A medical injury action may be brought within 1 year after the action occurs, except if before the 1 year expires the plaintiff gives written notice, then suit may be brought within 180 days of the notice. Persons with legal disability must bring suit within 4 years after occurrence.

TYPE OF PROVISION	CALIFORNIA	NEW YORK	OHIO
REDUCING DAMAGE AWARDS	AD DAMNUM CLAUSE - No statutory provision	AD DAMNUM CLAUSE - Enacted 1976. In a medical injury action, no dollar amount of damages shall be stated in the complaint, counterclaim, cross-claim, interpleader claim and third-party complaint. If complaint filed in supreme court, the pleading shall state that jurisdictional limit met.	AD DAMNUM CLAUSE - Enacted 1987. Damages in excess of $25,000 shall not be specifically stated in the complaint for a tort action.
	COLLATERAL SOURCE RULES - Enacted 1975. Discretionary offset: defendant may introduce evidence of collateral sources; plaintiff may introduce evidence of payments made to secure collateral source benefits. No source of collateral benefits introduced pursuant to this provision shall recover any amount from plaintiff or be subrogated to plaintiff's rights. No collateral source shall obtain reimbursement from a medical malpractice defendant.	COLLATERAL SOURCE RULES - Enacted 1975; repealed 1981. Discretionary offset: economic losses may be reduced by the amount of any collateral benefits, except those with liens against plaintiff. - Enacted 1981. Mandatory offset: the court shall reduce the economic award by the amount of any collateral source benefit, except those sources with liens against the plaintiff. The court shall reduce the offset by the amount of premiums paid by plaintiff for such benefits for the two-year period immediately preceding and less the amount equal to the projected future cost of maintaining the benefit.	COLLATERAL SOURCE RULES - Enacted 1975; struck down as unconstitutional in 1982 after appeal in Graley v. Satayathem. Mandatory offset: in any medial action, economic damages shall be reduced by the amount of collateral source benefits except insurance proceeds paid for by plaintiff or his employer. A collateral source of indemnity shall not be subrogated to the plaintiff against the defendant.
	LIMITS ON DAMAGE AWARDS - Enacted 1975. The amount of noneconomic damages may not exceed $250,000	LIMITS ON DAMAGE AWARDS - No statutory provision.	LIMITS ON DAMAGE AWARDS - Enacted 1975; struck down as unconstitutional in 1985 (Duren v. Suburban Hospital). In a medical claim, general damages shall not exceed $200,000.

TYPE OF PROVISION	CALIFORNIA	NEW YORK	OHIO
REDUCING DAMAGE AWARDS (continued)	JOINT AND SEVERAL LIABILITY RULES - Enacted 1986. The liability of multiple defendants for noneconomic damages shall be in direct proportion to each defendant's proportion of fault PERIODIC PAYMENT OF DAMAGE AWARDS - Enacted 1975. Mandatory periodic payment of future damages award exceeding $50,000 upon request of party; payments to continue after death of plaintiff to parties to whom judgment creditor owed a duty of support.	JOINT AND SEVERAL LIABILITY RULES - Enacted 1986. Defendant found to be 50 percent or less at fault shall only be liable for those noneconomic damages that are in proportion to the defendant's fault. PERIODIC PAYMENT OF DAMAGE AWARDS - Enacted 1985. In a medical injury claim, mandatory periodic payment of future damages in excess of $250,000.	JOINT AND SEVERAL LIABILITY RULES - Enacted 1987. Each party jointly and severally liable for economic damages. For noneconomic damages, where plaintiff contributorily negligent, each defendant is liable only for his proportionate share of fault. PERIODIC PAYMENT OF DAMAGE AWARDS - Enacted 1987. In medical claims, mandatory periodic payment of future damages, at the request of a party, where future damages exceed $200,000.
ALTERNATIVES TO LITIGATION	ARBITRATION - Enacted 1975. Voluntary arbitration. Agreement may be rescinded within 30 days of execution. Agreement must contain specific statutory language that plaintiff's signature constitutes a waiver of the right to trial regarding any dispute arising out of care or treatment for which the agreement was entered. Once agreement signed, provisions apply to all subsequent open-book account transactions for medial services for which agreement entered into unless rescinded by written notice.	ARBITRATION - Enacted 1986. Within 60 days after medical malpractice complaint filed, the defendant may demand that the plaintiff elect to consent to arbitration of damages upon a concession of liability. All claims arising from health care treatment provided by an HMO shall be subject to arbitration if an enrollee has so elected or failed to do so. The arbitration election notice shall state the statutorily required language regarding waiver of right to jury trial and the right to cancel the agreement. The HMO may also cancel an arbitration agreement. All agreements to arbitrate medical injury claims in the state are subject to the procedures provided in Article 75-A, "Health Care Arbitration."	ARBITRATION - Enacted 1975. A written contract entered into by the patient and health care provider to arbitrate treatment disputes, entered into before or subsequent to provision of services, is binding and irrevocable. The agreement must include statutorily required language regarding withdrawal of consent to arbitrate in the event of death or incapacity, that the agreement constitutes a waiver of the right to jury trial, and that treatment is not contingent upon execution.

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY

Projected Effect on New York Professional Liability Costs of Capping Noneconomic Damages

Prepared by:

Richard S. Biondi, FCAS, MAAA
Kenneth Quintilian, FCAS, MAAA

January 5, 1995

MILLIMAN & ROBERTSON, INC.

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ESTIMATED PREMIUM SAVINGS DUE TO CAP ON NONECONOMIC DAMAGES

Primary Coverage ($1M/$3M) Reflects All Expense Loadings		
Limit on Noneconomic Damage Award	*Assuming ALAE Unaffected by Tort Reform*	*Assuming ALAE Decreases Due to Tort Reform*
$ 100,000	34%	38%
250,000	28%	31%

Excess Coverage ($1M/$3M Excess of $1M/$3M) Reflects Underwriting Expense Loading Only	
Limit on Noneconomic Damage Award	*Assuming All LAE Retained in Primary Layer*
$ 100,000	70%
250,000	60%

OVERVIEW OF ANALYSIS

As our central, or "base line", scenario, we analyzed the effect of a $250,000 cap on noneconomic damages. We also examined the alternative of a $100,000 cap. We analyzed the effect of these tort reform measures on policies with $1 million and $2 million limits. These results are shown on Exhibit 1.

Our detailed analysis does not encompass the effect of tort reform on allocated loss adjustment expenses. Our base line model assumes that ALAE will be unchanged by tort reform. However, we do present an alternative result under the judgmental assumption that ALAE is decreased, but less than proportionally to loss.

In addition to our base line model, we subjected the model to a variety of sensitivity tests. Each test varies one of the assumptions in our base line model. The purpose of these sensitivity tests is to show how sensitive our results are to each of the assumptions underlying the model. The results of these tests are shown on Exhibit 2.

will have the greatest effect on the excess layer. The primary effect of a cap will be to lower the average severity of a claim. The first beneficiary of such a decrease will be the insurer of the excess layer. Thus our best estimate is that a $250,000 cap will lower the cost of the excess layer by 60%.

The results of this analysis are intended to apply to physicians malpractice. Although hospitals can also expect to see a change in their loss costs as a result of tort reform, many considerations make it difficult to directly draw conclusions for hospitals from this report. For example, hospitals have a significantly lower average severity than doctors. Also, hospitals are more likely than physicians to have co-defendants in a trial. These and other differences make this analysis inapplicable to hospitals.

A cap on noneconomic loss can have certain effects that we did not consider in the analysis. First, we only superficially examined the effect of tort reform on ALAE. Although Option 2 on Exhibit 1 presents a scenario in which ALAE expenditures are decreased by tort reform, the parameter was selected entirely based on judgment. It is possible that a more detailed analysis would yield a significantly different result.

It is also possible that jury awards and settlements for economic loss will increase to partially offset the cap on noneconomic loss, or that the percentage of defense verdicts will decline. Legal arguments might be devised to narrow the types of damages subject to the cap, or to define new forms of damages that are outside the limitations on noneconomic loss. It is possible that certain types of lawsuits or damages may be exempted (either by statute or court decision) from the award cap. As a final example, greater care might be taken by plaintiffs to carefully define and fully list all elements of economic loss, if the possibility no longer exists to use noneconomic losses as a catch-all for ill-defined damages. All of these items could act to decrease the benefits realized by this type of tort reform. In our model we assumed that no such events would occur.

We also assumed that tort reform would have no effect on the frequency with which claims or suits are filed. In actuality, certain suits currently in the system (particularly those with very low or zero economic loss) might not be brought to court if the potential reward to the plaintiff is too low.

These are just some of the considerations that should be borne in mind when considering the implications of this report. Additional observations, and a comparison of this model to other analyses, can be found in Appendix D.

In Stage B we increase those claims to an "implied" verdict level reflecting what would have happened at verdict. In Stage C we calculate the total verdict amount, before any post-verdict appeals or settlements. In Stage D we subdivide the verdict into economic and noneconomic damages, and we subject the noneconomic damages to a cap in the tort reform scenario. At Stage E we reduce each component of the verdict by the appropriate post-verdict reduction percentage. Note that, in the tort reform scenario, we assume that the noneconomic losses will not be reduced at all on appeal.

At this point we can calculate the loss savings percentage for the sample case shown on Exhibit 3 (the loadings for expenses are not shown). In this case the savings comes out to 27.5%. A more detailed discussion of the example shown on Exhibit 3 can be found in Appendix C, where the simulation process is discussed at length.

Many assumptions went into the creation of this model. Among other things, we made assumptions about the expected number of defendants per lawsuit, the average severity of a claim, the percentage relationship between settlements and verdicts, the average percentage of a claim that is for noneconomic loss, the expected disposition of a claim after the return of the verdict, and the kind of effects that tort reform would have on each of these steps in the process. These assumptions were based on data from a variety of sources, combined with judgment. In order to increase our confidence in the reasonableness of our assumptions and our results, we conducted extensive sensitivity testing of the model; the results of these tests are presented on Exhibit 2. We attempted to select the most appropriate value for each assumption, but if inaccuracies in our assumptions exist, it appears to us that refinement of the assumptions would tend to increase the tort reform savings above the levels presented in this report.

DATA

Our work was based primarily upon the following information (in addition to our 1986 study on this issue):

(1) A verdict database (described above in the *Overview of Analysis* section) provided by MLMIC;

(2) The 1994-1995 review of the physicians rate level requirement for MLMIC;

Reasons for this uncertainty include statistical fluctuations, as well as unanticipated changes in claim procedures and settlement practices, legislative and judicial decisions, attitudes of claimants and the courts, social and economic inflation, and numerous other social, political, and economic factors. These forces are particularly important in an analysis of this type, i.e., a study of the potential effect of tort reform. Data limitations also contribute significantly to the uncertainty surrounding these results.

Furthermore, no simple theoretical model can reflect all of the forces underlying a complex insurance process. The various parameters and probability distributions within a simulation model reflect numerous assumptions. The underlying "true" distributions of the various quantities within the model may be significantly different from the estimated distributions.

In performing this analysis we relied upon data and other information provided to us by MLMIC, and industry sources of medical professional liability data. We did not audit any of this data or other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis will be affected.

DISTRIBUTION

To the extent that this report is distributed outside of MLMIC and its governing bodies, we request that it be distributed in its entirety, including all appendices and exhibits.

Very truly yours,

Kenneth Quintilian, FCAS, MAAA

Richard S. Biondi, FCAS, MAAA

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In Tests 2 through 8, we show the results which emerge when we vary one assumption at a time in our tort reform projection model. Each of these tests assumes a $250,000 noneconomic cap for the "After Tort Reform" projections.

We observe that our model is insensitive to the claim distribution's coefficient of variation (CV) (see Test 3), and to the empirical distributions around the means for the noneconomic portion and the appeals factor (see Test 8).

The model is moderately sensitive to the means for claim severity, claims per suit, the verdicts/settlements ratio, and the appeals factor (see Tests 2, 4, 5, and 7, respectively).

The model is most sensitive to the mean for the noneconomic portion as a percentage of the total loss (Test 6).

Exhibit 3

This exhibit presents in flowchart form a simplified summary of our model of the effect of tort reform on indemnity for a typical hypothetical lawsuit. This exhibit is intended to aid in understanding the model, and is discussed in Appendix C in connection with the step-by-step outline of the simulation.

Exhibit 4

This exhibit presents the distribution which we used in our base line model for the average number of claims in each of the modelled hypothetical lawsuits. It is based on MLMIC data presenting the number of claims per case, increased by an estimate of the number of non-MLMIC co-defendants in the average case.

Exhibit 5

Sheet 1 of this exhibit presents the selected distribution for the noneconomic portion of each case. It is based on the MLMIC verdict database compiled from Forms 131-D. In Sheets 2 through 5, we break down the economic versus noneconomic losses in four ways, showing:

(1) Total All Verdict Amounts (all insureds' portions)	(Sheet 2)
(2) Total Equitable Share of Verdict (MLMIC's insureds' portions)	(Sheet 3)
(3) Total Paid by Insurer (MLMIC)	(Sheet 4)
(4) Total Paid (including sources other than MLMIC)	(Sheet 5)

Exhibit 9

This exhibit provides an analysis of historical average verdict severities (on a total verdict basis) from MLMIC's verdict database. This exhibit also displays the average verdict trended to January 1, 2008, which is our estimate of the average date of final verdict for a case occurring in policy year 1994-1995. This value is compared on Exhibit 9 to the theoretically derived average settlement value. These relationships were used to assist us in determining the factor to convert the average settlement to the average implied verdict in the model. Further discussion of this exhibit and its implications is found in Appendix B.

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Claims Per Case

In order to model the number of claims per case, we obtained from MLMIC a distribution of closed cases, with individual claim detail, for cases with incurred amounts equal to or greater than $100,000. From this data we were able to calculate the percentage of all MLMIC cases that result in one claim, two claims, three claims, etc. All claims and cases in this part of the calculation were those that resulted in indemnity payments (CWIP's), so no claims in this calculation had payments of zero.

This "CWIP's-per-nonzero-settlement" distribution had two limitations that we had to take into account. First, the claims-per-case database only reflects MLMIC claims. The verdicts to which the pain and suffering cap will apply, will reflect a combination of MLMIC and non-MLMIC defendants. Some cases could involve just one at-fault MLMIC defendant, but a large number of non-MLMIC defendants. MLMIC will in such cases only be responsible for its pro-rata share of the noneconomic loss, whether it is capped by tort reform or not. Because this effect could dramatically increase the loss savings that MLMIC will realize from a cap, we felt it should be reflected in the analysis, as described below.

We used the verdict database prepared by MLMIC from the Forms 131-D, to ascertain the average percentage of losses per verdict that are allocable to MLMIC. We calculated this as MLMIC's "total equitable share" of all verdicts, divided by the total of all of the verdicts, for all cases resolved in 1989 through 1993. We assumed that this dollar-weighted percentage represented the percentage of all defendants represented by MLMIC - approximately 53% (this differs from the MLMIC total market share, because the database appropriately excludes those cases with which MLMIC had no involvement at all).

We judgmentally adjusted upward the number of claims per case from the excess claims database, to reflect the increased mean that was implied by this 53% factor. We did this by lowering the probability of a one-claim case, and increasing the probability of each of the larger claim counts, until the overall average number of claims in the selected distribution matched the mean from the MLMIC-only empirical distribution, divided by 53%. We judgmentally limited the maximum number of claims per case to ten (the largest number of MLMIC claims in an actual case was seven).

The second adjustment related to the fact that the MLMIC excess claims database excludes all cases with incurred amounts less than $100,000. These small cases contain, on average, a disproportionately small number of claims. Therefore, we ran a simple

Factor to Convert Settlements to the Verdict Level

The next consideration is to determine the relationship between the "settlement level" and the "verdict level." It is clear that cases do not settle for the same amount as their potential verdicts. Various influences affect the amount of the settlement. The time value of money works to decrease settlements, because claimants may be willing to accept a smaller amount immediately, rather than wait years for a larger award. The element of uncertainty also affects the settlement. Because there is a very significant probability that a jury in any particular case will return a verdict for the defense, the defendant will be likely to lower the offer in the face of the uncertainty. The plaintiff will be more likely to accept such an offer, to avoid taking the chance of receiving no award at all. Finally, the additional expense of continuing the litigation affects the settlement negotiation. Both sides incur expenses in one form or another by continuing the lawsuit, whereas a settlement terminates the expenditures immediately.

We did not quantify each of these effects separately. Rather, we combined them into one parameter by directly estimating the relative magnitude of the settlement and verdict values. This step is complicated by the fact that we think claims which go to verdict have different characteristics than those which settle. The motivations of the parties involved in the litigation is such, that claims that go to verdict are disproportionately more likely to result in defense verdicts. Furthermore, it appears that cases that yield plaintiffs' verdicts are, on average, more serious than cases that actually settle. Because we did not have access to data that would allow us to estimate the underlying seriousness of any given case (type of injury coding, nature of allegation, or magnitude of the initial demand are examples of information that would have assisted in this regard), we were unable to directly estimate the relative seriousness of cases yielding settlements versus those yielding verdicts.

Therefore, we used the results of a study performed by the Rand Institute for Civil Justice to estimate this relationship. The results were published in a pamphlet entitled "The Resolution of Medical Malpractice Claims - Modelling the Bargaining Process," which was authored by P. M. Danzon and L. A. Lillard in 1982. Although the analysis is not recent, we believe that the type of relationship we are seeking will not change quickly over time, and that the results of the Rand study are therefore still valid for this purpose.

The Rand report compared injury types and other lawsuit characteristics in order to ascertain the differences between the subset of claims that actually are settled, and the subset that goes to verdict. They estimated the relationships among three values: V_v (average verdict for those claims that actually go to verdict); S_s (average settlement for claims that are actually settled); and V_s (average *potential* verdict for claims that actually settled). Rand estimated that the ratio V_v/S_s = 264% (i.e. actual verdicts are, on average,

Nevertheless, the value we selected for V_S/S_P (1.3) already seemed to be at the low end of the range of reasonableness, so we decided against lowering it further. It seemed implausible that the litigating parties, even though operating without the constraint of insurance policy limits, would settle for an amount only 10% or 15% lower than the potential verdict, particularly in light of the uncertainty arising from the high probability that the verdict would actually be returned for the defense.

Another argument against lowering the V_S/S_S factor arises from considerations of the time value of money, which taken by itself could lead one to infer that New York's settlement-to-verdict factor might be higher than 1.3. The 1.3 factor that we selected was based upon Rand's countrywide data. MLMIC operates exclusively in New York, which seems to have an unusually long average lag between suit filing and verdict. Thus, present value considerations might tend to push MLMIC's ratio above the national norm.

We therefore settled on the countrywide value that was selected by Rand. The sensitivity test previously mentioned demonstrates that the result is not very sensitive to this selection.

Defense Verdicts

We also considered the fact that many claims that settle for payment, would have gone on to yield defense (no pay) verdicts. The Rand study and the MLMIC verdict database both yielded insights on this issue. Exhibit 8 displays the unadjusted percentage of verdicts in the MLMIC database that were returned for the defense.

However, when the Monte Carlo model was fully parameterized, it became clear that, based on the assumptions that we made, the frequency of defense verdicts would have no effect on the estimated savings from tort reform. Tort reform only affects expected losses, and there are no losses in a defense verdict. The percentage savings from tort reform, as modelled in this analysis, is only affected by the losses on plaintiffs' verdicts. For this reason, although Exhibit 8 shows that a high percentage of actual jury trials yield defense verdicts, we will not attempt to estimate the (presumably smaller) percentage of *settled* claims that would have yielded defense verdicts.

Noneconomic Loss Percentage

The next issue is the determination of the percentage of noneconomic loss in a given verdict. Because this model is a Monte Carlo simulation, we chose to vary this very important parameter on the basis of the distribution of verdicts actually observed in the MLMIC data. In the course of the random generation of verdict "samples," we picked for each verdict a percentage that would be considered noneconomic loss. Exhibit 5 displays

Implementation of Cap on Pain and Suffering Award

The next step, to evaluate the effect that a cap on noneconomic damages would have on the average verdict, was straightforward. In the base line model, the noneconomic portion of each sample verdict was capped at $250,000, and the result was retained for comparison to the unlimited verdict. Note that the cap was applied per case, as opposed to per claim.

Appeals Factor

Claims that go to verdict are very often settled thereafter for an amount different than the verdict amount, in lieu of the completion of an appeal. Additionally, some verdicts are reduced by the trial judge, or altered in amount by an appellate court. When the parties initially negotiating a settlement before trial consider the probable outcome of their case, they will consider all aspects of the case, through its final resolution. Therefore, we thought it important to reflect post-verdict appeals and settlements in our model.

The verdict database that we obtained from MLMIC allowed us to determine an approximation of the amount of this reduction. We based this calculation on the sum of all of the values actually paid in the case on behalf of MLMIC insureds, divided by the dollar value of the MLMIC insureds' equitable share of the total verdict. As can be seen on Exhibit 6, we selected 69% as the average reduction factor. This is similar to the 71% value from by the previous M&R study of this issue. We also assumed a distribution around this mean value, based on our observations from the data; i.e., there are probabilities that the paid amount will be 90% of the initial verdict; that it will be 30%; and even that the final payment will be more than the verdict. The random sample created by the model reflects each of these possibilities, according to the pattern shown on Exhibit 6.

It should be noted that the paid amounts used in calculating the 69% factor are limited by any applicable policy limits, although in using the factor we assumed that the paid values were uncensored. If uncensored paid values were available and had been used, it would have increased the savings due to tort reform; therefore, we consider this assumption to be reasonable.

This step in the process is another place where care must be exercised in evaluating the results, since the data may not be ideally suited to the purposes for which we use it. There are three paid values in the verdict database: amounts paid by MLMIC, by the insured, and by "others." We assumed that the sum of these three amounts represented all amounts paid by any party, on that portion of the verdict equitably allocated to MLMIC's

We assumed that settlement behavior is predicated on a rational evaluation by the litigating parties of the probable course that will be taken by the lawsuit in which the parties are involved. That is, the parties will evaluate the likely verdict, the potential reductions that will occur after the verdict, the time value of money and the added expense of protracting the litigation, and will make their settlement decision on that basis. We assumed that the parties have perfect information about expected values of various courses of action, but that they do not have the ability to "see the future". Although they know, for example, that the average verdict is reduced 31% in the appeals process, they do not know whether their particular case will be reduced 10% or 60%. Therefore, we reflected the effect of tort reform on settlements by decreasing each of our hypothetical pre-verdict settlements by the same percentage, that percentage being the average effect of tort reform on finally resolved *verdicts*.

Calculation of Final Savings

So far, all elements of the process have been assumed to exclude the effect of policy limits. At this point we therefore capped each pre-reform and each post-reform claim (as opposed to case) by the policy limit. The ratio of the sums of these censored values was the final factor by which we assumed the implementation of tort reform would reduce the expected insured losses of MLMIC's doctors. (Note the simplifying assumption, which bears repeating, that all MLMIC claims are settled before reaching a verdict. We felt this approximation was reasonable since about 95% of MLMIC claims are closed before reaching a verdict.)

As a final consideration, we reflected the effect that would arise from the loss adjustment expenses (LAE) and underwriting expenses. In our base line scenario we assumed that the dollar value of each of these elements of premium would be unaffected by tort reform. This assumption is questionable in the case of allocated LAE. The degree of effort expended by the defense to litigate a claim might be affected in complex ways by the imposition of a cap on damages. We did not attempt to model these possible effects in our base scenario, taking the conservative position that the cap would not affect ALAE at all. This result is shown on Exhibit 1, Sheet 1, as Option 1. However, in recognition of the fact that ALAE might reasonably be expected to decline under tort reform, we present an alternative option, judgmentally selected, wherein we assumed that ALAE would be reduced by a fraction equal to one-third of the fraction by which indemnity was reduced. This option is also presented on Exhibit 1, Sheet 1, where it is described as Option 2.

APPENDIX C: BASE LINE SCENARIO - SIMULATION PROCESS

The "base line scenario" represents our central estimate of the effects of tort reform, based on our selected parameters. It consists of the steps shown below. A summarized chart of these steps is shown on Exhibit 3, with typical values shown for the inputs. This chart is for illustrative purposes, and does not map step-for-step to the assumptions or results of the model itself. The parameters mentioned below are described fully in Appendix B.

(1) Use an empirical distribution to randomly generate *n*, the number of CWIP claims corresponding to the case (one claim corresponds to one defendant). For the mean of this distribution, we used 1.97; the entire distribution, which ranges from 1 to 10 claims, is shown on Exhibit 4. This reflects both MLMIC and non-MLMIC defendants. In stage A of Exhibit 3 we show an example of a two-claim case.

(2) Use a lognormal distribution to randomly generate *n* nonzero claim settlement values corresponding to the case. We used an unlimited mean of $570,353 and a coefficient of variation (CV) of 3.00 for the claim severity distribution.

(3) Multiply the case settlement value generated in step (2) by a verdicts/settlements ratio of 1.297 to estimate the dollar amount that would have emerged had the case gone to verdict. This step is shown on Stage B of Exhibit 3. Because it does not affect the result, we ignored the fact that many cases would have gone on to a defense verdict.

(4) Use an empirical distribution to randomly generate a split for the verdict into its economic and noneconomic components. We have used 70% as the mean of the distribution for the noneconomic portion; the entire distribution, which varies from 0% to 100% noneconomic loss, is shown on Exhibit 5, Sheet 1. Stage C of Exhibit 3 shows the total, unadjusted verdict. Stage D shows a typical split of this loss into its economic and noneconomic components.

(5A) For the "before reform" portion of step (5), multiply both the economic and noneconomic portions of the case by an "appeals" factor, or post-verdict reduction factor, to reflect negotiations and possibly formal appellate proceedings after a verdict is handed down. Use an empirical

reform reduction factor, at the *settlement* level. The complement of this value is the loss savings expected to be achieved by tort reform.

(8) Load the savings for the effects of ALAE and other expenses, to convert the loss savings to the premium savings displayed on Exhibit 1, Sheet 1.

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APPENDIX D: COMPARISON WITH OTHER ANALYSES

We presented the results of our model on Exhibit 1. The table below summarizes the comparison of these values to the results of the 1986 M&R analysis, and also to a set of "naive" results presented on Exhibit 7. The Exhibit 7 values are a straight calculation of the percentage of losses that would have been eliminated from recent verdicts in the MLMIC database, had a cap been in effect. These results are therefore unadjusted for any of the modelling considerations discussed in this report. Unlike the other two methods shown, note that the Exhibit 7 values do not reflect the effect of policy limits, loss adjustment expenses, or underwriting expenses.

PERCENT PREMIUM SAVINGS - $1 Million Limit			
Amount Of Cap	Current Analysis	Previous Analysis	Naive Analysis (Exhibit 7)
$ 100,000	34%	19%	59%
250,000	28%	12%	52%

Several things can be observed from this comparison. First, it is evident that the effect of a cap is dramatically higher now than it was in our study eight years ago. It is very likely that two primary determinants of this increase are the substantial severity trend that has occurred in the intervening years, and the apparent increase in the average percentage of noneconomic loss per claim. These two events have interacted to dramatically increase the average noneconomic loss cost per case, thus increasing the effect of a cap.

This is shown in the sensitivity tests on Exhibit 2. For example, if the noneconomic loss percentage is reduced from 70% to 60% (in the 1986 study the selected percentage was 55%), the indemnity-only savings declines in our model from 39% to 31%. This is equivalent to a premium savings drop to 22%, from our base line result of 28%.

A third important difference from the previous study is that the current model is a stochastic simulation that may reflect more of the potential variation among claims than did the static methodology employed in 1986, when the calculation was entirely based on

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EXHIBIT 1
SHEET 1

Results of Tort Reform Model
For $1MM Policy Limits ($000's)

(A) Average Indemnity per Case	(B) Average ALAE per Case	(C) Average Indemnity and ALAE per Case	(D) Average ULAE per Case	(E) Average Indemnity and LAE per Case	(F) Under-writing Expense Load per Case	(G) Average Indemnity, LAE, and Under-writing Expense per Case	(H) % Savings in Premium Due to Tort Reform
$250,000 CAP ON NONECONOMIC DAMAGES (BASE LINE MODEL):							
Before Tort Reform:							
$641	$197	$838	$25	$863	$33	$896	NA
After Tort Reform - Option 1 - Assume ALAE dollars are unchanged by tort reform:							
$393	$197	$590	$25	$615	$33	$648	28%
After Tort Reform - Option 2 - Assume ALAE dollars are decreased by tort reform (% decrease equal to 1/3 of indemnity % decrease):							
$393	$171	$564	$25	$589	$33	$622	31%
$100,000 CAP ON NONECONOMIC DAMAGES:							
Before Tort Reform:							
$641	$197	$838	$25	$863	$33	$896	NA
After Tort Reform - Option 1 - Assume ALAE dollars are unchanged by tort reform:							
$334	$197	$531	$25	$556	$33	$589	34%
After Tort Reform - Option 2 - Assume ALAE dollars are decreased by tort reform (% decrease equal to 1/3 of indemnity % decrease):							
$334	$165	$499	$25	$524	$33	$557	38%

NOTES:

A case represents all of the claims (i.e., all of the defendants) relating to one incident.
Policy limits apply on a per claim basis, not a per case basis.

(A) - See text for explanation
(B) - Before Tort Reform value equals (A) x 30.687% (consistent with 1994 - 1995 Physicians Rate Analysis);
After Tort Reform values determined according to the stated ALAE assumption
(C) = (A) + (B)
(D) - Before Tort Reform value equals (C) x 3.0% (consistent with 1994 - 1995 Physicians Rate Analysis);
After Tort Reform values assumed to be equal to Before Tort Reform values
(E) = (C) + (D)
(F) - Before Tort Reform value equals (E) x 3.8% (consistent with 1994 - 1995 Physicians Rate Analysis);
After Tort Reform values assumed to be equal to Before Tort Reform values. Taxes are not reflected in this item because they are directly proportional to premium.
(G) = (E) + (F). Taxes are not shown.
(H) = 1 - (G)/((G) for Before Tort Reform)

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EXHIBIT 2
SHEET 1

Sensitivity Testing of Tort Reform Model ($000's)

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
- Average Indemnity Per Case - ($1MM Policy Limit)			- Average Indemnity Per Case - ($2MM Policy Limit)			- Average Indemnity Per Case - (Unlimited Policy Limit)		
Before Tort Reform	After Tort Reform	% Savings	Before Tort Reform	After Tort Reform	% Savings	Before Tort Reform	After Tort Reform	% Savings
TEST 1 - VARIATION OF CAP AMOUNT OF $250,000 FOR NONECONOMIC DAMAGES:								
Low test - Cap of $100,000:								
$641	$334	48%	$807	$380	53%	$1,111	$432	61%
High test - Cap of $250,000 (i.e, base line model):								
$641	$393	39%	$807	$456	43%	$1,111	$536	52%
TEST 2 - VARIATION OF LOGNORMAL UNLIMITED MEAN OF $570,353:								
Low test - Decrease mean by 30%:								
$510	$326	36%	$616	$369	40%	$777	$418	46%
Low to middle test - Decrease mean by 10%:								
$601	$372	38%	$746	$429	42%	$999	$498	50%
Middle test - Leave mean unchanged (i.e., base line model):								
$641	$393	39%	$807	$456	43%	$1,111	$536	52%
Middle to high test - Increase mean by 10%:								
$678	$414	39%	$864	$483	44%	$1,221	$574	53%
High test - Increase mean by 30%:								
$747	$451	40%	$971	$534	45%	$1,443	$649	55%
TEST 3 - VARIATION OF LOGNORMAL COEFFICIENT OF VARIATION (CV) OF 3.00:								
Low test - Increase CV by 50%:								
$549	$337	39%	$704	$401	43%	$1,108	$520	53%
Middle test - Leave CV unchanged (i.e., base line model):								
$641	$393	39%	$807	$456	43%	$1,111	$536	52%
High test - Decrease CV by 50%:								
$828	$500	40%	$988	$544	45%	$1,114	$565	49%
TEST 4 - VARIATION OF MEAN OF 1.97 CLAIMS PER CASE (WHILE MAINTAINING DISTRIBUTION AROUND MEAN):								
Low test - Decrease mean to 1.50:								
$491	$307	37%	$617	$360	42%	$848	$424	50%
Middle test - Leave mean unchanged (i.e., base line model):								
$641	$393	39%	$807	$456	43%	$1,111	$536	52%
High test - Increase mean to 2.50:								
$823	$485	41%	$1,034	$560	46%	$1,421	$652	54%

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EXHIBIT 2
SHEET 3

Sensitivity Testing of Tort Reform Model ($000's) (Cont'd.)

NOTES:

A case represents all of the claims (i.e., all of the defendants) relating to one incident. Policy limits apply on a per claim basis, not a per case basis.

(A),(B),(D),(E),(G),(H) - See text for explanation
(C) = 1 - [(B) / (A)]
(F) = 1 - [(E) / (D)]
(I) = 1 - [(H) / (G)]

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EXHIBIT 4

Selection of Distribution for Claim Frequency

(A)	(B)
Number of Claims per Case	Selected Percentage Probability
1	52.6%
2	25.0%
3	10.2%
4	5.4%
5	2.8%
6	2.1%
7	1.0%
8	0.5%
9	0.3%
10	0.2%
Total	100.0%
Average Number of Claims per Case	1.97

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EXHIBIT 5
SHEET 2

Analysis of Economic versus Noneconomic Losses

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Total of All Verdict Amounts ($000's)							
Resolution Year	Past Economic	Future Economic	Total Economic	Past Noneconomic	Future Noneconomic	Total Noneconomic	Total Economic and Noneconomic	Ratio Noneconomic to Total
1981	$0	$0	$0	$0	$75	$75	$75	100.0%
1982	0	0	0	0	0	0	0	NA
1983	0	0	0	156	0	156	156	100.0%
1984	0	0	0	150	100	250	250	100.0%
1985	0	0	0	0	0	0	0	NA
1986	0	0	0	0	0	0	0	NA
1987	3,345	1,740	5,085	7,487	6,696	14,183	19,268	73.6%
1988	8,065	36,256	44,321	42,870	61,624	104,494	148,815	70.2%
1989	2,678	10,872	13,550	26,250	19,295	45,545	59,095	77.1%
1990	2,759	17,344	20,103	10,329	18,578	28,907	49,010	59.0%
1991	1,204	14,836	16,040	5,914	13,285	19,199	35,239	54.5%
1992	1,879	12,155	14,034	21,143	16,898	38,041	52,075	73.1%
1993	5,080	22,375	27,455	19,841	25,015	44,856	72,311	62.0%
Unknown	0	0	0	29	0	29	29	100.0%
Total	$25,010	$115,578	$140,588	$134,169	$161,566	$295,735	$436,323	67.8%
Total 89-93	$13,600	$77,582	$91,182	$83,477	$93,071	$176,548	$267,730	65.9%
Selected*	.							70%

* - Based upon analysis of Exhibit 5, Sheets 2 through 5

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) + (C)
(E),(F) - Source: MLMIC verdicts database
(G) = (E) + (F)
(H) = (D) + (G)
(I) = (G) / (H)

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EXHIBIT 5
SHEET 2

Analysis of Economic versus Noneconomic Losses

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Total of All Verdict Amounts ($000's)							
Resolution Year	Past Economic	Future Economic	Total Economic	Past Noneconomic	Future Noneconomic	Total Noneconomic	Total Economic and Noneconomic	Ratio Noneconomic to Total
1981	$0	$0	$0	$0	$75	$75	$75	100.0%
1982	0	0	0	0	0	0	0	NA
1983	0	0	0	156	0	156	156	100.0%
1984	0	0	0	150	100	250	250	100.0%
1985	0	0	0	0	0	0	0	NA
1986	0	0	0	0	0	0	0	NA
1987	3,345	1,740	5,085	7,487	6,696	14,183	19,268	73.6%
1988	8,065	36,256	44,321	42,870	61,624	104,494	148,815	70.2%
1989	2,678	10,872	13,550	26,250	19,295	45,545	59,095	77.1%
1990	2,759	17,344	20,103	10,329	18,578	28,907	49,010	59.0%
1991	1,204	14,836	16,040	5,914	13,285	19,199	35,239	54.5%
1992	1,879	12,155	14,034	21,143	16,898	38,041	52,075	73.1%
1993	5,080	22,375	27,455	19,841	25,015	44,856	72,311	62.0%
Unknown	0	0	0	29	0	29	29	100.0%
Total	$25,010	$115,578	$140,588	$134,169	$161,566	$295,735	$436,323	67.8%
Total 89-93	$13,600	$77,582	$91,182	$83,477	$93,071	$176,548	$267,730	65.9%
Selected*								70%

* - Based upon analysis of Exhibit 5, Sheets 2 through 5

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) + (C)
(E),(F) - Source: MLMIC verdicts database
(G) = (E) + (F)
(H) = (D) + (G)
(I) = (G) / (H)

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MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 5
SHEET 4

Analysis of Economic versus Noneconomic Losses

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	------- Total Paid by Insurer (i.e., by MLMIC) Against Verdict Amounts ($000's) -------							
Resolution Year	Past Economic	Future Economic	Total Economic	Past Noneconomic	Future Noneconomic	Total Noneconomic	Total Economic and Noneconomic	Ratio Noneconomic to Total
1981	$0	$0	$0	$0	$75	$75	$75	100.0%
1982	0	0	0	0	0	0	0	NA
1983	0	0	0	8	0	8	8	100.0%
1984	0	0	0	150	100	250	250	100.0%
1985	0	0	0	0	0	0	0	NA
1986	0	0	0	0	0	0	0	NA
1987	2,210	1,075	3,285	2,941	1,814	4,755	8,040	59.1%
1988	1,908	2,581	4,489	17,441	3,763	21,204	25,693	82.5%
1989	2,708	2,078	4,786	12,942	4,273	17,215	22,001	78.2%
1990	3,003	1,432	4,435	4,250	3,217	7,467	11,902	62.7%
1991	597	4,683	5,280	4,034	3,799	7,833	13,113	59.7%
1992	1,338	4,779	6,117	6,526	6,339	12,865	18,982	67.8%
1993	1,707	2,687	4,394	9,593	6,548	16,141	20,535	78.6%
Unknown	0	0	0	29	0	29	29	100.0%
Total	$13,471	$19,315	$32,786	$57,914	$29,928	$87,842	$120,628	72.8%
Total 89-93	$9,353	$15,659	$25,012	$37,345	$24,176	$61,521	$86,533	71.1%

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) + (C)
(E),(F) - Source: MLMIC verdicts database
(G) = (E) + (F)
(H) = (D) + (G)
(I) = (G) / (H)

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MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 5
SHEET 6

Analysis of Economic versus Noneconomic Losses

(A)	(B)	(C)	(D)	(E)
	- Total of All Verdict Amounts ($000's) -			
Resolution Year	Total Economic	Total Noneconomic	Total Economic and Noneconomic	Ratio Noneconomic to Total
FOR TOTAL VERDICT VALUES LESS THAN OR EQUAL TO INFINITY:				
1989	$13,550	$45,545	$59,095	77.1%
1990	20,103	28,907	49,010	59.0%
1991	16,040	19,200	35,240	54.5%
1992	14,033	38,041	52,074	73.1%
1993	27,455	44,856	72,311	62.0%
Total	$91,182	$176,548	$267,730	65.9%
FOR TOTAL VERDICT VALUES LESS THAN OR EQUAL TO $10,000,000:				
1989	$7,370	$41,045	$48,415	84.8%
1990	20,103	17,907	38,010	47.1%
1991	16,040	19,200	35,240	54.5%
1992	14,033	38,041	52,074	73.1%
1993	27,455	44,856	72,311	62.0%
Total	$85,002	$161,048	$246,050	65.5%
FOR TOTAL VERDICT VALUES LESS THAN OR EQUAL TO $5,000,000:				
1989	$4,370	$18,545	$22,915	80.9%
1990	10,980	14,407	25,387	56.7%
1991	8,209	12,000	20,209	59.4%
1992	10,283	35,541	45,824	77.6%
1993	7,921	22,806	30,726	74.2%
Total	$41,763	$103,298	$145,061	71.2%
FOR TOTAL VERDICT VALUES LESS THAN OR EQUAL TO $2,000,000:				
1989	$3,970	$16,045	$20,015	80.2%
1990	6,886	9,282	16,168	57.4%
1991	3,399	7,190	10,589	67.9%
1992	2,423	12,913	15,336	84.2%
1993	4,221	14,226	18,447	77.1%
Total	$20,899	$59,657	$80,556	74.1%

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) + (C)
(E) = (C) / (D)

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MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 5
SHEET 8

Analysis of Economic versus Noneconomic Losses

(A)	(B)	(C)	(D)	(E)
	- Total of All Verdict Amounts ($000's) -			
Resolution Year	Total Economic	Total Noneconomic	Total Economic and Noneconomic	Ratio Noneconomic to Total
FOR TOTAL VERDICT VALUES GREATER THAN $10,000,000 AND LESS THAN OR EQUAL TO INFINITY:				
1989	$6,180	$4,500	$10,680	42.1%
1990	0	11,000	11,000	100.0%
1991	0	0	0	NA
1992	0	0	0	NA
1993	0	0	0	NA
Total	$6,180	$15,500	$21,680	71.5%
FOR TOTAL VERDICT VALUES GREATER THAN $5,000,000 AND LESS THAN OR EQUAL TO $10,000,000:				
1989	$3,000	$22,500	$25,500	88.2%
1990	9,123	3,500	12,623	27.7%
1991	7,831	7,200	15,031	47.9%
1992	3,750	2,500	6,250	40.0%
1993	19,535	22,050	41,585	53.0%
Total	$43,239	$57,750	$100,989	57.2%
FOR TOTAL VERDICT VALUES GREATER THAN $2,000,000 AND LESS THAN OR EQUAL TO $5,000,000:				
1989	$400	$2,500	$2,900	86.2%
1990	4,094	5,125	9,219	55.6%
1991	4,810	4,810	9,619	50.0%
1992	7,860	22,627	30,488	74.2%
1993	3,700	8,580	12,280	69.9%
Total	$20,864	$43,642	$64,506	67.7%
FOR TOTAL VERDICT VALUES GREATER THAN $1,000,000 AND LESS THAN OR EQUAL TO $2,000,000:				
1989	$100	$5,166	$5,266	98.1%
1990	4,620	1,222	5,842	20.9%
1991	1,900	1,600	3,500	45.7%
1992	0	3,900	3,900	100.0%
1993	2,460	6,182	8,642	71.5%
Total	$9,080	$18,071	$27,150	66.6%

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) + (C)
(E) = (C) / (D)

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MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 6
SHEET 1

Selection of Distribution for Appeals Factor

(A) Range for Appeals Factor	(B) Midpoint of Range	(C) Distribution of Dollars ($MM)	(D) Distribution of Verdict Counts	(E) Percentage Distribution of Dollars ($MM)	(F) Percentage Distribution of Verdict Counts	(G) Selected Percentage Probability
Exactly 0%	0%	$0.2	2	0%	1%	0%
0%-10%	5%	0.0	0	0%	0%	0%
10%-20%	15%	16.9	4	12%	2%	8%
20%-30%	25%	9.2	5	6%	2%	8%
30%-40%	35%	19.2	8	13%	4%	8%
40%-50%	45%	11.5	11	8%	5%	8%
50%-60%	55%	9.0	6	6%	3%	8%
60%-70%	65%	8.7	13	6%	6%	8%
70%-80%	75%	21.7	20	15%	9%	8%
80%-90%	85%	6.7	15	5%	7%	8%
90%-100%	95%	6.7	22	5%	10%	8%
Exactly 100%	100%	13.9	47	10%	21%	14%
100%-110%	105%	8.9	28	6%	13%	7%
110%-120%	115%	1.9	9	1%	4%	7%
120%-150%	135%	1.5	11	1%	5%	0%
150%-200%	175%	3.8	8	3%	4%	0%
200%-300%	250%	4.0	7	3%	3%	0%
300%-1000%	650%	0.1	4	0%	2%	0%
Total		$143.9	220	100%	100%	100%
Weighted Avg of Midpoints				70%	104%	69%

NOTES:

(C) - Based upon MLMIC Verdict Database for Resolution Years 1989-93
(Rows 3 + 4 + 5, Columns a + b + d + e, divided by Row 2, Columns a + b + d + e)
(D) - Based upon MLMIC Verdict Database for Resolution Years 1989-93
(Rows 3 + 4 + 5, Columns a + b + d + e, divided by Row 2, Columns a + b + d + e)
(Excludes 20 verdicts for which Row 2 equals zero)
(E) = (C) / (Total (C))
(F) = (D) / (Total (D))
(G) - Selected based upon judgment
(Note that the 69% weighted average for this column ties to the selected value on Exhibit 6, Sheet 2)

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MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 7

Effect of Directly Applying Cap on Noneconomic Losses to Verdict Data

(A)	(B)	(C)	(D)	(E)	(F)
	---------- Total of All Verdict Amounts ($000's) ----------				
Resolution Year	Amount Before Applying Noneconomic Cap	Amount Eliminated by Applying $100,000 Noneconomic Cap	Amount Eliminated by Applying $250,000 Noneconomic Cap	% Eliminated by Applying $100,000 Noneconomic Cap	% Eliminated by Applying $250,000 Noneconomic Cap
1981	$75	$0	$0	0.0%	0.0%
1982	0	0	0	NA	NA
1983	156	56	0	35.9%	0.0%
1984	250	150	0	60.0%	0.0%
1985	0	0	0	NA	NA
1986	0	0	0	NA	NA
1987	19,267	11,374	8,496	59.0%	44.1%
1988	148,815	97,109	88,722	65.3%	59.6%
1989	59,095	41,104	36,090	69.6%	61.1%
1990	49,010	25,740	22,099	52.5%	45.1%
1991	35,240	16,448	13,778	46.7%	39.1%
1992	52,074	34,246	30,101	65.8%	57.8%
1993	72,311	40,139	35,924	55.5%	49.7%
Unknown	29	0	0	0.0%	0.0%
Total	$436,322	$266,366	$235,210	61.0%	53.9%
Total 89-93	$267,730	$157,677	$137,992	58.9%	51.5%

NOTES:
(B),(C),(D) - Source: MLMIC verdicts database
(E) = (C) / (B)
(F) = (D)/(B)

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY
PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY

EXHIBIT 9

Analysis of Average Verdict Severities

(A)	(B)	(C)	(D)	(E)
	---------- Total of All Verdict Amounts ($000's) ----------			
Resolution Year	Total Pay Dollars	Total Pay Count	Average Severity	Fitted Values
Unknown	29	1	29	
1981	$75	1	$75	
1982	0	0	NA	
1983	156	1	156	
1984	250	1	250	
1985	0	0	NA	
1986	0	0	NA	
1987	19,267	41	470	
1988	148,815	88	1,691	
1989	59,095	59	1,002	1,046
1990	49,010	41	1,195	1,081
1991	35,240	33	1,068	1,117
1992	52,074	47	1,108	1,154
1993	72,311	59	1,226	1,192
Total	$436,322	372	$1,173	Forecasted to
Total 89-93	$267,730	239	$1,120	1/1/2008 (Vv) : 1,918

	(F)	(G)	(H)	(I)
	Expected Claims per Case	Expected Claim Severity	Expected Case Severity (Ss) ($000's)	Vv/Ss
Each Claim Limited to $2 Million	1.968	413,570	814	236%
Unlimited Claim Amounts	1.968	570,353	1,123	171%

NOTES:

(B),(C) - Source: MLMIC verdicts database
(D) = (B) / (C)
(E) - Uses linear regression fit of ln(Col(D)) to Col(A),
where Col(A) is the independent variable.
(F) - Arises from the frequency assumption found on Exhibit 4.
(G) - Arises from the lognormal severity assumption.
(H) = (F) x (G) / 1000
(I) = Vv / (H)

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III

SUMMARY OF COLORADO TORT REFORM LAW UPDATED THROUGH 1995

1. Peer Review Immunity, C.R.S. Section 12-36.5-101 et seq. (1989): Provides good faith immunity to physicians who participate in peer review in compliance with statutory requirements of due process. Creates special committee to hear allegations of anti-competitive behavior in peer review. Should minimize exposure under the U.S. Supreme Court case of Patrick v. Burget.

2. Certificate of Review Required, C.R.S. Section 13-20-602 (1989): Provides that in an action for damages based upon professional negligence of a licensed professional, the complainant's attorney shall file a Certificate of Review with the court for each professional named as a party within sixty (60) days of the complaint, cross-claim, or counterclaim. The Certificate shall declare that an expert in the area of the alleged negligent conduct who meets the requirements of C.R.S. Section 13-64-401 (expert witnesses, #19 herein) has reviewed the facts, records, documents, and other material relevant to the alleged negligent conduct and, based upon that review, has found the complaint does not lack substantial justification. Failure to file a Certificate of Review shall result in the dismissal of the action. While filing of a Certificate creates a presumption of substantial justification, attorneys are still required to comply with good faith obligations of Rule 11 of Colorado Rules of Civil Procedure. Also, if a non-party defendant is designated, a Certificate of Review must be filed as to the non-party.

3. Good Samaritan Statute, C.R.S. 13-21-108 (1990): Provides that any physician or surgeon who provides emergency care in good faith to a person not presently his patient and without compensation shall not be liable unless his acts were grossly negligent, willful or wanton. This emergency care shall be rendered at the place of the emergency, including emergency care rendered in a health care institution, unless an obligation exists to "cover" that patient.

4. Joint and Several Liability, C.R.S. Section 13-21-111.5 (1986): Provisions contained in C.R.S. Section 13-21-111.5 provide that in an action alleging the death or injury of a person, a defendant shall be liable only for the degree of fault of negligence by that defendant that produced the injury or death, except that joint liability will be imposed upon two or more people who conspire to commit a tortious act, and a defendant shall be responsible for the degree of fault assessed to those persons held jointly liable. Each such defendant shall have a right of contribution from the other defendants acting in concert.

Non-Party Negligence Determined: Finders of fact may consider degree of fault of a non-party in determining degree of fault of parties. Negligence of a non-party may be considered if claimant made settlement agreement with such or if defending party gives notice within ninety (90) days of the fault of the non-party.

The jury or court will make special findings to determine the percentage of negligence attributable to each party and non-party and shall determine the amount of damages sustained by each. Entry of judgment shall be based on the special finding and no general verdict shall be returned by the jury.

5. Collateral Source Reduction of Damages, C.R.S. Section 13-21-111.6 (1986 and 1990): Provides that in an action brought to recover damages for a tort resulting in injury or death, the court shall reduce the amount of damages awarded by the finder of fact by the amount that the person, his estate, or his representative has been indemnified or compensated for the loss by any person, company, or fund related to the injury. However, this does not include any amount by which the person, his estate, or representative is indemnified or compensated by a benefit paid out of a contract entered into and paid for by or on behalf of such person.

See #20 herein. The plaintiff must give statutory notice of suit to a third party payor within 60 days of filing the complaint. If the third party payor does not respond to the court or arbitrator within 90 days, the claim of the third party payor is barred.

6. Volunteer Services, C.R.S. Section 13-21-115.5 (1992): Provides that a volunteer who provides services for a "non-profit organization" or a hospital without compensation shall be immune from civil liability for their acts or omissions performed in good faith and within the scope of their volunteer duties and if there was an absence of willful and wanton conduct by such volunteer.

This does not relieve the hospital or non-profit organization from its liability for the conduct of the volunteer.

7. Directors, Officers and Trustees Immunity, C.R.S. Section 13-21-115.7 (1992): Provides that directors, officers and trustees of non-profit organizations who are not compensated or salaried, (except reasonable expenses may be reimbursed and they may receive gifts not to exceed $1000 value in any 12 month period), shall be immune from civil liability for damages or injury incurred while acting within the scope of their duties and so long as any act or omission causing injury or damage was not willful and wanton.

8. Rape Shield, C.R.S. Section 13-25-131 (1991): Provides that evidence of a victim's past sexual history is not admissible in a civil suit against a medical professional unless the court finds such evidence to be relevant to the defense of the party seeking to use such evidence and that its probative value ourweighs its prejudicial effect.

9. Periodic Payments, C.R.S. Section 13-64-203 (1988): Provides that in an action for damages against a health care professional or institution, the judge shall enter a judgment ordering awards for future damages exceeding $150,000 be paid by periodic payments. However, a party may petition the court to enter judgment for the present value of the periodic payments if it is found that the mechanism selected to fund the payments is not adequate. Or, if the individual plaintiff can show he is making an informed decision, is twenty-one years old, and is not incapacitated, he may elect to receive an immediate lump-sum payment of the present value of the future damages award. If the future damages are less than $150,000, the judge may order the award be paid by periodic payments.

10. Special Damages Findings, C.R.S. Section 13-64-204 (1988): Provides that jury shall make separate findings specifying for each claimant the amount of: 1) past damages for health care costs, economic loss, loss of earnings and non-economic loss; 2) future damages for health care costs, economic loss, future earnings incurred in work life expectancy, and non-economic loss incurred for the life of the claimant.

11. Determination of Judgment, C.R.S. Section 13-64-205 (1988): Provides that court will apply setoffs, credits, comparative fault, additurs, and remittiturs to special damages findings in calculating the amount of past and future damages due to the claimant from each party. A court shall preserve the rights of a subrogee to be paid in a lump sum.

The court shall specify payments of attorneys' fees and costs in a lump sum or periodic payments, but this shall be separate from the periodic installments payable to claimant. The court shall enter judgment in a lump sum for past damages and any damages payable in a lump sum.

The jury shall determine the present value of future damages and the court shall enter judgment for periodic payment, except that the court may enter judgment for a lump sum payment if the need is presented for future major medical services.

12. Periodic Installment Obligations, C.R.S. Section 13-64-206 (1988): Provides that 1) payments be fixed; 2) payments cannot be accelerated, deferred, increased, or decreased; 3) the recipient shall be a general creditor of the qualified insurer; 4) payment shall be scheduled at 1-month intervals unless the parties agree and the court directs otherwise, and are payable at the beginning of the intervals; 5) money damages for loss of future earnings shall not be reduced or terminated because of the death of the judgment creditor, but payment for other future damages shall cease at the death of the judgment creditor.

13. Funding & Assignment of Periodic Payments, C.R.S. Section 13-64-207, 208 and 209 (1988): C.R.S. Section 13-64-207 provides that periodic payments be funded by 1) an insurance annuity contract; 2) an obligation of the U.S.; 3) evidence of collectible liability insurance; 4) an agreement of liability assignee to assume obligation of the debtor; 5) an obligation of Colorado; 6) other satisfactory funding.

C.R.S. Section 13-64-208: Provides that funding be provided within sixty (60) days of entry of the judgment. If funding has not been provided as required, the court, after motion by the creditor, shall order compliance within thirty (30) days, and if debtor does not comply, the court shall calculate present value of the obligation and enter judgment in that amount for the moving party. A co-debtor is entitled to the same rights as the creditor in moving for a debtor to comply with the funding provisions.

C.R.S. Section 13-64-209: Provides that the right to receive periodic payment is only assignable to: 1) payment of alimony, maintenance, or child support; 2) costs of services for medical care; 3) attorneys' fees and costs.

14. Satisfaction of Judgment, C.R.S. Section 13-64-212 (1988): Provides that a court shall order the judgment satisfied and the debtor discharged after ordering that the funding complies with those funding forms necessary for periodic payments and that the funding obligation has been met as provided in the above section, "Funding & Assignment of Periodic Payments", #13.

15. Financial Responsibility, C.R.S. Section 13-64-301 (1988): Provides that as a condition of active licensure, every physician or dentist (except public employees) providing health care in Colorado shall maintain commercial professional liability insurance coverage in a minimum indemnity amount of $500,000 per incident and $1.5 million annual aggregate per year, with an insurance company authorized to do business in Colorado.

If a physician has been reported two times or more to the Board of Medical Examiners regarding medical malpractice judgments or settlements against such physician in one year, the financial responsibility shall be twice as much. The physician shall have the right to present evidence that the reports did not represent a substantial failure to adhere to acceptable standards of care, and the Board may then reduce the amount of financial responsibility to the regular limits.

Standards may be waived by the Board of Medical Examiners for: 1) class of license holders performing medical or dental services who are in the military or on federal government assignments and/or who render limited or occasional services because of non-clinical duties or retirement; or 2) those who provide uncompensated care to patients but do not otherwise provide any compensated care; or 3) for other reasons that would render the financial standards unreasonable or unattainable.

16. Limitation of Liability, C.R.S. Section 13-64-302 (1988): Provides that the total amount recoverable in tort actions against health care professionals shall not exceed $1,000,000 present value, including derivative claims, [with a $250,000 present value cap on damages for non-economic loss or injury] for the past, present, and/or future damages, unless the court finds that imposition of the limitation would be unfair due to the extent of the past, present, and future damages or loss of income. In that case, the court may award the present value of excess future earnings and/or medical costs only.

17. Exemplary Damages, C.R.S. Section 13-64-302.5 (1989 and 1991): Provides that exemplary damages may be imposed against a health care professional only as a result of the negligence claim itself. Exemplary damages may not be included in the initial complaint. Exemplary damages may be sought only after completion of substantial discovery and only after the court or arbitrator finds prima facie proof of a triable issue.

Reasonable exemplary damages may be imposed only if the action complained of was attended by circumstances of fraud, malice, or willful and wanton conduct, and providing such is proved beyond a reasonable doubt.

Exemplary damages shall not exceed actual damages awarded, although the court may reduce them if deterrent effect has been achieved or may increase damages up to three times actual damage if the behavior has continued or plaintiff's damages have been aggravated.

No exemplary damages shall be imposed if injury arises from the use of any drug or product within approved federal or state standards, in accordance with standards of prudent health care professionals, or if there is written informed consent and the use is in accordance with prudent health care standards.

One-third of exemplary damages paid to the State General Fund (struck down by the Colorado Supreme Court) and no interest is payable on such damages.

18. Reporting Requirements, C.R.S. Section 13-64-303 (1988): Provides that any judgment, settlement, or award against a health care professional or health care institution shall be reported within fourteen (14) days by the professional's or institution's medical malpractice insurance carrier or the practitioner's institution to the appropriate licensing agency for review, investigation, and appropriate action. If any health care professional or health care institution or insurance carrier knowingly fails to make such a report, they shall be fined not more than $2,500.

19. Qualifications of Experts, C.R.S. Section 13-64-401 (1988): Provides that an expert witness testifying with regard to negligence in a medical malpractice action must be a licensed physician whose training, education, knowledge, and experience in evaluation, diagnosis, and treatment of disease makes him substantially familiar with the applicable standards of care relating to the act or omission which is the subject of the proceeding on the date of the incident. An expert in one medical sub-specialty may not testify against a physician in another sub-specialty unless the standards of care are similar in the two fields.

20. Collateral Source Evidence & Right of Subrogation, C.R.S. Section 13-64-402 (1988) (1992): Provides that the plaintiff in a personal injury action against a health care provider must serve written notice on any third-party payor of any amount paid or payable as a medical benefit to the plaintiff from any health, sickness, or insurance plan, or any contract to provide, pay for, or reimburse health care services costs. The notice must be properly served on the insurance commissioner or pursuant to the Colorado Rules of Civil Procedure within sixty (60) days of the commencement of the suit. The notice must also be filed with the court or arbitrator.

If the third-party payor has a right of subrogation for such payments, it shall file a written claim within ninety (90) days of receiving notice. The claim shall not specify a definite amount. Failure to file the written claim constitutes a complete waiver of the third-party payor's claim.

21. Alternative Arbitration/Medical Services Agreement, C.R.S. Section 13-64-403 (1988): Provides that a physician and patient may enter into a pre-treatment agreement that any dispute regarding professional negligence shall be decided by binding arbitration. Such an agreement must be voluntary and not a condition to the provision of health care services or health care insurance to the patient. The agreement must state that submission of the claim to arbitration precludes reliance upon court processes, except as they relate to judicial review of arbitration proceedings. The patient has the right to seek legal counsel and has the right to rescind the agreement within ninety (90) days after execution of the agreement or patient discharge from the hospital. In addition, a health care provider may not refuse services to a patient who will not sign an agreement, and any such refusal shall constitute unprofessional conduct. A court may declare the agreement invalid if the execution was induced by fraud, it failed to conform to statutory standards, the patient's execution was a result of negligent disregard of the patient's right to refrain from execution, or the patient did not speak the language in which the agreement is written. Punitive damages may be considered in arbitration.

22. Limitations on Action Re Genetic and Other Defects, C.R.S. Section 13-64-502 (1989): Provides that a health care professional or health care institution will not be liable to an infant, his personal representative, parents or next of kin for an injury occurring from genetic counseling and screening, or arising from pre-natal care, or during labor, delivery or the immediate post delivery period in the institution if the injury was the result of a genetic disease or disorder, or other natural causes unpreventable or avoidable by ordinary care by a health care professional or health care institution, unless it can be shown by a preponderance of the evidence that the injury could have been avoided by ordinary standard of care by the physician or health care institution. Medical records of genetic siblings, parents and grandparents are available to the defense.

23. Statute of Limitations, C.R.S. Section 13-80-102.5 (1988): Provides that tort or contract action against a health care professional shall be instituted within two (2) years after the date an action accrues, but absolutely no later than three (3) years after the act or omission giving rise to the action occurred, unless a) the act was knowingly concealed, or a foreign object was left in the body, or the injury or its cause could not have been discovered with reasonable diligence, in which case action must be instituted within two (2) years after action was discovered or should have been discovered; b) a child under eight (8) years is injured prior to 6th birthday, action may be instituted any time up to the age of eight; c) a person under disability is injured and has no legal representation, action must be instituted two (2) years from date disability is terminated.

24. Vaccine-Related Injury or Death-Limitations on Liability, C.R.S. Section 25-4-909 (1988): Provides that no person administering a required vaccine to an infant or child more than 20 days old shall be held liable for any injuries sustained pursuant to such vaccine if the vaccine was 1) given using accepted clinical methods, 2) if the vaccine was given according to a schedule of immunization published by the federal government, and 3) if there were no symptoms of history present which would keep a prudent health care professional from administering the vaccine. A party shall exhaust his remedies under the National Childhood Vaccine Injury Act of 1986 before maintaining an action for vaccine related injury or death. An injury or death which does not fall within the parameters of the federal vaccine injury table (42 USC 300aa-14) is presumed not to have been caused by the administration of a vaccine unless the preponderance of evidence shows otherwise.

25. Interest, C.R.S. 13-21-101 (1995): Amended to provide that prejudgment interest accrues only after the date the action is filed. Prejudgment interest no longer accrues from the date of the incident.

USA TODAY
NO. 1 IN THE USA ... FIRST IN DAILY READERS

USA TODAY · FRIDAY, JUNE 2, 1995

Breast cancer top cause of malpractice complaints

By Kim Painter
USA TODAY

Breast cancer accounts for more medical malpractice claims than any other condition, a new report said.

And it costs doctors' insurers more than any condition besides infant brain damage, said the Physician Insurers Association of America.

The apparent reason: Diagnosis is sometimes difficult and treatment sometimes delayed, said John Stanchfield, a Salt Lake City internist who chaired the study.

"It's even more difficult in younger women" who file a disproportionate number of malpractice claims, he said.

The new report focuses on 487 cases in which damages were awarded for delayed diagnosis. Most common reasons for delay:

▶ Doctors said cancer was unlikely after a physical exam of a woman with a complaint.

▶ Doctors did not follow up.

▶ Mammograms were negative or were misread.

There's a lesson for patients, Stanchfield said. "Be persistent. It's their breast ... They know it better than anyone else. If they think something isn't right, they have to go back and demand attention."

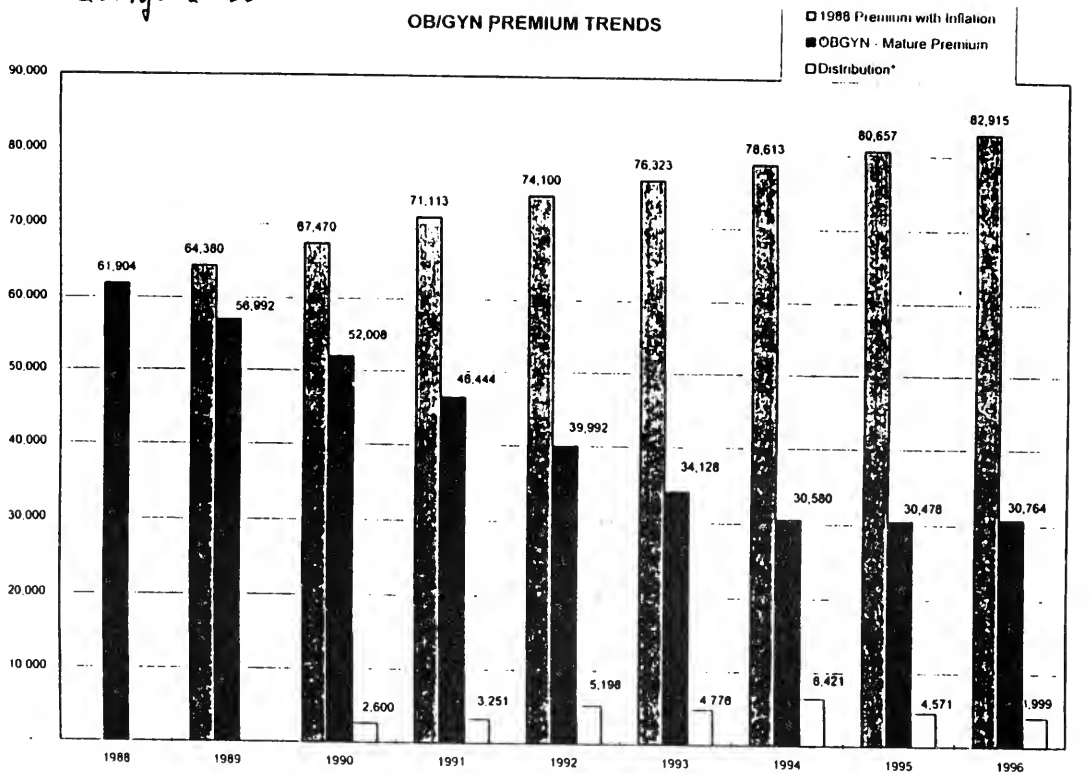
The group said 44% of breast cancer malpractice cases result in payments to patients. Average payment in 1994: $307,000.

Most often sued in breast cancer cases: radiologists and obstetrician/gynecologists.

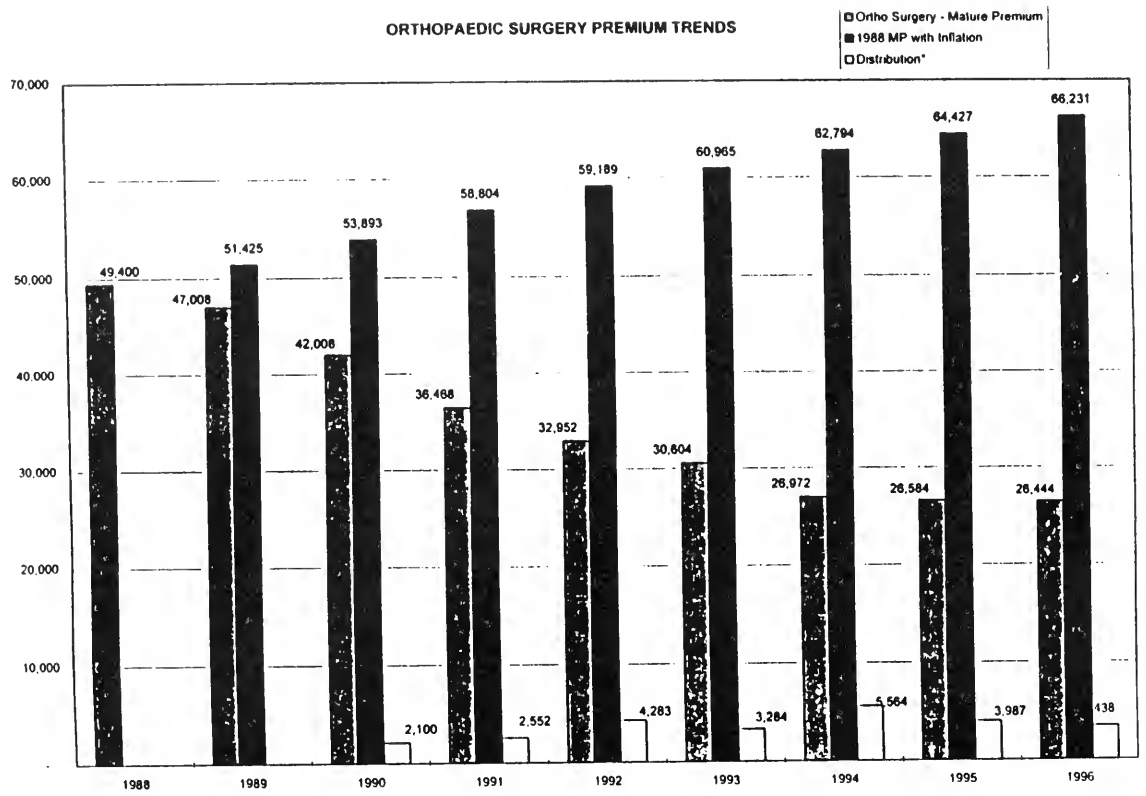
The next most common conditions named in lawsuits: infant brain damage, pregnancy and heart attack.

The association represents 50 malpractice insurance companies that cover 60% of private doctors in the USA.

George DiLeo



*Average percentage Actual amount varies based on premium, discounts, year of maturity and number of insureds



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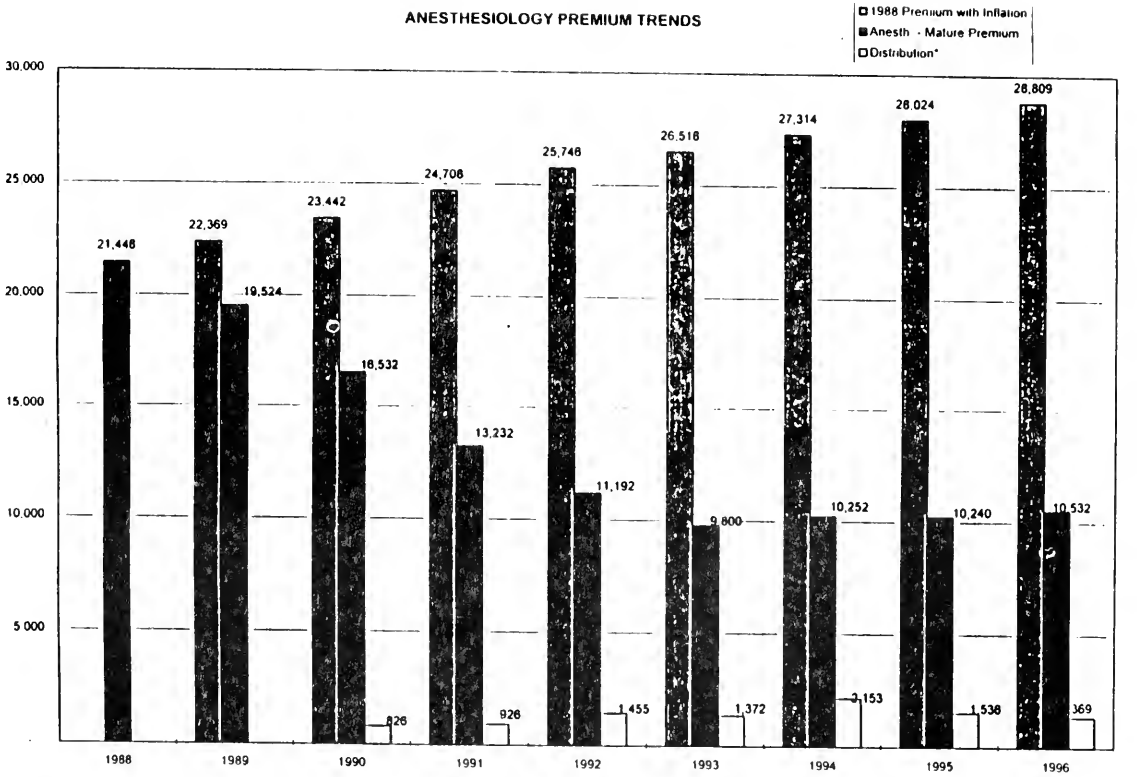

*Average percentage Actual amount varies based on premium, discounts, year of maturity and number of insureds

Mr. HYDE. Ms. Ross.

STATEMENT OF LINDA D. ROSS, YUCAIPA, CA

Ms. ROSS. Mr. Chairman and the members of the committee, I want to thank you for inviting me here to speak to you today. My name is Linda Ross and I am a resident of Yucaipa, CA. I am here today to tell you about the toll that medical malpractice takes on its victims and their families. I am here on behalf of my mother, Barbara Roberts, who in 1991 died from an untreated pulmonary embolism. She died at the age of 61 because of medical malpractice.

I want to recognize the other malpractice victims that are here today. I would like them to stand for a moment so you can see their faces.

Thank you.

I own a small business. I am a member of the U.S. Chamber of Commerce and I am a lifelong Republican. I don't think litigation is the answer to every problem, but malpractice victims are entitled to our day in court.

Many of the proposals that have been debated in this Congress are based on California's MICRA law. I know that MICRA has failed to adequately protect and compensate Californians. Two of MICRA's provisions, the $250,000 cap on pain and suffering and MICRA's allowance of mandatory arbitration clauses in health insurance contracts, were factors in our lawsuit against Kaiser Permanente, my mother's HMO.

As I stated, she was only 61 when she died. She made three different trips to the hospital, two after paramedics were called, complaining of symptoms that a first year medical student should have recognized as classic indications of a pulmonary embolism. Her independent orthopedist suspected a blood clot.

Numerous emergency room doctors and medical staff had multiple opportunities to save my mother from dying from this very common complication of a broken bone. However, it seems that no one felt any sense of urgency or concern when she turned for them to help, even when she told them she was afraid she was dying. She waited in the ER of her HMO for over 6½ hours for treatment that was never given and help that never came.

Her death was completely preventable. According to medical textbooks on the subject, if proper treatment had been started when she arrived, she had a 99-percent likelihood of a complete recovery. Instead, her life was placed in the hands of an unlicensed, unqualified and unsupervised medical student.

Later that year doctors tried to pass this student off to me as an M.D. After her death, we were lied to by those responsible. My mother's medical records were altered and falsified in an attempt to hide the malpractice. We have been completely unable to hold those individuals accountable.

After my mother's death I started suffering from depression. I was guilt-ridden, raging at the world and God, feeling that I had let her die because I hadn't demanded that the doctors do their job. Because they convinced me to go home, she died alone and I didn't have a chance to say goodbye.

All of our efforts to work through the system, medical boards, State consumer protection agency, district attorney's office, were a

waste. Because enforcement of existing malpractice law is so weak, no disciplinary actions were ever taken.

As of the end of last week, almost 7 months after the judgment was paid, these doctors still haven't been reported to either the State medical board or to the national practitioner data base, as is required by law. The public has no way of finding out that these doctors are responsible for a patient death.

MICRA created incredible hurdles for us, even in the case of such clear-cut negligence. We had trouble finding an attorney to take our case against Kaiser Permanente because the MICRA-imposed noneconomic damages cap severely limited what we would probably be able to recover, since my mother was not a high wage earner.

As our attorney told us after a unanimous arbitration decision came down, in California you get $250,000 for a maimed and crippled child who will live with the injuries for the rest of their life. Then you work backward from there to get to a 61-year-old woman. My sister and I received a judgment of $150,000 for the wrongful death of our mother. I would like to know which of the committee members would be willing to trade their loved one for $150,000 and be able to walk away feeling it was a fair trade.

Today the medical industry treats victims by vilifing us, and we are constantly cast as gold-digging opportunists whose goal in life is to persecute doctors unjustly. This is blame-the-victim mentality in the first degree. It is simple. If you want to stop malpractice litigation, stop malpractice. Treat the disease, not the symptom.

All that was promised under California's MICRA law proved hollow. The country will receive none of the benefits that you are now being promised. It is a failed and discredited law.

We were promised if MICRA was enacted we would be rewarded with reduced medical costs. They never materialized. Medical costs in California are among the highest in the country.

We were told that discipline of malpracticing doctors would be greatly increased, and that this would prevent those committing the malpractice from destroying the lives of Californians, promises also a sham. An auto mechanic in California is 10 times more likely to be disciplined for fouling up a car's tune-up then a doctor is for causing the death of one of his patients.

There is no incentive under MICRA to prevent malpractice. If these doctors had had their licenses revoked and the HMO had been severely fined, enough to make them take notice and be forced to make changes, this wouldn't be happening to other victims, justice would have been served, and our mother wouldn't have died in vain. When you are fighting a company that took in $12.2 billion just in California last year, $150,000 had all the effect of a mosquito biting an elephant. They didn't even know we were there.

My mother was a community activist in her town of Lake Elsinore, CA, for 10 years before her death. She contributed time, energy and money to make her community and this country a better place. She was an inspiration to me and everyone who knew her. As far as I am concerned, she was a true American patriot. She believed in the ideals of her country, what they were founded on, and she fought for them at every turn with every ounce of strength she had, right up to the last.

When we asked her why she spent all of her time and energy trying to make sure the politics in her community were held to a high standard and that wrongdoers were exposed, she would point to a saying she had pinned up next to her phone: "Democracy is not a spectator sport." Then she would tell us that this was the country her grandkids would have to live in long after she was gone, and she wanted it to be a country they could be proud of. She was doing her part to keep it that way. She taught her children those values, and her grandchildren.

To the majority members of the committee I want to say, she was one of your own. She was a lifelong Republican. She stood up for the ideals and values of the Republican Party at every turn. Now I am asking that you stand up for her and for others like her. Don't sell her and the rest of the country out to the AMA and the special interests.

Thank you for hearing me.

Mr. HYDE. Thank you for your very moving testimony, Ms. Ross.

[The prepared statement of Ms. Ross follows:]

PREPARED STATEMENT OF LINDA D. ROSS, YUCAIPA, CA

Mr. Chairman and members of the Committee, I want to thank you for inviting me here today to speak to you about the my family's experience with medical malpractice. My name is Linda Ross and I am a resident of Yucaipa, CA. I'm here today to tell you about the toll that medical malpractice takes on its victims and their families.

I am here today on behalf of my mother, Barbara J. Roberts -- who, in 1991, died from an untreated pulmonary embolism. She died at the age of 61 because of medical malpractice.

My mother isn't alone and I want to recognize the other victims that are here today. I would like them to stand for a moment so that you can see their faces.

I own a small business and I am a life-long Republican. I don't believe that litigation is the answer to every problem, but I do believe that injured people and their families need to be able to get into the courtroom, be fully compensated for their pain and suffering, and that some doctors and HMOs -- without the threat of medical malpractice lawsuits -- will cut costs and engage in reckless conduct that can kill or maim people like my mother.

Many of the proposals that have been debated in this Congress are based on California's MICRA law. I know -- and my mother knows -- that MICRA has failed to adequately protect and compensate Californians. Two of MICRA's provisions -- the $250,000 cap on pain and suffering, and MICRA's allowance of mandatory arbitration clauses in health insurance contracts -- were factors in our lawsuit against Kaiser.

Before going into the details of my mother's case, I want to ask you what price you would put on a lifetime of pain and suffering? Is $250,000 or $500,000 the amount of money you would assign to your mother or father's life? Your child's?

Three hospitals, including her own HMO, one independent orthopedist and numerous emergency room doctors and medical staff had multiple opportunities to save my mother from dying from this common complication of a broken bone. However, it seems that no one felt any sense of urgency or concern when she turned to them for help, even when she told them she was afraid she was dying. She made 3 different trips to the hospital, two after paramedics were called, complaining of symptoms that a first year medical student should have recognized as classic indications of a pulmonary embolism.

She waited in the E.R. of her HMO for 6 ½ hours for treatment that was never given and help that never came. Her death was completely preventable. According to medical textbooks on the subject, if proper treatment had been started when she arrived, she would have had a 99% likelihood of complete recovery. Instead, her life was placed in the hands of an unlicensed, unqualified and unsupervised medical student. Later the real doctors tried to pass off this student to me as an M.D.

After her death, we were lied to by those responsible, my mother's medical records were altered and falsified in an attempt to hide the malpractice and -- because of California's medical malpractice limits -- we have been unable to hold these individuals accountable.

Shortly after her death, I began suffering from depression. I was guilt-ridden, raging at the world and God, feeling that I had let her die, because I hadn't demanded that the doctors do what they should have done to save her, because the doctors convinced me to go home and she died alone, because I didn't have a chance to say goodbye, because...

My sister developed excruciating migraines, which she had never had before but she still has today. My depression was treated with anti-depressive drugs, along with a year of

therapy to help me deal with the overwhelming, murderous rage I felt at the people whose job it was to take care of her. People who had sworn an oath to do so, but who, instead, simply stood by and watched her die when they had the opportunity, ability, and means to save her.

I feel that, in the final analysis, my mother was killed by those who abandoned her. My desire for retribution grew as I realized that none of those responsible would ever be made to account by the medical disciplinary boards in California.

All of our efforts to work through the system: medical boards, state consumer protection agency, the district attorney's office, were a waste. No disciplinary actions were ever taken. As of the end of last week, almost 7 months after a $150,000 judgment was paid to my sister and me for my mother's wrongful death, these doctors still haven't been reported to either the State Medical Board or the National practitioner Database as required by law. The public has no way of finding out that these doctors were responsible for a patient's death. That is the medical malpractice crisis facing patients today -- not an explosion of lawsuits.

I want you to understand the kind of rage malpractice creates. Why? Because it is the only way you can understand one of the benefits of allowing injured people to be fully compensated for their pain and suffering -- the peaceful resolution of disputes with corporations or doctors that have injured them. The completely preventable death of a loved one, coupled with the realization that there isn't any person, agency, law or system that will offer any measure of real justice to a malpractice victim or their family member, can and does push some people to the brink, and others over the edge.

Only my realization that my family would suffer even more if I were to act on my rage, kept me from going after my pound of flesh.

Our lives turned into a nightmare of searching for answers no one would give, and the overwhelming need to make my mother's death count for something. We refused to let her become another statistic in the body-count of malpractice.

That's why I'm here talking to you today. You need to know the real impact of what you are thinking of doing to people like my mother and patients all across the country if you impose a California MICRA modeled law on a federal level.

Even with such a clear case of negligence, MICRA created incredible hurdles. We still had trouble finding an attorney to take our case against Kaiser Permanente because the MICRA imposed "non-economic" damages cap severely limited what we would probably be able to recover since my mother was not a high wage earner.

As our attorney told us after the unanimous arbitration decision came down, "In California, you get $250,000 for a maimed and crippled child who will live with those injuries for the rest of their life, then you work backward from there to get to a 61 year old woman." Incidently, he felt that $150,000 figure was a huge victory for us because damages for the death or injury of a senior citizen are normally much, much lower. Which one of you wants to tell me how much my mother's life is worth.

Another problem for the attorney was that we were subjected to litigating the case in the setting designed, controlled, and developed by the perpetrator's; Kaiser's mandatory binding arbitration, where they make all the rules. Under MICRA, HMO's can require patients to go to binding arbitration for medical malpractice disputes. I wanted a record of the proceedings made, however, I was told that was forbidden. Consequently there is no permanent record of the arbitration that could be used by other victims to show a pattern of malpractice by Kaiser. In a courtroom, Kaiser's attempts to seal the records of my case would have been subject to review by a judge.

No amount of money can ever give us back my mother, my best friend, but we hoped to use the judgement as a hammer to force Kaiser to change things, so no one else would lose a loved one.

However, when you're fighting a company that took in $12.2 billion dollars last year in

California, our $150,000 had all the effect of a mosquito biting an elephant. they didn't even know we were there.

As the federal government forces more and more of us into HMO's, people like my mother, seniors, stay at home moms, students, children, anyone who does not make a high wage are in double danger from malpractice.

This is because under MICRA, HMO's can now effectively place a dollar value on each member based on the profit potential of treating or not treating them. The worst case liability on the HMO balance sheet for not treating them under MICRA is $250,000., and as my sister and I have learned, a full figure award in California is extremely rare.

It becomes a basic accounting decision as HMO's rush to maximize stockholder return.

Why should the value of a person's life be solely determined by how much they earn? MICRA chooses to ignore the intrinsic value of a person's relationship to their family, friends, community and society.

The reason she is dead today is that malpracticing and incompetent doctors are allowed to continue practicing and their colleagues don't have the moral backbone to report them to licensing authorities or to purge them from their own professional organizations. The "Conspiracy of Silence" in the medical field still carries its full force and effect. I'm sure that my mother was not the first person to have her life destroyed be these people.

Today, the medical industry chooses to deal with a maimed, crippled, or damaged victim of malpractice as someone who has the audacity and affrontery to file a malpractice action to seek compensation for the destruction of his health and life. We are constantly cast as gold-digging opportunists whose goal in life is to unjustly persecute doctors. This is "blame the victim" mentality in the first degree.

It's simple, if you want to end malpractice litigation in this country, STOP MALPRACTICE!!! Treat the disease, not the symptom.

Malpractice victims' lawsuits are cited as the reason for virtually all the woes of the medical industry in this country. Now the AMA says that if only Congress would just rein in our right to seek compensation and accountability, the world would be a wonderful place for doctors once again. However, it would be a markedly more dangerous world for patients. Because you know as well as I, that wrongful acts that go unpunished are guaranteed to be repeated.

That you are considering California's MICRA as a model law to address the horrifying crisis of medical malpractice tells me how successful the AMA has been in their campaign to make malpractice victims the scapegoats for the problem of medically caused injuries and death.

The real agenda here is to ask Congress to grant doctors virtual immunity for their negligent and criminal acts. As patients, we clearly understand that this is what's really at stake here. They are asking you to shift the risk of providing medical care from the provider to the patient.

For all that was promised California under MICRA law, we have received less than nothing. The country will receive none of the benefits you are being promised. It is a failed and discredited law in California -- even the Los Angeles Times has written about its problems -- and propagating it nationwide will only serve to put ever greater numbers of patients at risk of death and injury.

We were promised that if severe limits were placed on the rights of medical malpractice victims to be fully compensated for medical injuries, all Californians would be rewarded with greatly reduced medical costs. This promised result never materialized. Medical costs in California are among the highest in the country.

Neither have malpractice insurance rates, blamed on lawsuits by malpractice victims,

been held to reasonable levels. This was also promised by the medical and insurance interests in 1976. Again, another empty promise.

We were also told that there would be greatly increased discipline of doctors to prevent those committing malpractice from destroying the lives of Californians. This promise was also a sham. An auto mechanic in California is 10 times more likely to be disciplined for fouling up a car's tune-up, than a doctor is for causing the death of one of his patients.

My sister and I received an arbitration judgement of $150,000 for the wrongful death of our mother. I would like to know which of the committee members would be willing to trade their loved one for $150,000 and be able to walk away feeling like it was a fair swap.

We were not dependant on our mother for financial support so we didn't need to use that $150,000 to support our family as many malpractice victims must do. The only reason money was an issue for us was that we were fighting back with the only lever we felt the HMO would understand: money. However, we couldn't make much of an impression because it is next to impossible to get punitive damages against an HMO in California.

If these doctors had their licenses revoked, and the HMO had been severely fined, to a point where the corporation would have really felt it, and had been forced to make changes that would have prevented this from happening to someone else's mother, sister, husband or child, that would have been the best satisfaction. And our mother would not have died in vain.

A judgement of $30,000 is supposed to be the threshold for triggering a report to the state medical board, this was our goal in bringing the suit. But as of the end of last week, there was still nothing on record either with the State Medical Board of California, nor with the National Practitioner Databank as required by law; nothing to inform the public about these doctors being responsible for a patient death. So much for the teeth in our enforcement laws we were promised under MICRA.

Ladies and gentlemen, it doesn't take a rocket scientist to understand that California's MICRA law resulted from the unholy alliance of the medical and insurance industries. It was always intended to serve their interests, never those of patients or victims. And for the last twenty years, their interests are the only ones that have been considered. Other victims and I plan to bring that situation to an end. We are organizing across the country. We vote. We write letters. We have friends and family who vote.

If our rights to pursue accountability in civil courts are further limited, we will remember who voted for those limits. We will push to enact criminal sanctions for these kinds of actions. Where would malpracticing doctors prefer to face their victims, in civil or criminal court?

My mother was a local community activist in her community of Lake Elsinore, California for 10 years before her death. She contributed time, energy, and money to try to make her community and this country a better place. She was an inspiration to me and to everyone who knew her. As far as I'm concerned, she was a true American patriot. She believed in the ideals her country was founded on and she fought for them with every ounce of strength that she had, right up to the last.

When we asked her why she spent all her time and energy trying to make sure the politics in her community were held to a high standard and that wrongdoers were exposed, she would point to a saying she had pinned up next to her phone "Democracy is not a spectator sport." Then she would tell us that this was the country her grandkids will have to live in long after she's gone and she wants it to be a country they can be proud of. She was doing her part to keep it that way. She taught her children those values and her grandchildren.

When my children hear of some injustice or a dishonest politician in our area, they invariably comment "Boy, if Grandma were still alive, that guy would be in big trouble. She would be all over him."

To the majority members of the committee I want to say, she was one of your own, a life

long Republican. She stood up for the ideals and values of the Republican Party at every turn.

Now, I'm asking that you stand up for her and others like her. Don't sell her nd the rest of us out to the interests of the AMA and other special interests.

As a society, on whose life should we place more value, and thus offer greater protection from malpractice? The rich, powerful, famous and well-connected will always have all the protection from malpractice they need. It's everyday people like my mother and the other victims like those you see here today that need to be protected from laws like MICRA and the doctors that shouldn't practice without it.

Mr. HYDE. Next, Robert T. Clarke, president and CEO of Memorial Health System, on behalf of the Health Care Liability Alliance. Mr. Clarke.

STATEMENT OF ROBERT T. CLARKE, PRESIDENT AND CEO, MEMORIAL HEALTH SYSTEM, ON BEHALF OF THE HEALTH CARE LIABILITY ALLIANCE

Mr. CLARKE. Yes. Thank you, Mr. Chairman.

Our health system includes a 600-bed tertiary hospital in Springfield, IL, affiliated with Southern Illinois University School of Medicine. We also sponsor two rural hospitals, Abraham Lincoln Memorial Hospital in Lincoln as well as St. Vincent Memorial Hospital in Taylorville. Our system includes physicians who practice in six communities as well as several mental health centers and home care agencies.

Today I am testifying on behalf of the Health Care Liability Alliance, which is a coalition of physicians, hospitals, insurers, manufacturers, organizations and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands national attention and a national solution. I would like to cite some cases for you that are familiar to the Health Care Liability Alliance. They show, I think, the other side of the picture.

A patient presents to a hospital with cancer, and during their admission is treated with radiation therapy. They subsequently go home and they come back to the hospital for outpatient radiation therapy treatment. A burn is noticed on the patient's hip. The patient claims they have been burned by a radiation therapy accident. The burn is not consistent with a radiation accident. No other incidents occurred in the department. The equipment calibrated correctly. Perhaps the most conclusive piece of evidence in the matter was that the patient had at one time mentioned to the nursing staff that she had burned herself with a hot water bottle in her home.

The hospital was asked for a nuisance settlement by the plaintiff's attorney.

An ER patient presents indicating they injured their back at home. That is recorded in the history and physical. Subsequently, an attorney contacts the hospital and threatens suit for improper recording of information which apparently was then interfering with a workman's compensation case.

A patient arrives with 28 percent body burns, first, second and third degree in nature. The doctor, of course, orders closely monitored input and output. The patient was incoherent and under emergency resuscitation status. A Foley catheter was put in the patient to monitor output. Subsequently, the patient recovered and went home, and filed a claim that there was no proper consent for the insertion of the Foley catheter and that pictures had been taken of his condition without his consent.

Finally, last case, a detailed surgical correction was done on a malformed foot. Post-discharge the patient developed an infection and came back to the hospital. The emergency room found the cast to be extremely dirty and, upon cutting it open, found fly maggots in the wound. The patient advised that they had been gardening

with their cast and with a barefoot. Subsequently the hospital was sued for the infection.

These are frivolous claims and suits, and waste time and energy and resources which, in our opinion, should be used for patient care or for those people who suffer real injury and have meritorious claims such as we have just heard.

Human beings make mistakes, unfortunately, but that doesn't justify not reforming our tort system. It is ineffective in reducing medical malpractice. It fails to compensate some who are injured and overcompensates others; benefits lawyers at the expense of injured patients; adds enormous cost and inefficiencies; and threatens access to care.

We have watched with interest the 1975 California Medical Injury Compensation Reform Act, which limits noneconomic damages to $250,000; provides a defendant's liability for noneconomic damages is several only; allows disclosure to the jury of collateral sources; allows installment payments; and creates a sliding scale for trial lawyers. It also has a 3-year statute of repose.

These reforms have led, in our opinion, to enormous success. It ensures fair and appropriate compensation for meritorious claims while limiting what had been skyrocketing insurance costs. We would encourage you to consider reforms such as MICRA. We would also ask you to consider State demonstration projects with alternative dispute resolution processes.

We thank you, Mr. Chairman.

Mr. HYDE. Thank you very much, Mr. Clarke.

[The prepared statement of Mr. Clarke follows:]

PREPARED STATEMENT OF ROBERT T. CLARKE, PRESIDENT AND CEO, MEMORIAL HEALTH SYSTEM, ON BEHALF OF THE HEALTH CARE LIABILITY ALLIANCE

Mr. Chairman and Members of the Committee:

My name is Robert Clarke. I am President and C.E.O. of the Memorial Health System of Springfield, Illinois. I am testifying on behalf of the Health Care Liability Alliance (HCLA). Our hospital has been working with HCLA to enact comprehensive reform of the health care liability system at the federal level.

The Health Care Liability Alliance is a coalition of physicians, hospitals, other health care givers, insurers, manufacturers, organizations and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands a national solution. A list of the members of HCLA is attached (Exhibit A).

We thank the Committee for holding this hearing and for offering us the opportunity to testify. We also commend Chairman Hyde for his unswerving commitment to improving this nation's fundamentally flawed liability system. As sponsor and leader of the effort to enact into law, H.R. 956, the Common Sense Legal Standards Reform Act of 1995, the Chairman has demonstrated steadfast leadership in the effort to rationalize our nation's legal system.

The members of HCLA asked me to express its collective gratitude to the House Leadership and to all members on both sides of the aisle who voted in favor of two amendments supported by HCLA during last year's debate on HR 956: 1) Congressman Cox and Geren's

amendment to limit the award of noneconomic losses in health care liability actions to $250,000; and 2) Congressman Cox's "fair share" amendment to eliminate joint and several liability for noneconomic losses in all civil actions.

I am also pleased to be here as a representative of the hospital community and to reaffirm hospitals' longstanding commitment to reform of our inefficient tort system. As the momentum for liability reform, and specifically health care liability reform, grows, we believe that Americans have the best opportunity in a generation to address this serious problem.

The refrain most often heard from the opponents of health care liability reforms is that patients suffer tragic injuries. These tragedies are compelling, and they evoke an understandably emotional response. Medical injury, and medical malpractice, do occur. Human beings make mistakes and in medicine they can be tragic. But that does not justify refusal to reform our tort system. That system, indeed, fails miserably in providing fair and expeditious remedy for these mistakes.

- It is ineffective in reducing medical malpractice, in anything but a haphazard way.
- It fails to compensate many who are injured, and overcompensates many others. It is slow to compensate those who are deserving.
- It adds enormous costs and inefficiencies to an already expensive and inefficient health care system.
- It benefits lawyers excessively at the expense of injured plaintiffs.
- And it threatens access to care.

3

The Need for Reform

Numerous reports document the failings of the current system. The 1995 Physician Payment Review Commission (PPRC) Annual Report to Congress states that "[t]he medical malpractice system does not adequately prevent medical injuries or compensate injured patients." It also notes a "concern that the current functioning of [the malpractice] system promotes the practice of defensive medicine."

The Harvard Medical Practice Study, based on a review of 31,429 medical records in 51 New York hospitals, concludes that of the 280 patients who suffered an adverse event due to negligence, only 1 in 16 received compensation from the tort liability system. On the other hand, at least half the claims that were filed were without merit--that is, 50% of the malpractice claims studied were not filed by a plaintiff who received negligent medical treatment. Similarly, of the over 117,132 closed claims and suits reported to the PIAA Data Sharing Project, only one third results in any payment to the plaintiff. In other words, litigation fails to sort out meritorious from nonmeritorious claims and to compensate those who are injured.

These conclusions are reinforced by GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement or payment to the plaintiff (Medical Malpractice, Characteristics of Claims Closed in 1984, U.S. General Accounting Office, 1987) and by a recent study funded by the U.S. Agency for Health Care Policy and Research that found no relationship between prior malpractice claims experience and the technical quality of practice by Florida obstetricians. ("The Relationship Between Malpractice Claims History and Subsequent Obstetric Care," JAMA, 272(20):1588-1591, November 23/30, 1994).

With so little correlation between the filing of lawsuits and physician negligent behavior, it is evident that the tort system is not effective in deterring medical injury or negligence.

Our system is costly and wasteful. In fact, the United States has the world's most expensive tort system. At 2.2 percent of GDP, the U.S. system costs substantially more than that of any other country and two and one half times the average of all developed countries. Tort costs have grown almost four times faster than the U.S. economy over the last 64 years. While the rate of growth of tort costs in general has moderated in recent years, the costs of medical malpractice continue to escalate at a double digit pace. (Tort Cost Trends: An International Perspective, Tillinghast Towers Perrin 1995).

A recent study, soon to be published in the Quarterly Journal of Economics, concludes that "doctors do practice defensive medicine" and that failure to enact liability reforms increases the cost of health care. (Kessler and McClellan, Do Doctors Practice Defensive Medicine?, Quarterly Journal of Economics (forthcoming)) (Exhibit B). The Hudson Institute published a study in April 1994, co-authored by then Hudson Senior Fellow, now Representative David McIntosh (R-IN) and Research Analyst David Murray, that examines the effect of liability on a large urban hospital in Indiana. The study concludes that "legal liability has become a key factor driving up the costs and decreasing the quality of medical care in the United States." The direct and indirect costs of liability added a total of $450 per patient admitted to the hospital, increasing medical costs at the hospital by 5.3%. On the physician side, while nationwide trends are mixed, medical liability insurance premiums continue to outpace inflation by substantial margins in States that have not achieved effective liability reform. For example, malpractice premiums increased by 14% in New York in 1993.

A particularly ominous trend in today's health system is the increase in the frequency of claims against primary care physicians, who play an ever larger role in the delivery of managed health services. (American Medical News, February 12, 1996, p. 1).

And the problem continues to get worse. According to the most recent Jury Verdict Research Study, released on January 4th of this year, "the median malpractice award for 1995 climbed ... to $500,000, a 40 percent increase in one year over 1994's median of $356,000. (News Release, Jury Verdict Research, January 4, 1996). Lawyers Weekly trumpeted these results:

> Medical Malpractice dominated the top verdicts of 1995. It accounted for half of the 10 largest awards to individual plaintiffs, with verdicts ranging from $40 million to $98.5 million. (Lawyers Weekly USA, January 15, 1996, Section B-1).

Four of these five mega-verdicts were awarded against hospitals. (Id.)

Thus, the PPRC Report, the Harvard Medical Practice Study, the 1992 and 1995 Tillinghast and Tillinghast Towers Perrin studies, the forthcoming Quarterly Journal of Economics, and the Hudson Institute Briefing Paper, to which could be added a host of other reports, collectively demonstrate the enormous flaws of the existing system. The current tort system simply is unable to resolve medical liability claims cost effectively and makes only a haphazard contribution to deterring negligent behavior or improving the safety of care.

The American Public Wants Reform

People know the liability system is out of control. Every recent poll has demonstrated that the American public strongly supports effective medical liability reform. A 1995 Poll conducted by HCLA in the week of March 10, 1995, shows large majorities of the public favor a variety of health care liability reforms, such as placing limits on the amount that can be

awarded for noneconomic losses like "pain and suffering," limiting the percentage that a lawyer can receive as a fee from any settlement or award for his client, and preventing plaintiffs from receiving money for items for which they have already been compensated. The Los Angeles Times found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. They are right.

A Better Way

The magnitude of the problems with the current system has spurred a dialogue on how to improve the system. There is a broad consensus among scholars, the public, and elected representatives on the objectives of health care liability reform and a developing consensus on the means to achieve those objectives.

1. Patient Safety Should be Promoted.

HCLA believes that any reform of the liability system must be built upon meaningful patient safeguards against both medical malpractice and avoidable harm from medical products or services. The key to patient safety is not trial lawyers and litigation. Rather, it is work that has been long underway in the health care community. There has been a revolution in the delivery of health care services since the Harvard Study was conducted ten years ago. Our health care system then was distinctly different than it is today. Hospital payments under Medicare were being constrained for the first time, and traditional independent, fee-for-service medical practices were commonplace. Little or no emphasis was placed on systemic quality, outcomes research or centralized medical management. Today, hospitals are clearly operating

in a different environment where capitated payments are the norm, and solo fee-for-service medical practices are increasingly being displaced by large networks of physicians and other providers. Both public and private sector payers are demanding systemic quality measurements that can continually demonstrate better outcomes and healthier patients.

It is in this atmosphere that patient safety and risk management programs have been established and are flourishing -- this trend has been an unanticipated benefit of private sector health care reform. HCLA members come from all aspects of the health care system and an overview of their risk management and patient safety activities will give the Committee a sense of the new environment. First of all, let me emphasize that risk management requires significant investment by hospitals, as it does of every HCLA member which conducts risk management activities. We know, though, that risk management is a sound investment because it improves the quality of services provided to patients, it decreases unnecessary health care costs incurred when patients suffer complications or additional injuries as a result of substandard care or when preventable health risks go unaddressed, and it promotes advances in medical treatment and technology designed to minimize patient exposure to risk. Examples of risk management activities include:

--Hospitals hiring full time risk managers who identify risk factors and help design plans to eliminate or mitigate them.

--The Physician Insurers Association of America, a national association of physician-owned medical professional liability insurance companies, routinely collecting and disseminating new knowledge regarding the prevention of medical misadventures through its Data Sharing Program and convening panels of experts on difficult cases to make risk

management recommendations.

--Harvard Medical School, and other medical educational institutions nationwide, developing practice standards for anesthesiologists, thereby improving anesthesiology for patients across the country.

The results of these activities are extremely encouraging. Anesthesiology has become many times safer in recent years because of the voluntary development, more than 10 years ago, of practice standards by the Harvard Medical School, for use in its affiliated hospitals, and adoption of those standards soon thereafter by the American Society of Anesthesiologists (ASA). Since then, insurance companies, managed care organizations and even a number of state medical regulatory authorities (e.g., New York, New Jersey) have adopted substantially similar standards. Before implementation by the Harvard Medical School of the anesthesia standards in July 1985, there was 1 intraoperative accident for every 75,700 anesthetics administered and 1 death for every 151,400 anesthetics administered between January 1976 and June 1985. Afterwards, between July 1985 and June 1990, there were no deaths at all and only 1 intraoperative accident for all 392,000 anesthetics administered. (See "Risk Reduction in Anesthesia," Anesthetic Risk and Complications, 6(2):289, June 1992).

There are many other examples of risk management/quality improvement activities which are improving the quality of care. Speaking on behalf of hospitals and the millions of hospital employees, physicians, pharmaceutical manufacturers, insurance companies and medical product makers I can honestly say that the investment in risk management and quality improvement is far less costly -- from both a caring perspective and a fiscal perspective -- than the price that any pay when a patient is injured or dies due to substandard medical care or medical negligence

during the course of medical treatment. Being dragged intc a health care liability suit is costly and time-consuming -- and it takes a human toll on hospitals, doctors, medical device manufacturers and other health care providers who strive every day for excellence in their disciplines. The vast majority of health care providers are committed to helping alleviate illness and suffering for all Americans seeking medical treatment -- risk identification and prevention is, by far, the preferable alternative to counterproductive litigation.

2. Injured Patients Should be Fairly Compensated, and the System's Focus Should be on Their Compensation, not Lawyers.

People wrongfully injured in the course of receiving health care treatment are entitled to be made whole. "If viewed as a mechanism for compensating victims for their economic losses, the tort system is extremely inefficient, returning less than 25 cents on the dollar for that purpose." (Tort Cost Trends: An International Perspective 1995, Tillinghast-Towers Perrin). The litigation system often can have the dual negative effect of both delaying and reducing the patient's recovery, since lawsuits can take years, and a large percentage of the award goes to pay court costs and legal fees. The RAND Corporation estimates that only 43 cents of every dollar spent in medical liability or product liability litigation reaches the injured patients.

Attached as Exhibit C to my testimony is an example of how the current system appears to serve lawyers better than patients. It is a final judgment order confirming a settlement agreement which involved a $200,000 cash payment to the plaintiffs (parents and injured minor), together with monthly payments for 20 years to the minor. Of the $200,000 cash payment, more than $160,000 was paid to the plaintiffs' attorney in expenses and fees, with less than $40,000 retained by the injured patient. Particularly striking is the fact that this case did not even go to

trial, nor was it especially complicated or drawn out.

3. The Tort Component of Health Care Costs Should be Contained.

The high cost of the tort system that doctors, nurses, hospitals, product manufacturers, health insurers and others must pay in order to stay in business, is inevitably passed through into the prices of the products and services they provide. Total cost of medical liability insurance, including self-insurance, is estimated at $9.2 billion, according to Lewin-VHI.

In addition to the actual cost of liability insurance, there are even greater costs associated with "defensive medicine"--diagnostic tests and services motivated primarily by the fear of litigation and the perceived need to build a medical record that documents a health care professional's decision. This factor is more difficult to quantify precisely, but is attested to by every health care professional. Lewin-VHI estimates that the combined cost of physician and hospital defensive medicine in 1991 was as high as $25 billion. (Estimating the Costs of Defensive Medicine, Lewin-VHI, 1993).

In a yet to be published study of the costs and effects of defensive medicine, two Stanford Professors found that "'[d]efensive medicine' is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies many times greater than the costs of compensating malpractice claimants." The authors then concluded that "[o]ur evidence on the effects of direct malpractice reforms suggests that doctors do practice defensive medicine." (Kessler and McClellan, Do Doctors Practice Defensive Medicine?, Quarterly Journal of Economics (forthcoming)).

The authors cite specific tort reforms as reining in the costs of defensive medicine:

> [o]ur analysis indicates that reforms that directly limit liability -- caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral source rule reforms -- reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear.

The Committee should also consider the cost of liability borne by manufacturers of drugs and devices--$10.8 billion paid to claimants in health care product liability cases in the U.S. in 1990, not including the cost of liability insurance and legal defense costs. Thus, the current cost of traditional health care liability exposure totals $45 billion a year and is growing.

A final cost factor that is potentially enormous, but has not yet been calculated, is the liability of health insurers and health networks for their utilization review activities that restrict payment for health care services. Recent verdicts and settlement reports suggest that payers who refuse to provide services may be exposed to multi-million dollar suits, even if the medical service demanded by the patient has not been proven effective and is clearly excluded by the terms of the managed care plan. (See Patients' Lawyers Lead Insurers to Pay for Unproven Treatments, New York Times, March 28, 1994, page A1). This phenomenon can be thought of as an institutional equivalent to defensive medicine. Managed care organizations and health systems are being forced by the risk of excessive damage awards, to provide treatment that is not necessarily needed or effective.

During this Congress, the Congressional Budget Office (CBO) finally recognized the savings to the consumer that can result from health care liability reform. It is an economic truth long recognized by advocates of tort reform. Finally, CBO "scored" the health care liability reforms passed by the House of Representatives in the budget, recognizing that these reforms would create savings for the ultimate purchaser of health care, in that case the federal government.

4. Access to Health Care and Innovation Should be Promoted not Thwarted.

One of the most serious societal costs inflicted by the current liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians and other health care providers to abandon practices or stop providing certain services in various areas of the country. More than a half million residents of rural counties are without any physician to provide obstetric services. (Health Care In Rural America, Office of Technology Assessment, September 1990). Liability induced access problems have been most clearly documented among ob/gyn physicians. An Institute of Medicine report found that the high cost of liability insurance and the threat of malpractice litigation have a particularly adverse effect on the delivery of obstetrical services to three categories of women: those living in rural areas, those with high risk pregnancies and those who are poor. (See Institute of Medicine, Medical Professional Liability, vol. II, pp. 61-62, 1989.) Similarly, the National Rural Health Association reports that many states and local communities are experiencing a serious lack of obstetric services and that increasingly this has been attributed to the medical malpractice problem.

Just last year, the House, the Senate and the President recognized the relationship between burgeoning liability costs and threatened access to health care for low income individuals. Unanimously, the House and Senate passed H.R. 1747, the Federally Supported Health Centers Assistance Act. This legislation, signed into law by the President, allows the Secretary of Health and Human Services to "deem" employees, contractors and other entities as employees of the Public Health Service. As "deemed" federal employees, individuals are sued under the specific provisions and procedures of the Federal Tort Claims Act (FTCA). This

"deeming" effectively takes patients in community health centers out of the conventional tort system. (See the Federally Supported Health Centers Assistance Act of 1995, Pub. L. 104-73, 109 Stat. 777; Report To Accompany H.R. 1747, the Federally Supported Health Centers Assistance Act of 1995, Rep. No. 104-398, December 12, 1995).

The FTCA, originally enacted by Congress in 1946, waives the federal government's sovereign immunity in tort actions, making it possible to sue the federal government under the terms of the FTCA. The FTCA applies a two year statute of limitations for the filing of an action, does not provide a jury trial, does not allow punitive damages or prejudgment interest, and caps attorneys fees. (See 28 U.S.C. §§ 2401, 2402, 2674, 2675, and 2678).

Why did Congress make this system apply to those who obtain health care from community health centers? It did so for exactly the right reasons - because the abuses of the conventional tort system, and their impact on the malpractice premiums paid by community health centers, were draining dollars from the provision of needed health care. In other words, Congress recognized that the tort system applied to non-government health care providers has a negative impact on access to health services. Applying the FTCA is one approach to solving the problems of the tort system. HCLA believes that its platform supplies an even better solution, which can be applied broadly to all litigants in a health care liability action.

Liability concerns are increasingly creating obstacles to the availability, affordability and innovation of medical drugs and devices as well. For example, in response to hundreds of claims filed against it, E.I. Dupont Company is restricting the sale of its Teflon product to the makers of lithium batteries used to power heart pacemakers. Even though Dupont had no role in designing the device, only in supplying the raw materials, it has been brought into lawsuits

involving the pacemakers most probably because of its deep pockets. Dupont and other companies are also restricting the sale of raw materials to manufacturers of jaw implants, artificial blood vessels, heart valves and sutures, among other devices. (Implant Industry is Facing Cutback by Top Suppliers, New York Times, April 24, 1994, page A1).

Fear of lawsuits by product and drug innovators has had an adverse impact on women. Citing fear of liability, Abbot Laboratories withdrew its participation in a National Institutes of Health Clinical Trial that would have tested a vaccine to prevent pregnant HIV-positive women from passing the virus to their unborn children. Likewise, liability was a key factor in the voluntary withdrawal from the market of Bendectin, the only drug ever approved in the U.S. for morning sickness.

Until some reasonable limits are put on the liability exposure of defendants in health care injury cases -- limits that provide fair, but not unlimited compensation for injured patients -- these access problems will continue.

PRECEDENTS FOR CHANGE

In 1975, California passed the Medical Injury Compensation Reform Act (MICRA). The Act creates a sliding scale limit on the amount that can be awarded to trial lawyers, allows the disclosure to the jury of double recovery by a plaintiff through the receipt of "collateral source" benefits, allows installment payments of future damages to plaintiffs, provides that a defendant's liability for noneconomic damages is several only, and limits noneconomic damages. California also has a 3 year statute of repose for health care liability actions. This set of reforms has led to enormous success in ensuring fair and appropriate compensation while limiting what had been skyrocketing insurance costs for providers.

In a March 1995 letter to Representative Steve Schiff of New Mexico, the American Academy of Actuaries conducted a comparison of California, Ohio and New York health care liability laws. The study found that as a result of the MICRA package enacted in 1975, California's medical malpractice costs have fallen as a percentage of the U.S. total.

In Ohio, after its cap on damages was overturned in 1985, costs rose dramatically and have remained high as a percentage of the U.S. total. According to the actuaries,

> [t]he data shows a gradual decline in the cost level following tort reform, from 1976 through 1982, and a sharp increase during the time the cap was under challenge in the courts with a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no indication of decreasing. Again, this data appears to support the benefits of a comprehensive tort reform package and the specific benefit from a cap on noneconomic damages, as seen by the increases in costs when the cap was no longer in effect.

In a trade-off that benefits both plaintiffs and defendants, the average California malpractice payment, including settlements and verdicts, is lower than the national average, but the award reaches California patients a year faster than the national average, according to the National Practitioner Data Bank. In California, there has been no political backlash or public outcry from patients claiming to be unfairly treated. There is no crisis in the quality of health care in California. In fact, an April 1992 survey revealed that 75% of Californians support the California medical malpractice reforms.

In California, MICRA has slowed the growth in malpractice insurance premiums and in the cost of health care relative to states without meaningful health care liability reform. The California package of tort reforms has been effective in achieving the goals of fair, efficient and timely compensation while not sacrificing quality of care. Those who oppose these changes have the burden of showing how their rhetoric matches the reality experienced in California and other

states throughout the nation that have enacted effective health care liability reform.

Twenty two states have enacted some limit on noneconomic or economic damages. Twelve states, and the federal government in the FTCA, have a statutory limitation on attorneys fees. Twenty eight states have either mandatory or discretionary rules on "collateral source" benefits. Twenty eight states have some rule addressing the periodic payment of future damages.

HCLA's Position

HCLA supports a comprehensive package of tort reforms based on MICRA that it believes will rationalize the liability system, decrease costs, increase access, and have no negative impact on the quality of care delivered to the American people.

FEDERAL FLOOR PREEMPTION

Like the product liability community, HCLA supports a "federal floor" concept of preemption. We do not support outright preemption of all state laws. Instead, we support the establishment of a federal minimum standard based on a set of basic reforms whose effectiveness has been demonstrated for over 20 years in creative states throughout the nation. This "federal floor" type preemption is often used by Congress when intervening in areas which are traditionally areas of state control. This type of preemption was used in the 1994 General Aviation Revitalization Act, Pub. L. 103-298 (1994). This legislation established a maximum statute of repose for suits against aviation manufacturers. Under the terms of the bill, states were permitted to enact shorter statutes of repose. In the Americans with Disabilities Act, 42 U.S.C. Sec. 12101 et seq. and the Civil Rights Act of 1964, 42 U.S.C. 2000e et seq., Congress permitted states to be more aggressive in combatting civil rights violations. Establishing a

federal minimum strikes the appropria : balance between remedying the flaws in the existing tort system and permitting states the freedom to experiment with more cost effective, creative ways to resolve health care liability disputes.

A CAP OF $250,000 ON NONECONOMIC DAMAGES

HCLA strongly supports a $250,000 cap on noneconomic damages. Limits on noneconomic damages are the single most effective reform in containing medical liability premiums, according to a September 1993 Report of the Office of Technology Assessment and a 1994 Report of the Hudson Institute. Noneconomic damages are inherently difficult to quantify and subjective by their nature, since they attempt to assign a monetary value to things intangible, such as pain and suffering, loss of enjoyment of life or loss of companionship. The reform is tried and true; it has been in effect in California as part of MICRA, and has proven to be a great success both in providing fair compensation to injured patients and in keeping the cost of health care liability under control. On the issue of damage caps, the recent Stanford study bears repeating:

> Our analysis indicates that reforms that directly limit liability -- caps on damages, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral source rule reforms -- reduce hospital expenditures by 5 to 9 percent within three to five years of adoption ... with no appreciable consequences for important health outcomes, including mortality and common complications of the diseases we studied. (Kessler and McClellan, Do Doctors Practice Defensive Medicine?, Quarterly Journal of Economics (forthcoming)).

The underlined portions of this sentence are important. The adoption of a statutory cap on noneconomic damages saves money, rationalizes the liability system and does not appear to diminish the quality of health care. The authors conclude that "direct liability limitations [including a cap on noneconomic damages] appear to be an effective policy reform for improving

the efficiency of the U.S. health care system." (Id.)

JOINT AND SEVERAL LIABILITY REFORM

HCLA supports the reform of joint and several liability for noneconomic damages so that the portion of such damages defendants pay is based on their degree of responsibility for, or fair share of, the harm. Under the current rule in many states, a defendant that is responsible for as little as one percent of the total fault may be held financially accountable for the entire award. Elimination of joint and several liability, at least in the area of noneconomic damages, takes an important step toward establishing fairness and accountability between defendants.

COLLATERAL SOURCE RULE REFORM

HCLA supports reform of the collateral source rule to stop double recovery and the fraud and abuse that it generates. This reform would permit the defendant to introduce evidence of reimbursement received or due to be received by a claimant from health or disability insurers or others for losses resulting from an injury. Claimants are permitted to provide evidence of amounts paid to secure the collateral source benefit. Providers of collateral sources would not be allowed to subrogate.

PERIODIC PAYMENT OF FUTURE AWARDS

HCLA supports a provision requiring the periodic payment of future damage awards, at the request of either party, on amounts over $50,000. Periodic payment of large future awards leads to more stable and consistent malpractice insurance rates because of the predictability provided through the purchase of annuities for large awards. Periodic payments also assure a steady flow of funds in the future for injured plaintiffs.

ATTORNEY CONTINGENCY FEE LIMITATION

The contingency fee is meant to be the "poor man's key to the court house." However, the contingency fee system is not serving this function well. Most persons with small health care injury claims never obtain access to the civil justice system because the contingency fee stimulates lawyers to be primarily interested in more "big ticket" cases.

STATUTE OF LIMITATIONS AND STATUTE OF REPOSE

A uniform statute of limitation should be enacted that establishes a standard rule that claims must be filed within one year from the date an injury is discovered, but provides for an outside limit of three years from the date the injury occurred. Exceptions to these general rules should be made for children under age six who may not be able to communicate the existence of an injury, and for instances where a foreign object, with no therapeutic purpose, is left in a claimant's body. As in all areas of the law, there is a need for balance between the rights of those bringing suit, and the rights of those defending themselves. A statute of limitations which permits a suit 23 years after a child is born cannot be found by any reasonable person as striking the appropriate balance.

REFORM OF PUNITIVE DAMAGES

HCLA supports a reasonable limitation on punitive damages and a defense to punitive damage claims based on compliance with government standards. Manufacturers and distributors of medical products that were subject to pre-market approval of the appropriate federal agency and marketed in accordance with federal regulations, or that met the "safe and effective" product requirements of the Food and Drug Administration, should have a defense against punitive damages on products for which they complied in good faith with these government requirements.

Pursuing the lengthy FDA process and complying with the multitude of safety demands required by the Agency should shield a manufacturer from the quasi-criminal accusation of malice, or "conscious disregard of substantial and unjustifiable risk of unnecessary injury."

ALTERNATIVE DISPUTE RESOLUTION

HCLA also supports State demonstration projects with alternative dispute resolution (ADR) mechanisms, such as Early Offer and Recovery, which encourage settlements and reduce litigation. The Early Offer and Recovery mechanism is an interesting example of this kind of ADR. It introduces incentives for both plaintiffs and defendants to settle cases quickly and fairly and thus avoid litigation. Defendants and potential defendants are encouraged to make an offer to pay the plaintiff's net economic loss. By making the offer, the defendant reduces the risk and cost of litigation. The plaintiff is encouraged to accept the offer because it gives him fair compensation for an injury quickly and without the need for litigation. If the plaintiff chooses not to accept the offer, he can go to court.

In order to provide the necessary incentive for settlement, some proponents of the Early Offer and Recovery mechanism have suggested that the rules applicable to any subsequent suit be adjusted:

1. a higher standard of liability (wanton or intentional misconduct) and a higher threshold of proof (beyond a reasonable doubt or clear and convincing evidence) would apply; and
2. a lower limit would be set on the amount of noneconomic damages that could be recovered.

By this mechanism, injured persons will receive compensation for their actual losses far more efficiently than under the current system. HCLA supports State demonstration projects

with this and other ADR mechanisms.

Finally, we want to express our support for applying the reforms to all potential defendants in disputes arising from injuries stemming from a health injury. The manufacturers of medicines and medical devices, providers of blood and tissue services or products, and health insurers are all at risk of lawsuits when a patient is injured. Hospitals, clinics and other institutional providers are sued not just for malpractice, but for personal injury alleged to result from distribution of medical devices, drugs and blood tissue. Addressing the liability issue in just one part of the health care sector may actually stimulate litigation in other parts that are not subject to the reform provisions. Liability reform must encompass all potential defendants in claims arising from health care injuries.

CONCLUSION

The current tort system fails in both of its main goals: compensation and deterrence. The public, the health care community and Congress share a common goal: the resolution of health care liability claims in a fair, cost-effective and timely manner. Only the trial lawyers benefit from the existing system, and they stand as a well-funded, formidable roadblock to reform. HCLA's approach promotes and strengthens risk reduction efforts, while making needed reforms in the legal system as it applies to health care injury disputes. Currently, the system is not working well for either patients or health care providers. We must get a handle on exploding liability costs and make health care more affordable and accessible. To do this, we must correct the incentives and create a system which compensates wrongfully injured patients fairly, cost-effectively and in a timely manner. California, a number of other states, and now the federal government on a limited basis, has enacted needed health care liability reforms with no reduction

in fairness or in the quality of health care. The federal government should look for guidance to the reforms and the results in California and should enact comprehensive health care liability reform this year.

Exhibit A

HCLA Member List

American Academy of Dermatology
American Academy of Healthcare Attorneys/Healthcare Liability Committee
American Academy of Ophthalmology
American Home Products Corporation
American Hospital Association
American Medical Association
AMA/Specialty Society Medical Liability Project
American Society of Healthcare Risk Managers
Biotechnology Industry Organization
Californians Allied for Patient Protection
Cooperative of American Physicians, Inc./Mutual Protection Trust
Council of Community Blood Centers
The Doctors' Company
Federation of American Health Systems
Health Industry Manufacturers Association
Health Insurance Association of America
Hoechst Marion Roussel
Medical Liability Mutual Insurance Company
Medical Mutual Liability Insurance Society of Maryland
Medical Protective Company
MEDMARC Insurance Company
Missouri Medical Insurance Company
MMI Companies, Inc.
National Council of Community Hospitals
NORCAL Mutual Insurance Company
Pennsylvania Medical Society Liability Insurance Company
Pharmaceutical Research & Manufacturers of America
Physician Insurers Association of America
PICOM Insurance Company
State Volunteer Mutual Insurance Co.

Exhibit E

forthcoming, Quarterly Journal of Economics

Do Doctors Practice Defensive Medicine?*

Daniel Kessler and Mark McClellan

* We would like to thank Randall Bovbjerg, David Genesove, Jerry Hausman, Paul Joskow, Lawrence Katz, W. Page Keeton, Gary King, A. Mitchell Polinsky, George Shepherd, Frank Sloan, seminar participants at Michigan, Northwestern, and NBER, and two anonomous referees for advice, assistance, and helpful comments. Jeffrey Geppert and Mohan Ramanujan provided excellent research assistance. Funding from the Harvard/MIT Research Training Group in Positive Political Economy, the John M. Olin Foundation, and the National Institute on Aging is greatly appreciated. All errors are our own.

Abstract

"Defensive medicine" is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies many times greater than the costs of compensating malpractice claimants. To obtain empirical evidence on this question, we analyze the effects of malpractice liability reforms using data on all elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990. We find that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications. We conclude that liability reforms can reduce defensive medical practices.

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Introduction

The medical malpractice liability system has two principal roles: providing redress to individuals who suffer negligent injuries, and creating incentives for doctors to provide appropriately careful treatment to their patients [Bell 1984]. Malpractice law seeks to accomplish these goals by penalizing physicians whose negligence causes an adverse patient health outcome, and using these penalties to compensate the injured patients [Danzon 1985]. However, considerable evidence indicates that the current malpractice system is neither sensitive nor specific in providing compensation. For example, the Harvard Medical Practice Study [1990] found that sixteen times as many patients suffered an injury from negligent medical care as received compensation in New York State in 1984. And, in any event, the cost of compensating malpractice claimants is not an important source of medical expenditure growth: compensation paid and the costs of administering that compensation through the legal system account for less than one percent of expenditures [OTA 1993].

The effects of the malpractice system on physician behavior, in contrast, may have much more substantial effects on health care costs and outcomes, even though virtually all physicians are fully insured against the financial costs of malpractice such as damages and legal defense expenses. Physicians may employ costly precautionary treatments in order to avoid nonfinancial penalties such as fear of reputational harm, decreased self-esteem from adverse publicity, and the time and unpleasantness of defending a claim [Charles, Pyskoty, and Nelson 1988; Weiler et al. 1993].

On one hand, these penalties for malpractice may deter doctors and other providers from

putting patients at excessive risk of adverse health outcomes. On the other hand, these penalties may also drive physicians to be too careful -- to administer precautionary treatments with minimal expected medical benefit out of fear of legal liability -- and thus to practice "defensive medicine." Many physicians and policymakers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for a substantial portion of the explosive growth in health care costs [Reynolds, Rizzo, and Gonzalez 1987; OTA 1993, 1994]. The practice of defensive medicine may even have adverse effects on patient health outcomes, if liability induces providers either to administer harmful treatments or forego risky but beneficial ones. For these reasons, defensive medicine is a crucial policy concern [Sloan, Mergenhagen, and Bovbjerg 1991].

Despite this policy importance, there is virtually no direct evidence on the existence and magnitude of defensive medical practices. Such evidence is essential for determining appropriate tort liability policy. In this paper, we seek to provide such direct evidence on the prevalence of defensive medicine by examining the link between medical malpractice tort law, treatment intensity, and patient outcomes. We use longitudinal data on all elderly Medicare recipients hospitalized for treatment of a new heart attack (acute myocardial infarction, or AMI) or of new ischemic heart disease (IHD) in 1984, 1987, and 1990, matched with information on tort laws from the state in which the patient was treated. We study the effect of tort law reforms on total hospital expenditures on the patient in the year after AMI to measure intensity of treatment. We also model the effect of tort law reforms on important patient outcomes. We estimate the effect of reforms on a serious adverse outcome that is common in our study

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population: mortality within one year of occurrence of the cardiac illness. We also estimate the effect of tort reforms on two other common adverse outcomes related to a patient's quality of life: whether the patient experienced a subsequent AMI or other cardiac illness requiring hospitalization in the year following the initial illness.

To the extent that reductions in medical malpractice tort liability are associated with decreases in intensity but not with increases in adverse health outcomes, medical care for these health problems is defensive – that is, doctors supply a socially excessive level of care due to malpractice liability pressures. Put another way, tort reforms that reduce liability also reduce inefficiency in the medical care delivery system to the extent that they reduce health expenditures that do not provide commensurate benefits. We assess the magnitude of defensive treatment behavior by calculating the cost of an additional year of life or an additional year of cardiac health achieved through treatment intensity induced by specific aspects of the liability system. If liability-induced precaution results in low expenditures per life saved relative to generally accepted costs per life of other medical treatments, then the existing liability system provides incentives for efficient care; but if liability-induced precaution results in high expenditures per life saved, then the liability system provides incentives for socially excessive care. Because the precision with which we measure the consequences of reforms is critical, we include all U.S. elderly patients with heart diseases in 1984, 1987, and 1990 in our analysis.

The first section of the paper discusses the theoretical ambiguity of the impact of the current liability system on efficiency in health care. For this reason, liability policy should be guided by empirical evidence on its consequences for "due care" in medical practice. The second section reviews the previous empirical literature. Though the existing evidence on the

effectiveness of alternative liability rules has provided considerable insights, direct evidence on the crucial effects of the tort system on physician behavior is virtually nonexistent. The third section presents our econometric models of the effects of liability rules on treatment decisions, costs, and patient outcomes, and formally describes the test for defensive medicine used in the paper. We identify liability effects by comparing trends in treatment choice, costs, and outcomes in states adopting various liability reforms to trends in those that did not; we also review a number of approaches to enriching the model, assisting in the evaluation of its statistical validity and providing further insights into the tort reform effects. The fourth section discusses the details of our data, and motivates our analysis of elderly Medicare beneficiaries for purposes of assessing the costs of defensive medicine. The fifth section presents the empirical results. The sixth section discusses implications for policy, and the last section concludes.

I. Malpractice Liability and Efficient Precaution In Health Care

In general, malpractice claims are adjudicated in state courts according to state laws. These laws require three elements for a successful claim. First, the claimant must show that the patient actually suffered an adverse event. Second, a successful malpractice claimant must establish that the provider caused the event: the claimant must attribute the injury to the action or inaction of the provider, as opposed to nature. Third, a successful claimant must show that the provider was negligent. Stated simply, this entails showing that the provider took less care than that which is customarily practiced by the average member of profession in good standing, given the circumstances of the doctor and the patient [Keeton et al. 1984]. Collectively, this three-part test of the validity of a malpractice claim is known as the "negligence rule."

In addition to patient compensation, the principal role of the liability system is to induce doctors to take the optimal level of precaution against patient injury. However, a negligence rule may lead doctors to take socially insufficient precaution, such that the marginal social benefit of precaution would be greater than the marginal social cost; or, it may lead doctors to take socially excessive precaution -- that is, to practice defensive medicine -- such that the marginal social benefit of precaution would be less than the marginal social cost [Farber and White 1991]. The negligence rule may not generate socially optimal behavior in health care because the private incentives for precaution facing doctors and patients differ from the social incentives. First, the costs of accidents borne by the physician differ from the social costs of accidents. Because malpractice insurance is not strongly experience rated [Sloan 1990], physicians bear little of the costs of patient injuries from malpractice; however, physicians bear significant uninsured expenses in response to a malpractice claim, such as the value of time and emotional energy spent on legal defense [OTA 1993: 7]. Second, patients and physicians bear little of the costs of medical care associated with physician precaution in any particular case because most health care is financed through health insurance and because physicians may not be perfect agents for the managers of the organizations in which they practice [McClellan 1995]. Generally, insured expenses for drugs, diagnostic tests, and other services performed for precautionary purposes are much larger than the uninsured cost of the physician's own effort. Third, physicians only bear substantial costs of accidents when patients file claims, and patients may not file a malpractice claim in response to every negligent medical injury [Harvard Medical Practice Study 1990].

The direction and extent of the divergence between the privately and socially optimal levels of precaution depends in part on states' legal environments. Although the basic

framework of the negligence rule applies to most medical malpractice claims in the United States, individual states have modified their tort law to either expand or limit malpractice liability along various dimensions over the past 30 years. For example, several states have imposed caps on malpractice damages such that recoverable losses are limited to a fixed dollar amount, such as $250,000. These modifications to the basic negligence rule can affect both the costs to physicians and the benefits to patients from a given malpractice claim or lawsuit, and thereby also affect the frequency and average settlement amount ("severity") of claims. We use the term *malpractice pressure* to describe the extent to which a state's legal environment provides high benefits to plaintiffs and/or high costs to physicians (Malpractice pressure can be multidimensional.)

If the legal environment creates little malpractice pressure and externalized costs of medical treatment are small, then the privately optimal care choice may be below the social optimum. In this case, low benefits from filing malpractice claims and lawsuits reduce nonpecuniary costs of accidents for physicians, who may then take less care than the low cost of diagnostic tests, for example, would warrant. However, if the legal environment creates substantial malpractice pressure and externalized costs of treatment are large, then the privately optimal care choice may be above the social optimum: privately chosen care decisions will be defensive. For example, increasing technological intensity (with a reduced share of physician effort costs relative to total medical care costs) and increasing generosity of tort compensation of medical injury would lead to relatively more defensive medical practice.

Incentives to practice defensively may be intensified if judges and juries impose liability with error. For example, the fact that health care providers' precautionary behavior may be ex

post difficult to verify may give them the incentive to take too much care [Cooter and Ulen 1986, Craswell and Calfee 1986]. Excessive care results from the all-or-nothing nature of the liability decision: small increases in precaution above the optimal level may result in large decreases in expected liability.

Because privately optimal behavior under the basic negligence rule may result in medical treatment that has marginal social benefits either greater or less than the marginal social costs, the level of malpractice pressure that provides appropriate incentives is an empirical question. In theory, marginal changes to the negligence rule can either improve or reduce efficiency, depending on their effects on precautionary behavior, total health care costs, and adverse health outcomes. Previous studies have analyzed effects of legal reforms on measures of malpractice pressure, such as the level of compensation paid malpractice claimants. To address the potentially much larger behavioral consequences of malpractice pressure, we study the impact of changes in the legal environment on health care expenditures to measure the marginal social cost of treatment induced by the liability system, and the impact of law changes on adverse health events to measure the marginal social benefit of law-induced treatment. As a result, we can provide direct evidence on the efficiency of a baseline malpractice system and, if it is inefficient, identify efficiency-improving reforms.

II. Previous Empirical Literature

The previous empirical literature is consistent with the hypothesis that providers practice defensive medicine, although it does not provide direct evidence on the existence or magnitude of the problem. One arm of the literature uses surveys of physicians to assess whether doctors

practice defensive medicine [Reynolds, Rizzo, and Gonzalez 1987; Moser and Musaccio 1991; OTA 1994]. Such physician surveys measure the cost of defensive medicine only with further untestable assumptions about the relationship between survey responses, actual treatment behavior, and patient outcomes. Although surveys indicate that doctors believe that they practice defensively, surveys only provide information about what treatments doctors say that they would administer in a hypothetical situation; they do not measure behavior in real situations.

Another body of work uses clinical studies of the effectiveness of intensive treatment [Leveno et al. 1986; Shy et al. 1990]. These studies find that certain intensive treatments which are generally thought to be used defensively have an insignificant impact on health outcomes. Similarly, clinical evaluations of malpractice control policies at specific hospitals have found that intensive treatments thought to serve a defensive purpose are "overused" by physicians [Masters et al. 1987]. However, this work does not directly answer the policy question of interest: does intensive treatment *administered out of fear of malpractice claims* have any effect on patient outcomes? Few medical technologies in general use have been shown to be ineffective in all applications, and the average effect of a procedure in a population may be quite different from its effect at the margin, for example in the additional patients who receive it because of more stringent liability rules [McClellan 1995]. Evaluating malpractice liability reforms requires evidence on the effectiveness of intensive treatment in the "marginal" patients.

A third, well-developed arm of the literature estimates the effects of changes in the legal environment on measures of the compensation paid and the frequency of malpractice claims. Danzon [1982, 1986] and Sloan, Mergenhagen, and Bovbjerg [1989] find that tort reforms that

cap physicians' liability at some maximum level or require awards in malpractice cases to be offset by the amount of compensation received by patients from collateral sources[1] reduce payments per claim.[2] Danzon [1986] also finds that collateral-source-rule reforms and statute-of-limitations reductions reduce claim frequency. Based on data from malpractice insurance markets, Zuckerman, Bovbjerg, and Sloan [1990] and Barker [1992] find similar results: Zuckerman, Bovbjerg, and Sloan find that caps on damages and statute-of-limitations reductions reduce malpractice premiums, and Barker finds that caps on damages increase profitability.

Despite significant variety in data and methods, this literature contains an important unified message about the types of legal reforms that affect physicians' incentives. The two reforms most commonly found to reduce payments to and the frequency of claims, caps on damages and collateral source rule reforms, share a common property: they *directly* reduce expected malpractice awards. Caps on damages truncate the distribution of awards; mandatory collateral source offsets shift down its mean. Other malpractice reforms that only affect malpractice awards *indirectly*, such as reforms imposing mandatory periodic payments (which require damages in certain cases to be disbursed in the form of annuity that pays out over time) or statute-of-limitations reductions, have had a less discernable impact on liability and hence on malpractice pressure.

However, estimates of the impact of reforms on frequency and severity from these analyses are only the first step toward answering the policy question of interest: do doctors practice defensive medicine? Taken alone, they only provide evidence of the effects of legal reforms on doctors' incentives; they do not provide evidence of the effects of legal reforms on doctors' behavior. Identifying the existence of defensive treatment practices and the extent of

inefficient precaution due to legal liability requires a comparison of the response of costs of precaution and the response of losses from adverse events to changes in the legal environment.

A number of studies have sought to investigate physicians' behavioral response to malpractice pressure. These studies generally have analyzed the costs of defensive medicine by relating physicians' actual exposure to malpractice claims to clinical practices and patient outcomes [Rock 1988; Harvard Medical Practice Study 1990; Localio et al. 1993; Baldwin et al. 1995]. Rock, Localio et al., and the Harvard Medical Practice Study find results consistent with defensive medicine; Baldwin et al. do not. However, concerns about unobserved heterogeneity across providers and across small geographic areas qualify the results of all of these studies. The studies used frequency of claims or magnitude of insurance premiums at the level of individual doctors, hospitals, or areas within a single state over a limited time period to measure malpractice pressure. Because malpractice laws within a state at a given time are constant, the measures of malpractice pressure used in these studies arose not from laws but from primarily unobserved factors at the level of individual providers or small areas, creating a potentially serious problem of selection bias. For example, the claims frequency or insurance premiums of a particular provider or area may be relatively high because the provider is relatively low quality, because the patients are particularly sick (and hence prone to adverse outcomes), because the patients had more "taste" for medical interventions (and hence more likely to disagree with their provider about management decisions), or because of many other factors; the sources of the variation in legal environment are unclear and probably multifactorial. All of these factors are extremely difficult to capture fully in observational datasets, and could lead to an apparent but noncausal association between measured malpractice pressure and treatment

decisions or outcomes.

Thus, while previous analyses have provided a range of insights about the malpractice liability system, they have not provided direct empirical evidence on how malpractice reforms would actually affect physician behavior, medical costs, and health outcomes.

III. Econometric Models

Our statistical methods seek to measure the effects of changes in an identifiable source of variation in malpractice pressure influencing medical decision making -- state tort laws -- that is not related to unobserved heterogeneity across patients and providers. We compare time trends across reforming and nonreforming states during a seven-year period in inpatient hospital expenditures, and in outcome measures including all-cause cardiac mortality as well as the occurrence of cardiac complications directly related to quality of life. We model average expenditures and outcomes as essentially nonparametric functions of patient demographic characteristics, state legal and political characteristics, and state- and time-fixed-effects. We model the effects of state tort law changes as differences in time trends before and after the tort law changes. We test for the existence and magnitude of defensive medicine based on the relationship of the law-change effects on medical expenditures and health outcomes.

While this strategy fundamentally involves differences-in-differences between reforming and nonreforming states to identify effects, we modify conventional differences-in-differences estimation strategies in several ways. First, as noted above, our models include no potentially restrictive parametric or distributional assumptions about functional forms for expenditures or health outcomes. Second, we do not model reforms as simple one-time shifts. Malpractice

reforms might have more complex, longer-term effects on medical practices for a number of reasons. Law changes may not have instantaneous effects because it may take time for lawyers, physicians, and patients to learn about their consequences for liability, and then to reestablish equilibrium practices. Law changes may affect not only the static climate of medical decision making, but also the climate for further medical interventions by reducing pressure for technological intensity growth. Thus, the long-term consequences of reforms may be different from their short-term effects. By using a panel dataset including a seven-year panel, our modeling framework permits a more robust analysis of differences in *time trends* before and after adoption.

We use a panel-data framework with observations on successive cohorts of heart disease patients for estimating the prevalence of defensive medicine. In state s = 1...S during year t = 1...T, our observational units consist of individuals I=1...N_{st} who are hospitalized with new occurrences of particular illnesses such as a heart attack. Each patient has observable characteristics X_{ist}, which we describe as a fully-interacted set of binary variables, as well as many unobservable characteristics that also influence both treatment decisions and outcomes. The individual receives treatment of aggregate intensity R_{ist}, where R denotes total hospital expenditures in the year after the health event. The patient has a health outcome O_{ist}, possibly affected by the intensity of treatment received, where a higher value denotes a more adverse outcome (O is binary in our models).

We define state tort systems in effect at the time of each individual's health event based on the existence of two categories of reforms from a maximum-liability regime: direct and indirect malpractice reforms. Previous studies, summarized in Section II, found differences

between these types of reforms on claims behavior and malpractice insurance premiums (Section IV below discusses our reform classification in detail). We denote the existence of direct reforms in state s at time t using two binary variables L_{mst}: $L_{1st}=1$ if state s has adopted a direct reform at time t, and $L_{2st}=1$ if state s has adopted an indirect reform at time t.

We first estimate linear models of average expenditure and outcome effects using these individual-level variables. The expenditure models are of the form

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}\phi_m + v_{ist} , \qquad (1)$$

where θ_t is a time fixed-effect, α_s is a state fixed-effect, X_{ist} is a fully-interacted vector of binary variables describing observable individual characteristics, W_{st} is a vector of variables describing the legal-political environment of the state over time, β and γ are vectors of the corresponding average-effect estimates for the demographic controls and additional state-time controls, L_{st} is a two-dimensional binary vector describing the existence of malpractice reforms, ϕ_m is the two-dimensional average effect of malpractice reforms on growth rate, and v_{ist} is a mean-zero independently-distributed error term with $E(v_{ist} | X_{ist}, L_{st}) = 0$. Because legal reforms may affect both the level and the growth rate of expenditures, we estimate different baseline time trends θ_t for states adopting reforms before 1985 (which were generally adopted before 1980) and nonadopting states. Our dataset includes essentially all elderly patients hospitalized with the heart diseases of interest for the years of our study, so that our results describe the actual average differences in trends associated with malpractice reforms in the U.S. elderly population. We report standard errors for inferences about average differences that might arise in potential populations (e.g., elderly patients with these health problems in other years). Our model

assumes that patients grouped at the level of state and time have similar distributions of unobservable characteristics that influence medical treatments and health outcomes. Assuming that malpractice laws affect malpractice pressure, but does not directly affect patient expenditures or outcomes, then the coefficients ϕ identify the average effects of changes in malpractice pressure resulting from malpractice reforms.

To distinguish short-term and long-term effects of legal reforms, we estimated less restrictive models of the average effects of legal reforms that utilize the long duration of our panel. These "dynamic" models estimate separate growth rate effects ϕ_{md} based on time-since-adoption:

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}d_{st}\phi_{md} + v_{ist} \qquad (2)$$

where we include separate short-term average effects ϕ_{m0} and long-term average effects ϕ_{m1}. We estimate the short-term effect of the law (within two years of adoption) ϕ_{m0} by setting $d_{st0}=1$ for 1985-87 adopters in 1987 and 1988-90 adopters in 1990, and we estimate the long-term effect (three to five years since adoption) ϕ_{m1} by setting $d_{st1}=1$ for 1985-87 adopters in 1990.

The estimated average effects ϕ_{md} in these models form the basis for tests of the effects of malpractice reforms on health care expenditures and outcomes, and thus for tests of the existence and magnitude of defensive medicine. In all of these models, there is strong evidence of defensive medicine if, for direct or indirect reforms m, $\phi_{md}<0$ in our models of medical expenditures and $\phi_{md}=0$ in our models of health outcomes. In other words, if a state law reform is associated with a reduction in the growth rate of intensive treatment use and does not adversely affect the growth rate of adverse health outcomes through its impact on treatment

decisions, then malpractice pressure is too high from the perspective of social welfare and defensive medicine exists. More generally, defensive medicine exists if the effect of malpractice reforms on expenditures is "large" relative to the effect on health outcomes. Thus, in the results that follow, we test both whether expenditure and outcome effects of reforms differ substantially from zero, as well as the ratio of expenditure to outcome effects.

The power of the test for defensive medicine depends on the statistical precision of the estimated effects of law reforms on outcomes; consequently, we evaluate the confidence intervals surrounding our estimates of outcome effects carefully.[3] It is not feasible to collect information on *all* health outcomes that may matter to some degree to individual patients. Instead, our tests focus on important health outcomes, including mortality and significant cardiac complications, which are reliably observed in our study population. Because the cardiac complications we consider reflect the two principal ways in which poorly-treated heart disease would affect quality of life (e.g., through further chest pain symptoms or through impaired cardiac function), estimates of effects on these health outcomes along with mortality would presumably capture any substantial health consequences of malpractice reforms.

We estimated additional specifications of our models to test whether reform adoption is not in fact correlated with unobserved trends in malpractice pressures or patient characteristics across the state-time groups. One set of specification tests was based on the inclusion of random effects for state-time interactions or the use of Huber-White standard error corrections to account for any important error correlations arising after accounting for state and time effects, i.e., within state-time cells.[4]

Another set of specification tests involved evaluating a range of variables W_{st}

summarizing the political and regulatory environment in each state at each point in time, to test whether various factors that might influence reform adoption influence our estimates of reform effects on either expenditure or health outcomes. Since the main cause of the tort reforms that are the focus of our study was nationwide crisis in all lines of commercial casualty insurance, it is unlikely that endogeneity of reforms is a serious problem [Priest 1987; Rabin 1988]. However, Campbell, Kessler, and Shepherd [1996] show that the concentration of physicians and lawyers in a state and measures of states' political environment are correlated with liability reforms, and Danzon [1982] shows that the concentration of lawyers in a state are correlated with both the compensation paid to malpractice claims and the enactment of reforms.[5] Consequently, we control for the political party of each state's governor, the majority political party of each house of each state's legislature, and lawyers per capita in all of the regressions.[6]

A third set of specification tests relied on other tort reforms enacted in the 1980s which would not be expected to have much impact on malpractice liability cases in the elderly during the time frame of our study. However, these reforms might be correlated with relevant malpractice reforms, for example if general concerns about liability pressures in all industries led to broad legal reforms. If such reforms were correlated with included reforms, then our estimates might overstate the impact of the malpractice law reforms that we analyze.

Although results from the malpractice-claim studies discussed above suggest that these omitted reforms are unimportant relative to reforms with a more direct effect on awards, we investigate the validity of our assumption of no omitted variable bias by estimating the impact of reforms to states' statutes of limitations. Statutes of limitations are most relevant in situations involving latent injuries; malpractice arising out of AMI in the elderly would involve an injury

the adverse consequences of which would appear before any statute of limitations would exclude an injured patient. Nonetheless, statutes of limitations are the potentially most important reform not included in our study (23 states shortened their statutes of limitations between 1985 and 1990, and Danzon [1986] found shorter statutes of limitations to reduce claims frequency). If our models are correctly specified, then statute of limitations reforms should have no effect on the treatment intensity and outcome decisions that we analyze; if omitted variable bias is a problem, however, statute of limitations reforms may show a significant estimated effect.

Finally, because all of our specifications control for fixed differences across states, they do not allow us to estimate differences in the baseline levels of intensive treatment and adverse health outcomes. Thus, we also estimate additional versions of all of our models with region effects only, to explore baseline differences in treatment rates, costs, and outcomes across legal regimes.

IV. Data

The data used in our analysis come from two principal sources.[7] Our information on the characteristics, expenditures, and outcomes for elderly Medicare beneficiaries with heart disease are derived from comprehensive longitudinal claims data for the vast majority of elderly Medicare beneficiaries who were admitted to a hospital with a new primary diagnosis (no admission with a either health problem in the preceding year) of either acute myocardial infarction (AMI) or ischemic heart disease (IHD) in 1984, 1987, and 1990. Data on patient demographic characteristics were obtained from the Health Care Financing Administration HISKEW enrollment files, with death dates based on death reports validated by the Social

Security Administration. Measures of total one-year hospital expenditures were obtained by adding up all reimbursement to acute-care hospitals (including copayments and deductibles not paid by Medicare) from insurance claims for all hospitalizations in the year following each patient's initial admission for AMI or IHD. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers) in the year following the patient's initial admission. Cardiac complications included rehospitalizations within one year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure. Treatment of IHD and AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of heart failure requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequences. The programming rules used in the data set creation process and sample exclusion criteria were virtually identical to those reported in McClellan and Newhouse [1995a , 1995b].

We analyze cardiac disease patients because the choice of a particular set of diagnoses permits detailed exploration of the health and treatment consequences of policy reforms. Cardiac disease and its complications are the leading cause of medical expenditures and mortality in the United States. A majority of AMIs and IHD hospitalizations occur in the elderly, and both mortality and subsequent cardiac complications are relatively common occurrences in this population. Thus, this condition provides both a relatively homogeneous set of patients and outcomes (to analyze the presence of defensive medicine with reasonable clinical detail), and medical expenditures are large enough and the relevant adverse outcomes common enough that the test for defensive medicine can be a precise one. Furthermore, because AMI is

essentially a more severe form of the same underlying illness as is IHD, we can assess whether reforms affect more or less severe cases of a health problem differently by comparing AMI to IHD patients.

In addition, cardiovascular illness is likely to be sensitive to defensive medical practices. In a ranking of illnesses by the frequency of and payments to the malpractice claims that they generate, AMI is the third-most prevalent and costly, behind only malignant breast cancer and brain-damaged infants [PIAA 1993]. AMI is also distinctive because of the severity of medical injury associated with malpractice claims: conditional on a claim, patients with AMI suffer injury that rates 8.2 on the National Association of Insurance Commissioners nine-point severity scale, the second-highest severity rating of any malpractice-claim-generating health problem [PIAA 1993]. Cardiovascular illnesses and associated procedures also include 7 of the 40 most prevalent and costly malpractice-claim-generating health problems [PIAA 1993].

We focus on elderly patients in part because no comparable longitudinal microdata exists for nonelderly U.S. patient populations. However, there are other advantages to concentrating on this population. Several studies have documented that claims rates are lower in the elderly than in the nonelderly population, presumably because losses from severe injuries would be smaller given the patients' shorter expected survival [Weiler et al. 1993]. This hypothesis suggests that physicians are least likely to practice defensively for elderly patients; thus, treatment decisions and expenditures in this population would be the least sensitive to legal reforms. Similarly, relatively low baseline incentives for defensive practices and the relatively high frequency of adverse outcomes in the elderly implies that this population can provide the most sensitive tests for adverse health effects of reforms. These considerations suggest that

analysis of elderly patients provides a lower bound on the costs of defensive medicine. In any event, trends in practice patterns over time have been similar for elderly and nonelderly patients (e.g., intensity of treatment have increased dramatically and survival rates have improved for both groups, National Center for Health Statistics [1994]); thus, we would expect the findings for this population to be qualitatively similar to results for the nonelderly, were such a longitudinal empirical analysis possible.

Table 1 describes the elderly population with AMI and IHD from the years of our study. Between 1984 and 1990, the elderly AMI population aged slightly and the share of males in the IHD population increased slightly, but the characteristics of AMI and IHD patients were otherwise relatively stable. The number of AMI patients in an annual cohort declined slightly (from 233,000 to 221,000) while the number of IHD patients increased (from 357,000 to 423,000). Changes in real hospital expenditures in the year following the AMI or IHD event were dramatic, for example, one-year average hospital expenditures for AMI patients rose from $10,880 in 1984 to $13,140 in 1990 (in constant 1991 dollars), a real growth rate of around 4 percent per year. These expenditure trends are primarily attributable to changes in intensity; because of Medicare's "prospective" hospital payment system, reimbursement given treatment choice for Medicare patients actually declined during this period. This growth in expenditures and treatment intensity was associated with significant mortality reductions, from 39.9 percent to 35.3 percent for AMI patients (with the bulk of the reduction coming after 1987) and from 13.5 percent to 10.8 percent for IHD patients (with the bulk coming before 1987). However, the AMI survival improvements -- but not the IHD improvements -- were associated with corresponding increases in recurrent AMIs and in heart failure complications. This underscores that the role of

changes in intensity versus other factors -- as well as any role of changes in liability -- in all of these trends is difficult to identify directly.

Second, building on prior efforts to collect information on state malpractice laws (e.g., Sloan, Mergenhagen, and Bovbjerg [1989]), we have compiled a comprehensive database on reforms to state liability laws and state malpractice-control policies that contain information on several types of legal reforms from 1969 to 1992.[8] The legal regime indicator variables are defined such that the level of liability imposed on defendants in the baseline is at a hypothetical maximum.[9]

Eight characteristics of state malpractice law, representing divergences from the baseline legal regime, are summarized in Table 2A. We divide these eight reforms into two groups of four reforms each: reforms that directly reduce malpractice awards and reforms that only reduce awards indirectly. "Direct" reforms include reforms that truncate the upper tail of the distribution of awards, such as caps on damages and the abolition of punitive damages, and reforms that shift down the mean of the distribution, such as collateral-source rule reform and abolition of mandatory prejudgment interest. "Indirect" reforms include other reforms that have been hypothesized to reduce malpractice pressure but only affect awards indirectly, for instance through restricting the range of contracts that can be enforced between plaintiffs and contingency-fee attorneys. As discussed in Section II above, we chose this division because the previous empirical literature generally found the impact of direct reforms to be larger than the impact of indirect reforms on physicians' incentives through their effect on the compensation paid and the frequency of malpractice claims. Each of the observations in the Medicare data set was matched with a set of two tort law variables that indicated the presence or absence of direct

or indirect malpractice reforms at the time of their initial hospitalization.

Table 2B contains the effective dates for the adoption of direc and indirect reforms for each of the 50 states. The table shows that a number of states have implemented legal reforms at different times. For example, 13 states never adopted any direct reforms, 23 states adopted direct reforms between 1985 and 1990, and 18 states adopted direct reforms 1984 or earlier (adoptions plus nonadoptions exceed 50 because some states adopted both before and after 1985). Similarly, 16 states never adopted any indirect reforms, 22 states adopted indirect reforms between 1985 and 1990, and 18 states adopted indirect reforms 1984 or earlier. Adoption of direct and indirect reforms is not strongly related; 16 states that never adopted reforms of one type have adopted reforms of the other.

V. Empirical Results

Table 3 previews our basic difference-in-difference (DD) analysis by reporting unadjusted conditional means for expenditures and mortality for four patient groups, based on the timing of malpractice reforms. Expenditure levels in 1984 (our base year) were slightly higher in states passing reforms between 1985-87 and lower in states passing reforms between 1988-90. Baseline mortality rates were slightly lower for AMI and higher for IHD in the 1985-87 reform states, and conversely for the 1988-90 reform states. Thus, overall, reform states looked very similar to nonreform states in terms of baseline expenditures and outcomes. States with earlier reforms (pre-1985) had slightly higher base year expenditures but similar base year mortality rates. The table shows that expenditure growth in reform states was smaller than in nonreform states during the study years; altogether, growth was two to six percent slower in the

reform compared to the nonreform states for AMI, and trend differences were slightly greater for IHD. Though mortality trends differed somewhat across the state groups, mortality trends on average were quite similar for reform and nonreform states. These simple comparisons do not account for any differences in trends in patient characteristics across the state groups, do not account for any effects of other correlated reforms, and do not readily permit analysis of dynamic malpractice reform effects. Nonetheless, they anticipate the principal estimation results that follow.

Table 4 presents estimates of a standard DD specification of the effects of tort reforms between 1985 and 1990 on average expenditures and outcomes for AMI; that is, no dynamic reform effects are included. In this and subsequent models, we include fully-interacted demographic effects -- for patient age (65-69, 70-74, 75-79, 80-89, 90-99), gender, black or nonblack race, and urban or rural residence -- and controls for contemporaneous political and regulatory changes described previously. For each of the four outcomes -- one-year hospital expenditures, mortality, and AMI and CHF readmissions -- two sets of models are reported. The first set includes complete state and year fixed effects. The second set, intended to illustrate the average differences of states that had adopted reforms before our study began as well as the sensitivity of the results to a more complete fixed-effect specification, includes only time and region effects. As described in Section II, both specifications are linear, the dependent variable in the expenditure models is logged, all coefficient estimates are multiplied by 100 and so can be interpreted as average effects in percent (for expenditure models) or percentage points (for outcomes models), and the standard errors are corrected for heteroskedasticity and grouping at the state/zip-code level.

The estimates of average expenditure growth rates in both specifications are substantial, showing an increase in real expenditures of over 21 percent between 1984 and 1990. The estimated DD effects show that expenditures declined by 5.3 percent relative to nonreform states in states that adopted direct reforms. The corresponding DD estimate of the effect of indirect reforms, 1.8 percent, is positive but small; these reforms do not appear to have a substantial effect on expenditures. In the region-effect models, the estimated DD reform effects are slightly larger but qualitatively similar. States that adopted reforms prior to our study period had 1984-1990 growth rates in expenditures that were slightly larger, by around 3 percent. The region-effect model shows that these states as a group also had slightly higher expenditure levels in 1984. Because these states generally adopted reforms at least five years before our panel began, our results suggest that direct reforms do not result in relatively slower expenditure growth more than five years after adoption. However, lack of a pre-adoption baseline for and adoption-time heterogeneity among the early-adopting states, as well as the sensitivity of the early-adopter/nonadopter differential growth rates to alternative specifications (as discussed below), makes interpreting estimates of differential early-adopter/nonadopter growth rates as a long-term effect problematic. And, in any event, in no case would the differential 1984-1990 expenditure growth rate between adopters and nonadopters offset the difference-in-difference "levels" effect; in total, malpractice reforms always result in a decline in cost growth of at least 10 percent.

The remaining columns of Table 4 describe the corresponding DD estimates of reform effects on AMI outcomes. Mortality rates declined but readmission rates with cardiac complications increased during this time period, confirming the results of Table 1. Outcome trends were very similar in reform and nonreform states; the cumulative difference in mortality

and cardiac-complication trends was around 0.1 percentage points. These small estimated mortality differences are not only insignificantly different from zero; they are estimated rather precisely as well. For example, the upper 95 percent confidence limit for the effect of direct reforms on one-year mortality trends between 1984 and 1990 is 0.65 percentage points. Coupled with the estimated expenditure effect, the expenditure/benefit ratio for a higher-pressure liability regime is over $500,000 per additional one-year AMI survivor in 1991 dollars; even a ratio based on the upper-bound mortality estimate translates into hospital expenditures of over $100,000 per additional AMI survivor to one year.[10] The estimates in the corresponding region-effect models are very similar. Indirect reforms were also associated with estimated mortality effects that were very close to zero. Results for outcomes related to quality of life -- that is, rehospitalizations with either recurrent AMI or heart failure -- also showed no consequential effects of reforms. In this case, the point estimates (upper bound of the 95 percent confidence interval) for the estimated effect of direct reforms were -0.18 (0.22) percentage points for AMI recurrence and -0.07 (0.29) percentage points for the occurrence of heart failure. Again, compared to the estimated expenditure effects, these differences are not substantial.

Table 5 presents estimated effects of malpractice reforms on IHD expenditures and outcomes, with results qualitatively similar to those just described for AMI. IHD expenditures also grew rapidly between 1984 and 1990. Direct reforms led to somewhat larger expenditure reductions for IHD (9.0 percent) and indirect reforms were again associated with relatively smaller increases in expenditures (3.4 percent). The effects of reforms on IHD outcomes are again very small: the effect of direct reforms on mortality rates was an average difference of -0.19 percentage points (95 percent upper confidence limit of 0.11), and the effects on

subsequent occurrence of AMI or heart failure hospitalizations were no larger.[11] Estimates from the models with region effects were very similar. Thus, direct liability reforms appear to have a relatively larger effect on IHD expenditures, without substantial consequences for health outcomes.

As we noted in Section III, the simple average effects of liability reforms estimated in the DD specifications of Tables 4 and 5 may not capture the dynamic effects of reforms. Table 6 presents results from model specifications that estimate reform effects less restrictively. In these specifications, we use our seven-year panel to estimate short-term and long-term effects of direct and indirect reforms on expenditures and outcomes, to determine whether the "shift" effect implied by the DD specification is adequate. The models retain our state and time fixed effects.[12]

We find the same general patterns as in the simple DD models, but somewhat larger effects of malpractice reforms three to five years after adoption compared to the short-term effects. In particular, Table 6 shows that direct reforms lead to short-term reductions in AMI expenditures of approximately 4.0 percent within two years of adoption, and that the reduction grows to approximately 5.8 percent three to five years after adoption. This specification also shows that the positive association between indirect reforms and expenditures noted in Table 4 is a short-term phenomenon; the long-term effect on expenditures is approximately zero.[13]

As in Table 4, both direct and indirect reforms have trivial effects on mortality and readmissions with complications, both soon and later after adoption. For example, the average difference in mortality trends between direct-reform and nonreform states is -0.22 percentage points (not significant) within two years of adoption, with a 95 percent upper confidence limit of 0.4 percentage points. At three to five years, the estimated effect is 0.12 percentage points (not

significant) with a 95 percent upper confidence limit of 0.76 percentage points. These point estimates translate into very high expenditures per reduction in adverse AMI outcomes.

The results for the corresponding model of IHD effects over time are presented in the right half of Table 6. Direct reforms are associated with a 7.1 percent reduction in expenditures by two years after adoption (standard error 0.5) and an 8.9 percent reduction by five years after (standard error 0.5).[14] In contrast, mortality trends for states with direct reforms do not differ significantly by two years (point estimate of -0.15 percentage points, 95 percent upper confidence limit 0.19) or five years after adoption (point estimate -0.11 percentage points, 95 percent upper confidence limit 0.23). Direct reforms also have no significant or substantial effects on cardiac complications, either immediately or later. Indirect reforms are again associated with small positive effects on expenditure growth (3.1 percent within two years), but these effects decline over time to a relatively trivial level (1.4 percent at three to five years). Indirect reforms are also associated with slightly lower mortality rates and slightly higher rates of cardiac complications, but the size of these effects are very small (e.g., the upper limit of the 95 percent confidence interval around the estimated effect of indirect reforms three to five years after adoption is 0.47 percentage points for AMI recurrence and 0.30 percentage points for heart failure occurrence). Thus, the pattern of reform effects for IHD is again qualitatively similar to that for AMI, with direct reforms having a somewhat larger effect on expenditures.

Taken together, the estimates in Tables 4 through 7 consistently show that the adoption of direct malpractice reforms between 1984 and 1990 led to substantial relative reductions in hospital expenditures during this period -- accumulating to a reduction of more than five percent for AMI and nine percent for IHD by five years after reform adoption -- and that these

expenditure effects were not associated with any consequential effects on mortality or on the rates of significant cardiac complications.

We estimated a variety of other models to explore the robustness of our principal results. We tested the sensitivity of our results to alternative assumptions about the excludability of state/time interactions. One set of tests reestimated the models with random state/time effects, to determine whether correlated outcomes at the level of state/time interactions might affect our conclusions. Our estimated effects of reforms did not differ substantially or significantly with these methods. Using the model presented in Tables 4 and 5, the estimated difference-in-difference effect of direct reform on expenditures for AMI patients, controlling for random state/time effects, is -4.9 percent (standard error 2.1); for indirect reform, the estimated effect is -0.6 percent (standard error 2.0). The estimated DD effect of direct reform on mortality for AMI patients, controlling for random state/time effects, is 0.15 percentage points (standard error 0.32); for indirect reform, the estimated effect is -0.19 percentage points (standard error 0.32). Similar results obtained for IHD patients: direct reform showed a negative and statistically significant effect on expenditures with an insubstantial and precisely estimated effect on mortality, and indirect reform showed no substantial effect on either expenditures or mortality. Estimated differential 1984-1990 expenditure growth rates between early-adopters and nonadopters were insignificant in the random effects specification. For AMI patients, the differential growth rate for early adopters of direct reforms is 0.61 percent (standard error 3.1); for early adopters of indirect reforms, the differential growth rate is 0.61 percent (standard error 2.3). For IHD patients, the differential growth rate for early adopters of direct reforms is -1.9 percent (standard error 3.0); for early adopters of indirect reforms, the differential growth rate is

-3.2 percent (standard error 2.2). Another related diagnostic involved estimating the models with Huber-White [1980] corrections for state/time grouped errors instead of corrections for zip-code/time grouped errors. Standard errors corrected for state/time grouping were greater than those corrected for zip-code/time grouping but less than those obtained under the random effects specification.

Although they did have a statistically significant influence on expenditures in some models, the broad set of political and regulatory environment controls that we used did not change our results substantially. Using the models presented in Tables 4 and 5 but excluding controls for the regulatory and legal environment, the estimated DD effect of direct reforms on expenditures for AMI patients is -9.1 percent (standard error 0.44); for indirect reforms, the estimated DD effect is 3.3 percent (standard error 0.40). In addition, the difference in 1984-1990 growth rates between early-reforming and nonreforming states changes sign from positive to negative for states enacting direct reforms before 1985 (3.1 percent with legal environment controls (Table 4), -3.1 percent without them); the difference in growth rates for states enacting indirect reforms before 1985 remains about the same (2.76 percent with legal environment controls (Table 4), 3.5 percent without them). These two specification checks, taken together, underscore the points made by Tables 4 and 5. Direct reforms reduce expenditure growth without increasing mortality; indirect reforms have no substantial effect on either expenditures or mortality; and differential 1984-1990 expenditure growth rates for early-adopting states are not robust estimates of the long-term impact of reforms.

Finally, we reestimated the models in Tables 4 and 5 including controls for statute-of-limitations reforms. Statute-of-limitation reforms have a very small positive effect on

expenditures and no effect on mortality, which is consistent with their classification as an indirect reform. Using the models presented in Tables 4 and 5, statute-of-limitations reforms are associated with a 0.96 percent increase in expenditures for AMI patients (standard error 0.46), and a 0.003 percentage point increase in mortality (standard error 0.28). Inclusion of statute-of-limitation reforms did not substantially alter the estimated DD effect of either direct or indirect reforms: for AMI patients, the estimated effect of direct reforms went from -5.3 percent (Table 4) to -5.5 percent, and the estimated effect of indirect reforms remained constant at 1.8 percent (Table 4).

To explore the sources of our estimated reform effects more completely, we estimated additional specifications that analyzed effects on use of intensive cardiac procedures such as cardiac catheterization, that used alternative specifications of time-since-adoption and calendar-year effects, and that estimated the effects of each type of tort reform separately (see Table 2A). These specifications produced results consistent with the simpler specifications reported here for both AMI and IHD. Specifically, reforms with a determinate, negative direct impact on liability led to substantially slower expenditure growth, somewhat less growth in the use of intensive procedures (but smaller effects than would explain the expenditure differences, suggesting less intensive treatments were also affected), and no consequential effects on mortality.

VI. Policy Implications

We have developed evidence on the existence and magnitude of "defensive" medical practices by studying the consequences of reforms limiting legal liability on health care expenditures and outcomes for heart disease in the elderly. These results provide a critical

extension to the existing empirical literature on the effects of malpractice reforms. Previous studies have found significant effects of direct reforms on the frequency of and payments to malpractice claims. Because the actual costs of malpractice litigation comprise a very small portion of total health care expenditures, however, these litigation effects have only a limited impact on health care expenditure growth. To provide a more complete assessment of malpractice reforms, we have studied their consequences for actual health care expenditures and health outcomes. Our study is the first to use exogenous variation in tort laws not related to potential idiosyncrasies of providers or small geographic areas to assess the behavioral effects of malpractice pressure. Thus, our analysis fills a crucial empirical gap in evaluating the U.S. malpractice liability system, because the effects of malpractice law on physician behavior are both a principal justification for current liability rules and potentially important for understanding medical expenditure growth.

Our analysis indicates that reforms that directly limit liability -- caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral-source rule reforms -- reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear. The effects appear to be somewhat smaller for actual heart attacks than for a relatively less severe form of heart disease (IHD), for which more patients may have "marginal" indications for treatment. In contrast, reforms that limit liability only indirectly -- caps on contingency fees, mandatory periodic payments, joint-and-several liability reform, and patient compensation funds -- are not associated with substantial effects on either expenditures or outcomes, at least by several years after adoption. Neither type of reforms led to any consequential differences in mortality or the

occurrence of serious complications. As we described previously, the estimated expenditure/benefit ratio associated with direct reforms is over $500,000 per additional one-year survivor, with comparable ratios for recurrent AMIs and heart failure. Even the 95-percent confidence bounds for outcome effects are generally under one percentage point, translating into over $100,000 per additional one-year survivor. While it is possible that malpractice reforms have had effects on other outcomes valued by patients, this possibility must be weighed against the absence of any substantial effects on mortality or the principal cardiac complications that are correlated with quality of life. Thus, the results indicate that liability rules that are more generous in terms of award limits are a very costly approach to improving health care outcomes.

Approximately 40 percent of patients with cardiac disease were affected by direct reforms between 1984 and 1990. Based on simulations using our effect estimates, we conclude that if reforms directly limiting malpractice liability had been applied throughout the United States during this period, expenditures on cardiac disease would have been around $450 million per year lower for each of the first two years after adoption and close to $600 million per year lower for each of years three through five after adoption, compared with nonadoption of direct reforms.

While our panel is relatively lengthy for a DD study, it is not long enough to allow us to reach equally certain conclusions about the long-term effects of malpractice reforms on medical expenditure growth and trends in health outcomes. Plausible *static* effects of virtually all policy factors cannot explain more than a fraction of expenditure growth in recent decades [Newhouse 1992], and we have also documented that outcome trends may be quite important. Whether policy changes such as malpractice reforms influence these long-term trends through effects on

the environment of technological change in health care is a critical issue. Do reforms have implications for trends in expenditures and outcomes long after they are adopted, or do the trend effects diminish over time? Preliminary evidence on this question from early-adopted (pre-1985, mostly pre-1980) reforms suggest that long-term expenditure growth is not slower in states that adopt direct reforms; on the other hand, subsequent growth does not appear to offset the expenditure reductions that occur in the years following adoption. Moreover, we found no evidence that direct reforms adopted from 1985-1990 had smaller effects in states that had also adopted direct reforms earlier, suggesting that dynamic malpractice policies may produce more favorable long-term expenditure/benefit trends. In any event, our conclusions about long-term effects are speculative at this point, given the absence of baseline data on expenditures and outcome trends in reform states. Follow up evaluations of longer-term effects of malpractice reforms should be possible within a few years, and might help confirm whether liability reforms have any truly lasting consequences for expenditure growth or trends in health outcomes.

Hospital expenditures on treating elderly heart disease patients are substantial -- over $8 billion per year in 1991 -- but they comprise only a fraction of total expenditures on health care. If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms could lead to expenditure reductions of well over $50 billion per year without serious adverse consequences for health outcomes. We hope to address the generalizability of our results more extensively in future research. More detailed studies using both malpractice claims information and patient expenditure and outcome information, linking the analysis of the two policy justifications for a malpractice liability system, should be particularly informative. Such studies could provide more direct evidence on

how liability rules translate into effects on particular kinds of physician decisions with implications for medical expenditures but not outcomes. Thus, they may provide more specific guidance on which specific liability reforms -- including "nontraditional" reforms such as no-fault insurance and mandatory administrative reviews -- will have the greatest impact on defensive practices without substantial consequences for health outcomes.

Our evidence on the effects of direct malpractice reforms suggests that doctors do practice defensive medicine. Given the limited relationship between malpractice claims and medical injuries documented in previous research, perhaps our findings that less malpractice liability does not have significant adverse consequences for patient outcomes but does affect expenditures are not surprising. To our knowledge, however, this is the first direct empirical quantification of the costs of defensive medicine.

VII. Conclusion

We have demonstrated that malpractice liability reforms that directly limit awards and hence benefits from filing lawsuits lead to substantial reductions in medical expenditure growth with no appreciable consequences for important health outcomes, including mortality and common complications of the diseases we studied. We conclude that fostering appropriate provider incentives for quality care is not a reasonable justification for the current malpractice liability system for elderly patients with cardiac disease. Thus, direct liability limitations appear to be an effective policy reform for improving the efficiency of the U.S. health care system.

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TABLE I: AVERAGE HEALTH CARE COSTS, OUTCOMES, AND DEMOGRAPHIC CHARACTERISTICS FOR AMI AND IHD POPULATION

	AMI Population		
	1984	1987	1990
1-Year Mortality	39.9	38.8	35.4
1-Year AMI Re-admit	10.9	11.4	14.6
1-Year Heart Failure Re-admit	9.6	10.1	11.0
1-Year Total Hospital Expenditures	$10,881	$11,996	$13,140
Mean Age (Standard Deviation)	75.6 (7.0)	75.9 (7.2)	76.1 (7.3)
Female	48.5	49.6	49.6
Black	5.1	5.4	5.5
Rural	29.4	30.3	30.3
Sample Size	232,768	227,360	220,550
	IHD Population		
	1984	1987	1990
1-Year Mortality	13.5	11.6	10.6
1-Year AMI Re-admit	5.5	4.7	4.3
1-Year Heart Failure Re-admit	7.8	6.9	7.7
1-Year Total Hospital Expenditures	$10,638	$11,187	$12,515
Mean Age (Standard Deviation)	74.6 (6.9)	74.3 (6.8)	74.3 (6.8)
Female	55.2	53.4	51.4
Black	5.7	5.7	5.8
Rural	30.6	30.4	29.7
Sample Size	356,717	372,871	381,222

Notes: Hospital Expenditures in 1991 Dollars. Outcome measures and demographic characteristics except age in percentage points.

TABLE IIA: LEGAL REFORMS USED IN ANALYSIS

Reform	Description of Reform	Predicted Impact on Liability
Caps on damage awards	Either noneconomic (pain and suffering) or total damages payable are capped at a statutorily-specified dollar amount	Direct
Abolition of punitive damages	Medical malpractice defendants are not liable for punitive damages under any circumstances	Direct
No mandatory prejudgment interest	Interest on either noneconomic or total damages accruing from either the date of the injury or the date of filing of the lawsuit is not mandatory	Direct
Collateral-source rule reform	Total damages payable in a malpractice tort are statutorily reduced by all or part of the dollar value of collateral source payments to the plaintiff	Direct
Caps on contingency fees	The proportion of an award that a plaintiff can contractually agree to pay a contingency-fee attorney is capped at a statutorily-specified level	Indirect
Mandatory periodic payments	Part or all of damages must be disbursed in the form of an annuity that pays out over time	Indirect
Joint-and-several liability reform	Joint and several liability is abolished for noneconomic or total damages, either for all claims or for claims in which defendants did not act in concert	Indirect
Patient compensation fund	Doctors receive government-administered excess malpractice liability insurance, generally financed through a tax on malpractice insurance premiums	Indirect

Table IIB: Chronology of Legal Reforms*

State	Year Effective Direct Reform	Indirect Reform	State	Year Effective Direct Reform	Indirect Reform
Alabama	1987	1987	Montana	1987	
Alaska	1976, 1986	1988	Nebraska	1960, 1976	1976
Arizona		1988	Nevada		
Arkansas			New Hampshire	1986	
California	1975	1975, 1986	New Jersey	1987	1972, 1976
Colorado	1986	1986, 1988	New Mexico	1976	1976, 1987
Connecticut	1985	1986	New York	1967, 1984	1970, 1985
Delaware		1976	North Carolina		
Florida	1976, 1986	1980, 1985	North Dakota	1987	1987
Georgia			Ohio	1975	1988
Hawaii	1986		Oklahoma		1953, 1978
Idaho	1987, 1990	1986, 1987	Oregon	1975, 1987	1975**, 1987
Illinois	1976, 1985	1985	Pennsylvania		1975
Indiana	1975	1975, 1985	Rhode Island	1976	
Iowa	1975		South Carolina		1976
Kansas	1986, 1988	1974, 1976	South Dakota	1976	1988
Kentucky			Tennessee	1975	1975
Louisiana	1975, ***	1975, 1984	Texas	1977	
Maine	1989	1985, 1988	Utah	1985, 1986	1985, 1986
Maryland	1986		Vermont		1970
Massachusetts	1986, ***	1986	Virginia	1974	
Michigan	1986	1981	Washington	***	1986
Minnesota	1986		West Virginia	1986	
Mississippi			Wisconsin	1986	1975, 1986
Missouri	1986	1986	Wyoming		1986, 1987

Notes: * - Except prejudgment interest. Montana imposed prejudgment interest in 1985. No other states repealed or imposed prejudgment interest 1985-1990. The following states imposed mandatory prejudgement interest effective before 1984: AK, CO, IA, LA, ME, MA, NH, NJ, NC, OK, RI, UT, WV.

** - Oregon repealed in 1987 those indirect reforms effective as of 1975.

*** - Common law effective before 1984 prohibits punitive damages.

Table III: Hospital Expenditures and Mortality Outcomes in States With and Without Direct Reforms, AMI and IHD Patients, 1984-1990

	1-Year Total Hospital Expenditures					1-Year Mortality				
	1984	1987	1990	1984-87 %Change	1984-90 %Change	1984	1987	1990	1984-87 Change	1984-90 Change
AMI										
States without Direct Reforms	$10,194	$11,810	$12,618	15.9%	23.8%	40.2%	39.1%	35.7%	-1.1%	-4.5%
States with Direct Reforms in Effect Before 1985	$10,513	$11,722	$13,022	11.5%	23.9%	40.1%	39.0%	35.4%	-1.1%	-4.7%
States Enacting Direct Reforms Effective Between 1985 and 1987	$11,304	$12,595	$13,186	11.4%	16.6%	39.5%	38.6%	35.3%	-0.9%	-4.2%
States Enacting Direct Reforms Effective Between 1988 and 1990	$8,960	$9,865	$10,925	10.1%	21.9%	41.9%	39.2%	35.7%	-2.7%	-6.2%
IHD										
States without Direct Reforms	$9,439	$10,859	$12,083	15.0%	28.0%	14.1%	12.0%	11.0%	-2.1%	-3.1%
States with Direct Reforms in Effect Before 1985	$10,331	$11,064	$12,505	7.1%	21.0%	13.5%	11.7%	10.7%	-1.8%	-2.8%
States Enacting Direct Reforms Effective Between 1985 and 1987	$10,527	$11,315	$12,300	7.5%	16.8%	13.8%	11.6%	10.5%	-2.2%	-3.3%
States Enacting Direct Reforms Effective Between 1988 and 1990	$9,241	$9,623	$11,421	4.1%	23.6%	14.1%	12.3%	11.5%	-1.8%	-2.6%

Note: Hospital Expenditures in 1991 Dollars.

Table IV: Effects of Tort Reforms on Expenditures and Outcomes of Acute Myocardial Infarction, Difference-in-Difference Specification

Variable	State- and Time-Fixed Effects				Region- and Time-Fixed Effects			
	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Difference-in-Difference Effects of Reforms								
Direct Reforms	-5.30	0.07	-0.18	-0.07	-6.71	0.05	-0.31	-0.14
	(0.47)	(0.29)	(0.20)	(0.18)	(0.46)	(0.28)	(0.19)	(0.18)
Indirect Reforms	1.81	-0.13	-0.04	-0.02	3.37	0.10	-0.09	0.14
	(0.46)	(0.28)	(0.19)	(0.18)	(0.43)	(0.26)	(0.18)	(0.16)
Baseline 1984-1990 Growth Rate								
	21.01	-5.46	5.02	0.99	22.64	-5.51	4.78	1.10
	(0.70)	(0.46)	(0.32)	(0.29)	(0.76)	(0.44)	(0.31)	(0.28)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	3.08	0.36	-1.60	0.43	1.24	0.17	-1.25	0.25
	(0.77)	(0.47)	(0.32)	(0.30)	(0.73)	(0.44)	(0.31)	(0.28)
Indirect Reforms	2.76	-0.57	0.52	-0.28	4.88	-0.45	0.56	-0.16
	(0.50)	(0.30)	(0.21)	(0.19)	(0.49)	(0.30)	(0.21)	(0.19)
Differential 1984 Level, States with pre-1985 Reforms								
Direct Reforms					4.97	-0.89	-0.08	0.21
					(0.57)	(0.34)	(0.23)	(0.21)
Indirect Reforms					1.75	-0.12	0.12	0.32
					(0.40)	(0.24)	(0.17)	(0.15)

Notes: Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping in parentheses. Hospital Expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

Table V: Effects of Tort Reforms on Expenditures and Outcomes of Ischemic Heart Disease, Difference-in-Difference Specification

Variable	State- and Time-Fixed Effects				Region- and Time-Fixed Effects			
	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Difference-in-Difference Effects of Reforms								
Direct Reforms	-9.02	-0.19	-0.20	-0.12	-10.02	0.05	-0.19	-0.03
	(0.45)	(0.15)	(0.10)	(0.12)	(0.44)	(0.15)	(0.10)	(0.12)
Indirect Reforms	3.42	-0.42	0.24	0.19	4.06	-0.61	0.23	0.10
	(0.44)	(0.15)	(0.10)	(0.12)	(0.40)	(0.14)	(0.09)	(0.11)
Baseline 1984-1990 Growth Rate								
	17.16	-2.78	-0.84	-0.92	18.56	-2.91	-0.98	-1.00
	(0.75)	(0.25)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	-1.41	0.33	-0.39	0.56	-3.06	0.42	-0.21	0.61
	(0.76)	(0.26)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Indirect Reforms	-1.04	-0.32	0.11	-0.29	0.87	-0.31	0.01	-0.22
	(0.47)	(0.16)	(0.11)	(0.13)	(0.46)	(0.16)	(0.11)	(0.13)
Differential 1984 Level, States with pre-1985 Reforms								
Direct Reforms					6.88	-0.66	-0.34	-0.61
					(0.57)	(0.19)	(0.13)	(0.15)
Indirect Reforms					2.71	-0.24	-0.19	-0.01
					(0.38)	(0.13)	(0.09)	(0.10)

Notes: Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping in parentheses. Hospital expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

Table VI: Effects of Tort Reforms on Expenditures and Outcomes
Time-Since-Adoption Specification

Variable	AMI, State- and Time-Fixed Effects				IHD, State- and Time-Fixed Effects			
	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Time-Since-Adoption Effects of Reforms								
Adopted 1985 to 1990, within the past 2 years or less								
Direct Reforms	-3.95	-0.22	-0.25	-0.29	-7.08	-0.15	-0.17	-0.23
	(0.52)	(0.31)	(0.22)	(0.20)	(0.49)	(0.17)	(0.11)	(0.13)
Indirect Reforms	1.71	0.10	-0 32	-0.01	3.09	-0.24	0.21	0.31
	(0.48)	(0.29)	(0.20)	(0.18)	(0.46)	(0.15)	(0.10)	(0.12)
Adopted 1985 to 1990, within the past 3 to 5 years								
Direct Reforms	-5.80	0.12	0.19	0.03	-8.88	-0.11	-0.16	0.08
	(0.53)	(0.32)	(0.22)	(0.21)	(0.50)	(0.17)	(0.11)	(0.14)
Indirect Reforms	-0.14	-0.23	0.06	-0.12	1.43	-0.70	0.21	-0.00
	(0.58)	(0.35)	(0 24)	(0.23)	(0.55)	(0.19)	(0.13)	(0.15)
Baseline 1984-1990 Growth Rate								
	21.54	-5.51	4 84	0.94	17.11	-2.91	-0.98	-1.00
	(0.72)	(0.47)	(0.33)	(0.30)	(0.77)	(0.27)	(0.20)	(0.20)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	3.54	0.39	-1.56	0.47	-0.53	0.37	-0.35	0.67
	(0.77)	(0.47)	(0.32)	(0.30)	(0.76)	(0.26)	(0.17)	(0.21)
Indirect Reforms	3.20	-0.52	0.49	-0.25	-0.42	-0.24	0.13	-0.22
	(0.51)	(0.31)	(0.21)	(0.20)	(0.48)	(0.16)	(0.11)	(0.13)

Notes: Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping in parentheses. Hospital expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

References

Barker, D.K., "The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis," Journal of Health Politics, Policy and Law XVII (1992): 143-161.

Baldwin, L.M., et al., "Defensive Medicine and Obstetrics," JAMA CCLXXIV (1995): 1606-1610.

Bell, P.A., "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability," Syracuse Law Review XXXV (1984): 939-993.

Campbell, T.J., D.P. Kessler, and G.B. Shepherd, "Liability Reforms' Causes and Economic Impacts," in The Mosaic of Economic Growth, Landau, R. et al. (ed.) (Stanford, CA: Stanford University Press, 1996).

Charles, S.C., C.E. Pyskoty, and A. Nelson, "Physicians on Trial - Self-Reported Reactions to Malpractice Trials," The Western Journal of Medicine CXLVIII (1988): 358-360.

Cooter, Robert D. and Ulen, Thomas S., "An Economic Case For Comparative Negligence," New York University Law Review LXI (1986): 1067-1110.

Craswell, Richard and Calfee, John, "Deterrence and Uncertain Legal Standards," Journal of Law, Economics, and Organization II (1986): 279-303.

Cutler, D.M. and McClellan, Mark, "What is Technological Change?" Harvard Mimeo (1995).

Danzon, P.M., "The Frequency and Severity of Medical Malpractice Claims," RAND R-2870-ICJ/HCFA (1982).

Danzon, P.M., Medical Malpractice: Theory, Evidence, and Public Policy (Cambridge, MA: Harvard University Press, 1985).

Danzon, P.M., "New Evidence on the Frequency and Severity of Medical Malpractice Claims," RAND R-3410-ICJ (1986).

Farber, H.S. and White, M.J., "Medical Malpractice: An Empirical Examination of the Litigation Process," RAND Journal of Economics XXII (Summer 1991): 199-217.

Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report of the Harvard Medical Practice Study to the state of New York (Cambridge, MA: The President and Fellows of Harvard College, 1990).

Keeton, W.P., et al., Prosser and Keeton on Torts, 5th. ed., (St. Paul, MN: West Publishing Co., 1984).

Leveno, K.J., et al., "A Prospective Comparison of Selective and Universal Electronic Fetal Monitoring in 34,995 Pregnancies," The New England Journal of Medicine CCCXV (1986): 614-619.

Localio, A.R., et al.,"Relationship Between Malpractice Claims and Cesarean Delivery," JAMA CCLXIX (1993): 366-373.

Masters, S.J., et al., "Skull X-Ray Examinations After Head Trauma: Recommendations by a Multidisciplinary Panel and Validation Study," New England Journal of Medicine CCCXVI (1987): 84-91.

McClellan, Mark, "Why Do Hospital Costs Keep Rising? Hospital Reimbursement, Hospital Production and the Puzzles of Medicare's Prospective Payment System", Harvard Mimeo (1994).

McClellan, Mark, "Uncertainty, Health Care Technologies, and Health Care Costs," American Economic Review LXXXV (1995): 38-44.

McClellan, Mark and Newhouse, Joseph P., "The Marginal Benefits of Medical Treatment Intensity: Acute Myocardial Infarction in the Elderly," NBER Working Paper (1995a).

McClellan, Mark, and Newhouse, Joseph P., "The Marginal Costs and Benefits of Medical Technology: Acute Myocardial Infarction," Journal of Econometrics, forthcoming (1995b).

Moser, J. and R. Musaccio, "The Cost of Medical Professional Liability in the 1980s," Medical Practice Management (Summer 1991): 3-9.

National Center for Health Statistics, Health United States, (Washington, DC: U.S. Government Printing Office, 1994).

Newhouse, J.P., "Medical Care Costs: How Much Welfare Loss?" Journal of Economic Perspectives VI (1992): 3-22.

Physician Insurers Association of America (PIAA), Data Sharing Reports (1993).

Priest, George L., "The Current Insurance Crisis and Modern Tort Law," Yale Law Journal XCVI (1987): 1521-1589.

Rabin, Robert L., "Some Reflections on the Process of Tort Reform, San Diego Law Review XXV (1988): 13-48.

Reynolds, R.A., J.A. Rizzo, M.L. Gonzales, "The Cost of Medical Professional Liability," JAMA CCLVII (1987): 2776-2781.

Rock, S.M., "Malpractice Premiums and Primary Cesarian Section Rates in New York and Illinois," Public Health Reporter CVIII (1988): 459-468.

Shy, K.K., et al., "Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants," The New England Journal of Medicine CCCXXII (1990): 588-593.

Sloan, F.A., "Experience Rating: Does It Make Sense for Medical Malpractice Insurance?" American Economic Review LXXX (1990): 128-133.

Sloan, F.A., P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," Journal of Health Politics, Policy and Law XIV (1989): 663-689.

U.S. Congress, Office of Technology Assessment, Impact of Legal Reforms on Medical Malpractice Costs, OTA-BP-H-119, (Washington, DC: U.S. Government Printing Office, 1993).

U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H-602, (Washington, DC: U.S. Government Printing Office, 1994).

Weiler, P.C., et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (Cambridge, MA: Harvard University Press, 1993).

White, H., "A Heteroskedasticity-Consistent Covariance Matrix Estimator and a Direct Test for Heteroskedasticity," Econometrica XLVII (1980): 817-838.

Zuckerman, S., R.R. Bovbjerg, and F. Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry XXVII (1990): 167-182.

Endnotes

1. Reforms requiring collateral-source offset revoke the common-law default rule which states that the defendant must bear the full cost of the injury suffered by the plaintiff, even if the plaintiff were compensated for all or part of the cost by an independent or "collateral" source. Under the common-law default rule, defendants liable for medical malpractice always bear the cost of treating a patient for medical injuries resulting from the malpractice, even if the treatment were financed by the patient's own health insurance. Either the plaintiff enjoys double recovery (the plaintiff recovers from the defendant and his own health insurance for medical expenses attributable to the injury) or the defendant reimburses the plaintiff's (subrogee) health insurer, depending on the plaintiff's insurance contract and state or federal law. However, some states have enacted reforms that specify that total damages payable in a malpractice tort are to be reduced by all or part of the value of collateral source payments.

2. Estimates of the impact of reforms on claim severity vary over time and across studies. Based on 1975-1978 data, Danzon [1982: 30] reports that states enacting caps on damages had 19 percent lower awards, and states enacting mandatory collateral source offsets had 50 percent lower awards. Based on 1975-1984 data, Danzon [1986: 26] reports that states enacting caps had 23 percent lower awards, and states enacting collateral source offsets had 11 to 18 percent lower awards. Based on 1975-1978 and 1984 data, Sloan, Mergenhagen, and Bovbjerg [1989] find that caps reduced awards by 38 to 39 percent, and collateral source offsets reduced awards by 21 percent.

3. Again, because all elderly patients with serious heart disease during the years of our study are included, this consideration applies only to extending the results to other patient populations.

4. Of course, if such state-time specific effects exist, there is no reason to expect that they would be normally distributed; normality assumptions in error structures generally have not perfo. ned

well in models of health expenditures and outcomes. However, incorporating such random effects permits us to explore the robustness of our estimation methods to possible state-time specific shifts.

5. According to Danzon [1982, 1986], urbanization is a highly significant determinant both of claim payments to and the frequency of claims and of the enactment of tort reforms; we control for urbanization at the individual level as discussed below.

6. Although we did not include controls for the number of physicians per capita in the reported results because of concerns regarding the exogeneity of that variable, results conditional on physician density are virtually identical. We include both a current- and a one-year-lagged effect to account for the possibility that past political environments influence current law.

7. Data on lawyers per capita for 1980, 1985, and 1988 are from The Lawyer Statistical Report (Chicago, IL: The American Bar Foundation, 1985, 1991). Intervening years are calculated by linear interpolation. Data on state political environments are courtesy of Gary King.

8. Our data set is partially derived from Campbell, Kessler, and Shepherd [1996].

9. The baseline is defined as the "negligence rule" without any of the liability-reducing reforms studied here and with mandatory prejudgment interest.

10. That is, (.053*$13,140)/.0065≈$107,000 using the 95% upper bound of the estimated mortality effect and (.053*$13,140)/.0007≈ $1,000,000 using the actual DD estimate. Both of these ratios are very large; the difference in absolute magnitude of the two estimates results from the denominator being very close to zero.

11. Because we were concerned that reforms might affect the rate of IHD hospitalization as well as outcomes among patients hospitalized, we estimated models analogous to the specifications reported using population hospitalization rates with IHD as the dependent variable. We found no significant or substantial effects of either direct or indirect reforms on IHD hospitalization

rates.

12. Models with region effects only, analogous to the right half of Tables 4 and 5, again showed very similar effect estimates.

13. We also estimate separate time-trend effects for early-reform (pre-1984) states. This approach may permit the development of some evidence on "long-term" effects of reforms on intensity growth rates; as noted previously, we find no evidence for such effects. Of course, our lack of a pre-adoption baseline for the early-adopting states precludes DD identification and makes the long-term conclusion more speculative. A follow up study using more recent expenditure and outcome data would provide more convincing evidence on effects beyond five years.

14. In contrast to AMI, the slower rate of expenditure growth between 1984 and 1990 for early-reform states (see Table 5) suggests that reforms may have longer-term effects on slowing IHD expenditure growth.

Exhibit C

3678
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NO. 86-CI-10557

GILBERTO and ROSARIO ALVAREZ, Individually and as Next Friend of AURORA ALVAREZ, a Minor	•	IN THE DISTRICT COURT
VS.	•	45TH JUDICIAL DISTRICT
ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC	•	BEXAR COUNTY, TEXAS

AGREED FINAL JUDGMENT

On this day came on to be heard the above-styled and numbered cause, wherein GILBERTO AND ROSARIO ALVAREZ, INDIVIDUALLY AND AS NEXT FRIENDS FOR AURORA ALVAREZ, A MINOR, are Plaintiffs; and ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER AND RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC are Defendants.

It appearing to the Court that AURORA ALVAREZ is a minor, suing by and through her next friends, GILBERTO and ROSARIO ALVAREZ, both of whom also have individual claims, and the Court being of the opinion that there might be a conflict of interest between said Minor and her next friends, the Court has heretofore appointed Gene Toscano as Guardian Ad Litem for said Minor Plaintiff.

All Parties appeared by and through their respective attorneys of record and appearance was also made by the Guardian Ad Litem and all present announced to the Court that they had agreed to compromise and settle all matters in dispute and at issue between them, subject to the approval of the Court. It was further announced that the Guardian Ad Litem had made his investigation and had determined that the agreement of the Parties was fair and just and in the best interests of his ward, AURORA ALVAREZ, and that in the opinion of the Guardian Ad Litem said agreement should be ratified and approved by the Court. The Parties' written Compromise Settlement Agreement has been filed with the Court and examined by the Court. The Court further examined the pleadings and heard the evidence presented by the Parties regarding the occurrence made the subject of Plaintiffs' suit, the resulting injuries and damages alleged, the manner in which those injuries were alleged to have been received, and the nature,

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extent and effect of same. After considering all of the facts and circumstances and studying the Compromise Settlement Agreement executed by the Parties, their respective attorneys of record and the Guardian Ad Litem, and with the recommendation of the Guardian Ad Litem, the Court is of the opinion and finds that the Compromise Settlement Agreement is, under all of the facts and circumstances, fair and reasonable, that it is in the best interest of the minor child, AURORA ALVAREZ, and that such Agreement should be ratified and approved by the Court.

The Court further finds, after hearing all of the evidence, that the settlement consideration, both the present payments and future payments as herein set forth, are to be paid as full and final settlement of all claims of Plaintiff, GILBERTO and ROSARIO ALVAREZ, individually, and as Next Friend for AURORA ALVAREZ, a minor.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED by the Court that the Compromise Settlement Agreement filed with the Court is ratified and approved in all respects. IT IS FURTHER ORDERED by the Court that Plaintiffs GILBERTO and ROSARIO ALVAREZ, individually and as next friends for AURORA ALVAREZ, a minor, do have and recover of and from ROBERTO H. GONZALEZ, M.D., DR. ROBERTO H. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, the sum of TWO HUNDRED THOUSAND DOLLARS ($200,000.00), out of which sum all attorney's fees and expenses of Plaintiffs herein, including those of the minor Plaintiff, are to be paid.

IT IS FURTHER ORDERED by the Court that Defendants shall make future payments to the minor Plaintiff AURORA ALVAREZ, by and through her legal guardian, in the amount of EIGHT HUNDRED FORTY AND 08/100THS DOLLARS ($840.08) per month. Said monthly payments shall commence on Apr. 26,1987 with all future monthly payments continuing thereafter payable on the first day of each and every month throughout the lifetime of the minor Plaintiff, AURORA ALVAREZ, or for twenty (20) years (240 monthly payments), whichever is longer. Beginning on April 26,1988, the monthly payments will be increased at the rate of 3% per annum, compounded annually and increased every year thereafter on the anniversary date of April 26 during the total time that such payments shall be made. In the event the minor Plaintiff, AURORA ALVAREZ, dies prior to March 26, 2007, then all future monthly

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payments, through and including March 26,2007, shall be made jointly to her parents, GILBERTO ALVAREZ and ROSARIO ALVAREZ. Unless otherwise provided, all future payments made in accordance with the terms of this judgment shall be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ, for the use and benefit of AURORA ALVAREZ.

IT IS FURTHER ORDERED that TEXAS MEDICAL LIABILITY TRUST, the insurer of Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, as a matter of right, and in its sole discretion, may elect to assign the duties and obligations to make the future payments herein ordered to be made by Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC; and that such assignment, if made, shall be accepted and binding upon Plaintiffs GILBERTO and ROSARIO ALVAREZ, individually, and as Next Friends of AURORA ALVAREZ, a minor, without right of rejection, in full discharge and release of the duties and obligations of ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST to make such future payments.

IT IS FURTHER ORDERED that if TEXAS MEDICAL LIABILITY TRUST elects to assign Defendants' and its duties and obligations to make the aforesaid future payments to METROPOLITAN PROPERTY AND LIABILITY COMPANY, Plaintiffs and the Guardian Ad Litem be, and they are hereby authorized, empowered and ordered to execute a "Release and Satisfaction of Judgment" as to ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER, RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and TEXAS MEDICAL LIABILITY TRUST. METROPOLITAN PROPERTY AND LIABILITY COMPANY shall thereafter be solely responsible for the duties and obligations to make such future payments.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that when ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICAL SURGICAL FAMILY CLINIC or their insurer have paid the aforesaid sums presently due unto the Plaintiffs and TEXAS MEDICAL LIABILITY TRUST has made the assignment of Defendants' and its duties and obligations to make the future payments as provided for herein,

that this Judgment shall be deemed fully satisfied, and Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST, and any agent, servant, employee or principal thereof, shall stand fully, finally and forever acquitted and discharged of and from any and all claims, demands or causes of action asserted in this cause, or which could, may or might have been asserted by GILBERTO and ROSARIO ALVAREZ, Individually, and as Next Friend for AURORA ALVAREZ, a Minor, by reason of the medical treatment, care and injuries complained of in Plaintiffs' Original Petition on file herein; and Plaintiffs and the Guardian Ad Litem are ordered to then promptly execute and deliver to said Defendants the aforesaid Release and Satisfaction of Judgment.

It appearing to the Court that the recovery of the Plaintiffs should be apportioned between the minor Plaintiff, AURORA ALVAREZ, Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and their attorneys, Tinsman & Houser, Inc., and after having heard the recommendations of the Guardian Ad Litem for the minor Plaintiff;

IT IS ORDERED, ADJUDGED AND DECREED that the recovery to the Plaintiffs in the sum of TWO HUNDRED THOUSAND DOLLARS ($200,000.00) in cash, and the future payments be apportioned as follows:

(1) The Plaintiff, GILBERTO ALVAREZ, have and recover from the Defendants the sum of $ 10,000.00 in cash;

(2) The Plaintiff, ROSARIO ALVAREZ, have and recover from the Defendants the sum of $ 10,000.00 in cash;

(3) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants the sum of $ 19,153.93 in cash; said sum to be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ;

(4) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants future monthly payments as provided for herein; those being $840.08 per month, increasing at 3% per annum, the first payment to be Apr. 26,1987 and continuing for the life of AURORA ALVAREZ or twenty (20) years, whichever is longer;

(5) The attorneys for the Plaintiffs, Tinsman & Houser, Inc.,

have and recover the sum of $ 100,846.07 in cash as attorneys' fees for representing the Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and the minor Plaintiff AURORA ALVAREZ, in this action, said sum to include reimbursement of all expenses incurred and to be incurred on the Plaintiffs' behalf in this suit.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Court that all costs of Court herein shall be paid by the Defendants, ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, including a fee of $5000.00, which shall be paid to the Guardian Ad Litem, Gene Toscano, for his services as such, and which said fee is hereby taxed as part of the Court costs in this suit and should be paid by said Defendants.

SIGNED this 18TH day of March, 1987.

JUDGE PRESIDING

APPROVED:

State Bar I.D. No. 20145000

GUARDIAN AD LITEM FOR AURORA ALVAREZ, A MINOR

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ATTORNEYS FOR DEFENDANTS AND TEXAS MEDICAL LIABILITY TRUST

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Mr. HIEPLER. Mr. Chairman, members of the committee, I speak first and foremost as a brother of Nelene Fox. My name is Mark Hiepler, and I became involved in this whole area of the legal practice through my sister's case. The cases that I have represented, three since then, and have gotten national attention, are not anecdotal, but are in essence part of what is going on in the system where 56 million members, voters, are now a part of an HMO system. As you look into tort reform or tort regulation, you must first understand how managed care works.

The jury in my sister's case found that the health maintenance organization operated with fraud, oppression and malice in the denial of care and the coercion of the doctors operating under that system. Since then, we have been in numerous major HMO's throughout the Nation and been able to shine some bright lights on the practices of corporate medicine.

I am a Republican. I belong to no trial lawyer associations or groups, other than the Ventura County Bar Association, and I represent more doctors than I have ever sued.

I have two rather simple and straightforward points, that in a managed care environment where most HMO's pay a doctor incentives not to treat, not to see and not to refer patients, you must look at the perception of defensive medicine practices. The perception and the big argument used by people, often incorrectly, is that litigation causes people to practice medicine in a defensive manner.

That argument is tenuous at best, given all the factors and all the reports that are in all the documents that you have seen and been submitted to you. It becomes weak and nonexistent in an HMO environment where we have had 60 million patients involved in care; where doctors are, I know, incentivized not to treat, not to care and not to refer by their HMO's. That point has completely gone out the door if you look at malpractice reform in the context of HMO's, and that is the growing wave of the future.

Secondly, arbitrary limits on a per economic basis, the myth is that that is fair, that is reasonable, that is just, that we can predict what the outcome will be. But as you have just heard from Ms. Ross, as you have heard from many others throughout the day and you will hear, that is not fair because the person who is a 61-year-old retired person, the person who is a spouse and stays at home, is unfairly relegated to $250,000 in damages, while the CEO of an HMO who makes $15 million a year gets a better benefit. If we want to choose to honor those with higher incomes when they are victims of medical malpractice in a better way than we choose those other members of society who deserve equal honor, such as mothers, wives, senior citizens, that is wrong.

Predictable outcomes is not something that you want in a system that is to deter negligent and arbitrary behavior by physicians, and especially HMO's. In the context of HMO's, you must remember that physicians are caught also. They are caught in a system that rewards them for not treating, for not caring.

If we have a Federal law that limits the recovery for noneconomic damage, we are only helping to bait HMO's into the corporate practice of medicine, because they can figure out, through a business formula, why it is better not to give mammograms, why it is better not to do colon prescreening tests, because the most that

is at risk is $250,000. They can take risks with lives. They can gamble with lives and they can call it efficient because a message will never be sent to them.

In my sister's case, since that case, we have had 127 requests by patients to get treatments that have been denied. We have only had to file three lawsuits. That is the best form of tort reform I could ever imagine, and people have gotten care on time.

If we had those same limits that are imposed on medical malpractice in other areas of the practice, you would be flooded with lawsuits. Or, as Ms. Ross testified very articulately, you are not allowed to even find an attorney, and if you are allowed to find an attorney, the senior citizens and the people who don't have the highest earning capacity are disproportionately affected.

Finally, I think that the Government must channel its efforts towards adopting a series of meaningful remedies, if anything. I think this is best served by the States. But if the Federal Government does get involved, we cannot go after deceptive quick fixes in an attempt to placate one side of the debate occupied by health care providers and HMO's, at the expense of completely ignoring the innocent victims and consumers. New Federal limits on medical malpractice actions will only serve to insulate a minority of incompetent and negligent health providers and further support the HMO's industry of practice of medicine from a corporate level, all the while yielding very little financial savings to the American health care system.

We request that in the name of Nelene Fox, my sister, Joyce Jenkins, who you have materials on and who received national publicity, Christy Demure, all of whom received national attention only because of their tragic deaths, that you not fall prey to the misguided arguments that were presented in California; that consumers of medical care in America, who are each and every one of us, will benefit from true health care reform, reform that does not unfairly restrict our rights or remove our protection from injury. To the degree we allow artificial limits on the most important damages, those that are noneconomic, that which causes a child to lose his mom, to miss his parents, the feeling of the loss of love, care and society, we have done a great injustice.

If we allow the corporate practice of medicine to destroy the doctor-patient relationship, we will be allowing the corporate practice of medicine to predict the averages and gamble with the care and treatment and remedies and judgment that physicians should honor. Reform should not be a euphemism for regulation. Arbitrary caps further foster the corporate practice of medicine and reduce the doctor-patient relationship.

Thank you for this. I would be happy at any time, informally, formally or anywhere, to meet with any Members of Congress to explain how these HMO's work, so that you can better address tort reform should you choose to proceed that way.

Mr. HYDE. Thank you very much, Mr. Hiepler.

Mr. HYDE. Lastly, Mr. Philip Corboy, a Chicago attorney. I must state for the record, I have known Mr. Corboy for 65 years. We went to grammar school together, high school together, law school together. We have our political and professional differences, but I

admire Mr. Corboy as a person and as a trial lawyer immensely. So it is a pleasure to have him here today.

Those are the last kind words I will say to you, Phil.

STATEMENT OF PHILIP H. CORBOY, IMMEDIATE PAST CHAIR, SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. CORBOY. Thank you, Mr. Chairman, and gentlemen. Thank you very much for that truncated introduction.

All we have heard so far is a defense of organized money. Now, there is nothing wrong with medical associations, doctors and hospitals and doctors' associations and insurance companies organizing to protect their money, whether it be overall costs, whether it be overhead or whether it be premiums, and I am talking about insurance premiums. But in the gargantuan job ahead for this committee, which will be reporting to the full Congress and eventually, I suppose, to the committee that will eventually decide this on a bipartisan basis, let me just point out a few things.

First of all, let me inform Mr. Hiepler that he is not alone in being antagonistic to the California system of caps, even though I live in Illinois. Mr. Hiepler has pointed out that he is a Republican. I don't think that attitude is restricted to Republicans. I think it is restricted to people who have analyzed the problem and have analyzed just exactly what is going on here.

I have a lot of hats, but so that you folks are completely aware of my background, although Chairman Hyde is—I happen to be a former chairman of the Democratic Party of the State of Illinois. I happen to be a practicing lawyer in Illinois. I got my license the same year Chairman Hyde did. I also am a plaintiff's personal injury lawyer. I do nothing but work on a contingent fee. I speak, however, today as a representative and as a former chairman of the Special Committee on Medical Malpractice of the American Bar Association. However, I want you to know my bent, and that is why I supplied to you the type of work I do.

I am not a member of the Federal Government's enterprise in any way, and I am certainly not in any way connected with the Office of Technology Assessment, which in 1993 came out with the following findings:

Malpractice premiums increased substantially over the past 20 years but have stabilized since the 1980's. In 1991, the total cost of medical malpractice premiums in the United States was $4.86 billion. These premiums account for only .66 percent of total health care spending in the United States, but they exclude malpractice costs of self-insured hospitals. OTA estimates that the insurance costs of self-insured hospitals are roughly 20 to 30 percent of total insurance premiums.

Based on this estimate, the direct cost of the malpractice system in the United States of America is still less than 1 percent of total national health care expenditures. That means for every $100 that you gentleman are paying for your medical care, $1 is going to be assessed and supplied to the medical malpractice litigation system. If you were to supply that in a circle, as I show you, the red mark shows how much of your dollar—less than 1 percent—is attributed to the medical malpractice system.

So why is there need for a change? There is only a need for a change if we look again at the symptoms that are supplied and the problems that are supplied by organized money.

I respectfully suggest that there may be obstetricians who leave the practice of law—excuse me, the practice of medicine. I would guess that last year there were 2,500 or 2,400 alone that went out of business in the State of Illinois. There were 3,500 that probably came back into the business.

The fact that somebody leaves obstetrical care may mean a lot of things. It may mean he is incompetent or she is incompetent. I do not say that he or she is, but it may be. It may be that he or she is tired. It may be that the abilities to control family size supply a lack of need for obstetricians in an area.

But whatever it is, the young people of America are not running away from obstetrics. In 1985 there was a total of 30,867 obstetricians in the United States of America. In 1989, 4 years later, there were 33,697 obstetricians in America. In 1995, last year, the last available statistics, a figure that was 30,000 in 1985 has risen to almost 37,000 in 1995. There is no lack of ability to acquire obstetrical care in the United States of America today. There are 37,000 of them.

It has been suggested that a $24,000 premium in Colorado—and, by the way, I forgot to mention something else. I have a son that practices medicine. He lives in Colorado, the same place where obstetricians' premiums have been reduced to $24,000. They are fortunate out there. If we took not only the inability to acquire more than $250,000 in noneconomic loss compensation, we could perhaps reduce that even further.

But I have never heard any suggestion by any representatives defending organized money which has in any way suggested that if there is a cap of $250,000 or $500,000, that that cap somehow is going to change the care of a doctor. Is he going to be either less or more careful merely because there is a cap? I dare say I have more confidence in American doctors than that.

Doctors are not going to change their practice because you put a cap on damages. By the way, we enjoy the best medical care in the world in this country. We don't have to interfere with it and be concerned about premiums for doctors. We don't have to be concerned about obstetricians going out of practice.

I also respectfully suggest—and this is a house organ I am about to read from. It is called Medical Economics. It is dated February 27, 1995. Medical Economics is a house organ of the medical profession. There is nothing wrong with house organs. I belong to the American Bar, the Chicago Bar, the Illinois State Bar. They all put out statistics.

In 1995, they had an overhead breakdown by specialty in the United States of America. We can all talk about what money means in terms of a $24,000 premium in Colorado, but what does the gross overhead of the doctor who has to pay that premium mean? In the United States of America, OB specialists pay, on the median, $34,020 a year. That is more than Colorado. However, that $34,000 premium per year is 7.5 percent of gross income.

So if you figure it out, that is not a lot of money. It is about one automobile. And that premium, by the way, is subject to the in-

come tax laws of the country, which means 60 percent of that is what the doctor pays. Forty percent of it is paid by our Government.

Now, let's talk for just a moment about the problem of—I have it written here somewhere—frivolous lawsuits. This gentleman from Illinois, two people over from me, talked about the frivolous lawsuits and he gave us anecdotes. Of course those are problems, but we live in a free country. I don't know how a $500,000 cap is going to have anything to do with frivolous lawsuits. I don't know what a million dollar cap would do. Certainly the $250,000 cap in Colorado has nothing to do with frivolous lawsuits. All a cap does, no matter what the size of it, is limit the noneconomic damages to an individual.

Now, I represent a lot of children. I represent a lot of wives, wives or husbands, house persons who are not employed and don't intend to be employed. If they are submitted to a malpractice enterprise of any kind, and they are restricted to a cap, you can obviously see the discriminatory aspect of it. A person who gets a million dollars, the argument is always made, well, they can always be compensated for their actual out-of-pocket expenses. They can't. They can't, because they have to pay to get it. Whether the lawyer charges 15 percent or 30 percent, the lawyer still has to be paid in order to acquire those economic damages.

Mr. HYDE. Do you know a lawyer that charges 15 percent?

Mr. CORBOY. Fifteen?

Mr. HYDE. Fifteen, I thought you said.

Mr. CORBOY. Oh, no, I didn't say 50. In Illinois we are restricted to 20 percent over a million dollars.

Mr. HYDE. Really?

Mr. CORBOY. Yes, sir. In California, it is 15 percent. You would be surprised the statistics that are out there protecting the consumers.

In any event, consumers are not going to be affected in any way other than a detrimental way if there is a cap on noneconomic damages. There are a lot of problems that we are all aware of in litigation, but one of the things that we should not be concerned with is depriving people who are damaged, whether they are quadriplegics, whether they are killed, whether they are paraplegics, whether they have lost an arm, by suggesting that an arbitrary, capricious amount of dollars will somehow or another aid the consumer. The only thing that will do is reduce—admit it. It is easy. If you take away benefits, you can decrease premiums. It is real easy. The doctors who suggest that they are entitled to a reduction in premiums only mean that their patients are entitled to a reduction in compensation.

Thank you, gentlemen.

Mr. HYDE. I thank the gentleman very much for his contribution.

[The prepared statement of Mr. Corboy follows:]

PREPARED STATEMENT OF PHILIP H. CORBOY, IMMEDIATE PAST CHAIR, SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of health care reform. I am Philip H. Corboy, Immediate Past Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1992, and again in February 1994, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges, a State Supreme Court Justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers

In February 1987, the ABA House of Delegates considered the Commission's recommendatic ıs and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some discrete exceptions, is inappropriate.

The ABA believes that federal pre-emption of the state medical professional liability laws would constitute an unwise and unnecessary intrusion of major proportions on the long-standing authority of the states to promulgate tort law. Such pre-emption would cause the whole body of state tort law to become unsettled and create new complexities for the federal system. Unequal results would occur when medical professional liability litigation is combined with other fields of law with differing rules of law. An example of this would be a situation where a medical malpractice claim is joined with an automobile liability claim. If state tort laws differ from the federal law in areas such as caps on damages, the collateral source rule or joint and several liability, conflicts and uncertainty would likely result; and one defendant in an action could well be treated entirely differently than another. Having one set of rules to try medical professional liability cases and another set of rules to try other tort cases is not consistent with the sound and equitable administration of justice.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recover fully from injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs

make up only a small fraction of the dollars spent on health care in the United States the changes in the tort laws would have no real impact on costs of health care

In addressing access to health care proposals that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

WHAT IS THE COST OF THE MEDICAL LEGAL SYSTEM?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

- Reliance on modern, sophisticated and expensive treatment.
- Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- An aging population, which adds to Medicare and Medicaid expenditures;
- High administrative costs of the health care system; and
- The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant. The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice

insurance premiums, account for 0.74 percent of the national health expenditures.[1] I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[2]

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.[3] That

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[1] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

[2] Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

[3] The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care"

uncertainty has resulted in the inability to statistically measure the cost [4] In some published studies, "defensive medicine" has included erroneously the cost of t e consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest [5] Some have considered the cost of new technology and advancements in medical knowledge, care

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Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

[4] The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates" Physician Payment Review Commission 1991 Annual Report to Congress

[5] Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s Defensive Medicine vs. Offensive Profits", Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services See Mitchell, Jean M . Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI scans Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians". The New England Journal of Medicine, Vol 327, No.21, Nov 19 1992, pages 1502-1506.

and treatment. In that regard, patients expect the use of very modern sophisticated and expensive technology to refine diagnosis and eliminate uncertainties

Therefore, to examine the impact of the medical-legal system the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to specifically measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable [6] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[7] Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

The Office of Technology Assessment released a report in 1994 that attempted

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[6] Patricia M. Danzon, "Liability for Medical Malpractice", Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69 Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice

The Physicians Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine

*Physicians and hospitals often benefit financially by delivering more care

*Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford

*So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care

[7] Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

to determine the cost of "defensive medicine". Under OTA's definition, a "medical practice is defensive even if it is done for other reasons (such as belief in a procedure's effectiveness, desire to reduce medical uncertainty, or financial incentives), provided that the primary motive is to avoid malpractice risk". The study found that "it is impossible to measure the overall level and national cost of defensive medicine" It found that "many physicians say they would order aggressive diagnostic procedures in cases where conservative management is considered medically acceptable by professional expert panels" and that "most physicians who practice in this manner would do so primarily because they believe such procedures are medically indicated not primarily because of concerns about liability". It found that "only a few clinical situations represent clear cases of wasteful or low-benefit defensive medicine" [8]

HAVE TORT PROPOSALS, WHEN ENACTED, LOWERED OVERALL HEALTH CARE COSTS?

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states

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[8] U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice (July 1994) pages 1-2.

with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs. This study found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[9] Regarding caps on damages, the Coalition's study concluded as follows:

> Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages.
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> Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A 1992 study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal

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[9] Andrea Dubin, False Claims: The Relationship between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, page 2.

cost savings impact on the overall health care delivery system in Texas [10]

The cost of medical malpractice insurance, for the most part reflects the cost of the medical-legal system. In contrast to the increase in health care costs medical malpractice costs have been relatively stable in recent years [11] The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures we have found From 1985 to 1990 the overall rate declined at an average annual rate of 8.9 per cent [12]

A July 1994 study by the Office of Technology Assessment found that "traditional tort reforms -- particularly caps on damages and amendments to the 'collateral source' rule -- reduce malpractice insurance premiums, but their effects on defensive medicine are largely unknown and are likely to be small To the extent that these reforms do reduce defensive medicine, they do so without differentiating between defensive practices that are medically appropriate and those that are wasteful or very costly in relation to their benefits" [13]

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence Typically, the insurer

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[10] "Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992

[11] 1989 Profitability Study (By Line By State) 1990 Profitability Study (By Line By State), 1991, Profitability Study (By Line By State), 1992 Profitability Study, (By Line By State), 1993 Profitability Study (By Line By State), National Association of Insurance Commissioners, 1990, 1991, 1992,1993 and 1994.

[12] Martin L. Gonzalez, "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice, 1992, page 23

[13] Defensive Medicine and Medical Malpractice, see footnote 8

will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public -- injured persons -- of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are injured by of medical malpractice.

ABA RECOMMENDATIONS RELEVANT TO CAPS ON PAIN AND SUFFERING AWARDS.

The ABA believes there should be no ceilings on pain and suffering awards, but instead, trial and appellate courts should more effectively control pain and suffering awards which are either so excessive or so inadequate as to be

disproportionate to the injury suffered or to community expectations

I call to your attention two recent publications that provide evidence that it is the norm for juries in medical malpractice cases to award damages in amounts that are fair and reasonable. The first book entitled "Medical Malpractice and the American Jury" was published in 1995 by Duke law professor and psychologist Neil Vidmar. The second book entitled "Civil Juries and the Politics of Reform" was published in 1995 by Dr. Stephen Daniels, Senior Research Fellow at the American Bar Foundation, and Joanne Martin, Assistant Director of the American Bar Foundation.

ABA RECOMMENDATIONS ON THE COLLATERAL SOURCE RULE.

The ABA recommends that the collateral source rule be retained and that third parties who have furnished monetary benefits to plaintiffs be permitted to seek reimbursement out of the recovery.

ABA RECOMMENDATIONS ON ALTERNATIVE DISPUTE RESOLUTION IN MEDICAL MALPRACTICE ACTIONS?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; however, during the past 16 years, the

ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation s dispute resolution agenda The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the ABA Blueprint for Improving the Civil Justice System. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after filing suit, as welcome components of the justice system. (Adopted August 1989.)

2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)

3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)

4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators - an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

5 The ABA opposes the enactment of any legislation mandating that Federal Courts adopt rules that permit local District Courts to order mandatory but non-binding arbitration as a condition precedent to a trial before a judge or jury. (Adopted August 1994)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation Voluntary alternative dispute resol tion for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path

ABA RECOMMENDATIONS ON PUNITIVE DAMAGES

The ABA has adopted recommendations on punitive damages in tort cases that we believe can and should be implemented by the courts and legislatures at the state and not the federal level. This is in keeping with the ABA's views that the tradition of state fashioned tort principles remain fundamentally sound. States have acted during the past decade to address concerns with punitive damages. They should be permitted to continue to handle this area of the law. The ABA believes that no justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct. We believe that no disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

The ABA believes that punitive damages are appropriate in certain tort cases, but their scope should be limited. They should not be commonplace. A threshold requirement for the submission of a punitive damages case to a finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. The standard of proof should be "clear and convincing" evidence and not a lesser standard such as a "preponderance of the evidence".

The ABA believes that the litigation process for awarding punitive damages

could be improved on the state level as follows:

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages.

The ABA is concerned that no defendant should be subjected to punitive damages that are excessive in the aggregate for the same wrongful act. There should therefore be safeguards to prevent the imposition of redundant awards of punitive damages. The purpose of punitive damages is to punish, not to confiscate. The ABA recognizes that the principal responsibility to control excessive awards for punitive damages rests on the courts; however, state legislation may be necessary to assure more effective judicial review of punitive damage awards.

The ABA believes that in certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions.

Since the ABA adopted its policy relevant to punitive damages in tort cases in February, 1987, the vast majority of states has taken steps to reduce the frequency and size of punitive damages awards. In 1993, the Institute for Court Management of the National Center for State Courts devoted an issue of "The Justice System Journal"

to tort issues in state courts. An article by Thomas Koenig and Michael Rustad at page 21, Volume 16, number 2 of the "Journal" entitled "The Quiet Revolution Revisited: An Empirical Study of the Impact of State Tort Reform of Punitive Damages in Products Liability" empirically documents the significant changes that have taken place in the area of punitive damages between 1987 and 1992 at the state level. Since the article was published, additional action has taken place in the states.

Thank you for giving us this opportunity to submit our views to you

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APPENDIX A.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 11, 1986

Be It Resolved, That

(1) The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

(2) Consistent with these goals, the American Bar Association adopts the following principles:

a. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

b. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

c. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

d. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

e. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

f. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

g. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

h. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

i. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

j. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

k. The use of structured settlements should be encouraged.

l. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 133)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the scope of damages to be awarded for pain and suffering in a particular case.

C Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to ensure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested progress for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a persons who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to assure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

II. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993. Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
1 Massachusetts	$1,508	$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18	Wisconsin	1,219	2,449	101
19	Nebraska	1,216	2,452	102
20	Colorado	1,209	2,415	100
21	Alaska	1,187	2,367	99
22	Iowa	1,176	2,351	100
23	Washington	1,165	2,311	98
24	Oregon	1,165	2,312	98
25	South Dakota	1,154	2,322	101
26	Delaware	1,153	2,268	97
27	Tennessee	1,144	2,262	98
28	New Jersey	1,115	2,224	99
29	Arizona	1,112	2,211	99
30	Texas	1,110	2,192	97
31	Louisiana	1,106	2,185	98
32	Indiana	1,101	2,201	100
33	Maine	1,091	2,175	99
34	Oklahoma	1,086	2,139	97
35	West Virginia	1,057	2,088	98

RANKING/STATE*	HCFA data*	LEWIN/ICF Estimates*	% of INCREASE**
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
AUGUST 1988

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution by Federal administrative agencies consistent with the following

A. General

1 Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, minitrials and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudications, in rulemaking, in issuing or revoking permits, and in settling disputes including litigation brought by or against the government.

2 Congress and the courts should not inhibit agencies' uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3 Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.

4 Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:

(a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.

(b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

(c) Arbitrators need not be permanent government employees, but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.

(d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency's order or the agency does not have any right of review.

(e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.

(f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.

(g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.

5 Factors bearing on agency use of arbitration are:

(a) Arbitration is likely to be appropriate where —

(1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial-type hearing.

(2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.

(3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.

(4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

(1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.

(2) Maintaining established norms or policies is of special importance.

(3) The case significantly affects persons who are not parties to the proceeding.

(4) A full public record of the proceeding is important.

(5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6 Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.

7. Mandatory arbitration is likely to be appropriate only where the matters to be resolved —

(a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;

(b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;

(c) Involve disputes between private parties; and

(d) Do not involve the establishment or implementation of major new policies or precedents.

8. Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4. (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act, but with the courts' bearing in mind the purposes to be gained by arbitration.

Mr. HYDE. We are ready for the questioning, and the Chair is pleased to yield to Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman. I welcome the witnesses.

I had constituents here that had to leave. The chairman of Detroit Primary Care Network, Father D.M. Lutas, was here, accompanied by Ruby McCaskell and Louise Stanton. So if all of you will bear witness that I mentioned their names afterward, I might get a vote out of them in November.

What an interesting panel. I am so happy to see you all sitting next to each other; Ms. Ross, surrounded by one lawyer who brags about caps, and the other part of the AMA crowd busily defending himself.

You know, Ms. Ross, there is nothing about being a Republican that requires you to leave your brains outside the room before you come in. A lot of people I know used to be Republicans, and they started figuring out where in a democratic society their own self-interest lies. It is a terrible price for you to have to suffer through this medical crap, at the expense of your mother's life, to begin to look at other things a little bit differently.

Ms. ROSS. I just want to say that I don't see this as a partisan issue at all. This is an issue about people and about how it directly affects them, I have received support and help from both sides of the political spectrum.

Mr. CONYERS. Well, that is great, because you asked about who were the people here in this room that were putting these caps and restrictions on. I guess you are going to have to go to lesson 2 to find out who it is, if you think you are getting support from both sides. I will refer you to the October 15 issue of not the Democratic Digest but the New York Times, which explains to you why we are here today. The Speaker of the House—you know who he is——

Ms. ROSS. Yes, indeed.

Mr. CONYERS [continuing]. Brought the American Medical Association behind his bill by handing out three concessions. This is real life. This isn't partisan politics. This is what they are preying on around here.

Ms. ROSS. Congressman, I signed a letter that was drafted along and signed along with other victims to Mr. Gingrich to instruct him that we, as Republicans and victims, in no way supported the concessions that he made and that we were more than righteously upset about it.

Mr. CONYERS. Well, I am glad you are disturbed.

Let me remind you of what those concessions were:

Soften proposed cuts in fees that doctors can charge for patients to stay in fee-for-service coverage, they agreed to that to support his bill. Second, agreed to ease antitrust laws for the purpose of permitting doctors and hospitals to create their own health plans. That is the bill in front of you right now. Three, to cap malpractice awards at ridiculously low levels, and that is right here in front of you.

Now you want to find out who is going to support you and how you are going to be outraged.

Well, Mr. Entin, I believe the weight of the studies show that capping noneconomic damages saves money, but what does that

prove? We could cap damages, economic and noneconomic, to lower health care costs, but where is the justice in that, when we are finding out that only 1 percent of all malpractice costs arise out of the whole system of health care?

Mr. Hanss misleads this committee. AMA statistics reveal that Ob-Gyn claims have dropped while insurance premiums have increased. Why isn't he seeking insurance reforms instead of trying to impair victims' rights?

And our lawyer that sits on the board, also, Mr. Dikeou by identification, does little more than present one-sided data which will help their members save money and avoid liability for malicious negligence. I hope he would spend as much time and energy helping the Congress repeal the McCarran-Ferguson antitrust exemption so that we could bring more competition to the insurance industry in this country. If anybody would like to respond to me at this hearing or after this hearing, I will be around when this session ends.

I thank you, Mr. Chairman.

Mr. HYDE. Mr. Dikeou.

Mr. DIKEOU. Mr. Chairman, may I accept that invitation and respond?

Mr. HYDE. Surely.

Mr. CONYERS. Oh, I am happy to hear about it.

Mr. DIKEOU. Well, I suspect——

Mr. CONYERS. Anybody else?

Ms. ROSS. Yes, I would very much like to respond.

Mr. CONYERS. OK. You are welcome. Mr. Corboy, you are always welcome.

Mr. GEKAS. Mr. Chairman, I would like to respond, as well.

Mr. HYDE. Your turn will come.

Mr. GEKAS. My problem is, I have to be on the floor.

Mr. HYDE. We are working up to you.

Mr. CONYERS. I don't want to meet with him. He is a Member of Congress.

Mr. GEKAS. Mr. Chairman, I have to go to the floor because of a 12:30 opening in which I am involved. I, too, want to answer the gentleman from Michigan.

Mr. HYDE. If you want to make a statement now, if Mr. Dikeou doesn't mind waiting, go ahead, Mr. Gekas.

Mr. GEKAS. Yes. What I wanted to outline as to what I have gleaned from the testimony, mostly from the written and the sporadic oral testimony that I have heard, is that the crisis is still with us.

Notwithstanding the gentleman from Michigan and his criticisms, he has offered nothing, nor have his colleagues offered anything, to try to solve this crisis that we have: obstetricians leaving their offices for good and not any access to women who are about to give birth for their medical needs; and the astronomical costs that have to be paid by physicians, physician groups and hospitals, for malpractice coverage, that impinges against the service to the very poor and to the others whom we want to serve.

That is what I think is the overall message that has been brought by this panel, and I think we ought to expand on how we

are to deal with the crisis, not to criticize the present advocates of change.

I will refer myself to the floor.

Ms. ROSS. Congressman, I would just like to make a comment that calling something a crisis doesn't indeed make it so.

Mr. GEKAS. Well, we can debate that.

Mr. HYDE. I would like to recapture the management of this hearing.

Mr. Dikeou.

Mr. DIKEOU. Yes. Mr. Chairman, Representative Conyers, you know, I think there is hyperbole on both sides of this issue, and I think that perhaps people don't benefit from a lot of that, but I think some facts should be presented.

Mr. CONYERS. I would love to hear them.

Mr. DIKEOU. First of all, with regard to Mr. Hiepler's testimony about his sister, his sister's case involves an HMO that denied a bone marrow transplant. It has nothing to do with any of the issues before this committee with regard to tort reform. A $250,000 cap didn't change that case. Nothing under MICRA changed that case. It had to do with denial of treatment by an HMO. So while the example is dramatic and you share his pain, it has nothing to do with the issues before this committee.

Mr. CONYERS. Do you share his pain?

Mr. HIEPLER. I disagree.

Mr. DIKEOU. I am sorry?

Mr. CONYERS. Do you share his pain?

Mr. DIKEOU. I think that any human being shares the pain of any human being.

Mr. CONYERS. Yes, but you are a human being.

Mr. DIKEOU. I hope you don't attribute to me some sort of the heartless——

Mr. CONYERS. No, you indicated I shared his pain. I am just asking you, do you share his pain?

Mr. DIKEOU. Of course.

Mr. CONYERS. You do? OK.

Mr. DIKEOU. But I think it is important that it has nothing to do with this legislation. I think Ms. Clarke's situation, she made reference to an arbitration provision in a Kaiser contract. Kaiser is also in Colorado, with a mandatory arbitration provision. That is an HMO issue. That is not a tort reform issue, and I think it is important to clarify that.

The $250,000 cap, as I am sure you know, addresses only the issue of noneconomic damage. We are talking pain and suffering. We are talking emotional distress. It in no way inhibits recovery for incurred medical costs, future medical costs, or any of the things like that.

In Colorado, whether you would share this view or not, our legislature felt that a $250,000 cap represented an appropriate societal balance between the needs of recovery for the injured and the needs of our system to keep physicians practicing.

Mr. CONYERS. Well, that is an important consideration. You know, it could have been a $150,000 cap. I mean, somebody is going to say, why $250,000?

Mr. DIKEOU. $250,000 is a quarter of a million dollars. It is not an insignificant amount of money.

Mr. CONYERS. Ah, that is an important fact. I didn't know that.

Mr. HYDE. Ms. Ross, do you have anything further to add to the gentleman's question, if it was a question?

Ms. ROSS. Yes, I do. To my sister and I who proceeded with the wrongful death case, the problem that the cap posed for us, since we were not financially dependent on my mother, was that it wasn't sufficient to prompt any change or alteration in the way the HMO deals with its patients. It wasn't enough to make sure that this wasn't going to happen to someone else.

As far as I am concerned, the idea that a senior citizen or a child or a woman who stays home with her children can be relegated to a known dollar amount on an HMO or a medical provider's balance sheet indicates to me that they don't have the same kind of protection as somebody else that earns a high wage. I think it is extremely discriminatory.

Mr. HYDE. Thank you very much.

Mr. Entin.

Mr. ENTIN. I would like to make a couple of points. First, with regard to the costs to the system, the 1 percent figure that Mr. Corboy mentioned refers to premiums for medical malpractice insurance. I pointed out in our testimony, and it is in the written testimony, that there are studies that have attempted to estimate the cost to the system of defensive medicine, which far exceeds the cost to the system to purchase insurance premiums.

Secondly, I think we need to sort out what we are trying to accomplish here with a medical liability system, and what it can do and what it cannot do. There has been a lot of talk here about deterrent effect of medical malpractice and the ability to reduce the amount of error that occurs in the system.

I think that the conclusion anyone can draw from looking at the results is that this system does not deter medical malpractice. It does not do that very effectively or at all. Where the system has fallen down is at the medical licensing area, and the inability or the unwillingness of States to take more effective measures to address the problems of those physicians or those practitioners who should not be practicing medicine. But to turn that over to the medical liability system, to the tort system, has been proven to be a failure.

Mr. CONYERS. So you support the deal that was worked out between the Speaker and the American Medical Association?

Mr. ENTIN. We support medical malpractice reforms, yes.

Mr. HYDE. The gentleman from Rhode Island, Mr. Reed.

Mr. REED. If the real crux of the problem is medical licensure and making sure that physicians perform at the very highest standards that they want to perform and that we demand as consumers, and that is exclusively a State function, what sense does it make to have a Federal law that alters the tort system? So the situation could arise that through Federal law someone is subject to these caps if there is no real improvement in medical licensure at the State level and they will, in fact, be subject to the real problem in the medical system, which is poorly trained, poorly licensed physicians, with improper supervision.

Mr. ENTIN. My response to that would be that we still have a problem with the medical liability system that unfairly and inadequately distributes compensation and addresses problems. To the extent that we have a system where providers are not properly policed, there ought to be resources and attention devoted to that problem. But that does not alter the fact that the medical liability system, in and of itself, doesn't need to be addressed.

Mr. REED. Well, I will accept for the moment your premise that we have to work on the liability system, the tort system. But the point is that if we have exclusively relegated to the States—and I think this is with very few if any exceptions, and there is no one here that would argue that we should do that—the licensure and the standards of conduct and the supervision and all those things, there is absolutely no assurance if we were to pass Federal tort reform that we would change that in any way, shape or form.

You could even create a situation in which some jurisdictions with very lax standards would have a situation where victims would be even further prejudiced. They would be suffering with poor physicians at the time that the Federal law would say that you can't collect more than *x* number of dollars.

I see a disconnect between what should be done by the States and what we should do at the Federal level. But thank you.

One other point, I think Mr. Hiepler was trying to respond or wanted to respond when the notion was brought up that these limits on pain and suffering have no effect on the conduct of HMO's in terms of denying treatment or anything else. Mr. Hiepler, maybe you would want to comment.

Mr. HIEPLER. I would appreciate that. Mr. Dikeou said that *Fox* v. *Healthnet,* which was the largest verdict in the Nation's history for the denial of care, has no bearing on what you are doing here today. I would not have traveled from California at my own expense to tell you about HMO's if it didn't.

First, there are two points. First of all, you have to understand that HMO's are dominating the practice of medicine. Doctors are being controlled by them. If you are going to regulate malpractice reform, you have to understand the incentives, the referrals, the denials, the benefits that people get by not treating. That is an impact that *Fox* v. *Healthnet* has had on the system.

Secondly, there is a deterrent effect when a punitive damage message is sent, and I gave you this illustration. Just the people that have called my office, 127, only 3 lawsuits, because the companies have done the right thing as a result of my sister's tragedy.

If you translate that, you do have to make one logical jump into the area of malpractice, which I also do. You have to make the logical assertion that people can factor in, in the corporate practice of medicine, a $250,000 number when they decide, "We are not going to pay for this. We are not going to pay for this. We are going to overcome medical judgment, and we are going to make MBA decisions not MD decisions."

That is what is happening with 60 million people who are in HMO's. That is how *Fox* v. *Healthnet* is very applicable to your debate, in that you must understand the way an HMO works as you look at medical malpractice reform, and the State laws on punitive damages have protective measures. We only read about large ver-

dicts, but there are appeal processes. Judges can do remittiturs and so forth. So the State system is well equipped to take care of someone if they determine it is an excessive verdict, so therefore it is very applicable.

Mr. HYDE. Mr. Scott.

Mr. REED. Excuse me, Mr. Chairman.

Mr. HYDE. Well, all right.

Mr. REED. I think Mr. Corboy wanted to make a remark.

Do you want to follow up?

Mr. CORBOY. Yes, sir. Thank you.

I would like to just bring up a term which I have heard for the first time this morning, or this afternoon, and that is defensive medicine. I am going to make a statement which sounds pejorative. It is not meant to be. But if defensive medicine is that type of practice which a doctor engages in because he is afraid if he doesn't do something extra special, it is malpractice, if a doctor tells me, "You don't need this but I'm going to give it to you because you might sue me," I am going to go to another doctor who has a lot more confidence in his ability.

Mr. HYDE. You might not have a choice if you are in an emergency room.

Mr. CORBOY. No, but if I am in an emergency room in most hospitals, Mr. Chairman, you get pretty good care in America. America is a very, very good place to get sick.

Mr. HYDE. You know, very honestly, and I don't want to get polarized by political positions, I am not enamored of caps. You lose a leg, they can't give you enough money. You would rather have your leg back, please.

But on the other hand, there are abusive litigators. They file them by the ton for the nuisance value, and doctors are scared to death of lawsuits. I know plenty of them.

I saw a man hit by a car at the intersection of Irving Park and Pulaski, and I saw a doctor's office and I ran up to get the doctor.

"No, sir. I'm not going down there to help that man."

He was afraid of being sued. He might move him the wrong way. He was wrong, deadly wrong, deathly wrong, but that is out there and we up here have to help solve that.

Mr. CORBOY. But, Mr. Chairman——

Mr. HYDE. We have to get rid of the bad suits and the shakedown suits and yet give adequate compensation to somebody when that is all that is left to care for some illness.

Mr. CORBOY. Is that doctor at Crawford and Irving Park, up there in that drugstore, office above the drugstore, is he going to say, "Well, there is a cap at $500, therefore I will go down and treat the patient." Is he going to do that?

Mr. HYDE. I don't know what motivated him, but running out and helping the man in the intersection——

Mr. CORBOY. What I am respectfully suggesting is that putting a cap is not going to supply him with the incentive to go down and treat somebody.

Mr. HYDE. No, but it might provide an insurance company with some element in calculating its premiums, which can be confiscatory.

Mr. CORBOY. But in California, Massachusetts, the two States which have had caps for a long time, the costs of medical care have gone up just like they have in every other State. California is the highest State in health care costs where medicine is practiced, with the expense that has gone up 101 percent in 10 years.

Mr. HYDE. My own view, which is under development, I can assure you—I am not locked in anywhere—is a recognition of the utility, possible utility of caps, but the desperate need for carveouts so injustices can't occur.

Mr. CONYERS. Mr. Chairman——

Mr. HYDE. I don't know if that is oil and water.

Mr. CONYERS. You are making good progress, Mr. Chairman. I want to commend you.

Mr. HYDE. No thanks to you.

Mr. CONYERS. You have come a long way.

Mr. HYDE. No thanks to you.

Mr. CONYERS. You have come a long way, and I am so proud of you today.

Mr. HYDE. No thanks to you. I am very concerned that you putting Mr. Scott and Mr. Watt together, that only can bode difficulties in the future for me.

Mr. Scott.

Mr. REED. Thank you, Mr. Chairman.

Mr. HYDE. Are you through, Mr. Reed? I didn't mean to cut you short.

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. I will try to do the best I can to add to your difficulties.

On the last example that was given, I don't know about the other States, but in Virginia a doctor running into an emergency is essentially immunized for anything but gross negligence anyway, and I assume most of the other States have the Good Samaritan type protection. So if he is hiding behind, in that situation, hiding behind a liability, he is just trying to make up an excuse and he wouldn't have gone out there with a cap.

Mr. Corboy mentioned defensive medicine and suggested that doing something that is not medically indicated is malpractice. I view it as fraud. I mean, if you are providing services to somebody that are obviously not needed and charging them for it, you have stolen their money. Isn't that right? Mr. Entin.

Mr. ENTIN. It may be.

Mr. SCOTT. And that if they would not have done what was medically indicated but for the fear of a lawsuit, then the system is working well. Isn't that right?

Mr. ENTIN. Mr. Scott, what I am trying to do, though, is just to describe, not to defend but to describe, what happens to be a consequence of the system that we have and the behavior that it creates.

Mr. SCOTT. Part of the behavior is that HMO's have a medical incentive not to provide care, and will provide care because of a threat of a lawsuit. Doesn't that mean the system is working?

Mr. ENTIN. Most of the patients, however, still are not under managed care plans. When you put the incentives differently in a managed care plan, then you have a different dynamic in place, but

the system we all grew up under, which was a fee-for-service system, there are no controls or effective controls on the ability of physicians to order services and tests.

Mr. SCOTT. I did not hear you agree but I did not hear you disagree that the system, the liability system, if someone would not provide what is medically indicated but only provide it because of the threat of lawsuit, then that means that the system is working.

Let me ask a question of the obstetricians. We mentioned all obstetricians going out of business. Mr. Corboy mentioned some. How many have gone out of business because they got sick and tired of getting up in the middle of the night, having no control over their life, and figured out they could just practice Gyn from 9 to 5?

Dr. HANSS. The statistics ACOG has collected indicate that 12½ percent in the State of Arizona, have quit obstetrics mainly with the intent to avoid either the costs or the risks of litigation. In other words, there are lots of——

Mr. SCOTT. What is the average income of an Ob-Gyn?

Dr. HANSS. Probably around $120,000 a year.

Mr. SCOTT. What is the average income of somebody just doing Gyn?

Dr. HANSS. Probably very similar.

Mr. SCOTT. About the same?

Dr. HANSS. Yes.

Mr. SCOTT. Without having to get up at night?

Dr. HANSS. That is probably correct.

Mr. SCOTT. Being able to go to dinner and being able to sit through the whole dinner without getting beeped?

Dr. HANSS. Not necessarily.

Mr. SCOTT. How do you pronounce your name?

Mr. DIKEOU. Dikeou, like in Dairy Queen.

Mr. SCOTT. Your graph showed that the premiums went down after the law was passed?

Mr. DIKEOU. Yes, sir.

Mr. SCOTT. That is the premiums. Do you have a similar graph showing what you actually paid out in damages?

Mr. DIKEOU. I can furnish you that, yes. I don't have that with me.

Mr. SCOTT. Can you describe to us what it is going to show?

Mr. DIKEOU. I think that in the last 2 years we have shown a slight increase in both frequency of lawsuit and severity of lawsuit, but still significantly controlled.

I am not sure I can answer your question.

Mr. SCOTT. Well, in Virginia we had insurance reform that did more to reduce the premiums than any malpractice reform could have ever hoped to have done.

Mr. DIKEOU. Yes.

Mr. SCOTT. And the suggestion that your premiums went down at the same time the malpractice reforms went in may be a coincidence, or it may be that you are reacting to the insurance commissioner, not the legal reforms.

Before my time ends up, you had an apportioned liability. I guess that is a limitation of joint and several?

Mr. DIKEOU. That is correct.

Mr. SCOTT. You say your doctors' premiums went down. Did the nurses get caught up in suits? Sometimes nurses make a mistake, too. Are you going to apportion some liability to her or him?

Mr. DIKEOU. Yes, to nurses, to hospitals.

Mr. SCOTT. Did their premiums go up commensurate?

Mr. DIKEOU. Slightly.

Mr. SCOTT. Did you incur additional legal expenses because now four people have to get a lawyer rather than one?

Mr. DIKEOU. Sometimes. It depends on the conflict nature of the defense.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. HYDE. Thank you, Mr. Scott.

Mr. CLARKE. Mr. Chairman, may I comment on Mr. Scott's question.

Mr. HYDE. Mr. Clarke, briefly.

Mr. CLARKE. Just two things, Mr. Scott. One is in regards to the definition of defensive medicine, I think it is clear to us that it is a response to the threat of suits, not necessarily meritorious suits, and, therefore, it is a waste of resources talking about the earlier definition.

Secondly, we are trying to recruit obstetrical coverage into two rural communities with extreme difficulty. Any suggestion there are adequate services available is not our experience. Family practitioners very often provide obstetrical services but they won't do it in rural areas, in part because they are afraid of the malpractice situation generally. They won't do it anywhere, and they could add to the availability of obstetrical services. But I can assure you whatever is going on with obstetrician numbers, physician numbers and obstetrics, they aren't available in the areas that 500,000 citizens live in in the United States.

Mr. CONYERS. That has nothing to do with caps. They don't want to practice in the Upper Peninsula of Michigan, period. So don't give us that kind of phony baloney.

Mr. DIKEOU. Mr. Chairman, could I add one thing?

Mr. HYDE. Mr. Dikeou.

Mr. DIKEOU. I am sorry.

Mr. HYDE. That is all right. You waited all morning to testify, and we are going to hear you out.

Mr. DIKEOU. Representative Scott, I think the issue around doing obstetrics and not doing obstetrics is the differential in the premium. If you are paying $60,000 a year to do obstetrics and you are paying $20,000 a year when you don't do obstetrics, then you have to shift that $40,000 differential to your delivery patients.

The decision process, at least in Colorado, was that an awful lot of doctors couldn't do enough procedures safely to offset that differential. So it is not a matter of how much you make or how much you don't make. It had to do with that absolute differential; particularly difficult in rural Colorado with family medicine physicians, where they may only do 20 deliveries a year. So if they have to offset a large premium differential, it becomes significant in their economic life. So I think that is the issue around premium differentials.

Mr. HYDE. Dr. Hanss.

Dr. HANSS. Thank you, Chairman Hyde. I just wanted to respond to Mr. Conyers' original question.

The failure of the tort system and in the jury system is in the inability to distinguish malfeasance from malpractice. I will not believe that 90 percent of the physicians in New York State practice malpractice. I am very certain that there is malfeasance.

Life is a very difficult journey. It is a very dangerous journey. The passage from conception to birth is probably the most dangerous time in our entire existence. It is also one where we are totally defenseless. We cannot protect ourselves against starvation. We cannot protect ourselves against tobacco, nicotine, alcohol, cocaine, or abuse, both physically and emotionally. Life is a very difficult journey, and it is frequently complicated by serious illness and, ultimately, death.

The problem with the tort system is we are in a lottery system.

We have spent a great deal of time and effort learning about cerebral palsy. This is a particularly puzzling and a particularly complex and a disturbing event for an obstetrician. It is extremely unhappy, in my experience, to deliver a baby with cerebral palsy. As we have studied this problem, we have come to the understanding that most cerebral palsy develops in that most difficult passage between conception and birth, and the birth process has only a very small percentage of contributing factors that may cause cerebral palsy.

These are our difficult situations in obstetrics. This is the reason why 90 percent of us get sued, and yet these are events in the passage of life that are well beyond our control. As we have learned more and more—that cerebral palsy does occur in the conception stages and in the fetal stages of life—we become less and less sued and, in fact, the bad baby cases have diminished to a great deal across this country. We as obstetricians-gynecologists are now being increasingly sued for failure to timely diagnosis cancer of the breast.

Our system is broken. Malfeasance is not supposed to be rewarded in a court of law, and yet it does provide an opportunity for the lottery. Buy a hundred tickets, you might win; you have a hundred times chance more than if you only buy one. These are our problems in today's life.

Mr. CONYERS. Dr. Hanss, that is exactly why I don't agree with knocking $270 billion out of the Medicare bill to achieve a balanced budget. I think you are exactly right, and I think the leadership of this House is exactly wrong.

Mr. HYDE. Well, I don't intend to argue Medicare with the gentleman because the gentleman ought to know that we are increasing, not cutting, Medicare. It can't continue to increase over 10 percent a year and be less than bankrupt. If we are going to have a system for 37 million people, we have got to restrain its growth but not cut it. But that is an argument for another day, Mr. Conyers, although you have a comprehensive view of things today.

Mr. CONYERS. Well, think of this witness' statement when you start cutting it more than $270 billion.

Mr. HYDE. I don't want to cut it a dime. I want it to increase more slowly.

Mr. CONYERS. It is not going to get more efficient by making more cuts, I will tell you that.

Mr. HYDE. Mr. Corboy, you have a comment.

Mr. CORBOY. Yes, sir. I am somewhat concerned that the last commentator found such terrible things wrong with the jury system. The jury system is protected by the Constitution of the United States of America and 50 States within the Union. Whenever we criticize a verdict, we are criticizing people. Now, if this committee has jurisdiction over the sixth and seventh amendments to the Constitution of the United States, please inform us, and we will come back and give you statistics as to why most of the people want a jury system.

I am also amused when I hear doctors complain about the jury system. The jury system supplies them with 70 percent of "not guiltys" in all civil litigation. I am not suggesting that they were not wrong. I am only suggesting that is what juries do.

Juries are a very, very serious impediment to any loss of justice, and to sit here and criticize the jury system, when we are talking about costs, is absolutely intolerable as far as I am concerned. I don't know how we can discuss dollars and say let's do away with the jury system at the same time. It is an impediment to logic. You cannot sit here and say there is something wrong with the jury system and then file demands for jury systems in these cases and win two-thirds of the cases.

Mr. HYDE. I thank the gentleman.

Mr. Watt.

Mr. WATT. Thank you, Mr. Chairman. I want to start by apologizing to the members of this panel whose testimony I did not hear. I had to go out for awhile. I got the last, I guess, all of the last two and part of the third, Mr. Clarke, and I apologize for that.

I was actually sitting here kind of minding my own business and debating whether to stay out of this what appears to be more and more partisan discussion until the chairman rang my bell. So I wanted to start by just asking him to elaborate on what he meant by pulling me into this discussion and associating me in some way with Mr. Scott in what appeared to be a derogatory manner. I hold Mr. Scott in the highest regard, and you seem to be saying something about us that I didn't understand. Could you help enlighten me?

Mr. HYDE. Certainly. The potential of the two of you together leverages greatly my difficulties as chairman. I think when you are here, Mr. Watt, and Mr. Scott is back there, it is more manageable for me. It is certainly not meant to be derogatory. Indeed, it is a compliment to your acumen and your legislative skill.

Mr. WATT. I understand much better, and my only response is that as far as I have been able to determine, the majority in the Congress is always in control of seating patterns, not the minority.

Mr. HYDE. I would never exercise any such power over you.

Mr. WATT. If you want to put Mr. Scott back on the top level, it is fine with me. In fact, I enjoyed being right there because when the cameras come, they always hit the chairman, and that is a very choice seat to be in from a visibility perspective.

Mr. HYDE. I hadn't thought of that at all, Mr. Watt.

Mr. WATT. I apologize to you all again for the aside. We have to get these in-house matters squared away here. I always want to understand what my chairman is saying about me and Mr. Scott, whom I hold in very high esteem.

I still may not ask any questions. I would make a couple of comments, and just say that I was in the North Carolina State Legislature in the mid-80's when we had this almost manic movement toward tort reform at the State level, only to find—and at that time North Carolina was one of the lowest malpractice premium states and had, I think, at that time only one or two verdicts in the whole history of the State over a million dollars in any kind of litigation. That may have changed some since then. But I never quite understood the obligation we had at the State level to deal with this, and in fact a couple of years later we found that it wasn't a real malpractice or tort crisis. It was, in fact, an insurance crisis, and so we came back.

I also practiced law for 22 years, and I might draw a response to this, but lawyers and insurance companies, in the legal context, have a way of dealing with issues. I have heard somebody say that this is about meritorious lawsuits and nonmeritorious lawsuits. I want to advance the argument for you all to ponder that quite possibly a $250,000 cap might increase nonmeritorious lawsuits. Just think about that as we go along.

I want to advance one other possibility, that a $250,000 cap might also increase the amount of money that is actually paid out to people for medical negligence. As a plaintiff's lawyer when I was practicing law, what I found was when there was a maximum that could be paid, insurance companies were a lot more willing to pay that maximum even for nonmeritorious claims. They didn't want to run the risk of a major recovery, so they would just pay you to get rid of you, factor it into their cost structure and go on. Whereas, that nonmeritorious claim, if they stared the lawyer down, might not have ever been filed, or if it had been filed the jury might have given $100,000 rather than the $250,000 that the insurance company would end up paying.

So in the real life that we operate in, I think you may be moving toward paying people with nonmeritorious claims at the expense of those who really have the meritorious claims, because, you know, they say when you teach toward the middle you might help the people who are down at the bottom but you also hurt the people who are at the top. I hope that you all will contemplate these things.

I want to assure you that I think depriving an individual who has a serious injury or death, whether they be a spouse who is home-employed or other, capping that person arbitrarily without evaluating the merits or lack of merits of his or her case is, in my estimation, un-American. And I will just——

Mr. HYDE. I thank the gentleman. The gentleman's time has expired.

The gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, I thank you.

Obviously, again we have a panel that has covered the breadth of this issue. I will summarize somewhat, gentlemen and lady, and probably pose questions in writing.

I am reminded of the times that my pediatrician of yesteryear made house calls, and so I think in the 1996 we can all collectively recognize that we do have a different medical arena in the delivery of health care. I do find it disturbing, as I started out earlier, that we would be addressing these very vital issues, though they may be, without an overall response to health reform, and of course in the backdrop of an unconfirmed response to Medicare and Medicaid.

What I would like to comment on, however, and I will be making statements and, Dr. Corboy—I have got you in the medical profession—Mr. Corboy, though, in law school they call lawyers doctors, so we are rejected before—we know where we stand. But in any event, I noticed you said former. That does not in way take away from the fact that this is an ABA sanctioned statement that I have before me that you presented.

Mr. CORBOY. Exactly.

Ms. JACKSON LEE. I just want to make it very clear, and I appreciate it.

Mr. CORBOY. I come with portfolio.

Ms. JACKSON LEE. You came with a very good chronicling of the reach that lawyers have made under the American Bar Association to grapple with this issue. I would not want it to be stated out of these hearings that we are at odds with each other about good health care and good lawyering, and I think we all have a responsibility.

Ms. Ross, I think your testimony is really the heart of what we are trying to address. And the reason I am saying that is because it showed more clearly, in your time of grief, the burdens we put on you through a system that appeared to be broken. Your inability to get information, your inability to find relief, even though I think you went into an arbitration process, forced in, as you—the suggestion that wasn't that enough, discarding a loved one for $150,000—I don't think you can put a price on anyone so I am not going to suggest that. But I think if this hearing should reflect on anything, and with respect to all of the panelists that have come here, it is to bring into line the consumers, the offerors of the service are the consumers of the service. My physician friends, we have a great fondness for each other, and I do believe that we should try to find common ground.

But as I looked at your grief and your chronicling of your process with your sister, it seems to me that everywhere you went the door was closed. Is that accurate, in terms of securing information, in terms of knowing who the physician was, in terms of knowing the qualifications, during your time when your mother's life was lost?

Ms. ROSS. That is very accurate. We received no help at any point along the stages that we went through, none. And as I said, even as of the end of last week, these doctors have not been reported either to the State medical board nor the National Practitioner Database, even though there are Federal and State fines for not doing so. So I have seen no enforcement action of any kind.

Ms. JACKSON LEE. With that in mind, whether or not we use the concept of medical malpractice and its ability to have petitioners, litigants, in court as a deterrent, I think that it would behoove us, Mr. Chairman, that as we listen to these members of the panel—

we have this legislation before us—that we really need more documentation as to whether or not the real culprits in all of this are, in fact, the causes attributable to some medical malpractice lawsuits.

Mr. Hiepler, I think you had—certainly your testimony attributes to the question of whether or not we have all of the documentation to say that this is the remedy to the injury; this is the remedy to the problem that we have.

I need to know more about California. Have in fact the rates gone down? Has it impacted the average consumer, that in fact because of these caps there is a nirvana there, that there is an oasis of opportunity? What has actually happened to our Ob-Gyns, for which I have the greatest amount of respect? That profession has been under siege on many different areas, the choice question. Is that really the reason, and what can we do in addition to—when I say in addition to, instead of the representation of the noneconomic damages cap?

So I am not sure that we really have all of the facts. Certainly the calls have come in saying we need this, but I want to see the ultimate results. If California is a prime example and then we are hearing that that has not been effective, then what am I doing for the national cause?

So my last comment is to thank everyone for being here. I will have some questions in writing posed to the lawyers and also physicians, to ask some more precise and directed questions. Please appreciate my confusion and my complete willingness to remain open, but yet I am not sure, where there have been caps already there, whether we have gotten to the point we would like to be.

I yield back the balance of my time. Thank you, Mr. Chairman.

Mr. HYDE. I thank the gentlelady.

I want to thank this panel. We have reached the end of our hearing for today. We are going to resume tomorrow with other aspects.

We are going to submit questions to the witnesses in writing, and we would appreciate their responses for the record. I have some questions that I was going to ask but I don't feel like prolonging the hearing. But there are questions about arbitration on these cases, questions of graduated caps depending on the negligence, whether gross or simple negligence or the kind of injury.

We are searching. We are searching for answers to what we believe is a serious problem, and we must reconcile justice for everybody, including the medical profession as well as the plaintiffs and the bar. We are going to make a good-faith effort to solve these problems. Your help has been inestimable, and I thank you all. The meeting is adjourned.

[Whereupon, at 1:10 p.m., the committee adjourned.].

HEALTH CARE REFORM ISSUES: ANTITRUST, MEDICAL MALPRACTICE LIABILITY, AND VOLUNTEER LIABILITY

WEDNESDAY, FEBRUARY 28, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The committee met, pursuant to notice, at 9:38 a.m, in room 2141, Rayburn House Office Building, Hon. Henry J. Hyde (chairman of the committee) presiding.

Present: Representatives Henry J. Hyde, Carlos J. Moorhead, F. James Sensenbrenner, Jr., George W. Gekas, Bob Inglis, Bob Goodlatte, Stephen E. Buyer, Martin R. Hoke, Ed Bryant of Tennessee, Steve Chabot, John Conyers, Jr., Patricia Schroeder, Howard L. Berman, Jack Reed, Robert C. Scott, Xavier Becerra, José E. Serrano, and Zoe Lofgren.

Also present: Alan F. Coffey, Jr., general counsel/staff director; Diana L. Schacht, counsel; Dan Freeman, parliamentarian; and Kenneth Prater, clerk.

Mr. HYDE. The committee will come to order. We have a quorum for purposes of the hearing, and so because we have a full array of good witnesses, expert witnesses, we don't want to keep them overtime.

Today we continue with our hearings on matters specifically within the jurisdiction of the Judiciary Committee which relate to health care reform. We will again consider the appropriate antitrust enforcement standards for physician networks, the need for reform of the medical liability system, and how a relaxation on the liability of volunteers could encourage more people to donate their time to non-profit organizations.

This morning the committee will hear from Senator Mitch McConnell, who will be along soon; Congressman Bill Archer, who is here; Congressman Bob Goodlatte, who is here, and Congressman Pete Stark. Pete Stark just walked in. They will be followed by a panel on the Antitrust Health Care Advancement Act of 1996. That's H.R. 2925, which grants rule-of-reason consideration to certain health care provider networks.

The committee will then hear from a panel of witnesses who will discuss the subject of volunteer liability. We will specifically discuss legislation introduced by Mr. Goodlatte relating to free clinics, H.R. 2938, and H.R. 911, Mr. Porter's bill to encourage States to enact laws to protect volunteers from liability. I'm sure that members of the panel will also share with the committee other ap-

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proaches to eliminating this risk of liability, a fact which keeps many otherwise willing individuals from volunteering their time to worthy causes.

I might just add, parenthetically, if ever a flat tax is enacted that eliminates the contribution for charities from being a deduction, the importance of volunteers is even doubly important.

So without further ado, let's turn to our first panel of the day. Congressman Bill Archer is the very distinguished chairman of the House Ways and Means Committee and represents Houston in Congress, and we're delighted to have you here, Congressman Archer.

STATEMENT OF HON. BILL ARCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ARCHER Mr. Chairman, thank you.

I do not take Austin as pejorative. I think it's one of the great beautiful cities of the State of Texas, so it's a compliment to have it thrown in there.

Mr. Chairman, I thank you for holding these hearings today. As you know, you and I have talked about this issue for many years. I've been a long time proponent of antitrust reform in the health care field. I feel that it's essential to move toward more efficient, more available, better quality health care for all of our citizens. And your bill, H.R. 2925, is a modest step in the right direction. As the first cosponsor of that bill, I like to call it the Hyde-Archer Act, and I hope that won't be unacceptable to the chairman.

I think that we should do all that we can to ensure that providers in the health care marketplace have the opportunity to pursue appropriate alliances that will provide better services and lower costs for health care consumers. Government, in my opinion, Mr. Chairman, should be a catalyst for such alliances rather than an impediment to their formation. I believe it's a function of government to foster the provision of quality health care services and competition in the marketplace, rather than to concoct burdensome mandates and other disincentives that drive up the cost of care and price it out of the marketplace for many.

Mr. Chairman, I'm going to orally give a synopsis of my entire testimony, and if it's permitted, I'd like to have the entire testimony printed in the record.

Mr. HYDE. Without objection, so ordered. And I'm honored to refer to the legislation as the Hyde-Archer bill.

Mr. ARCHER. Thank you, Mr. Chairman.

During your service in Congress and my service, which pretty much overlaps, you and I have seen dramatic changes in the health care marketplace. We've seen doctors and hospitals and other providers attempt to band together to build efficient cost-effective delivery systems which extend services to our citizens, especially those who live in the most underserved rural and urban areas. And we have seen the long arm of the Justice Department and the Federal Trade Commission reach down to stymie the most effective of these collaborations in all areas of our country, large and small.

Evolution of the health care marketplace will continue and should continue with or without a restructuring of our health care system. Effective and creative alliances will be forged among all

types of health care providers in all areas of this country. Mr. Chairman, the committees on which you and I serve, Ways and Means and Judiciary, have held many hearings over the past few years examining the role of our antitrust laws and how they can harm those who receive health care services, rather than protect them.

Is it against our citizens' interest to see these providers combine and improve their efficiency? Is it against our citizens' interest for these networks to effect millions of dollars in cost savings while eliminating duplicative services, staffing, and unnecessary care? Or, more importantly, is it against our citizens' interest for the Government to spend millions on needless investigation and litigation, millions which could have been spent on patient care to satisfy a Washington witch hunt? As responsible Members of the Congress who would like to see improvements to our health care delivery system, both now and in the future, we cannot stand by and allow the Federal Trade Commission and the Justice Department to drive up health care costs through such unwarranted antitrust actions.

We cannot stand by while uncertain regulatory evaluation processes create a chilling effect on providers trying to form cost-effective, provider-sponsored networks. Now I applaud the administration's effort in its attention to developing guidelines, but I'm concerned that their efforts offered little in the way of antitrust clarity. The administration has offered general operating guidelines, but they are vague, nonbinding, and have no effect whatsoever in reducing the costs of private party antitrust litigation. I believe, Mr. Chairman, that you have crafted modest statutory change which will both continue Federal protections against self-serving monopolies and institute the measure of flexibility necessary to foster provider-sponsored networks and organizations that allow additional choices for consumers in the health care marketplace.

I don't know why some in this body want to deny choice to people in the health care marketplace. It seems to me that we should be facilitating that. And we should stimulate the formation of procompetitive, cost-reducing, new health care products.

Mr. Chairman, if I could have your indulgence for just a minute, and I know that you've got a long list of witnesses, I'd just like to throw in another subject, and that is my concern for medical liability reform which also so dramatically affects the cost of the health care in the marketplace. I have asked the GAO to study the impact of this. And they have come back with a study which shows that the cost is far greater than just the insurance premiums. The cost of defensive medicine driving up the cost of health care to everyone is an extremely large cost factor. And I know that your committee has looked into this and you will continue to do so and I applaud you for that.

And, Mr. Chairman, again, thank you for letting me have the opportunity to testify today.

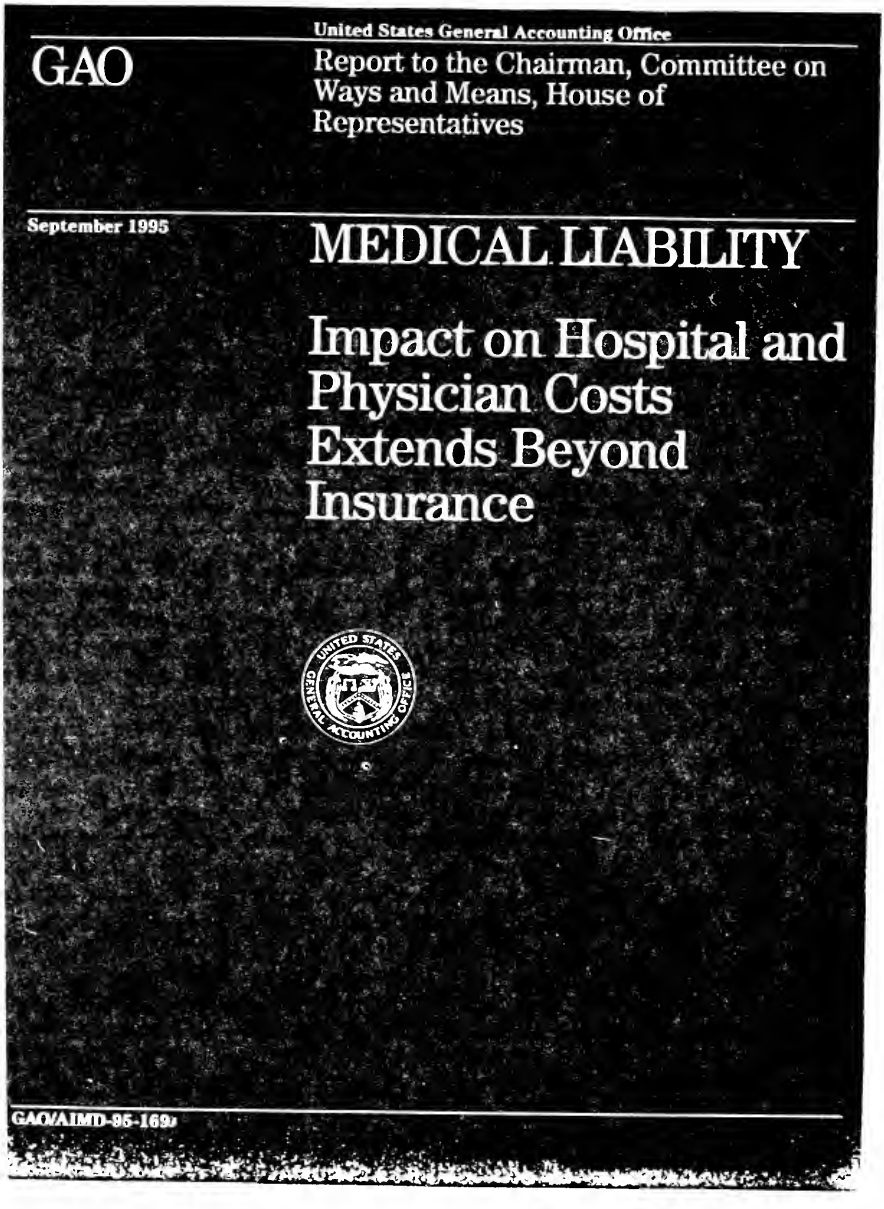
Mr. HYDE. Mr. Archer, do you have that figure, the cost of defensive medicine as the GAO interpreted it?

Mr. ARCHER I can submit the entire report to you, Mr. Chairman, so that you and your committee members can have it.

Mr. HYDE. I recall the number $25 billion. Is that far from the mark? Well, we'll look at the full report.

Mr. ARCHER I think it would be very instructive if you could do so.

[The information follows:]



actions that do occur, such as the management and settlement of claims; and

- medical device and pharmaceutical liability costs: manufacturers' insurance and liability-related production and warning costs passed on in the price of their products.

With the exception of commercial malpractice insurance premiums, only a portion of the first category mentioned above, medical liability costs have not been fully measured. State insurance laws generally require licensed insurance companies to report the costs of physician and hospital malpractice insurance policies and, thus, these costs are easily quantifiable. Because these reporting requirements do not capture other aspects of insurance costs, such as hospital self-insurance and uninsured losses, those costs are more difficult to quantify. In addition, due to the absence of information on liability costs in the medical device and pharmaceutical industries, costs that they pass on to hospitals and physicians are also difficult to quantify. Furthermore, the cost of defensive medicine is difficult to measure because it has not been clearly defined and "defensive" practices cannot be distinguished easily from medical care provided for clinical reasons. Similarly, for liability-related administrative cost estimates, it is difficult to distinguish hospital and physician activities designed to improve service quality or adhere to accreditation standards from activities intended to minimize medical liability.

Background

The major goals of medical tort laws are to (1) deter poor quality health care, (2) compensate the victims of negligent acts, and (3) penalize negligent providers. The system operates under the assumption that negligent behavior can be controlled and corrected by the hospitals and physicians themselves. It relies primarily on deterrence due to the threat of liability and disciplinary action. While this report focuses on the cost of medical liability borne by hospitals and physicians, the deterrence threat of tort law may lower costs incurred by consumers by reducing the number and severity of negligent medical acts. (See appendix I for a discussion of the legal basis for medical liability actions.)

At least two factors have prompted calls for medical liability reform. First, some research suggests that the medical tort system is not achieving its goals. For example, one study reported that only a fraction of malpractice injuries result in claims, compensation is often unrelated to the existence of medical negligence, the legal system is slow at resolving claims, and legal fees and administrative costs consume almost half of the

GAO

United States
General Accounting Office
Washington, D.C. 20548

Accounting and Information
Management Division

B-260671

September 29, 1995

The Honorable Bill Archer
Chairman, Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

As the Congress considers a number of legislative proposals intended to reduce tort liability in the health care industry, little consensus exists on the extent to which medical liability-related spending contributes to overall hospital and physician expenditures, a central issue in the health care reform debate. While such costs have long concerned hospitals and physicians, some ecc omists and health care policy analysts assert that medical liability is not a major factor affecting health care costs. To provide a more comprehensive picture of medical liability's impact on hospital and physician costs, you asked us to identify and describe the types of medical liability costs that affect hospitals and physicians and to determine whether existing studies include these costs in their estimates of hospital and physician liability expenses.

Results in Brief

Widely cited estimates of hospital and physician medical liability costs are often misinterpreted. These estimates, roughly 1 percent of national health care expenditures, represent only a portion of all hospital and physician medical liability costs, generally those associated with malpractice insurance premiums. However, hospitals and physicians incur and pass on to consumers additional expenses that directly or indirectly relate to medical liability. Therefore, estimates of malpractice premiums—taken by themselves—understate the total effect of medical liability costs on national health care expenditures.

A more complete description of these costs would include the following four categories:

- medical malpractice insurance costs: insurance premiums, contributions to self-insurance trust funds, and uninsured losses;
- defensive medical costs: medical treatment that would not be provided if there were no threat of being sued;
- liability-related administrative costs: nonmedical activities performed to minimize the risk of liability and the expenses associated with legal

compensation.[1] The second factor is the perception among some hospital officials and physicians that the current tort system places an unreasonable burden on their industry. Officials from the American Hospital Association and the American Medical Association contend that liability-related costs are too high and unduly influence the way hospitals deliver services and physicians practice medicine. The Congress has before it a number of legislative proposals that are intended to directly and indirectly reduce tort liability in the health care industry.

Scope and Methodology

To identify the various types of medical liability costs, we interviewed and collected data from a variety of sources, including the American Hospital Association, the American Medical Association, the American Bar Association, the St. Paul Fire and Marine Insurance Company,[2] and individual hospitals and hospital systems. In addition, we reviewed recent professional and academic journals, such as the Journal of the American Medical Association and Health Affairs.

From our research, we identified three studies that estimate certain hospital and physician medical liability costs. These studies were prepared by the General Accounting Office (GAO),[3] the Congressional Budget Office (CBO),[4] and the Office of Technology Assessment (OTA).[5] We reviewed these studies to determine whether their estimates included all types of medical liability costs. In addition, we examined other studies that (1) estimated components of medical liability costs not included in these three studies or (2) used different methodologies to arrive at their estimates.

We cannot project costs or generalize our findings because we did not use statistical methods to select the sources of the liability cost data we collected and did not collect data associated with all four categories of

[1]Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report of the Harvard Medical Practice Study to the State of New York (Cambridge, Mass. President and Fellows of Harvard College, 1990)

[2]The St. Paul Fire and Marine Insurance Company is the largest malpractice insurer in the United States. Its share of the medical malpractice insurance market was 11.6 percent in 1993.

[3]Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, September 15, 1986)

[4]A CBO Study: Economic Implications of Rising Health Care Costs. CBO (October 1992) and Statement of Robert Reischauer, CBO, before the Committee on Ways and Means, U.S. House of Representatives, Appendix F, March 4, 1992.

[5]Impact of Legal Reforms on Medical Malpractice Costs. OTA (September 1993)

liability costs we identified. Also, because our work often involved data that some sources regarded as proprietary or sensitive, we agreed not to identify some sources in examples cited in our report. We did not verify the accuracy of the data.

We performed our review from January 1995 through April 1995 in accordance with generally accepted government auditing standards. We discussed a draft of our report with CBO and OTA officials and have incorporated their comments where appropriate.

Studies Focused on Purchased Malpractice Insurance

Malpractice insurance is the first category of medical liability costs we identified and the cost specifically measured by each of the three studies. Most physicians and hospitals purchase medical malpractice insurance to protect themselves from medical malpractice claims. In most cases, the insurer will pay any claims up to a specific limit of coverage during a fixed period in return for a fee. The insurer investigates the claim and defends the physician or hospital. While hospital and physician insurance contracts can vary greatly, we have included the following types of costs in the medical malpractice insurance cost category:

- premiums for purchased insurance,
- hospital contributions for self-insurance, and
- payments made from hospitals' general revenues and reserves and physicians' personal assets to cover uninsured malpractice losses.

(See appendix II for a detailed discussion of the types of hospital and physician insurance policies and related costs.)

The Studies Measured Components of Malpractice Insurance Costs

The CBO and OTA studies estimated costs primarily associated with purchased insurance. The CBO study reported the cost of purchased insurance in 1990, which totaled $5 billion and represented 0.74 percent of national health care expenditures. The OTA study measured purchased insurance and self-insurance costs in 1991 and reported that purchased insurance totaled $4.86 billion in 1991, or 0.66 percent of national health care expenditures. The study estimated self-insurance costs at 20 percent to 30 percent of premiums, which would mean that purchased insurance and self-insurance amounted to between $5.8 billion and $6.3 billion in 1991, less than 1 percent of national health care expenditures.

Other studies that measured purchased insurance and self-insurance for the same periods studied by CBO and OTA estimated costs to be higher. Tillinghast, an actuarial and consulting firm, used its internal database of state-by-state malpractice insurance costs rather than insurance industry data because those data do not include self-insurance. Tillinghast estimated malpractice insurance costs in 1990 at over $8.2 billion.[6] Another consulting firm, Lewin-VHI, Inc., used an estimate that malpractice insurance other than that purchased represents 86 percent of purchased insurance. This firm estimated malpractice insurance costs at $9.2 billion in 1991.[7] Table 1 summarizes the estimates of malpractice insurance costs in 1990 and 1991.

Table 1: Estimates of Costs for Malpractice Purchased Insurance and Self-Insurance for 1990 and 1991

Dollars in billions

Source of estimate	Amount
Estimates for 1990	
CBO	$5.0*
Tillinghast	$8.2
Estimates for 1991	
OTA	$4.86
Lewin-VHI, Inc.	$9.2

*The CBO estimate included only the cost of purchased insurance, not self-insurance.

Our mid-1980s study measured all elements in our malpractice insurance cost category. To obtain information on hospital malpractice insurance costs, we analyzed data from a randomly selected sample of 1,248 hospitals. We obtained physician malpractice expense data from (1) American Medical Association reports quantifying expenses incurred by every known self-employed physician in the United States and (2) information collected from leading physician malpractice insurance companies. We reported that malpractice insurance costs for self-employed physicians averaged 9 percent of their total professional expenses in 1984, while malpractice insurance costs for hospitals accounted for 1 percent of their average inpatient per-day expense in 1985. Insurance company officials stated that the insurance market has changed since 1985 as more hospitals have established self-insurance programs and increased their self-insurance limits, thereby reducing their reliance on purchased insurance. However, the impact of this trend on costs has not been measured.

[6]Tillinghast, Tort Cost Trends: An International Perspective, 1992.

[7]Lewin-VHI, Inc., "Response to Medical Malpractice Article," memorandum to Jay Michael, President, Californians Allied for Patient Protection, April 15, 1994.

Malpractice Insurance Costs Affect Some Physicians and Hospitals More Than Others

Physician malpractice insurance costs vary by state and can vary within a state. Figure 1 presents The St. Paul Fire and Marine Insurance Company's 1994 rates for mid-range liability risk physician[8] mature claims-made policies[9] with limits primarily at $1 million/$3 million.[10] In certain states, lower limits are mandatory or more common due to patient compensation funds.[11] Variations by state and within states generally reflect the insurance company's claims and loss experience.

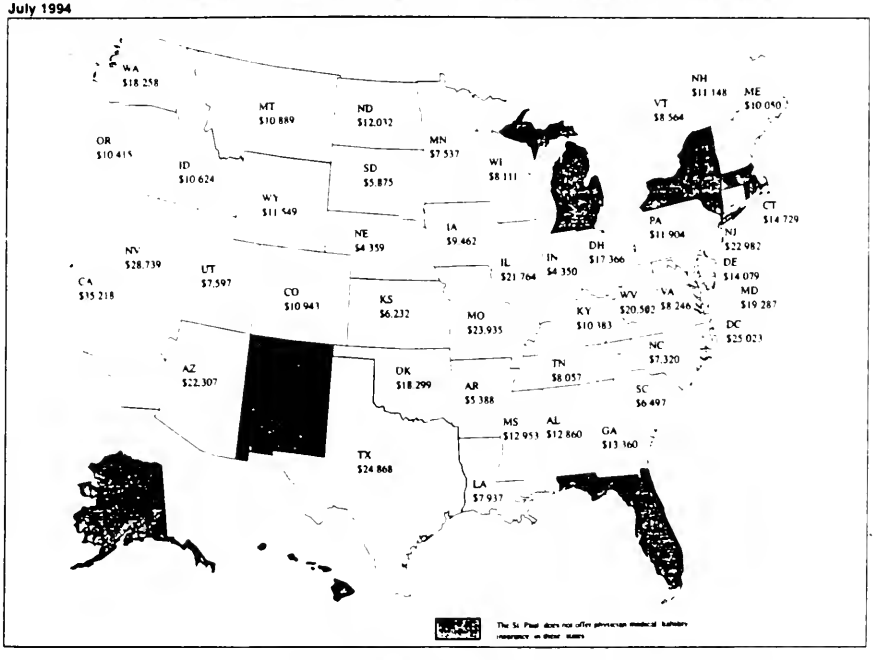
[8]A family practitioner performing standard obstetric procedures is an example of a mid-range liability risk physician.

[9]Generally, malpractice insurance is written on either an occurrence or a claims-made basis. An occurrence policy covers malpractice events that occurred during the policy period, regardless of the date of discovery or when the claim may be filed. A claims-made policy covers malpractice events that occurred after the effective date of coverage and for which claims are made during the policy period. Because the risk exposure to the insurer is lower, premiums for claims-made policies are generally lower during the first year of coverage but increase to approximate those of occurrence policies after about 5 years—when they "mature."

[10]Policy limits represent the maximum that the insurer will pay on each claim against the insured (per occurrence limit) and the maximum amount for all claims against the insured (aggregate limit) for the policy period. For example, limits of $1 million/$3 million means the insurer will pay up to $1 million on a single claim and up to $3 million for all claims during the policy period.

[11]State-run patient compensation funds intend to limit the liability of participants to a specific amount and pay the full excess over that amount of any judgement or settlement against a member.

Figure 1: St. Paul Fire and Marine Insurance Company Average Annual Physician Malpractice Insurance Rates as of July 1994



Note: The rates are for policies with limits of $1 million/$3 million except for Wisconsin ($400,000/$1 million), Kansas, Nebraska, and Pennsylvania ($200,000/$600,000), and Indiana and Louisiana ($100,000/$300,000).

Source: The St. Paul Medical Services, Physician and Surgeon Update, June 1994.

Table 2 presents the rates the company provided for selected metropolitan areas that have rating territories separate from the remainder of their respective states. Across all rating territories, the annual premium for $1 million/$3 million coverage under claims-made policies ranged from a low of $5,388 in Arkansas to a high of $48,718 in Chicago.

Table 2: Average Malpractice Insurance Rates for Physicians as of July 1994 in Major Metropolitan Areas Established as Separate Rating Territories Compared With State Rates

Metropolitan area	Metropolitan rate	State rate
Bridgeport, CT.	$19,315	$14,729
Chicago	$48,718	$21,764
Houston	$37,246	$24,888
Los Angeles	$43,001	$35,218
St. Louis	$28,702	$23,935
San Francisco	$39,114	$35,218

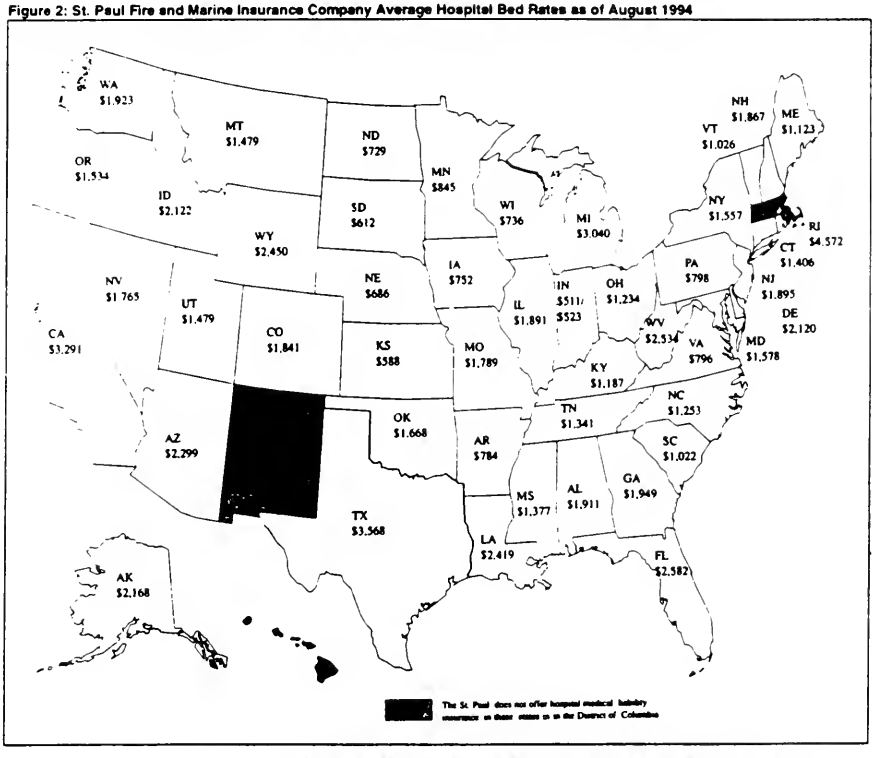
Note: These rates are based on class 3 doctor/mature claims made rates with $1 million/$3 million limits.

Source: The St. Paul Medical Services, Physician and Surgeon Update, June 1994.

Within each rating territory, physicians' malpractice insurance costs also vary by specialty. For example, one insurer's average 1993 mature claims-made rates for policies providing $1 million/$3 million coverage limits to physicians in Texas ranged from $7,410 (except $9,877 in Houston) for family practitioners performing no surgery, a low-risk practice, to $54,834 (except $73,089 in Houston) for physicians specializing in obstetrics and gynecology, a high-risk specialty. While malpractice insurance rates are generally insensitive to a physician's malpractice history, a physician's malpractice claims history can lead to denial or termination of coverage.

Hospital malpractice insurance costs vary according to claim trends in the state where the hospital is located, the number of occupied beds and outpatient visits, the limits of liability selected, the types of procedures performed, and the number of years the hospital has been insured under claims-made coverage. Malpractice insurance rates for hospitals are also frequently based on the malpractice loss experience (in terms of the number of claims filed and the amount per paid claim) of the individual hospital. Figure 2 presents The St. Paul Fire and Marine Insurance Company's per-bed average acute care rates for mature claims-made coverage at $1 million/$3 million limits of liability except in states where lower limits are mandatory or in states with patient compensation funds

Figure 2: St. Paul Fire and Marine Insurance Company Average Hospital Bed Rates as of August 1994



Note: The rates are for policies with limits of $1 million/$3 million except for Wisconsin ($400,000/$1 million), Kansas ($200,000/$600,000), Indiana ($100,000/$2 million and $100,000/$3 million), and Pennsylvania ($200,000/$1 million).

Source: The St. Paul Medical Services Hospital Update, August 1994.

Table 3 presents The St. Paul Fire and Marine Insurance Company's per-bed average acute care rates for hospitals in selected metropolitan areas that have rating territories separate from the remainder of their respective states. The annual per-bed rates ranged from a low of $612 in South Dakota to a high of $7,734 in Detroit.

Table 3: Average Acute Care Bed Rates for Hospitals as of July 1994 in Major Metropolitan Areas Established as Separate Rating Territories Compared With State Rates

Metropolitan areas	Metropolitan rate	State rate
Chicago	$3,309	$1,891
Cleveland	$2,467	$1,234
Detroit	$7,734	$3,040
Kansas City and St. Louis, MO	$4,472	$1,789
Los Angeles	$4,114	$3,291
Miami	$3,367	$2,582
New York City	$3,424	$1,557
Richmond	$1,113	$796
San Francisco	$2,797	$3,291

Source: The St. Paul Fire and Marine Medical Services Hospital Update, August 1994

Defensive Medical Costs Were Not Measured

Defensive medicine includes the following hospital and physician actions aimed at reducing the risk of medical malpractice claims:

- additional or more complex diagnostic tests and procedures and
- additional patient visits and time spent with patients.

The costs of defensive medicine cannot be easily estimated because of difficulties in defining it and distinguishing it from clinically justified medical care. For example, if the definition includes only conscious defensive medicine, it could exclude defensive medical practices acquired during medical training. Thus, the definition would need to address the question of the physician's motive for performing tests: Should cost estimates for defensive medicine encompass only procedures performed for "purely" defensive purposes or should they also include procedures performed for "primarily" defensive purposes? Cost estimates would vary greatly depending upon the definition used. Also, it is difficult to segregate the costs of those defensive acts that produce little or no medical benefit from those that are medically justified, such as additional tests that rule out certain diagnoses.

Defensive medical practices can be classified as positive and negative. Positive defensive medicine involves tests and treatment that would not be provided if the threat of being sued were not present. For example, physicians may order more tests or procedures, take more time to explain risks or treatment options, and spend more time maintaining patient records than they would if there were no threat of malpractice suits. Negative defensive medicine involves not performing services because of the risk of malpractice actions. For example, physicians may restrict the scope of their practices to low-risk patients or procedures. While positive defensive medicine drives up the cost of health care, negative defensive medicine reduces its availability. The following discussion is limited to positive defensive medicine.

Certain physician specialists may practice more defensive medicine than others. Defensive medicine is generally considered to be more extensive in surgery, radiology, cardiology, emergency medicine, and obstetrics and gynecology. As we previously reported, in 1990 Maine imposed practice guidelines[12] by law that state officials expect will decrease these specialists' motivation to practice defensive medicine.[13] These practice guidelines are intended to reduce the number of diagnostic tests and procedures that are performed for defensive purposes, including preoperative tests, such as some electrocardiograms and chest x-rays, cervical spine x-rays for some emergency room patients, some breast biopsies, and some colonoscopies. High rates of caesarean section are also cited as evidence of defensive medicine.

According to the results of our earlier review,[14] the hospitals we visited analyzed their physicians' practice patterns in an effort to reduce costs. In some cases, the hospitals found that some physicians provided a significant amount of unnecessary or excessively sophisticated services but could not determine whether the provision of these services represents defensive medicine. For example, one hospital we visited

[12]Practice guidelines are also known as practice standards, protocols, algorithms, parameters, and preferred practice patterns. Maine's practice patterns attempt to resolve malpractice claims by specifying recommendations for medical treatment which, if followed by a physician, can be used to demonstrate that any injury to the patient did not result from negligent care.

[13]Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs (GAO/HRD-94-8, October 25, 1993).

[14]Hospital Costs: Cost Control Efforts at 17 Texas Hospitals (GAO/AIMD-95-21, December 9, 1994).

reviewed its physicians' use of low osmolality contrast agents[15] in its cardiac catheterization lab. Among health care professionals, the widespread use of low osmolality contrast agents is often viewed as a function of defensive medicine. Physicians use the low osmolality agents because high osmolality contrast agents have been associated with mild to moderate adverse reactions, such as nausea and vomiting, as well as more serious adverse reactions. The average cost of the low osmolality agent used in that hospital was $146.10, compared to $6.96 for the high osmolality agent, and represented 95 percent of the contrast media used in its cardiac catheterization laboratory. Because numerous research articles have suggested that the incidence of adverse effects were easily manageable and did not result in increased medical costs, the hospital limited the use of low osmolality agents to the approximately 30 percent of patients considered to be at high risk. Because the hospital performs 5,000 procedures in its cardiac catheterization laboratory annually, it projects yearly savings of over $400,000. While hospital officials provided no conclusive evidence linking the unnecessary costs to defensive medicine, they stated that the physicians' desire to avoid adverse effects had prompted their use of the low osmolality contrast agent.

Neither our 1986 report nor the OTA study estimated the cost of defensive medicine. We reported that the cost of defensive medicine is impossible to quantify with any degree of confidence because of the difficulty in isolating defensive practices from medical care provided for clinical reasons. The OTA study, like our study, cited the difficulty in measuring the cost of defensive medicine and did not provide an estimate. The CBO study concluded that defensive medicine is probably not a major factor in the cost of medical care and did not provide an estimate.

In a separate study,[16] OTA reported that it found evidence that defensive medicine exists, estimating that as much as 8 percent of diagnostic procedures result primarily from physicians' conscious concern about professional liability. The strongest evidence found by OTA was produced in a study of caesarean deliveries in New York State.[17] That study reported that obstetricians who practice in hospitals with high malpractice claim

[15]A contrast agent is a substance used to improve the visibility of structures during radiologic imaging procedures such as angiography, computerized tomography, and cardiac catheterizations. Low osmolality contrast agents have an osmolality (that is, concentration of dissolved particles in solution) that is closer to the osmolality of body fluids than the other contrast agents.

[16]Defensive Medicine and Medical Malpractice, OTA, July 1994.

[17]Localio, Lawthers, Begston, Hebert, Weaver, Brennan, and Landis, "Relationship Between Malpractice Claims and Caesarian Delivery," vol. 269, Journal of the American Medical Association, pp. 366-373, January 20, 1993.

frequency and premiums do more caesarean deliveries than obstetricians practicing in areas with low malpractice claim frequency and premiums. However, OTA also reported that it does not know whether the report's findings for obstetricians and caesarean deliveries can be generalized to other states, specialties, clinical situations, or procedures. OTA concluded that it is virtually impossible to accurately measure the overall level and national cost of defensive medicine because of the methodological problems associated with isolating defensive medical practices.

Through our research, we identified two studies that attempted to quantify the total cost of defensive medicine.[18] An American Medical Association study estimated that in 1984, defensive medical costs were between $9 billion and $10.6 billion for primarily defensive medicine purposes.[19] The $10.6 billion estimate is based on the results of a physician survey, which may not accurately reflect the cost of defensive medicine. The $9 billion estimate assumes a statistical correlation between an increase in physician fees and higher malpractice costs. This method might overstate the costs of defensive medicine because increases in fees might result from many factors besides physicians' defensive medical practices. A second study, prepared by Lewin-VHI, Inc., estimated hospital and physician defensive medicine costs at between $4.2 billion and $12.7 billion in 1991.[20] This estimate is based primarily on the earlier AMA estimates and is subject to the same methodological limitations.

Liability-related Administrative Costs Were Not Measured

This third category of medical liability costs we identified includes

- certain risk management activities,
- time and travel associated with litigation, and
- creating and maintaining records subject to discovery[21] or required for defense.

[18]The Hudson Institute, a not-for-profit research institute located in Indiana, estimated defensive medicine costs for one large urban hospital in Indiana. It reported that medical liability increased costs at the hospital by 5.3 percent, or $460 per admission. It broke down the medical liability cost into two components: (1) defensive medicine, which accounted for 3.9 percent of the cost increase, or $327 per admission, and (2) insurance, payments to patients, attorney's fees, and the cost of litigation, which increased costs by 1.4 percent, or $123 per admission. David McIntosh and David Murray, "The High Cost of Medical Liability," Hudson Briefing Paper, No. 163, April 1994

[19]Reynolds, R.A., et al, "The Cost of Medical Professional Liability," Journal of the American Medical Association, Vol. 257, No. 20, May 22/29, 1987.

[20]Estimating the Costs of Defensive Medicine, Lewin-VHI, Inc., report prepared for MMI Companies, Inc., January 27, 1993

[21]The term "discovery" refers to procedures for ascertaining facts prior to the time of trial

Our study and the CBO and OTA studies did not attempt to provide a measure of liability-related administrative costs. Nor did we identify, during the course of our research and discussions, other studies that estimated hospital and physician liability-related administrative costs.

Hospital risk management activities are designed to (1) reduce the hospital's and its physicians' risk of malpractice suits by maintaining or improving the quality of care, (2) reduce the probability of a claim being filed by negotiating compensation with an injured patient prior to the patient filing a claim, and (3) preserve the hospital's assets once a claim has been filed. Risk management was first applied to health care facilities during the 1970s when jury awards and settlements increased sharply. During this period, many insurance companies either substantially increased hospitals' premiums or stopped writing malpractice insurance for them. Many hospitals intensified their risk management activities in the 1980s when an increasing number became at risk for malpractice losses as they began to self insure for smaller damage awards and settlements.

While hospitals perform some risk management activities specifically to reduce liability-related costs, they do not segregate the costs of these activities from the cost of practices designed to promote quality assurance or to satisfy accreditation standards. For example, occurrence screening systems—which are designed to identify deviations from normal procedures or expected treatment outcomes—involve costs associated with both promoting quality and reducing liability risk. By contrast, claims management is an example of a purely liability-related risk management cost. Claims management activities include claims investigation, claims filing, damage evaluation and reserve determination, planning remedial medical care, settlement strategy formulation, settlement structuring, and negotiating and "posturing" for defense or settlement.

Hospital officials and physicians also identified time spent at trials and other litigation-related events as liability-related administrative activities. As with liability-related risk management activities, hospitals and physicians did not routinely account for these activities separately. Examples of these activities include time and travel expenses associated with answering interrogatories and depositions. For instance, if a nurse is a defendant, the hospital will pay the nurse's expenses and salary while he or she prepares for and attends trial. The hospital would also incur additional costs contracting with a temporary nurse agency or using its supplemental nurse pool to perform the duties of the defendant nurse.

Similarly, a defendant physician would have to contract with another physician to care for patients during litigation.

Hospital officials also reported incurring additional liability-related administrative expenses associated with creating and maintaining records that may be required for defense. Such records would include detailed staffing schedules and precisely worded training, policy, and procedures manuals. Hospitals archive these records for decades since they may be needed for litigation long after an alleged negligent act. In some cases, hospitals spend considerable time locating physicians and other staff when malpractice actions involve events that occurred in the distant past, such as a law suit filed years after the birth of a child.

Medical Device and Pharmaceutical Liability Costs Were Not Measured

Hospitals and physicians incur the following types of medical device and pharmaceutical liability costs in the prices that they pay for their products:

- manufacturers' liability insurance and
- costs associated with product design and marketing that would not be incurred in the absence of the threat of suit.

Neither our study nor the CBO or OTA studies estimated manufacturers' medical device and pharmaceutical liability costs incurred in the purchase price hospitals and physicians pay for their products. During our research and discussions with industry officials, we did not identify other studies that estimated the liability costs passed on to hospitals and physicians in the prices of medical devices and pharmaceuticals.

Medical device and pharmaceutical industry officials and others we spoke with expressed concern about liability costs associated with medical products. They believe that litigation involving medical products is extensive and increasing. Because state product liability laws differ and most manufacturers sell products in many states, manufacturers are at risk of simultaneous suits in numerous jurisdictions with different legal standards. They also stated that drugs intended for chronic conditions or devices remaining in the body indefinitely may be used by patients for periods longer than the products were tested in clinical trials. As a result, problems may not be discovered until decades after use, when many patients may be using the product. Because only claims-made insurance is generally available for medical products, manufacturers with such coverage are not insured for suits in future years. When suits appear, the insurer can refuse to renew the policy, leaving the manufacturer without

insurance. Medical device and pharmaceutical industry officials told us that this legal environment drives up the cost of medical products.

Manufacturers pass on their liability costs to hospitals and physicians in their products' prices. Their liability costs include insurance and liability-related production and marketing costs. Manufacturer insurance costs, like those of hospitals, can include periodic self-insurance payments, payments made for purchased insurance, and payments made from general revenues to cover uninsured losses. Liability-related production and marketing costs include expenses associated with actions taken primarily to protect the manufacturer from liability, such as multiple layers of packaging and repeated safety warnings.[22]

Certain medical devices and pharmaceuticals involve a greater degree of liability risk than others. For example, stethoscopes pose little threat of liability risk. However, implanted devices such as heart valves, intrauterine devices, and breast implants have been involved in the most prominent medical device suits. Likewise, some pharmaceuticals like generic drugs and nonprescription drugs generally involve little risk of liability action. Most pharmaceutical litigation has involved brand name prescription drugs, such as Bendectin.[23]

While some medical device and pharmaceutical cases and settlements have been widely publicized, such as those involving silicon breast implants and the Dalcon shield, little information is now available on the prevalence of litigation throughout the industry or the magnitude of the costs passed on to hospitals and physicians. Industry and insurance company officials stated that out of court settlements are common, and manufacturers are reluctant to disclose settlement terms for fear of encouraging new suits or inflating future claims. Manufacturers are also reluctant to disclose their pricing strategies because of competition.

Conclusion

Hospitals and physicians incur a variety of medical liability costs. Studies attempting to measure such costs have focused on the cost of purchased

[22]Medical device and pharmaceutical industry officials believe that the threat of liability influences manufacturers' business operations in addition to imposing costs. The officials believe that some manufacturers will (1) not engage in research in areas with potential high litigation risk, (2) not market high-risk products, (3) withdraw high-risk products from the market, and (4) attempt to minimize the use of their products by potentially high-risk patients, such as children and women of child-bearing age.

[23]Garber, Steven, Product Liability and the Economics of Pharmaceuticals and Medical Devices, prepared for the RAND Institute for Civil Justice, 1993.

malpractice insurance, which is readily quantifiable due to state reporting requirements. Other hospital and physician liability costs, however, are impractical, if not methodologically difficult to measure with any precision. Such costs include defensive medicine, liability-related administrative expenses, and medical device and pharmaceutical manufacturers' liability expenses that they pass on to hospitals and physicians in the prices of their products. However, a broader understanding of such costs and their implications is useful to the ongoing medical liability reform debate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we will not distribute it until 30 days from its date. At that time, we will send copies to the Ranking Minority Member of the House Committee on Ways and Means and to other interested Members of the Congress. Copies of this report will also be available to interested parties upon request.

Please contact me at (202) 512-9542 if you or your staff have any questions concerning this report. Major contributors are listed in appendix III.

Sincerely yours,

Lisa G. Jacobson

Lisa G. Jacobson
Director, Civil Audits

Contents

Abbreviations

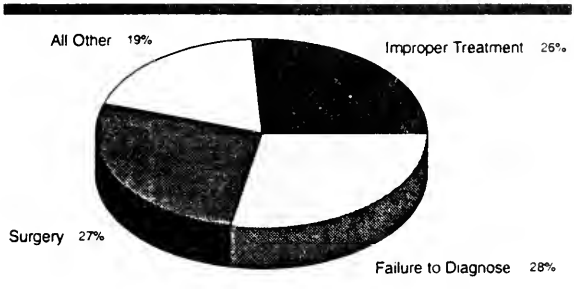
CBO	Congressional Budget Office
OTA	Office of Technology Assessment

Legal Basis for Medical Liability Actions

Generally, medical malpractice suits are based on tort law. Plaintiffs select tort theory instead of alternatives, such as breach of contract,[1] because they may recover larger damages and because the statute of limitations generally runs from the date the harm was discovered rather than the date the alleged malpractice occurred. When a third party such as a surviving spouse or parent brings suit, it generally must select tort theory because the plaintiff is neither a party to the original contract nor a third party beneficiary.[2]

Figure I.1 summarizes the types of malpractice action filed against physicians insured by The St. Paul Fire and Marine Insurance Company during the 5-year period from 1989 through 1993.

Figure I.1: Types of Malpractice Claims Filed Against Physicians Insured by the St. Paul Fire and Marine Insurance Company, 1989-1993



Source: The St. Paul Medical Services Physicians and Surgeons Update, June 1994.

According to The St. Paul Fire and Marine Insurance Company, failure to diagnose was the most common malpractice claim—28 percent of all

[1]Although a written contract between a patient and a physician generally does not exist, a contract is implied in fact. If a contract was not created, a physician would not have a cause of action for fees against a patient for not paying for services rendered.

[2]A third party beneficiary is a third person whom the parties to a contract intend to benefit by the making of the contract and to confer upon such person the right to sue for breach of contract, such as a life insurance contract wherein the insurance company promises the insured to make payments to the beneficiary.

claims—filed against physicians it insured during the 5-year period spanning 1989 through 1993. Failure to diagnose cancer was the most common claim in this category. Other frequent failure to diagnose claims involved fractures and dislocations, infections, myocardial infarctions, and pregnancy problems. Claims stemming from surgical procedures constituted the next largest category, 27 percent of all claims. The most frequent malpractice claim related to surgery was "postoperative complication." Inadvertent surgical acts and inappropriate or unnecessary surgeries also were frequent allegations in this category. Claims alleging improper treatment represented the third largest category, making up 26 percent of all claims during the period. Most of these claims were birth-related. Other claims made up the final category, including adverse reaction to anesthesia, injection site injuries, and lack of informed consent.

In addition to asserting physician negligence, plaintiffs may file malpractice claims against hospitals where treatment was provided through the vicarious liability[3] doctrine or by establishing hospital corporate negligence in areas such as the selection and review of medical staff.[4] In some jurisdictions, hospitals can be jointly and severally liable, which enables plaintiffs to recover most or all damages from a hospital even when the hospital was only partially responsible for the negligent act.

Plaintiffs can also file claims against medical device and pharmaceutical manufacturers under various legal theories, such as negligence, strict liability, and breach of warranty. Manufacturers are liable for negligence if they did not exercise due care and this lack of care caused injury. Manufacturers are liable under strict liability if their products are defective, making the products unreasonably dangerous and causing the injury. The three types of defects for which manufacturers can be found to be strictly liable are (1) a flaw in the product introduced in the manufacturing process (manufacturing defect), (2) a defect in the design of the product (design defect), and (3) a failure to adequately warn consumers of risks or give instructions regarding product use (warning defect). Under breach of warranty, manufacturers are liable if the product fails to work as expressly or implicitly warranted or promised.

[3]Under vicarious liability, an employer or principal can be held liable for the actions of an employee or agent.

[4]For example, in Darling v. Charleston Community Memorial Hospital, 211 N.E. 2d 253 (1965), the plaintiff had been admitted to the defendant hospital for treatment of a broken leg. Complications arose shortly after the physician fitted the leg with a cast. Ultimately, the plaintiff's leg became gangrenous and had to be amputated. The plaintiff then brought a successful action against the hospital for negligent medical treatment by claiming that the hospital failed to ensure quality care.

Hospital and Physician Malpractice Insurance Policies and Costs

Hospital and physician insurance coverage and costs can vary greatly. This appendix briefly discusses types of insurance and factors that can affect their costs.

Purchased Insurance Contracts and Costs

Several factors influence the cost of purchased malpractice insurance. The number of claims and the average cost per claim are the primary factors. However, within the prevailing legal environment, hospitals and physicians can reduce the cost of their premiums by purchasing insurance policies with characteristics that allow them to retain risk or to defer costs to future years.

One malpractice policy characteristic that influences the cost of insurance is the amount of coverage provided. Typically, medical malpractice insurance policies have a dollar limit on the amount that the insurance company will pay on each claim against the hospital or physician (per occurrence limit) and a dollar limit for all claims against the insured (aggregate limit) for the policy period. For example, limits coverage of $1 million/$3 million means that the insurer will pay up to $1 million on a single claim and up to $3 million for all claims during the policy period. The higher the limits, the more costly the policy. However, since small claims occur more frequently then large ones, the cost per dollar of coverage decreases as the coverage limits increase.

A deductible provision can also influence the cost of purchased insurance. Under a policy with a deductible provision, an insurer is liable only for losses in excess of a stated amount up to the policy limits. For example, if a hospital incurred a $300,000 malpractice loss while insured under a $1 million per occurrence policy with a $100,000 deductible, the hospital would pay $100,000 of the loss and the insurer would pay $200,000. Generally, the higher the deductible, the lower the premium.

The type of policy purchased can also influence the cost of medical malpractice insurance. Generally, malpractice insurance is written on either an occurrence or a claims-made basis. An occurrence policy covers malpractice events that occurred during the policy period, regardless of the date of discovery or when the claim may be filed. A claims-made policy covers malpractice events that occurred after the effective date of the coverage and for which claims are made during the policy period. Because the risk exposure to the insurer is lower, premiums for claims-made policies are generally lower during the first year (approximately 25 percent of occurrence policies) but increase to approximate the

occurrence basis after about 5 years when they mature. To cover claims filed after a claims-made policy has expired—when, for example, a hospital changes insurers or after a physician retires, the hospital or physician must purchase insurance known as "tail coverage," which insurance company officials stated can cost between 100 percent and 200 percent of the last claims-made policy cost.

Self-insurance Costs

To minimize the cost of purchased malpractice insurance, most medium-size and large hospitals self-insure for smaller settlements and damage awards. In many cases, these hospitals establish self-insurance trusts[1] that they administer themselves or contract with third parties to administer. Self-insuring hospitals make periodic contributions to these trusts to pay for losses as defined under formal trust agreements. Generally, the contribution amounts are generally actuarily determined based upon the estimated present value of future indemnity payments and expenses.[2] Indemnity payments include amounts that the trusts will pay claimants as a result of settlements and damage awards. Expenses include defense attorneys, medical experts, private investigators, court reporters for depositions, and court costs.

Most self-insuring hospitals purchase "excess" insurance to cover that portion of large losses that exceeds their self-insurance limits. Whereas self-insurance coverage typically pays settlements or damage awards up to a few million dollars, excess coverage pays up to tens of millions of dollars above the self-insurance coverage limits. Some hospitals obtain an additional layer of coverage above their excess layer, often referred to as "blue sky" coverage, which pays that portion of settlements or damage awards exceeding the excess coverage limit up to $100 million. Generally, the higher the limits, the more costly the insurance. However, the cost per dollar coverage decreases as the limits increase.

Like purchased insurance, hospital self-insurance costs are determined by the expected number and severity of claims. However, other factors can influence self-insurance costs. Costs can vary over time because estimated future losses may differ from actual losses. If the hospital incurs fewer losses than expected, the resulting surplus will enable the hospital to reduce trust contributions. If the hospital incurs more losses than

[1]Some hospitals have established captive insurance companies, which operate like self-insurance trusts, to pay for smaller damages and awards.

[2]The estimated present value is used because the contributions are invested into interest-bearing securities.

expected, the resulting deficit will force the hospital to increase trust contributions. Costs can also vary over time if estimated trust investment income differs from actual investment income. If trust investments return a higher or lower yield than expected, hospitals may be able to lower, or may be required to raise, trust contributions accordingly.

Uninsured Losses

In addition to self-insurance and purchased insurance, hospitals and physicians can also incur malpractice liability costs associated with uninsured losses. The most common uninsured loss involves deductibles paid by hospitals and physicians that have purchased primary coverage. Hospitals and physicians are also at risk for losses that exceed the limits of coverage. Hospitals and physicians can also incur losses associated with causes of action not covered by policies.

Appendix III

Major Contributors to This Report

Accounting and Information Management Division, Washington, D.C.	Shirley Abel, Assistant Director
Dallas Regional Office	Russell E. Hand, Auditor-in-Charge Elaine Coleman, Evaluator Claudine Makofsky, Evaluator

Mr. HYDE. Well, I thank you very much, Congressman Archer, for your contribution.

[The prepared statement of Mr. Archer follows:]

PREPARED STATEMENT OF HON. BILL ARCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, during our years of service in the Congress, you and I have seen dramatic changes in the health care marketplace.

We have seen the Government encourage hospital construction and expansion, with federal aid from the Hill-Burton Program. And we have seen the Government encourage hospital closures and consolidations, with the pressures for efficiency forced by the prospective payment system and other Medicare reimbursement changes.

We have seen the Government work to limit the flow of technological advances to the marketplace, with the implementation of the Health Planning and Resources Development Act, Public Law 93–641. And we have seen the Government recognize that consumers want, and need, access to the latest medical technology breakthroughs, with repeal of that Act in 1986.

We have seen doctors, hospitals and other providers attempt to band together to build efficient, cost-effective delivery systems which extend services to our citizens, especially those who live in the most under served rural and urban areas. And we have seen the long arm of the Justice Department and the Federal Trade Commission reach down to stymie the most effective of those collaborations, in all areas of our country, large and small.

Evolution of the health care marketplace will continue, and should continue, with or without a restructuring of our health care system. Effective and creative alliances will be forged among all types of health care providers in all areas of this country.

I believe that government should be a catalyst for such alliances, rather than an impediment to their formation. I believe that it is the function of government to foster the provision of quality health care services and competition in the marketplace, rather than to concoct burdensome mandates and other disincentives that drive up the cost of care and price it out of the marketplace for many.

Mr. Chairman, your bill, H.R. 2925, the Antitrust Health Care Advancement Act, of which I am proud to be the first cosponsor, is a modest, but necessary measure to ensure that all providers in the health care marketplace have the opportunity to pursue appropriate alliances that will provider better services and lower costs for health care consumers.

The committees on which we serve, Ways and Means and the Judiciary, have held many hearings over the past few years examining the role of our antitrust laws and how they can harm those who receive health care services, rather than protect them.

We have heard countless stories of costly duplications of services and unnecessary care. Our study of this issue has forced us to question the Government's motive in challenging provider networks.

Is it against our citizens' interest to see these providers combine and improve their efficiency?

Is it against our citizens' interests for these networks to effect millions of dollars in cost savings while eliminating duplicative services, staffing and unnecessary care?

Or, more importantly, is it against our citizens interests for the Government to spend millions on needless investigation and litigation, millions which could have been spent on patient care, to satisfy a Washington witch hunt?

As responsible Members of Congress who would like to see improvements to our health care delivery system, both now and in the future, we cannot stand by and allow the Federal Trade Commission and the Justice Department to drive up health care costs through such unwarranted antitrust actions. We cannot stand by while uncertain regulatory evaluation processes create a chilling effect on providers trying to form cost-effective provider sponsored networks.

While I applaud the administration's attention to developing guidelines, I am concerned that their efforts offer little in the way of antitrust clarity. The administration has offered general operating guidelines, but they are vague, nonbinding and have no effect whatsoever in reducing the costs of private party antitrust litigation.

I believe, Mr. Chairman, you have crafted modest statutory change which will both continue Federal protections against self-serving monopolies and institute the measure of flexibility necessary to foster provider sponsored networks and organiza-

tions that allow additional choices for consumers in the health care marketplace and stimulate the formation of pro competitive cost reducing new "health care products."

Your bill, Mr. Chairman, provides specific criteria that must be met by the provider network—it provides clarity and specificity that are unknown in the arbitrary rules promulgated by the Department of Justice and the Federal Trade Commission. today. It doesn't guarantee permissibility under antitrust laws, but ensures that providers are not stifled simply because they do not meet unknown "black box" criteria. Secondly, your bill mandates that the Department of Justice and the Federal Trade Commission will specify their enforcement policies and analytical principles for provider networks—eliminating uncertainties that have plagued us for years.

It is abundantly clear to me that the Federal Government needs to take immediate action to clarify the rules of the game so that those in the health care community who wish to undertake alliances are assured a stable, predictable playing field. Your bill, Mr. Chairman, does just that.

Mr. Chairman, before I leave, I would also like to express my strong support for medical liability reform, including medical product liability reform. Along with antitrust, malpractice is one of the main cost drivers of our health care system today. And like antitrust, our tort system fosters costly duplication of health care services and unnecessary medical care.

Last year, the General Accounting Office reported on the second phase of a study that I requested which examined and attempted to quantify the chief cost drivers of our health system. One of the cost drivers that was identified as significant by the study participants was medical liability costs. The study participants listed premium costs, liability related administrative costs, staffing, equipment, supplies, clinical protocols, and other direct and indirect liability expenditures. GAO found that most studies of malpractice costs, including the Office of Technology Assessment and Congressional Budget Office studies did not identify areas other than premiums as even potential contributors to medical liability costs. It is inaccurate not to acknowledge the existence of these additional factors.

There is no doubt that high malpractice costs effect efficient delivery of health care. At times, these costs can make the difference between care and no care at all. Obstetrical malpractice premiums remain among the highest liability premiums in the country. These extraordinary high premiums have been shown to be a primary factor contributing to a shortage of medical care services. In 1995, eight Texas counties had no obstetrician/gynecologist. In addition, thirty-six other Texas counties had fewer than twenty obstetrician/gynecologists per one hundred thousand Texans. This means that, in forty-four counties or about twenty percent of all counties in Texas, women were less likely to receive cost saving prenatal and other primary care.

In conclusion, I believe that we must make changes to our antitrust laws and to our tort system. We must set aside partisan politics and create laws that are in the best interest of all Americans. The changes that will allow increased consumer choice and lower consumer prices in the health care market place are apparent in the Hyde Antitrust Health Care Advancement Act. The needed malpractice reforms have already been passed by the House.

Mr. Chairman, we must be diligent in our efforts to see that these changes occur. I look forward to working with you and our colleagues in the Senate to ensure passage of these important legislative initiatives prior to the adjournment of the 104th Congress.

Thank you again, Mr. Chairman, for the opportunity to testify today.

Mr. HYDE. The gentleman from California, the very distinguished member of the Ways and Means Committee, Congressman Pete Stark.

STATEMENT OF HON. FORTNEY PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Thank you, Mr. Chairman, and it's indeed a pleasure to testify before this committee.

As the Chair knows, I grew up in Mr. Sensenbrenner's home State as a Republican admiring Teddy Roosevelt and Bob LaFollette, and I'm sure that I can still find that spirit of fairness and trust-busting in this committee, if not in every committee of the House. And it is in that spirit of my former life that I would

like to suggest, respectfully, that H.R. 2925 is anticompetitive and anticonsumer.

Physicians can join together and agree on price and other terms so long as they integrate by sharing financial risk. The Mayo Clinic, the Cleveland Clinic, and many others have integrated and are now competing in virtually every market in the country without any special preferences under antitrust. My physician friends, all three of them—[laughter]—tell me that this bill is necessary to allow them to practice medicine creatively, that weakening antitrust law is necessary to the formation of provider-based networks; I think that's a ludicrous argument.

Physician networks are blossoming all over the country without any changes in antitrust law. Most importantly, antitrust enforcement policies were designed to protect the consumer, not the physician. What the AMA is really asking for is the ability to compete outside the free market principles by which every other competitor in this country has to operate. When did we stop thinking of our medical system in terms of keeping patients healthy and well, and when did we get to the point where we think of our medical system as a fiercely competitive business in which the survivors concentrate on making tremendous amounts of money? The goal isn't health care anymore; it's stockholder interest. We're talking about relief for physicians, the highest paid group of professionals, higher even than trial attorneys in this country.

There is an empire being built by physician investors in for-profit hospitals—they are related issues because each addresses the physician's ability to creatively practice medicine and to organize into structures that buy and sell patient referrals like pork bellies on the Chicago Exchange. Columbia HCA, the Nation's largest for-profit hospital chain, is a perfect example. It is the PAC man of the industry, gobbling up nonprofit hospitals. I just received a legal update from a newsletter about a class action suit against Columbia, who is offering physicians—in some cases I think illegal incentives—to refer only to their own home care agencies, really hurting small businesses in every community in which they open and begin to expand.

These are the people we should be protecting—the small, independent business person who can innovate, who can provide creative and family service that benefits the community. I think this is the issue that we overlook. As the Chair knows, I am not a lawyer, but I am concerned about our ability to have creative health care expand in this country, but not by just making physicians wealthier.

The case of malpractice was raised. It's about $2.5 billion; 1 or 2 percent is the maximum that malpractice costs and half of that is not negligence. Going to the hospital is a very dangerous trip. You're apt to get hurt. Now, if a doctor negligently causes that, it seems to me they should do their own callbacks. If it's not negligent, somebody should pay. If people don't have insurance, it becomes a public cost and burden. I urge you when you think of malpractice to not only think of the embarrassment to a doctor, but of the cost to the patients who undertake a very uncomfortable, often dangerous journey. The patient should be protected.

So physicians have got to remember one thing: if they want to compete, there was a guy named Adam Smith. We now have more physicians in this country than ever before and they're making more money than ever before. That isn't how it works. They may have to learn to compete by making a little less money, by dropping the cost of their services to get more business. And to give them a shelter from antitrust is not, in my opinion, the way to protect the consumer, the patient who is least apt to be able to fend for him or herself in this melee of health care.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Stark follows:]

PREPARED STATEMENT OF HON. FORTNEY PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to present testimony concerning recent efforts to reform antitrust law and medical malpractice law.

H.R. 2925 IS ANTI-COMPETITIVE AND ANTI-CONSUMER

H.R. 2925 is an attempt to change federal and state antitrust laws to allow more lenient treatment of loosely affiliated provider-based health care networks. This antitrust bill is anti-competitive, anti-consumer, and anti-states' rights. It is costly and unnecessary.

My physician friends tell me this bill is necessary to allow them to practice medicine "creatively"—that weakening of antitrust law is necessary to the formation of provider-based health care networks. This is a ludicrous argument. A burst of legitimate physician networks has formed across the country recently without any changes in antitrust law.

Physicians can join together and agree on price and other terms, so long as they "integrate" by sharing financial risk. Numerous physician groups, including the renowned Mayo Clinic and the Cleveland Clinic, have successfully "integrated" and are now competing in virtually every market in the country. These multi-specialty physician group practices were formed under existing antitrust laws, without special preferences.

Most importantly, antitrust enforcement policies were designed to protect consumers, not competitors. Physicians don't need special antitrust preferences—joint ventures arranged by like competitors in every other industry are subject to essentially the same level of scrutiny as physician sponsored networks. What the AMA is really asking for is the ability to compete outside the free market principles by which every other competitor must abide.

When you loosen integration requirements, as this bill allows, consumers are harmed because it reduces the incentives for providers to compete. Proponents of this bill would say that current integration requirements prevent the formation of physician-sponsored plans, but this isn't true. What current requirements prevent is price-fixing, boycotts and other forms of anti-market activities.

When did we stop thinking of our medical system in terms of keeping patients well or helping them get better? How did we get to this point—the point where we think of our medical system as a fiercely competitive business in which survivors concentrate on making tremendous amounts of money.

The goal isn't health care anymore—it's care of the stockholder interest. Today we are talking about "relief" from antitrust laws for physicians. But there's another important chapter to this story—an empire being built by physician investors in for profit hospitals. They are related issues because each addresses a physician's ability to "creatively" practice medicine—to organize into structures that buy and sell patients while profits are made for the physicians involved.

PSOS ALREADY CREATING TRUST PROBLEMS

Weaker Antitrust Laws are Totally Inappropriate: Example of Columbia Hospital Chain

Columbia HCA, the nation's largest for-profit hospital chain is a perfect example of this phenomena. This organization is characterized as the PAC–MAN of the industry—gobbling up non-profit hospitals as it expands its market share in a community. Nationwide, Columbia HCA is riding high from dozens of acquisitions of hos-

pitals that have made it not only the biggest (with 355 hospitals) but also one of the wealthiest for-profit chains with $18 billion in annual revenue.

The questionable practices of Columbia HCA are numerous, but one issue is particularly important to today's discussion. In Florida, health care officials cited the possibility that Columbia hospitals engage in cream-skimming. They allege that doctors, who own stakes in Columbia facilities, send the most profitable patients there—and steer less-profitable patients to the public and charity hospitals. Columbia HCA and its doctor affiliates are in the business of building medical trusts and destroying public and non-profit hospitals who take the tougher, less profitable cases. We need stronger antitrust laws, not weaker ones.

As for-profit, physician investor health care entities continue to expand their market share, who will take care of the poor? When the Columbia HCA, the PAC MAN of the industry, enters a community, buys and then closes the only community-based, not-profit hospital, who will treat the uninsured?

Columbia continues on its path to greater market share in many communities. Isn't the flexibility seen in the physician-investor structure the same type of "flexibility" being sought today? The AMA wants flexibility to "creatively" practice medicine—to creatively make money—but until we have universal health coverage, someone must continue to worry about the uninsured and the underinsured.

In his testimony, Robert Pitofsky, Chairman of the FTC states:

"Let me emphasize that it is not the Commission's role—and neither is it our desire—to drive market developments in any particular direction. Rather, our goal is to deter private restraints that limit the range of options available, or raise prices, to consumers."

If patients are sent to one facility based on their profitability to that physician, this is a limit on a consumer's choice. In the words of Mr. Pitofsky, this consumer, although perhaps an uninsured consumer, is faced with "private restraints that limit the range of options available." I hope the FTC watches this phenomena closely.

DON'T WEAKEN MALPRACTICE LAWS

I strongly urge the Committee not to weaken the current malpractice laws. The American consumer and patient is being subjected to an entirely new world of medicine. Government agencies are totally unprepared to protect the consumer in this new medical world. Therefore we must not abandon the protections provided by the judicial system.

In the past, doctors and hospitals often did harm by doing too much or by doing it erroneously. Under the fee-for-service indemnity insurance system, they had an incentive to do more—often more than they should have. But there was no question that they were trying to help the patient as best they knew how—and in the process were making money.

In the new world of managed care and HMO's, the financial emphasis has been totally reversed: you can make money by doing nothing, by not ordering tests, by not doing surgery.

As awful as the first system could be, I submit that these new incentives to under serve will lead to countless deaths and injuries as doctors and hospitals deny treatment. Government agencies are geared to fighting the fraud of abusive over treatment. They are not yet prepared to detect the malpractice of under treatment. As the OTA wrote in a study, "Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice may act to check potential tendencies to provide too few services."

I could offer dozens of examples of the malpractice of under-treatment. I would just like to submit for the Record, two items. The first is the editorial from *The Hill* of February 21, 1996 describing what happened recently to a Senate staffer, Vicky Collins, at the hands of her HMO. (I disagree with the editorial that the provisions in the vetoed Medicare bill would have done much to help; they are entirely too weak.)

The second is a portion of a letter I received from a constituent in Newark, California, that describes her and several friends' experience with breast cancer and HMO's.

After reading these items, I do not understand how you can be considering weakening the malpractice laws.

WE SHOULD CONCENTRATE ON SOLVING THE PROBLEM OF TOO MUCH MALPRACTICE

There is a malpractice crisis—there is too much of it! You have seen the estimates from the Harvard study and others. It is estimated that of the 40 million hospital admissions per year, 400,000 patients or 1% suffer preventable injuries from sub-

standard care. 50,000 of these people die from that "care." The other 350,000 suffer non-fatal injuries resulting in 30 days disability or longer. Yet only 2% of these incidents—8,000 cases—come to a malpractice trial. I would note other studies estimate the number of fatalities to be higher, perhaps as much as 80,000 to 180,000 unnecessary deaths per year throughout the health care system.

These malpractice cases are the true cost to our economy and society. Malpractice insurance premiums and settlements account for less than 1% of our nation's medical bill. As for unnecessary defensive medicine, in the new age of managed care, that is the very last thing we have to worry about. The OTA, CBO and other objective scholars who have studied the defensive medicine issue have never found it to be a significant cost or a clear-cut issue. (If members are worried about unnecessary medical testing and referrals, I urge them to oppose the provisions in the Republican Medicare Budget bill which weaken the physician anti-referral laws. Innumerable studies have shown that when a doctor has a financial interest in a testing or other facility, he will refer far more tests and more expensive tests. The CBO estimates that the weakening provisions in the Republican bill will cost Medicare alone at least $200 million over the next few years.)

Some will cite the California MICRA law (Medical Injury Compensation Reform Act) as a model for the nation and a law that has helped hold down costs in California. I don't agree. It has prevented lower income people, women, children, and others who do not have a strong economic earnings potential from obtaining legal counsel and help in pursuing blatant malpractice cases. As for costs, California has consistently remained a very high cost health care state, and I doubt that many of you would want to trade your state's health costs with California's.

Until we find better ways to make health care providers more "quality and care conscious," I believe the threat of a malpractice case can help deter careless and callous errors. Weaker malpractice laws are likely to lead to more careless practice. Society will end up with much larger costs in needless disabilities and deaths.

ANTITRUST RELIEF NOT THE ANSWER TO DISCIPLINING BAD DOCTORS

To combine antitrust relief for providers with malpractice relief would be the ultimate legislative malpractice.

Doctors and medical societies already fail miserably to discipline members they know to be deficient and dangerous. On a per capita basis, I suspect that the House Ethics Committee has a better ratio of discipline than the nation's good old-boy network of doctors.

Some doctors will argue they need antitrust relief in order to act against a fellow doctor. I think it is a terrible gamble to take that argument. The history of the AMA on dealing with minorities, their fight against chiropractors and the history of women in medicine makes one think that antitrust relief will be used more to support the dominant "culture" than to improve quality.

It is true that the 1986 data bank legislation has not worked well, because of problems with the slander and libel laws and because of questions of due process. The failure of that legislation to protect doctors against reporting malpractice should not be an excuse for a general weakening of the antitrust laws.

The most opposition I have ever had to a legislative proposal was my bill to require periodic recertification or re-testing of physicians. The violent reaction against this bill which was designed to improve quality and weed out incompetent physicians was absolutely astounding. As another example of the fight against quality, a group of back surgeons currently has a vendetta against the Agency for Health Care Policy and Research and has helped cause serious reductions in its budget because the Agency dared suggest in a peer-review scientific report that back surgery was often useless or dangerous and that sometimes it made sense to use a chiropractor.

I mention these examples to make the point: Until the medical community cooperates better in weeding out malpracticing doctors and is more supportive of efforts to improve quality, they do not deserve malpractice or antitrust relief.

Mr. HYDE. Well, I thank you, Congressman Stark.

We're going to have a question period, but it is my firm belief that the legislation before us does not immunize people from the antitrust laws; it merely changes the per se to rule of reason. So they're still subject to the antitrust laws, but under a different standard.

Mr. STARK. The chairman, as he is so apt to do, has just stripped away my veil of intelligence and exposed the ignorance of the law that I carry with me.

Mr. HYDE. Would the court reporter write that up, please? [Laughter.]

Mr. STARK. As I say, I make the case that proceeding to weaken antitrust, one should be very cautious to protect the patient's right.

Mr. HYDE. Well, I agree.

Mr. STARK. You have now reached the limit of my ability to plead for your indulgence in that area.

Mr. HYDE. I would welcome the gentleman to the side of defending the use of vouchers for schools, thinking of the kids instead of the system, because that's the argument you have just made and effectively, I might add persuasively, that we ought to think of the patients as well as the system and the doctors, and I would like to think of the kids having some options to get a decent education and not always be protecting the system. Just a wild, random thought.

Mr. CONYERS. Yes, Mr. Chairman? While we're indulging in wild, random thoughts?

Mr. HYDE. How appropriate, Mr. Conyers. [Laughter.]

Mr. CONYERS. Following your lead, could I just point out that giving out these wonderful vouchers for kids, what happens when you run out of the few good schools and then everybody is holding a voucher for the kids?

Mr. HYDE. Some kid is getting a decent education who isn't getting one now.

Mr. CONYERS. Well, guess what? Some are getting it right this minute as you tell me they aren't.

Mr. HYDE. Well, let's build more private and parochial schools then.

Mr. CONYERS. Well, how about building more good public schools?

Mr. HYDE. We've been trying that for billions of dollars a year for years.

Mr. CONYERS. Well, let's hold a hearing on it, what do you say?

Mr. HYDE. Will someone call for order here, please?

Thank you.

We'll now hear from our good friend, Bob Goodlatte, the Congressman from Virginia, who is one of the most valuable members of this full committee, and we welcome your comments, Congressman Goodlatte.

STATEMENT OF HON. BOB GOODLATTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. GOODLATTE. Well, thank you, Mr. Chairman. And I appreciate the opportunity to participate. [Laughter.]

Actually, I want to thank you for the opportunity to testify regarding my bill, H.R. 2938, the Charitable Medical Care Act, and I do have a statement for the record, but I also would like to speak for a few moments about it.

This bill deals with a problem in the medical liability area that is narrowly crafted and it creates for free medical clinics attempting to recruit health care professionals to volunteer their services

a better opportunity to do so. A number of my colleagues on the Judiciary Committee are original cosponsors of this bill, and I want to thank Representatives Moorhead, McCollum, Smith, Hoke, and Bryant of Tennessee for their willingness to take a lead on behalf of free clinics and the indigent.

This important legislation will make it easier for free medical clinics to recruit medical professionals to volunteer their services and enable them to provide care for a greater number of patients. Free clinics have developed as a privately-funded, grassroots effort to provide outpatient health services primarily to the working poor. There are over 200 free clinics in the United States which have evolved with no Federal support and with little local government support. My district is privileged to be the home of several outstanding free clinics, including one of the finest free clinics in the country, the Bradley Free Clinic of Roanoke, VA. The Bradley Free Clinic is also headquarters of the Free Clinic Foundation of America which has been working to provide services to assist and establish free clinics across the country.

My friends at the Bradley Free Clinic brought to my attention the problems free clinics nationwide encounter finding medical staff willing to volunteer their time and services because of concerns over medical liability. Retired medical professionals don't have liability coverage and therefore can't volunteer. Actively practicing medical professionals who would like to provide free care for the indigent are discouraged by the possibility it will put their medical malpractice at risk.

I am in full agreement with a statement made by Chairman Hyde at yesterday's hearing, that whether this threat of liability is just a perception, or in fact a reality, it is truly a factor in volunteer recruitment. As a result, many low income people do not get the care they need. In response, I introduced H.R. 2938, which is similar to legislation passed in Virginia during the 1980's, to exempt health care professionals who provide free services in connection with a free clinic from liability in simple negligence only. In fact, Virginia is one of eight States that have laws in place exempting doctors who voluntarily provide free care, in good faith, from liability for simple negligence.

While medical liability suits against health care professionals who volunteer their services at free clinics are very rare, in fact, the Catholic Health Association will testify that they have not come across a single reported case of a free clinic or a free clinic volunteer being sued. Under this legislation health care professionals would not be protected if they commit gross negligence or willful misconduct. In addition, the exemption would only apply if the patient received the care at no charge, there was no reimbursement to the health care professional for providing the service, and the patient had informed consent before the service was rendered that any liability incurred by their health care provider would be limited to gross negligence and willful misconduct.

With over 30 million uninsured Americans, the need for privately-sponsored free clinics and health services has never been more acute. It is estimated that charitable medical care provides care to 30 percent of the Nation's uninsured, and is an important alternative to expensive emergency room care, which is far too

often the only care available for the uninsured or underinsured. This legislation would help ensure that free clinics continue to fulfill this important role by making it possible for them to attract volunteers.

Mr. Chairman, I might add, if one might ask, "Why do we need this legislation if there have been no reported cases," well, it's kind of like a negative lottery. A retired physician does not want to go to the great expense of purchasing malpractice insurance simply for the opportunity to volunteer a few hours a week. On the other hand, if they do not do it, and they are the one person who gets it, they're looking at a six-figure or seven-figure potential award against them that could wipe them out. So they're simply not going to get involved, and, therefore, there is a shortage of health care professionals for free clinics that we need to change by encouraging this.

And I also want to say a good word for our friend Mr. Porter's legislation, which is headed in the same direction. His is broader; it covers more than free clinics; it covers all volunteers. I think mine goes deeper in targeting what I think is needed for free clinics in that it gives the coverage to the health care provider as well as the clinic itself. And it gets right to the heart of doing it right now. He noted that this was an emergency and this legislation will most quickly address that emergency.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Goodlatte follows:]

PREPARED STATEMENT OF HON. BOB GOODLATTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, I thank you for the opportunity to testify on my bill, H.R. 2938, the Charitable Medical Care Act and for holding these hearings to identify the problem that medical liability creates for free medical clinics attempting to recruit health care professionals to volunteer their services.

A number of my colleagues on the Judiciary Committee are original cosponsors of this bill. I want to thank Representatives Moor head, McCollum, Smith, Hoke and Bryant of Tennessee for their willingness to take a lead on behalf of free clinics and the indigent. This important legislation will make it easier for free medical clinics to recruit medical professionals to volunteer their services and enable them to provide care for a greater number of patients.

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Thank you Mr. Chairman.

Mr. HYDE. Well, I thank the gentleman very much for his contribution.

I might say that I misspoke to Congressman Stark. There will not be a question period of the Members of Congress, so I didn't want you to be waiting around for that if you had other things to do.

Mr. ARCHER Thank you, Mr. Chairman.

Mr. HYDE. You bet.

Our next witness we're very pleased to have with us this morning, Senator Mitch McConnell from Kentucky. He is the author of two bills in the Senate: the Volunteer Protection Act, that's S. 1435, and the Health Care Liability Reform Act, which is S. 454, which relate to these issues. I'm sure Senator McConnell's input on these two subjects will be of great benefit to the committee.

Senator McConnell.

STATEMENT OF HON. MITCH McCONNELL, A SENATOR IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. MCCONNELL Thank you very much, Mr. Chairman. I appreciate the chance to take a couple of minutes here just to outline those two issues.

During the 1994 national conversation on health care, Congress rejected very vividly, as we all recall, the dismantling of the world's best health care system. We did, however, learn that there are aspects of our medical system that need to be changed and today I'd like to address one important component, the health care liability system.

Our medical liability system impedes access to quality health care and rewards some people who take their chances in the lawsuit lottery. A few facts are notable. A half a million rural women can't find an obstetrician close to their homes and most of those truly injured don't get fairly compensated when only 43 cents of every dollar spent in the liability system actually goes to the patients. Last year I, along with Senators Lieberman and Kassebaum, introduced a bill, S. 454, to change the medical liability system in a way that would ensure those who are injured get fully and fairly compensated, to make quality health care more accessible,

contain costs, strengthen the doctor-patient relationship, encourage medical innovation, and promote patient safety.

Senator Kassebaum held a hearing on our bill and the Labor Committee reported it out last April. When the Senate considered product liability reform, I offered our medical liability bill as an amendment; it passed the Senate but could not withstand a filibuster against the final product liability product which had been enhanced, not only by a punitive damage cap, but also by the medical liability amendment. So we had to strip that out in order to get 60 votes to get it cleared out of the Senate. Without going into the details of my bill, let me suggest some items for your consideration as you evaluate how to approach the needed changes to our medical liability system.

First, any reform effort should apply to all aspects of the health care system: doctors, hospitals, and drug and device manufacturers. The standards must be the same for all parties in the health care delivery system or else we will clearly create more litigation when injured parties bring multiple lawsuits for the same negligence. And, more litigation enriches only the lawyers, as we all know, not the injured parties.

Second, our legal system must stop rewarding those who overuse and abuse the health care system. While the injured party should be made whole economically, the patient should only be paid once for injuries suffered, not once from insurance and a second time from a lawsuit. And punitive damages should reflect punishment of the defendant, not a windfall to the injured party based on some multiple of excessive medical expenses.

Third, the fortunes of the legal profession should not be linked to those of their clients. In a perverse incentive structure lawyers' contingent fees depend on hitting the jackpot and thus continuing the lawsuit instead of settling it. Lawyers' contingent fees should be capped or be permissible only in those cases where a lawyer takes a risk in taking the case to trial.

Fourth, we must develop a system for those injured who want prompt payment and those responsible parties who are willing to pay without protracted litigation. Some forms of alternative dispute resolution may accomplish this, but I favor a system called Early Offer which Congressman Gephardt, interestingly enough, called about a decade ago a proposal to make the medical malpractice recovery system cheaper, more rational, and fair. Senator Spencer Abraham and I included Early Offer in our bill, S. 300, which is a comprehensive legal reform initiative.

Finally, some consideration should be given to the impact of the recent extension of the Federal Tort Claims Act to medical malpractice claims arising in federally-funded community health centers. This may provide a possible reform for other federally-provided health care.

Let me just briefly turn to another aspect of the legal crisis; that is, those who are victimized by lawsuits who are essentially selfless volunteers who help at worthy organizations and institutions. When the legal ensnares these individuals, this results in too many people pointing fingers and too few offering a helping hand.

Last year I introduced another bill, S. 1435, to create immunity under certain conditions for those who volunteer—this is very nar-

rowly crafted—for those who volunteer for nonprofit organizations. As long as volunteers act within the scope of their responsibilities, are properly licensed or certified where necessary, and do not cause harm willfully, they could not be held liable for harm. Of course, the organization or institution could still be held accountable for damages negligently inflicted. I've been working with Congressman Porter on this initiative, and while our proposals take different approaches, our goal is the same: to eliminate the lawsuit burden from the caring citizens who give their time and service to their communities.

Mr. Chairman, we've created a litigious society which drains scarce economic resources from more productive uses. In the health care arena the adversary process drives doctors from certain specialties and it keeps advanced medical technologies and products from the patients who need them. The health care liability system can be changed to reverse these trends and at the same time put more money in the hands of injured parties. Our legal system, including the health care liability system, is suffering from "lawsuitenitus," according to one editorial cartoonist. The cure has to be taken by Congress, a strong dose of legal reform. I think these hearings we're having, Mr. Chairman, are a great idea and I look forward to seeing what products you've produced.

Thank you very much.

[The statement of Mr. McConnell follows:]

PREPARED STATEMENT OF HON. MITCH MCCONNELL, A SENATOR IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. Chairman and members of the Committee, thank you for inviting me to testify on the legal aspects of our health care system. During the 1994 "national conversation" on health care, Congress rejected the dismantling of the world's best health care system. We did, however, learn that there are aspects of our medical system that need to be changed, and today, I would like to address one important component: the health care liability system.

Our medical liability system impedes access to quality health care and rewards some people who take their chances in the "lawsuit lottery."

A few facts are notable: Half-a-million rural women can't find an obstetrician close to their homes. And, most of those truly injured don't get fairly compensated when only 43 cents of every dollar spent in the liability system goes to the patients.

Last year, I, along with Senators Lieberman and Kassebaum, introduced a bill (S. 454) to change the medical liability system in a way that would ensure those who are injured get fully and fairly compensated; make quality health care more accessible; contain costs; strengthen the doctor-patient relationship; encourage medical innovation; and promote patient safety.

Sen. Kassebaum held a hearing on our bill and the Labor Committee reported it out last April. When the Senate considered product liability reform, I offered our medical liability bill as an amendment. I'm pleased to say that we had a majority of the Senate support the amendment, but unfortunately, my amendment could not withstand a filibuster on the final product liability bill by those trial lawyer supporters who populate the Senate.

Without going into the details of my bill, let me suggest some items for your consideration as you evaluate how to approach the needed changes to our medical liability system.

First, any reform effort should apply to all aspects of the health care system: doctors, hospitals *and drug and device manufacturers.* The standards must be the same for all parties in the health care delivery system or else we will clearly create more litigation when injured parties bring multiple lawsuits for the same negligence. And more litigation enriches only the lawyers, not the injured parties.

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insurance and a second time from a lawsuit. And, punitive damages should reflect punishment of the defendant, not a windfall for the injured party, based on some multiple of excessive medical expenses.

Third, the fortunes of the legal profession should not be linked to those of their clients. In a perverse incentive structure, lawyers' contingent fees depend upon hitting the jackpot, and thus, continuing the lawsuit instead of settling it. Lawyers' contingent fees should be capped or be permissible only in those cases where the lawyer really takes a risk in taking the case to trial.

Fourth, we must develop a system for those injured who want prompt payment and those responsible parties who are willing to pay, without protracted litigation. Some forms of alternative dispute resolution may accomplish this, but I favor a system called "early offer" which Congressman Gephardt called a proposal to make the medical malpractice recovery system "cheaper, more rational . . . and fair" when he first introduced it a decade ago. Sen. Abraham and I included "early offer" in our bill, S. 300, which is a comprehensive legal reform initiative.

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I have been working with Congressman Porter on this initiative and while our proposals take different approaches, our goal is the same: to eliminate the lawsuit burden from the caring citizens who give their time and service to their communities.

Mr. Chairman, we've created a litigious society which drains scarce economic resources from more productive uses. In the health care arena, the adversary process drives doctors from certain specialities, and it keeps advanced medical technologies and products from the patients who need them. The health care liability system can be changed to reverse these trends and, at the same time, to put more money in the hands of injured patients.

Our legal system, including the health care liability system is suffering from "lawsuitenitus," according to one editorial cartoonist. The cure has to be taken by Congress—a strong dose of legal reform.

Mr. HYDE. Thank you very much, and we've appreciated having your contribution.

Our next panel of witnesses will be testifying principally on H.R. 2925, the Antitrust Health Care Advancement Act of 1996. The exception to this is Dr. Nancy Dickey, who appears on behalf of the American Medical Association. Dr. Dickey will be presenting the AMA's position on medical malpractice liability reform and volunteer liability as well. Dr. Dickey was elected chair of the AMA's Board of Trustees November 1995, having previously served as its vice chair. She is a board-certified family physician from Texas.

On behalf of the American Association of Nurse Anesthetists, we have Ms. Gayle McKay with us today. Ms. McKay is the associate program director for the Abbott Northwestern Hospital School of Anesthesia in Minneapolis. She is a registered nurse and a certified registered nurse anesthetist.

Speaking on behalf of the Group Health Association of America/American Managed Care and Review Association is Margaret Metzger. Ms. Metzger is the senior vice president and corporate

general counsel for Tufts Associated Health Plan headquartered in Massachusetts.

We also have Prof. Clark Havighurst with us today. Professor Havighurst is the William Neal Reynolds Professor at Duke University School of Law. He has taught courses in health care law and policy and antitrust law and has written several articles on antitrust issues related to the health care field.

And so we will proceed with, we'll go from this side to that side saving the best for last, as the wedding feast at Canna did, and so we'll proceed with you, Ms. Dickey, not that you're not the best, too. Go ahead. I had to wiggle out of that one.

Mr. CONYERS. That was pretty rough.

Mr. HYDE. Mr. Conyers was kicking me, I might add.

STATEMENT OF NANCY DICKEY, M.D., CHAIR, AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES

Dr. DICKEY. Thank you very much, Mr. Chairman.

My name is Nancy Dickey. I am a practicing family physician and the program director for the family practice residency training program at Texas A&M University College of Medicine. I also serve as chair of the American Medical Association's Board of Trustees.

I'm pleased to testify today regarding H.R. 2925 and health care liability reforms. Physicians applaud your continued leadership in seeking meaningful antitrust and liability reforms. We especially appreciate your recent introduction of the Antitrust Health Care Advancement Act of 1996.

Mr. Chairman, we're aware that the Chairman of the FTC testified yesterday before this committee and we'd like to set the record straight. First, doctors are not here seeking special treatment. For years, we've been getting special treatment. For years, the FTC and the DOJ have analyzed physician joint ventures differently than joint ventures in any other industry and this must stop. We'd be satisfied if we could just get equal treatment under the antitrust laws.

Second, there's a very real problem here. The agencies are using antitrust enforcement policy to restrict competition by physicians. This is especially true of those physicians who wish to offer products with a high degree of patient choice, such as PPO's. Those physician networks that exist or have been approved, which have been cited to show the FTC's flexibility, fit within its very narrow safe harbors. And overall, there are very few of them. The FTC routinely strikes down legitimate ventures that fall outside its rules, or it chills doctors from even starting such ventures.

Finally, we are not alone in our beliefs, as I'm sure you'll hear more later. Professor Havighurst, one of the FTC's strongest supporters, agrees that the agency's policy on physician joint ventures is wrong. He says and I quote, "The issue is not even a close one." Further, he says that "The agency is caught in a time warp."

H.R. 2925 would serve the public good by requiring the legitimate physician networks, as defined by the legislation, receive the same antitrust treatment as joint ventures in other industries. H.R. 2925 would require that physician ventures meet several significant components of integration in order to receive rule-of-reason

treatment. It would exempt no physician network from agency review.

Provider networks that engage in anticompetitive conduct could still be challenged by enforcement agencies or any private party, and rightly so. Physicians and other providers who form networks would not, however, be automatically subject to per se condemnation with its criminal penalties provided their network meets the criteria of the legislation. Again, H.R. 2925 does not contain an antitrust exemption for physician joint ventures. Likewise, it doesn't provide special treatment for physician networks. What it would provide is more choice, better quality, and greater competition in the health care marketplace. It would provide for those very patients that concerns were set forth by Congressman Stark, and which we think are always at the heart of the AMA's policies and concerns.

Clarifying the law through legislation is both necessary and appropriate. As Professor Havighurst says, Americans are currently being denied access to care. Based on public interest concerns, Congress approved the National Cooperative Research Act of 1984, establishing rule-of-reason treatment for research ventures. Congress extended that protection to production joint ventures in 1993. These laws were passed to address the strong fear among U.S. companies that cooperative ventures, in responding to consumer demand, would violate antitrust laws. They sought the clarification in order to move forward in the public's best interest.

Mr. Chairman, physicians are asked, or even expected, to play a role in bringing innovative health care products to the marketplace. Yet many times they're fearful to do so due to a threat of antitrust prosecution. The important root question for all of us is, do current enforcement policies, which result in different treatment toward physician networks, serve the public interest? We believe they do not. There is growing evidence to indicate that health care delivery networks perform best when led by physicians and other providers. Proper antitrust enforcement would recognize the benefits of provider consideration and coordination and not be hostile to that coordination.

H.R. 2925 provides us with this opportunity.

We look forward to working with you, Mr. Chairman, and the committee, to ensure passage of the legislation. I know the committee heard testimony yesterday about health care liability. Our position is that we all have responsibilities. The AMA advocates two steps. First, a focused approach to challenge patient safety and make it better, and, secondly, legislative reform. The first step should be met by the profession. We're making good progress in that direction and have just approved a patient safety initiative that will move that agenda further forward. We think legislation is the responsibility of Congress to help make that system work better.

Mr. Chair, we thank you for the opportunity to share our thoughts and concerns and we'd be pleased to answer any questions, if you have any.

[The prepared statement of Dr. Dickey follows:]

PREPARED STATEMENT OF NANCY W. DICKEY, M.D., CHAIR, AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES

My name is Nancy W. Dickey, MD. I am the Program Director for the Family Practice Residency at the Texas A&M College of Medicine. I also serve as Chair of the American Medical Association's (AMA) Board of Trustees. On behalf of the AMA, I appreciate the opportunity to testify before this Committee concerning antitrust, health care liability reform and volunteer liability. We commend you, Mr. Chairman, for your continued leadership in recognizing the importance of passing into law meaningful antitrust and liability reforms. In this context, we especially appreciate your introduction of H.R. 2925, the Antitrust Health Care Advancement Act of 1996.

ANTITRUST RELIEF

There is no question that the health care market is undergoing substantial change in the way health care services are delivered. Ideally, this transformation should provide patients with greater choice of plans, including those formed by doctors and hospitals to provide health care services in competition with insurance companies. Yet, the antitrust enforcement policies of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) stand in the way of achieving this reality by unnecessarily restricting the ability of physicians to develop competitive products. Recognizing this roadblock to innovation, the House of Representatives courageously and correctly approved, as part of the Medicare Preservation Act of 1995, rule of reason treatment for legitimate provider networks serving the Medicare population. Although the antitrust provision was ultimately stricken from the Balanced Budget Conference Report under the guise of the so-called "Byrd Rule," the AMA is grateful for the House of Representatives' vision of a stronger Medicare program and its commitment to this issue.

The purpose of the antitrust laws is to preserve a competitive marketplace. The health care industry has been characterized in recent years by increased concentration, greater innovation, and the introduction of the new products. These changes have brought intensified antitrust scrutiny. A disproportionate share of this enforcement activity has been directed at discouraging the formation of relatively small physician networks.

The 1994 FTC/DOJ policy statements specify extremely narrow criteria that a physician network must meet in order to avoid a per se violation of the antitrust laws. In so doing, these agencies fail to treat physician ventures in the same manner as joint ventures in other industries, resulting in chilled innovation in the delivery of medical services, and dramatically reduced patient choice. The harsh treatment of physician networks is particularly inappropriate as the entities with which physicians must compete, insurance companies and managed care plans, continue to merge and grow ever larger.

Current DOJ/FTC policy unduly restricts the size and structure of provider groups, placing them at a competitive disadvantage. The agencies apply strict scrutiny to provider-owned ventures which include more than 30% of area physicians, while many insurer-owned plans have a greater number of physicians in their plans. In addition, the enforcement agencies treat collaborative conduct by physicians as per se unlawful, unless the physicians accept capitation contracts or apply substantial fee withholds, regardless of the degree of integration of the physician venture. While the enforcement agencies allude to other types of economic integration which would be acceptable, only physician networks utilizing capitation or fee withholds have been approved.

It is certainly true that legitimate joint ventures must demonstrate some economic integration by their members; however, nothing in the law requires that this be done through capitation or fee withholds. This extreme position by the enforcement agencies has prevented ventures using other types of financial risk sharing, such as pooling of capital to operate a discounted fee-for-service plan or PPO from receiving rule of reason treatment. These are among the types of products most in demand in today's market. In fact, more Americans are enrolled in PPOs than in HMOs and other capitated plans.

Moreover, the agencies' policy is at odds with the applicable case law upon which it is based. In *Arizona* vs. *Maricopa County Medical Society*, 457 U.S. 332 (1982), maximum fee schedules were established by two not-for-profit medical foundations. The foundations also performed utilization review and prohibited the physicians from balance billing. In this case, the U.S. Supreme Court held that the maximum fee schedules amounted to per se illegal price-fixing. In so holding, the Court noted that the foundations were not "analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and

share the risks of loss as well as the opportunities for profit." This decision clearly anticipates that legitimate ventures funded by equity investments would merit rule of reason treatment.

Likewise, the Supreme Court has regularly held that horizontal agreements which render markets more efficient and competitive are not to be condemned under the per se rule. In both the *Broadcast Music, Inc., et al.* vs. *Columbia Broadcasting System, Inc., et al.*, 441 U.S. 1 (1979) and *National Collegiate Athletic Association* vs. *Board of Regents of the University of Oklahoma, et al.*, 468 U.S. 85 (1984) cases, the Court refused to apply the per se rule to horizontal price and output agreements. The Court found that the nature of each market, and the need for some level of cooperation to deliver a product at all, required that the agreements be judged under the rule of reason. Similarly, physicians cannot deliver the comprehensive products demanded by employers and payers without engaging in collaborative activities. As long as this collaboration does not harm competition, there should be no requirement in the law that the joint activity be conducted in any particular manner.

Clark C. Havighurst, William Neal Reynolds Professor of Law at Duke University and long-time supporter of the agencies' enforcement policies, agrees that it is time for the agencies' disparate treatment of physician networks to end (see attached letter with accompanying draft paper sent to Anne Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice; and Robert Pitofsky, Chairman, Federal Trade Commission). Professor Havighurst strongly advocates applying the "rule of reason" to legitimate physician networks:

> Certainly, risk sharing and integration are appropriate requirements in defining safe harbors for certain physician collaborations. But they should not be made mandatory in all joint ventures by denying noncomplying ones a hearing under the rule of reason even when the parties make a plausible claim that their purpose is pro competitive and that their agreement on prices is ancillary to that purpose. In fact, absence of the features specified by the agencies does not unerringly identify a naked restraint deserving automatic condemnation without proof of the parties' anticompetitive purpose. . . . Thus, a correct analysis of a physician-sponsored network falling outside the guidelines' safety zones would walk sensitively through the elements of purpose, power, and effect, condemning it only if there is a probable net harm to competition or if the parties have employed unreasonable means to achieve their legitimate objectives.

As Professor Havighurst so aptly points out, the role of antitrust enforcement is to preclude anticompetitive conduct, not to require that competitive activities be conducted in a certain way. The latter endeavor is, and should be, the role of the health care market.

Chairman Hyde's Antitrust Health Care Advancement Act of 1996 (H.R. 2925) would accomplish this goal by requiring that legitimate physician networks, as defined in the legislation, receive the same antitrust treatment as joint ventures in other industries. The bill would merely apply the well-established rule of reason test to the conduct of legitimate provider networks, which means that networks engaging in anticompetitive conduct in any market could be challenged by the enforcement agencies or any private party. Physicians and other providers who form networks would not, however, be automatically subject to the *per se* rule with its criminal penalties if their network meets the substantive criteria of the legislation.

H.R. 2925 would require that physician ventures meet several significant components of integration to receive rule of reason treatment. The physician network must be organized by, operated by, and composed of members who are health care providers; be funded in part by capital contributions made by the members; and have in place integrative tools such as programs for utilization review, quality assurance, coordination of care and resolution of patient grievances and complaints. The network must contract as a group and require all members of the group to provide the services for which the network has contracted.

Applying the rule of reason to integrated ventures with a legitimate purpose, as the H.R. 2925 does, is consistent with the antitrust treatment of joint ventures in other industries. This legislation does not contain an antitrust exemption for physician joint ventures. Likewise, H.R. 2925 does not provide special treatment for physician networks.

Clarifying the law through legislation of this kind is both necessary and appropriate. In 1984, Congress determined that a legislative clarification of the antitrust laws would serve the public interest by promoting the development of research and development joint ventures. The National Cooperative Research Act of 1984 established a rule of reason standard for research ventures, and Congress extended that

protection to production joint ventures in 1993. These laws were passed to address a strong fear among U.S. companies, particularly those in emerging high-tech industries, that cooperative ventures would violate the antitrust laws.

A parallel situation exists in the health care industry today. The health care marketplace is evolving rapidly, with new products and services appearing almost daily. Physicians are increasingly asked, even expected, to play a role in these products. They are fearful to do so in large part due to the threat that their conduct will be judged per se unlawful and will subject them to severe civil and criminal penalties. The attached letter from Jeff Kraft, an antitrust attorney experienced in developing health care organizations, demonstrates that an overly restrictive application of the law can prevent competition and reduce patient choice.

The experience with the National Cooperative Research Act suggests that a carefully drafted clarification of the application of the antitrust laws to certain joint ventures will spur innovation without harming competition. In health care, innovation by experienced medical professionals is greatly needed to assure that efforts to reduce costs do not destroy quality in the process.

Antitrust policy should foster legitimate physician participation in the health care market. Recent media accounts have detailed the merger mania which has saturated the health care marketplace in recent years (see attached articles describing various mergers around the nation). In a five billion-dollar-plus transaction, two hospital chains merged to form Columbia/HCA Health trust, the country's largest for-profit hospital group. Blue Cross/Blue Shield of Texas and Blue Cross/Blue Shield of Illinois have announced plans to merge in order to better position themselves in the world of managed care. With large health care companies getting ever larger in the marketplace, the AMA finds it difficult to understand why a group of physicians cannot join forces to compete in the marketplace to provide quality health care services to our patients without fear of criminal sanctions.

Employers are increasingly looking to deal directly with provider groups in order to maximize savings, quality, and patient choice. The Buyers Health Care Action Group (BHCAG) located near the Twin Cities in Minnesota is evidence of this demand. BHCAG made national news when it announced last year that it had organized 24 of the nation's largest self-insured employers, including General Mills, Honeywell, and the 3M Company, into a purchasing group that would bid for direct contracts with provider organizations. This development was heralded as the first time that employers in a mature, managed care market had opted for direct contracting over other managed care arrangements such as HMOs.

BHCAG recognizes that provider networks present a real and substantial competitive alternative to insurance company plans. By removing the insurance company's administrative costs and profits, employers can devote a greater percentage of their premium dollars to patient care which will lead to improved quality and a healthier, competitive market.

Indeed, there is growing evidence to indicate that health care delivery networks perform best if led by physicians and other providers. A recent study led by Stephen M. Shortell, a Professor of Health Services Management at Northwestern University entitled, "New World of Managed Care: Creating Organized Delivery Systems," found that health care delivery systems which had significant "physician system integration" performed better than those which did not. The author defines physician system integration as the degree to which physicians use the system, including being involved in the planning, management and governance of the system. The study also found that the higher the degree of physician-system integration, the greater the delivery system's inpatient productivity.

Yet, provider networks cannot present a meaningful alternative to insurance company plans, and, thereby, improve the competitive process, if they are not permitted to operate effectively. Proper antitrust enforcement should recognize the benefits of provider integration, not be hostile to them. Such enforcement should be brought into line with the law, and Chairman Hyde's Health Care Antitrust Advancement Act of 1996 provides us with this opportunity. We urge the committee to advance its provisions through the legislative process as soon as possible.

MEDICAL LIABILITY REFORM

As the Committee is aware, the issue of liability exposure in medicine has been a priority for the AMA and the nation's physicians for many years. The volatility in the current system for resolving disputes and awarding compensation for health care injuries serves neither patients nor physicians well. Acknowledging this significant problem, the House of Representatives voted and approved for the first time in history a basic package of highly effective health care liability reforms as contained in the H.R. 956, the Common Sense Product Liability and Legal Reform Act

of 1995 and H.R. 2425, the Medicare Preservation Act of 1995. These reforms include:

A $250,000 limit on the recovery of Non-economic damages;

Collateral Source Reform, allowing juries to be informed when claimants have already been compensated through insurance for health care costs or lost wages;

Periodic Payment of Non-economic damages in excess of $50,000;

Limiting the time period for filing claims to no more than two years after the injury is discovered but in no event more than five years after initial injury occurred ("statute of limitations" reform);

Joint and Several Liability Reform for Non-economic damages; and

A defense against Punitive damages for claims involving medical products that have been approved by the FDA, after full disclosure of all material facts by the manufacturer.

The AMA remains committed to these reforms and is grateful for the leadership the House has shown in securing passage of these necessary and sensible proposals.

THE PHYSICIAN-PATIENT RELATIONSHIP

In this time of revolution in the way health care services are delivered, the AMA's central concern is preserving and strengthening the physician-patient relationship. We are convinced that the need for national reform of the legal system is crucial to preserve a constructive physician-patient relationship. But we also recognize that injuries do occur in a small percentage of health care interactions, and that they can be devastating to patients and their families as any serious illness can be. While some of these injuries are unavoidable, a fraction do involve a breach in the standard of care every patient has a right to expect. When such injury occurs, the AMA believes the patient is entitled to prompt and fair compensation.

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

Unfortunately, our health care liability system is neither fair nor cost effective in making the patient whole. Transformed by high stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended, non-economic damage awards and contingency fees that are equally unlimited. RAND Corporation research shows that juries give consistently higher non-economic damage (e.g. "pain and suffering") awards in medical liability cases than in other personal injury cases where comparable injuries are alleged. A very few patients, and their attorneys, actually become multi-millionaires as the result of a single judgment or settlement, while most persons with valid claims appear to be blocked from even gaining access to the civil justice system. Even when patients recover an award, U.S. General Accounting Office (GAO) studies show that they often fail to net their out of pocket losses, after contingency fees and legal expenses are deducted. The sad truth is that plaintiffs receive, on average, only 43 cents of every dollar awarded, while over 50 cents goes to legal fees.

As a result, the AMA believes two crucial steps are urgently needed: A focused approach to the challenge of patient safety; and, a comprehensive legislative reform of the legal system to put into place basic rules that ensure fair compensation, yet stop the lawsuit lottery. The first step is the job of the health care sector, and the AMA Board of Trustees has recently approved an initiative to promote patient safety that will focus on human error in our exceptionally complex health care delivery system. Working with public health experts and system design engineers from medicine and other fields, we hope to foster research, promote the exchange of ideas about error in medicine, and ultimately reduce the existing marginal rate of injury even further. The second step requires continued Congressional leadership and action to secure both House *and* Senate approval of appropriate and time-proven provisions addressing health care liability claims.

THE EVOLVING PROBLEM OF HEALTH CARE LIABILITY

Without doubt, the United States has the most expensive tort system in the world. In November 1995, Tillinghast-Towers Perrin, a leading health care actuarial firm published an updated study comparing tort costs internationally. The underlying finding was that our tort costs as a percentage of GNP far outstripped any other country. Indeed, we are the only country that allows unlimited open ended compensation for pain and suffering. No other country compensates for pain and suffering above the $250,000 cap passed last year by the House. Additionally, Tillinghast's study reflects the impact that our plaintiff's lawyer "contingency fee" compensation arrangement has on tort costs. In essence, we are the only country with a plaintiff's

lawyer compensation arrangement, that, because it is a percentage of an unlimited award, also is open-ended and unlimited. These are two prominent factors driving the lottery in tort cases in the United States.

Another important finding of the Tillinghast study is that liability costs in the health care sector are continuing to spiral upward in the 1990s. Whereas other tort-related trend lines have more or less stabilized, rising by 3–4% per year in accordance with inflation, health care liability insurance costs rose by 10–12% per year thus far in the 1990s.

The Tillinghast study is but one of a number of important indicators of the evolving and alarming change in health care liability cases in recent years. First, there has been an increase in claims against those physicians most involved in managed care internists and family physicians. Further, new data produced by Jury Verdict Research shows that verdicts in health care cases were significantly higher in 1995. Indeed, the average verdict rose by 40% from a median of $356,000 in 1994, to $500,000 in 1995. Moreover, 5 of the 10 largest verdicts in the country in 1995 were in health care cases, with hospital systems and managed care organizations represented as defendants.

While these patterns are still evolving, they confirm several significant points. The AMA has argued for some time the connection between health care liability reforms and health care costs. For instance, in 1975, California had the highest medical liability premiums in the world. Subsequent to MICRA enactment, the state's premiums have been effectively stabilized, and now are one-third to one-half lower on average than those in Florida, New York and other states that have been unable to achieve similar legislation. In contrast, the state of Ohio enacted California-like reforms and initially enjoyed similar results. However, Ohio's cap on non-economic damages was overturned, resulting in escalating losses and malpractice costs.

To substantially add to the weight of this argument, CBO last year for the first time ever scored savings directly attributable to health care liability reform, in particular a $250,000 limit on non-economic damages. Specifically, CBO found scorable federal government savings of $200 million in malpractice premium savings alone over the next seven years (a very conservative estimate since it was based only on physician liability insurance costs and failed to incorporate the similar costs of hospital systems, HMOs or medical product distributors). A GAO study just released found that there would be substantial additional savings from decreases in defensive medicine, another factor which the CBO failed to consider in its analysis. The fact that CBO has scored medical liability reform underscores that the reforms advocated by the AMA and approved by the House of Representatives reduce the cost of health care for consumers and payers, not just liability premiums of health care providers.

Next, piecemeal liability reform would result in unintended consequences. As indicated, the Tillinghast study confirms that health care liability is still the most volatile part of the tort system—the part most in need of effective reform. The AMA has argued for several years that product liability reform in isolation could shift liability exposure to health care services providers in mixed product/malpractice cases. For this reason, the AMA in 1993 adopted a reform platform that applies broadly to all parts of the health care sector and joined with other health care organizations to form the Health Care Liability Alliance (HCLA). Similarly, we are concerned that placing limits on punitive damage awards without simultaneously addressing non-economic damages would lead to gaming of the system. If only punitive damages are capped leaving non-economic awards with no ceiling, plaintiff's lawyers would simply change their complaints to plead greater non-economic damages. Indeed, evidence of this problem is illustrated in a January 1996 *Lawyer's Weekly USA* article. According to the *Lawyer's Weekly USA*, Georgia caps punitive damages at $250,000 unless there is a specific intent to harm. Therefore, the article notes, a plaintiff may actually be awarded more money in general damages. The attorney representing the Georgia plaintiff in a medical liability case decided not to seek punitive damages for this reason.

Finally, the AMA is very concerned that initiatives that encourage managed care without addressing liability concerns of physicians and hospitals will also shift liability exposure, at least in the short run. Because some managed care organizations have been shielded from liability due to "hold harmless" clauses, state laws which fail to define the managed care company as a health care provider or ERISA, physicians and hospitals are increasingly vulnerable to suits arising from the attempt to contain costs in managed care settings. Further, as the statistics cited above strongly indicate, managed care organizations themselves are experiencing increased liability exposure for non-economic damages. For these reasons, it is critical that any Medicare reform legislation or other initiatives that encourage managed care include a liability reform component.

HEALTH CARE LIABILITY REFORMS

As indicated, the AMA is pleased with the reforms approved by the House of Representatives last year, including a cap of $250,000 on non-economic damages. In the context of the Medicare Preservation Act, we continue to support the technical corrections package the AMA has advanced which includes specific limited preemption language that would clarify the status of states which have enacted reforms broader in scope than what the Congress enacts. In essence, the AMA supports a limited federal approach that would implement a basic package of reforms proven effective in the states yet leave states with substantial power to enact additional or alternative provisions tailored to a specific state's interests and needs.

The AMA strongly supports a cap of $250,000 on non-economic damages. Such a cap is crucial to effective and sensible liability reform. Every major independent study over the last 15 years has reached the same conclusion. Namely, that enacting a limit on non-economic damages is the most effective reform in containing runaway medical liability costs. These studies include those conducted by the OTA, IOM, President Bush's Council on Competitiveness, President Reagan's Tort Policy Working Group, and President Carter's Department of HEW. Additionally, a September 1995 study published by the American Academy of Actuaries concluded:

> What's needed to make medical malpractice reform effective is a package of reforms—reforms that have proved capable of some degree of success in stabilizing medical malpractice costs. To date, the most productive elements for such a package have proved to be (1) caps on noneconomic damages and (2) some form of offset for collateral payments from other sources.

In essence, this report confirms that a package of reforms that necessarily includes a limit on non-economic damages is crucial to containing malpractice costs. As previously indicated, California has had such a package, including a $250,000 cap on non-economic damages, since 1975 and has since seen its loss levels and premiums decline significantly relative to other states. The Medical Injury Compensation Reform Act (MICRA) screens out "lottery" awards in California and demonstrates that such a cap brings down costs, while maintaining the patient's right to be made whole—a right we strongly support. The report concludes:

> Again, this data appears to support the benefits of tort reform enacted as a coordinated package, as well as the specific benefit from a cap on non-economic damages, as seen by the increase in costs when the cap was no longer in effect.

There are those who argue that a $50,000 cap on non-economic damages will keep deserving patients from getting the million dollar settlements they may deserve. This is simply untrue. In fact, patients with valid claims and serious injuries continue to receive million-dollar-plus awards in California, despite the state's $250,000 cap on non-economic awards. The number of million dollar verdicts and settlements has hovered around 30 per year in the 1990s, with the average indemnity in these cases near $2 million. These million-dollar-plus cases include awards for wrongful death, birth injuries, diagnosis-related errors, failure or delay in treatment and substandard post-surgical care. The California system proves that patients who suffer severe injuries will not be left out in the cold.

A reasonable cap on non-economic damages would also play an important role in addressing access to higher risk medical services, such as obstetrics. Increasing premiums and the threat of virtually unlimited liability for non-economic damages have caused physicians to abandon practices and to cease provision of certain services in various areas of the country. As an example, a 1990 membership survey completed by the American College of Obstetricians and Gynecologists, showed that almost one out of eight obstetrician/gynecologists (12%) has dropped obstetrical practice as a result of liability risks. Without significant liability reforms, both rural and urban areas will continue to suffer the consequences.

In short, our goal as a society is to determine what constitutes fair compensation and then devise rules to achieve it. Clearly, much remains to be done at the federal level. History shows that when the federal government has taken action in the area of liability, it has made a societal difference: The Vaccine Compensation Act has helped solve the problem of DPT unavailability due to excessive liability exposure and the General Aviation Revitalization Act revived the industry. Finally, the Federally Supported Health Centers Assistance Act, which was approved last year, will help increase access to obstetric services for economically disadvantaged women. This proven track record demonstrates the need for the rational, highly effective medical liability reforms as passed by the House of Representatives just last year.

At this juncture, I might note the AMA's longstanding support for Volunteer Protection Liability Legislation such as the bills introduced by Congressman Goodlatte (H.R. 2938) and Congressman Porter (H.R. 911). The willingness of medical personnel to volunteer their services is undermined by the potential for personal liability. We support strong patient safeguards in such legislation to make certain the medical volunteer was acting in good faith and within the scope of the volunteer's certification. The AMA believes volunteer liability legislation would encourage the private sector in a sensible way to provide medical care to those who cannot afford it themselves.

In closing, no other country permits the kind of open-ended compensation of damages that our awards for pain and suffering has allowed. Indeed, studies conducted by the Harvard School of Public Health, the GAO, and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: While these can be emotionally charged issues, the fact remains that the current tort system, driven as it is by the potential for unlimited attorney's fees and unlimited compensation for intangible losses, is unable to resolve medical liability claims effectively and efficiently. Moreover, even with a cap of a quarter of a million dollars, the United States would be the most generous country in the world in compensating for non-economic losses.

CONCLUSION

Mr. Chairman, the AMA looks forward to working with you and the Committee to ensure passage by the Congress of antitrust and basic medical liability reforms, and we thank you for the opportunity to share our thoughts and concerns.

Mr. HYDE. Thank you, Dr. Dickey.

Next we'll hear from Gayle McKay on behalf of the American Association of Nurse Anesthetists. Ms. McKay.

STATEMENT OF GAYLE McKAY, CERTIFIED NURSE ANESTHETISTS, ON BEHALF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Ms. MCKAY. Chairman Hyde, members of the Judiciary Committee, good morning.

My name is Gayle McKay. I'm a certified registered nurse anesthetist, a CRNA. I'm the immediate past president and the president-elect to the Minnesota Association of Nurse Anesthetists. I am very pleased to be here today testifying on behalf of the American Association of Nurse Anesthetists, our national organization that represents 26,000 CRNA's. While many of my comments in my testimony are specific to nurse anesthetists, the views opposing the weakening of antitrust laws are also supported by the American Chiropractic Association, the American College of Nurse Mid-Wives, the American Occupational Therapy Association, the American Optometric Association, and the American Speech, Language and Hearing Association.

The Minnesota Association of Nurse Anesthetists is currently engaged in a lawsuit in Federal district court which seeks to restore competition to a marketplace where almost 10 percent of the CRNA's in Minnesota have been fired, for what we believe is price fixing, group boycotts, and market allocation by physician anesthesiologists. At the time the suit was filed, virtually every hospital in the Twin Cities was considering plans to terminate its CRNA employees as a result of a conspiracy by the anesthesiologists. Under current antitrust laws, a per se analysis may be applied to pernicious violations of the law, such as this, to address and correct the problem without a more expensive and time-consuming rule-of-reason analysis.

The threat of swift and vigorous enforcement of Federal antitrust laws, including the per se analysis, was the most important protection that CRNA's had against this anticompetitive behavior by the anesthesiologists. CRNA's are natural competitors to the anesthesiologist because we essentially do the same work more cost effectively. No study has ever shown that there is a significant difference between the quality of care to patients provided by CRNA's and anesthesiologists, and in rural hospitals, 75 percent of rural hospitals, CRNA's are the sole provider, and therefore they provide all the anesthesia services as allowed by both Federal and State laws.

Unfortunately, because of the power and influence of anesthesiologists in many Minnesota hospitals, decisions about anesthesia care are not always based on the health care needs of the patient, but rather upon the reimbursement potential and profitability to the anesthesiologist. We have alleged that nine major anesthesiology groups in Minnesota control over 85 percent of the market for anesthesia services. We believe those groups are in constant contact with each other. They do not act as competitors; rather, they allocate the market among themselves, refuse to compete on price, and engage in organized boycotts of both individual CRNA's and of CRNA groups. The average income of anesthesiologists in the Twin Cities is two times the national average and can go as high as a half million dollars yearly.

Under the guise of quality, anesthesiologists have required that CRNA's practice under the supervision of anesthesiologists, and they have restricted their ability to perform certain procedures such as regional anesthesia or placement of invasive monitoring lines. Those who do allow CRNA's to perform such procedures have been threatened by their colleagues and by their State association. In an attempt to eliminate the supply of CRNA's to the market in Minnesota, they restrict the student nurse anesthetists from obtaining clinical experiences that are necessary for their certification.

Perhaps the most egregious example of their attempt to obtain a stranglehold on the market for anesthesia services has occurred in the past 2 years when the anesthesiologists conspired to eliminate CRNA's as economic competitors, by forcing them to become their employees. Through a campaign that uses fraudulent Medicare billing, the widespread disparagement of CRNA's, and limitations on scope of practice, anesthesiologists have coerced four major hospitals in the State of Minnesota to terminate their CRNA employees to compel them to work for the anesthesiologists. CRNA's are left with no choice but leave their families, sell their houses, seek employment outside the State, or accept this employment with the anesthesiologists' competitors at dramatically lower salaries.

In the light of power and influence of the medical community, weakening of the antitrust laws would have a negative impact on the ability for nonphysicians to compete with their physician counterparts. For CRNA's, it would open the door for anesthesiologists to eliminate CRNA's as lower cost competitors and to seize unfettered control over the market and pricing of anesthesia services. For consumers, the predictable result would be higher prices and fewer choices.

I thank you for the opportunity to testify.
[The prepared statement of Ms. McKay follows:]

PREPARED STATEMENT OF GAYLE MCKAY, CERTIFIED NURSE ANESTHETISTS, ON BEHALF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Chairman Hyde, members of the Judiciary Committee, good morning. My name is Gayle McKay and I am a certified registered nurse anesthetist and immediate Past President and President elect of the Minnesota Association of Nurse Anesthetists ("MANA"). I am pleased to be testifying today on behalf of the American Association of Nurse Anesthetists.

While my testimony here today represents the views of AANA and the comments about antitrust litigation provided are specific to CRNAs, the views opposing the weakening of antitrust laws are also supported by the American Chiropractic Association, the American College of Nurse-Midwifes, the American Occupational Therapy Association, the American Optometric Association, and the American Speech-Language-hearing Association.

INTRODUCTION

The American Association of Nurse Anesthetists ("AANA") is the professional association that represents over 26,000 certified registered nurse anesthetists ("CRNAs"), which is 96 percent of the nurse anesthetists in the United States. AANA appreciates the opportunity to provide our experience regarding antitrust issues in the health care market.

As a leader in the advanced practice nursing community, we applaud your efforts to create a more efficient and financially stable health care system. However, AANA is extremely concerned about any weakening of the antitrust laws. We strongly believe that providing provider networks with special antitrust exemptions could have severe unintended consequences and seriously undermine the larger goal of reforming our health care system and providing quality care. We believe that strong antitrust laws and enforcement is crucial to protect competition and consumer choice in the health care system.

Mr. Chairman and members of the committee, while my written statement will include our comments about the history of antitrust reform and some of the cases we have been involved with, I am here today to tell you about the situation in Minnesota which is currently the subject of a lawsuit in the United States District Court for the District of Minnesota which I believe exemplifies the need for rigorous enforcement of the antitrust laws in this area. I know that you are working to devise antitrust reform legislation which is responsive to today's changing health care system and I believe that a current "real life" discussion about what is happening in a pending lawsuit may be helpful to your deliberations.

BACKGROUND INFORMATION ABOUT CRNA'S

In the administration of anesthesia, CRNAs perform many of the same functions as physician anesthetists ("anesthesiologists") and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer more than 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in 75% of rural hospitals which translates into anesthesia services for millions of rural Americans. CRNAs are also front line anesthesia providers in under served urban areas, providing services for major trauma cases, for example.

CRNAs have been a part of every surgical team since the advent of anesthesia in the 1800s and until the 1920s, anesthesia was almost exclusively administered by nurses. Though CRNAs are not medical doctors, no studies have ever found any difference between CRNAs and anesthesiologists in the quality of care provided, which is the reason no federal or state statute requires that CRNAs be supervised by an anesthesiologist. Anesthesia outcomes are affected by such factors as the provider's attention, concentration, and organization, and not whether the provider is a CRNA or an anesthesiologist. That is why the Harvard Medical School Standards in Anesthesia focus on monitoring the patient; the standards are based upon data that indicate that anesthesia incidents are usually caused by lack of attention to detail and insufficient monitoring of the patient.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive a medical education while CRNAs receive nursing education. However, the anesthesia part of the education is

very similar for both providers and once they enter the work force, both professionals perform roughly the same services: (1) preanesthetic preparation and evaluation; (2) anesthesia induction, maintenance and emergence; (3) post anesthesia care; and (4) peri-anesthetic and clinical support functions, such as resuscitation services, acute and chronic pain management, respiratory care, and the establishment of arterial lines.

There are currently 90 accredited nurse anesthesia education programs in the United States, 94% of which offer a master's degree. The other 6% of programs are modifying their curricula to meet the requirement for all programs to offer master's degrees by 1998.

WHY THE ANTITRUST LAWS ARE IMPERATIVE TO CRNAS

The antitrust laws serve to protect competition between anesthesiologists and CRNAs. In the market for health services, a market which is widely considered complex and imperfect by economists, this sort of direct competition between rival professional groups should be vigorously defended. While many CRNAs practice in an anesthesia team which includes anesthesiologists and other ancillary support staff, CRNAs also practice as independent providers and receive direct reimbursement from multiple payors, as allowed by federal law. Independent CRNAs may function as independent contractors—negotiating the best price for the service with different health entities. Therefore, many CRNAs compete directly with their physician colleagues anesthesiologists. For this reason, the threat of swift and vigorous enforcement of the federal antitrust laws and the deterrent effect that the *per se* rule has on anticompetitive conduct are the most important protections that CRNAs have against anticompetitive conduct by physicians who may seek to exclude them from the market because they are lower cost competitors. In light of the power and influence of the medical community on staffing decisions, weakening the antitrust laws by providing a special exemption from the *per se* rule for doctors and hospitals could undermine the ability of CRNAs to compete with anesthesiologists, or any other similarly positioned health professional.

Further, the antitrust laws serve to protect the ability of other types of established health professionals to offer competitive health services. These groups include the nurse-midwives who provide obstetrical care to women in need; optometrists who provide post-op cataract eye care; doctors of chiropractic who provide a wide range of services; audiologists who perform hearing and balance assessments; occupational therapists who diagnose and provide rehabilitation care; and speech-language pathologists. It is no exaggeration to say that the antitrust laws have been a major force enabling non physician health professionals to compete with physicians when they provide comparable services. Such competition has been an enormous boon to consumers and third party payors which benefit from having a wider choice of providers.

A HISTORICAL PERSPECTIVE ON THE NEED FOR VIGOROUS ANTITRUST ENFORCEMENT

By the end of the nineteenth century, two developments—the discovery and utilization of anesthesia and the discovery and development of asepsis—resulted in an enormous expansion of the numbers and types of surgeries performed. Consequently, hospital construction flourished as the need grew for operating rooms to accommodate aseptic surgery. Simultaneously, demand grew for anesthesia specialists to focus their attention on the anesthesia care of patients while a physician performed surgery.

Nurses, whose hallmark is monitoring vital signs and administering medications, were a natural choice to provide anesthesia. Physicians turned increasingly to sisters in Catholic hospitals, as well as other registered nurses from a growing number of nurse training programs, to practice anesthesia with wide acceptance.

World War I accelerated the demand for qualified CRNAs. Advances made in medications and equipment and nurse anesthesia education during the war contributed to the nurse anesthetists' dominant position in the anesthesia services field. Even before World War I, however, the growth and acceptance of the nurse anesthesia profession and its training programs provoked anticompetitive reactions from anesthesiologists. As early as 1911, in a harbinger of future anti-nurse anesthetist activity, counsel for the New York State Medical Society declared that the administration of an anesthetic by a nurse violated the law of the State of New York. The following year, the Ohio State Medical Board passed a resolution stating that only registered physicians could administer anesthesia.

Early efforts to crush the nurse anesthesia profession gained momentum as anesthesiologists organized in their opposition to nurse anesthetists. In 1915, anesthesiologists founded the Interstate Association of Anesthetists ("IAA") which success-

fully petitioned the Ohio State Medical Board to withdraw recognition of Cleveland's Lakeside Hospital as an acceptable training school for nurses on the grounds that Lakeside's use of nurse anesthetists violated the Ohio Medical Board Act. Nurses and prominent surgeons alike protested the board's decision, and succeeded in having it reversed.

Similarly, in 1917, the Kentucky State Medical Association, with prompting from organized anesthesiologists, passed a resolution prohibiting members from employing nurse anesthetists. In a test lawsuit brought by a nurse anesthetist, the Kentucky Court of Appeals ultimately rejected the proposition that the administration of anesthesia by a nurse directed by a physician constituted the unauthorized practice of medicine.

In 1921, another anesthesiologist group, the American Association of Anesthetists, commenced a boycott by adopting a resolution prohibiting its members from teaching nurse anesthetists. Anesthesiologists also moved into the political arena, supporting legislation which would prohibit qualified nurse anesthetists from administering anesthesia.

Unlike anesthesiologists, the American College of Surgeons, comprised of physicians who utilized anesthetists, opposed legislative prohibitions of nurse-administered anesthesia. In a 1923 resolution, they opposed all legislative enactment which would prohibit qualified nurses from administering anesthesia.

Surgeon support of nurse anesthetists, however, did not stop the anesthesiologists' efforts to keep nurse anesthetists from practicing their profession. In 1933, anesthesiologists associated with the Los Angeles County Medical Association brought a lawsuit against a nurse anesthetist claiming that nurse anesthetists' administration of anesthesia constituted the illegal practice of medicine. As had other courts, the California court found that the administration of anesthesia under physician direction and supervision was not the practice of medicine.

In 1937, the American Society of Anesthesiologists ("ASA") was formed. (The American Association of Nurse Anesthetists had been founded in 1931). Immediately after its inception, the ASA presented a master plan for the eventual elimination of nurse anesthesia to the American College of Surgeons. The plan specified that nurses should not be permitted to continue to provide anesthesia. It also provided, inter alia, that a provision should be included in the Minimum Standards of Hospitals (the forerunners of the Joint Commission on Accreditation of Hospitals' standards) directing that the department of anesthesia in each hospital shall be under the direction and responsibility of a well-trained physician anesthetist. The plan cautioned, however, "that no legislation should be forced until physician anesthetists can take over the work in a competent way."

World War II increased the number of anesthesiologists. After the war, the anesthesiologists, as they sought to establish themselves in a civilian economy, renewed their activities against CRNAs. Between 1946 and 1948, the ASA launched a campaign to discredit CRNAs in the eyes of the public. The campaign was successful in reducing the numbers of nurses attending nurse anesthesia training programs. The campaign was halted when the American Medical Association, the American College of Surgeons, and the Southern Surgical Society expressed their opposition to the AS A's negative publicity, and expressed their support of, and continued intention to utilize, CRNAs.

Attempts to eliminate CRNAs has often been more subtle. For example, in 1947, the ASA adopted an "ethical principle" prohibiting members in good standing from participating in nurse anesthesia programs and from employing or utilizing CRNAs. Measures to enforce the ethical guidelines included the threat to revoke the American Board of Anesthesiology certificates of physicians training nurse anesthetists.

SUCCESSFUL ANTITRUST RELIEF AGAINST ANESTHESIOLOGISTS

CRNAs have brought actions against anesthesiologists for restricting competition. In many cases, CRNAs have alleged per se violations of the antitrust laws.

For example, in *Oltz* v. *St. Peter's Community Hospital,* 861 F.2d 1440 (5th Cir. 1988), Oltz, a nurse anesthetist, sued four anesthesiologists and the hospital that gave them an exclusive contract to provide anesthesia services, under the antitrust laws. Oltz charged the anesthesiologists and the hospitals with a group boycott, which can be a *per se* violation of the antitrust laws. The anesthesiologists settled before going to trial.

In affirming the district court's finding that the hospital joined the anesthesiologists' conspiracy to terminate Oltz's billing contract, the Ninth Circuit noted that the anesthesiologists had "pressured the hospital at St. Peter's to eliminate Oltz as a direct competitor." The court found that the anesthesiologists had threatened to boycott St. Peter's unless Oltz's independent billing status was terminated and that

the anesthesiologists annual earnings at the hospital increased by forty to fifty percent after Oltz was terminated.

Likewise, in *Anesthesia Advantage, Inc.* v. *Metz,* 708 F. Supp. 1171, 1175 (10th Cir. 1990), four nurse anesthetists in the Denver, Colorado area and their professional corporation, The Anesthesia Advantage, Inc. ("TAA"), brought suit against several anesthesiologists and Human a Hospital. The nurse anesthetists alleged per se violations of the antitrust laws, including price fixing, market allocation and a group boycott. The charges were based on (1) a hospital-instituted "call Schedule" for anesthesiologists and the anesthesiology staff's recommendation to adopt guidelines for supervising nurse anesthetists; (2) a conspiracy to induce another hospital to reject a fee-for-service proposal by TAA to provide out-patient ambulatory surgery anesthesia on pre arranged days; and (3) an attempt to persuade a third hospital to reject a proposal that the hospital use TAA for an obstetric epidural anesthesia program.

The nurse anesthetists alleged that they were "illegally squeezed out of business by anesthesiologists because the presence of CRNAs forced down the market price for anesthesiologist services."

The Tenth Circuit Court of Appeals reversed the trial court's dismissal of the case, and some of the defendants eventually settled the case, by among other things, agreeing that they would not interfere in the future with CRNAs right to practice anesthesia.

THE MINNESOTA CASE

Under current antitrust laws, a *per se* analysis is only applied to the most pernicious violations of the law. Long ago, the Supreme Court recognized that there where certain restraints of trade which are so inherently anticompetitive that there mere existence is a threat to a free market in competitive pricing. These *per se* violations include price fixing, group boycotts, and market allocation. When such conduct is present, the courts will address it and correct without the expense and time consuming task of analyzing each party's share of the market, defining various sub markets, and entertaining expert testimony, all of which generally occur under a *rule of reason* analysis.

All of these *per se* antitrust violations are currently present in one form or another in the health care market in Minnesota and have led to the firing of close to 100 CRNAs at four of the largest Minnesota hospitals, all as part of a blueprint by physician anesthesiologists to eliminate CRNAs as lower cost competitors and to seize unfettered control over the market in the pricing in anesthesia services.

The Minnesota Association of Nurse Anesthetists (MAN A) is currently engaged in a lawsuit in U.S. District Court for the District of Minnesota which seeks to bring this unlawful conduct to an end and to restore competition to the marketplace.

Since this matter is currently under litigation, I am somewhat constrained in what I am to discuss with your Committee. However, I can summarize the key disputes in the case which bear upon the antitrust exemptions under consideration.

For years, anesthesiologists have exchanged information about pricing, allocated territories between themselves and engaged in organized boycotts of both individual CRNAs and CRNA groups. Until recently, for the past ten years there had been virtually no pricing competition between any of the anesthesiology groups in the State. Instead the groups had allocated the various hospitals among themselves and entered into its de facto or actual exclusive agreements with those hospitals.

CRNAs are natural competitors to anesthesiologists for the provision of anesthesia services. Despite this fact, in Minnesota and many other states, anesthesiologists make over four times as much money as CRNAs.

The reason for this, at least in part, is that in Minnesota anesthesiologists have established and maintained substantial market power through a number of organized efforts which have successfully put them in a position to control anesthesia pricing and the method in which anesthesia is provided.

Unfortunately, the result in many hospitals in is that the method by which anesthesia is provided is based not upon the health needs of the patient but rather upon the reimbursement potential and the profitability to the anesthesiologist. Eight major anesthesiologist groups in Minnesota control over 85% of the market for anesthesia services. Those groups are constantly in contact with each other and do not act as natural competitors. Rather, they allocate the market among themselves and refuse to compete on price. The annual average income of anesthesiologist in the Twins Cities area is believed to exceed the average in every other state, going as high in some cases as one-half million dollars or more.

It is our understanding that in some cases, and possibly many cases, the cost of the anesthesia services provided in connection with a surgery may exceed the cost

of the surgery itself by a substantial amount. This is because the anesthesiologists have created barriers to entry and foreclosed the market for anesthesia not only to see CRNAs but to competing anesthesiologist who might seek to enter the Minnesota market and compete on pricing.

Some examples of these barriers to entry are the following:

1. Anesthesiologists have misrepresented government requirements for reimbursement as quality of care requirements. In other words, through the smoke screen of patient quality of care, they have imposed requirements that anesthesiologists be involved in, or at least get paid for, virtually every aspect of the anesthesia procedure, even though many of these aspects of the anesthesia procedure can be performed and are performed by CRNAs alone. In particular, federal and state laws, as well as AANA's certification requirements, permit CRNAs a wide scope of practice to provide virtually any anesthesia service. As stated earlier, CRNAs are the sole anesthesia provider in 75% of rural hospitals and therefore, provide all the services.

Nevertheless, under the guise of patient safety, anesthesiologists have introduced limitations on CRNAs' scope of practice. These limitations appear in hospital bylaws, written hospital procedures or in some cases, in unwritten hospital policies. For example, anesthesiologists have restricted CRNAs' ability to (1) perform regional anesthesia, (2) place arterial lines, and (3) place epidurals. AANA believes it is not a coincidence that Medicare and other third party payors pay substantial amounts of money for these procedures. Anesthesiologists who attempt to allow CRNAs to perform such procedures have been threatened by other anesthesiologists and often their state associations. Interestingly, procedures such as intubation and extubation, which are equally challenging but do not have a corresponding high rate of reimbursement, are routinely performed by CRNAs without objection by anesthesiologists.

2. Anesthesiologists have engaged in conspiracies with hospital personnel to prevent CRNAs from practicing on an independent basis in hospitals, downgrading CRNA status of health care providers and other restrictive practices which impede the CRNAs' ability to independently provide anesthesia services. Anesthesiologists have also attempted and succeeded at limiting CRNA's scope of practice.

Anesthesiologists' control of the market has extended to attempts to eliminate a supply of CRNAs in the Minnesota market. Anesthesiologists have recently refused to assist the school for CRNAs which provides new graduate CRNAs—again under the guise of quality of care concerns. Also, the anesthesiologists' refusal to permit other aspects of anesthesia have threatened the student's ability to obtain certification from AANA and therefore, unable to become a "certified" registered nurse anesthetist (CRNA). AANA requires advanced clinical experience in these areas before it will extend certification.

As Associate Director of the Abbott-Northwestern School of Anesthesia, I am intimately familiar with these problems which resulted in a large proportion of our graduating class leaving the state to seek employment elsewhere rather than attempt to take on the anesthesiologists.

Perhaps the most egregious example of the anesthesiologists' attempt to obtain a stranglehold on the market for anesthesia has occurred in the past two years during which the anesthesiologists have entered into a conspiracy to eliminate CRNAs altogether in Minnesota as economic competitors and to force them to work directly for the anesthesiologists. In this way, they can ensure that while CRNAs are still performing the work for them, CRNAs will be unable to affect or compete in the areas of pricing and other quality of service concerns.

Through a campaign which includes: (1) the use of improper and fraudulent billing to Medicare and other third party payers, (2) widespread dissemination of inaccurate and misleading statements disparaging CRNAs and their abilities to practice anesthesia, and (3) the limitations on scope of practice referred to above, anesthesiologist have coerced four of the major hospitals in the State of Minnesota including Unity Hospital, Mercy Hospital, St. Cloud Hospital, and Abbott-Northwestern Hospital, to terminate all of their CRNA employees and to compel them to work for the anesthesiologists. Because the anesthesiologists control the market for anesthesia, CRNAs were left with the choice of leaving their families, selling their houses and seeking employment outside the state.

As a result of this conspiracy, similar activities have been initiated at Fairview Ridge Hospital, Fairview South dale Hospital, St. John's Hospital, St. Joseph's Hospital, United Hospital, Norm Memorial Hospital, Fairview Riverside Medical Center, Midway Hospital, St. Paul Ramsey Hospital and Buffalo Hospital. Had it not been for the lawsuit brought by MANA, it would not be an exaggeration to state that by now competition in the areas of anesthesia services between the CRNAs and the anesthesiologists would be non-existent.

ANTITRUST REFORM

Most, if not all, of the health care reform legislation under consideration by the House of Representatives relies on competition to constrain, and even reduce, health care costs. To be effective, competition will have to take many forms including competition between CRNAs and their anesthesiologist counterparts for the provision of anesthesia services. Moreover, that competition must take place on a level playing field.

Today, however, a level playing field doesn't exist for many CRNAs. The fact is that physicians still wield much greater power and influence in the marketplace. And, we can expect them to use that power to protect their jobs and their incomes as the industry downsizes to become more efficient. That is exactly what we believe happened in the Minnesota, and what we suspect is happening in many other cities and towns around the country.

The antitrust laws are an essential tool for CRNAs and other non-MD providers to counteract the power and influence of physicians and hospitals. That is why AANA has grave concerns about the provisions in H.R. 2925 that would weaken the antitrust laws by allowing networks of providers ("Networks") to be exempt from the *per se* rule.

AANA understands the importance of private cooperative initiatives to help make the nation's health care system more efficient. We strongly believe, however, that exempting Networks from the *per se* rule will undermine that goal, and is as unwise as it is unnecessary. Today, as the law stands, legitimate Networks aren't subject to the *per se* rule. However, the very existence of the *per se* rule serves as an important deterrent to Networks that might otherwise engage in anticompetitive conduct of the worst kind—price fixing, market allocation and group boycotts. Moreover, from the AANA's perspective, elimination of the *per se* rule will put CRNAs, who have been victimized by the egregious anticompetitive conduct, at an even greater disadvantage vis-a-vis their physician counterparts because it will (1) increase the time and expense required to challenge such anticompetitive conduct, and (2) make it more difficult for the federal antitrust enforcement agencies—the Antitrust Division and the Federal Trade Commission ("FTC")—to bring suit on their behalf.

Moreover, providing Networks with an exemption from the *per se* rule is not necessary to foster their development. Networks, including those that were proposed in the Medicare legislation, H.R. 2485—PSOs and PSNs—are not subject to *per se* treatment if they are legitimate and share financial risk. Under the Medicare legislation, PSOs, and PSNs that were also PSOs, were required to share substantial financial risk for the services that they provided to Medicare beneficiaries, and therefore, would not have been subject to the *per se* rule. PSNs would have been subject to the same rules that apply to any other physician network. Consequently, legitimate PSNs would have received *rule-of-reason* treatment unless they were shams for anticompetitive conduct, such as price fixing.

There are five main reason why we believe that the *per se* exemption for Networks is unnecessary:

1. The requirement that doctors and hospitals economically integrate their practices in order to negotiate collectively, benefits consumers and competition in general.

Under the Policy Statements issued by the Department of Justice's Antitrust Division ("Antitrust Division") and the Federal Trade Commission ("FTC"), health care providers are permitted to negotiate collectively if they "share substantial financial risk." In other words, if they economically integrate by accepting capitation payments, adopting legitimate fee withholds, or using some other combination of financial arrangements to ensure that they have an incentive to provide health care in the most efficient manner and at the most economical price. Doctors and hospitals who negotiate collectively without the requisite financial integration lack those incentives, and could use their Network as a sham for price fixing or group boycotts.

Some physicians and hospitals have complained that these requirements are too rigid, and therefore, want Networks to be exempt from the *per se* antitrust rules that apply to virtually every other industry in America. That is, when they act as a cartel, doctors and hospitals want their conduct to be treated more leniently under the *rule-of-reason* standard that applies to legitimate joint ventures that are producing a new product or improving upon an existing product. Creating an exemption from the *per se rule* for doctors may discourage pro competitive integration and encourage anticompetitive pricefixing.

2. Exempting any type of providers from the per se rule would make it more costly and burdensome to challenge anticompetitive conduct, and therefore, would remove a powerful deterrent to that conduct.

Prosecuting anticompetitive conduct under a *rule-of-reason* standard takes longer and costs more than under a *per se* standard. That is why *rule-of-reason* is reserved

for conduct that could have pro competitive benefits for consumers. Requiring that the conduct of doctors or hospitals that form or participate in a Network receive *rule-of-reason* treatment, regardless of its anticompetitive effect, will make it more time consuming and more costly for the Antitrust Division and the FTC, and therefore, taxpayers, to prosecute. It will also undermine the powerful deterrent effect that the *per se* rule has on would-be violators because prosecution for anticompetitive conduct would be much less swift and certain.

3. There is no compelling evidence that the antitrust laws are chilling the development of legitimate Networks.

First, the Antitrust Division and the FTC eliminated most of the confusion about how the antitrust laws apply to physician-sponsored networks by issuing, and then updating, policy statements on provider-sponsored networks.

Moreover, since the policy statements were issued, the agencies have approved many physician-sponsored networks under their program to provide written guidance to providers within 9120 days of an inquiry.

The agencies have also lived up to their pledge to continue to review their policy statements as the health care industry evolves. On December 5, 1995, the FTC announced that it was actively seeking information on provider arrangements that share financial risk in ways not currently sanctioned in the policy statements. The lack of guidance in this area, specifically with respect to alternatives to capitation and fee withholds, has been the major complaint that providers have had about the policy statements. The fact that the FTC is actively examining the issue and seeking provider input, demonstrates that it intends to live up to its commitment to update the policy statements when there is a demonstrated need to do so.

Second, independent and authoritative bodies in the health care industry have also examined whether exemptions for physicians or hospitals are necessary to foster the growth of Networks. Most notably, the Physician Payment Review Commission ("PPRC") testified at the Ways & Means Committee's September 22, 1995 hearing on Medicare that there is no compelling evidence for exempting networks, created for Medicare beneficiaries, from the antitrust laws. The PPRC also warned that exemptions, even if they were limited to the Medicare market, could have unintended consequences: (a) they could increase anticompetitive conduct among physicians and hospitals, and (b) they could spill-over into other markets—Medicaid and private-pay. In other words, the proposed exemptions put consumers and nonphysician providers at risk of being victimized by exclusionary conduct and high prices.

4. Competition from non-MD health professionals, such as CRNAs, could be hurt by giving Networks an exemption from the per se rule.

Antitrust exemptions would make it easier for Networks to boycott non physician health professionals who compete with them. There are many examples of organized physician boycotts against nonphysician health professionals that have been prosecuted in the courts under *per se* standards. Exempting physician Networks from the *per se* analysis rule will make it more difficult for the antitrust agencies and for nonphysician health professionals to fight back to stop this kind of anticompetitive conduct.

Consumers in rural and under served areas are especially likely to be hurt because non-MD health professionals are often the only ones available to provide care. For example, recent press articles in Great Falls, Montana and Casper, Wyoming report that mothers in labor are being deprived of the choice to have pain-killing epidural blocks during delivery because of what could be hospital and/or anesthesiologist inspired boycotts against nurse anesthetists.

CRNAs routinely perform and administer epidural blocks which are known as a low reimbursement procedure. In this instance, the anesthesiologists reportedly didn't want to administer epidural blocks because they would be required to remain with the mother for several hours until she gives birth, which would cut down on the number of patients for which they are paid. In some geographically limited areas, women may not be offered an epidural because there are no providers available at all—either CRNA or anesthesiologist. However, in the Great Falls and Casper hospitals, CRNAs were available yet no alternate arrangements were made with nurse anesthetists (who were willing to administer epidural blocks) to provide this service during childbirth. The result in these rural areas has been that mothers who have been through a painful labor are outraged at having been denied a choice of pain killers because the hospitals and the anesthesiologists have not been willing to employ nurse anesthetists.

5. If CRNAs are limited to bringing suits under the rule-of-reason it will make it more difficult for them to challenge anticompetitive conduct that is depriving consumers of lower cost providers.

Many of the antitrust actions brought by nurse anesthetists against anesthesiologists have been for *per se* violations of the antitrust laws. For example, Vinnie

Bhan, a CRNA in California brought a case against a hospital and several anesthesiologists charging that they had conspired to boycott nurse anesthetists by adopting a physician only anesthesia policy. *Bahn* v. *NME Hospitals*, 772 F.2d 1467, 1471 (9th Cir. 1985). Bhan pointed out that an "MD only policy" was a coercive boycott (a *per se* violation) and introduced no other evidence. The court agreed that the case should go to trial. However, it required Mr. Bahn to try his case under the *rule-of-reason*. Faced with having to pay for the kind of expensive expert testimony required to establish and defend market definitions and similar issues, Mr. Bahn abandoned his effort and the case was dismissed.

Providing Networks with an exemption from the *per se* rule will insure that some meritorious cases are never brought because individual non physician health professionals, such as CRNAs, do not have the resources to pursue them. The ultimate losers will be consumers who are deprived of the benefits of competition.

ANTITRUST VIOLATIONS IN THE CURRENT ANESTHESIA MARKETPLACE

Current practices in the field of anesthesia do not reflect the normal workings of the marketplace. Economics alone suggest that hospitals would be anxious to use lower cost providers, such as nurse anesthetists, in order to reduce their costs, and thus their prices to patients and third-party payors. However, that it not always the case. Anesthesiologists have repeatedly used their influence to keep prices high by, for example, convincing hospitals to terminate nurse anesthetists so that they (the anesthesiologists) would not face price competition. This is not the way the market should work or that our health care system should work. However, unless those most immediately affected by anticompetitive conduct—nurse anesthetists—are able to bring suit successfully under the antitrust laws, consumers will be forced to pay higher prices and, in some cases, have fewer choice of services, such as not being able to receive an epidural block during childbirth.

There are many examples of anticompetitive conduct that affects the ability of nurse anesthetists to compete for patients. Some of this conduct could be a per se violation of the antitrust laws.

Creating Barriers to Practice to Eliminate CRNAs as Competitors

Attempts have been made, often in subtle ways, to keep CRNAs from competing vigorously with anesthesiologist by creating barriers to practice. Examples of barriers to practice include: (1) hospital medical staff bylaws that deny CRNAs clinical practice privileges, (2) restrictions on CRNAs clinical practice privileges, (3) the promulgation of inaccurate information about Surgeon's liability for CRNAs, and (4) the formation of large anesthesiologist groups. Whether specific barriers to CRNA practice constitute anticompetitive behavior under the antitrust laws obviously depend on the facts of each case. However, CRNAs need to be able to use the antitrust laws to the fullest when practice barriers result from attempts to price-fix, monopolize, or boycott.

1. Hospital Medical Staff Bylaws Which Deny CRNAs Clinical Practice Privileges.

Some physicians have created hospital medical staff bylaws that effectively eliminate the opportunity for independent CRNA practice. In one such case, the hospital, upon recommendation of a group of anesthesiologists, changed its bylaws to state that "nurse anesthetists could only practice in the institution if they were employees of the physician anesthesiologists." This bylaw effectively restricts an independent CRNA from applying for medical staff clinical practice privileges. Without the opportunity to obtain medical staff clinical practice privileges at a hospital, independent CRNAs do not have the ability to administer anesthesia to patients in that facility—regardless of permission by state law—and would have to become employees of an anesthesiologist group or some other entity in order to provide anesthesia services.

This kind of practice restriction would have costly consequences for consumers and third-party payors. That is because hospitals will almost certainly have to pay more for CRNAs who are employees of anesthesiologists than for independent CRNAs.

2. Restrictions on Clinical Practice Privileges of CRNAs.

While CRNAs do have the right to practice in many institutions, there have been situations where anesthesiologists, through the medical staff, have restricted their scope of practice. If their scope of practice is limited, then CRNAs cannot compete with "full service" anesthesiologists. Restrictions on scope of practice have included refusals to grant clinical practice privileges for regional anesthesia, insertion of invasive monitoring lines, postoperative pain management of patients, and refusal to allow administration of an epidural injection. Other CRNAs experience unnecessary limitations on which types of patients they may treat. These restrictions on clinical practice privileges are not related to education, ability or to what state law permits, but rather to an attempt to limit competition.

3. Promulgation of Inaccurate Information about Surgeon's Liability for CRNAs.

It is difficult for CRNAs to compete in the market when anesthesiologists use inaccurate information to persuade surgeons not to utilize CRNA services. In one such situation in Southern California, an anesthesiologist sent promotional and marketing letters to plastic surgeons, ophthalmologists and other physicians stating that the surgeons had increased liability if they used a CRNA rather than an anesthesiologist. It is important to understand that typically in cosmetic plastic surgery, the patient pays for the procedures, as insurance does not cover such operations. Plastic surgeons, recognizing the competitive pricing and high quality of care provided by CRNAs, have utilized CRNAs as practitioners for many years. However, inaccurate information regarding liability of the surgeons for care provided by CRNAs could have had a significant adverse influence on surgeon's use of nurse anesthetists.

4. Formation of Large Anesthesiologist Groups.

Formation of anesthesiologist groups that have the potential to control a large share of the market also pose a threat to competition. Such groups are likely to have enough market power to force hospitals and other facilities to boycott low cost providers, such as CRNAs. As in any monopoly or near monopoly situation, the result would be the consumers pay higher prices and have fewer choices of services.

In recent months, large anesthesiology groups have been able to monopolize anesthesia services in hospitals in a few major metropolitan areas. In those situations, competitors are likely to be prohibited from gaining access to the hospital, which eliminates competition altogether.

In 1994, there was a merger of two anesthesiologist groups (Middle Tennessee Anesthesiology, P.C. and Anesthesiology Consultants of Nashville, P.C.), both of which served metropolitan Nashville, Tennessee and surrounding Davidson County. The new group, called Anesthesia Medical Group ("Group"), includes nearly 50% of the non-teaching anesthesiologists serving the metropolitan Nashville area. The Group also employs 105 of the 175 CRNAs practicing in the same area.

In the Nashville area there are 3,906 staffed hospital beds distributed among 12 hospitals. The Group is the sole anesthesia provider in two hospitals comprising one third of the available staffed hospital beds in Nashville. In a third hospital, with 571 staffed beds, the group does not have an exclusive arrangement, but provides approximately 65 percent of the anesthesia.

In total, the Group has approximately 50% of the practicing anesthesiologists in the area, controls 60% of the CRNAs in the area, and has exclusive or nonexclusive access to nearly one half of the areas staffed hospital beds. The market power of the Group appears to be well beyond the safety zones established in the Antitrust Division's and the FTC's Policy Statements for physician joint ventures, and because of that may have the ability to increase prices and reduce services for patients in the area.

A second potential exclusive contract situation exists in Denison, Texas. Texoma Medical Center, Inc. ("TMC") is a non-profit corporation that operates a hospital in Denison, Texas. It is estimated that TMC provides medical care and treatment and surgical facilities for approximately 95 percent of the residents of Denison, Texas. TMC has approximately 15 to 20 surgeons on staff and has extended clinical privileges to four anesthesiologists and four CRNAs.

In January 1994, TMC's hospital administrator and CEO announced that hospital's intention to enter into an exclusive provider agreement "with a single source for all anesthesia care required by surgeons and patients of TMC." In conjunction with this announcement, certain physicians were requested to submit a proposal to the hospital for an exclusive provider agreement. No request for proposal was made to any of the CRNAs at the hospital with staff privileges, even though CRNAs charge less for anesthesia services than anesthesiologists. Presumably, CRNAs would have been allowed to continue providing services at the hospital only if they were employed by the exclusive provider group.

In order to keep the market competitive, three CRNAs and one anesthesiologist practicing at the hospital announced their intention to bring an antitrust suit against the hospital for exclusive dealing. The hospital subsequently droned its exclusionary plan, but it might not have done so if the CRNAs had been hamstrung in their ability to bring an antitrust suit.

CONCLUSION

In conclusion, special antitrust exemptions for certain groups of providers will increase not decrease the cost of health care. All health care providers should compete on a level playing field. By nature of practice, CRNAs are more than familiar with their competitive role, and consequently, welcome competition with any provider based on price and quality. AANA is concerned, however, that exemptions from the

per se rule for doctors and hospitals will hamstring CRNAs' ability to challenge anti-competitive conduct, and thereby increase prices for and reduce the choice of anesthesia services for many patients.

While my testimony here today represents the views of AANA and the comments we have provided are specific to CRNAs, the views opposing the weakening of antitrust laws are also supported by: American Chiropractic Association; American College of Nurse-Midwives; American Occupational Therapy Association; American Optometric Association; and American Speech-Language-Hearing Association.

Thank you for your consideration of our views.

Mr. HYDE. Thank you very much, Ms. McKay.

Next, Margaret Metzger, the senior vice president and corporate general counsel of Tufts Associated Health Plan, and she's speaking on behalf of the Group Health Association of America/American Managed Care and Review Association.

Ms. Metzger.

STATEMENT OF MARGARET METZGER, SENIOR VICE PRESIDENT AND CORPORATE GENERAL COUNSEL, TUFTS ASSOCIATED HEALTH PLAN, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA/AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Ms. METZGER. Thank you. Good morning, Mr. Chairman and members of the committee.

My name is Margaret Metzger. I'm the senior vice president and corporate general counsel for Tufts Associated Health Plan. Tufts is headquartered in Massachusetts. We are the third largest managed care company in New England, with over 500,000 members.

I'm testifying here today actually for GHAA/AMCRA under its new name, the American Association of Health Plans. I understand I'm the first one testifying under that new name. AAHP is the largest national organization of patient care networks, representing over 1,000 member companies nationwide, including health maintenance organizations, preferred provider organizations, third-party administrators, and utilization review organizations. Together we provide quality health care services for over 100 million people. These consumers consistently give our plans positive reviews and those reviews are reflected through high enrollment and renewal rates.

On behalf of our members and enrollees, we do appreciate your invitation to testify. On a personal note, I did bring my sixth grade son and we're both very delighted to be here.

The American Association of Health Plans is testifying today to express genuine concern about H.R. 2925 and I really would like to explain why. There are two basic reasons. First, because we believe the proposed legislation is unnecessary. The existing antitrust laws, in our view, do not stand in the way of legitimate procompetitive provider networks, the networks that today are creating at rapid-fire pace new products and economic efficiencies. There's ample evidence that these networks are forming and prospering under current antitrust laws.

Second, we're very concerned because the proposed legislation will make it more difficult to combat really genuine pernicious practices, practices such as price fixing, boycotts, and market allocation schemes. We see no reason to make it more time-consuming

and expensive to take action against that sort of anticompetitive activity. Please let me elaborate.

Provider networks are not inhibited by current law and don't need a special legislative treatment. I want to refer to the 1995 report to Congress by the Physician Payment Review Commission. I'm going to quote because it concluded that, "The available evidence of problems is not sufficient to warrant creating safe harbors or other exemptions from the antitrust laws for physician sponsored networks at this time. Amending the antitrust laws is a serious step that should be undertaken only in the face of compelling evidence that change is required. The limited available factual evidence, however, does not currently suggest the widespread existence of problems." That's their quote.

In fact, hundreds of provider-sponsored networks have formed in recent years, and in many States—those States would include Colorado, Ohio and Wisconsin—at least 50 percent of the recent HMO licenses have actually been issued to either physician hospital organizations or other physician-sponsored ventures. The health care marketplace is incredibly dynamic right now. New health plans of all types are forming and providing both health care providers and consumers with a wide variety of choices.

I guess on the subject of joint ventures I have a very personal perspective because Tufts Health Plan in fact is often in the same position as the providers. We've considered a number of joint ventures with competitors, and that would be both actual and potential competitors, and I've had to evaluate how we could create economically integrated joint ventures that would pass antitrust muster. I found that when our goals are genuinely procompetitive they can be achieved. Obviously, when they are not, we can't go forward. That experience, plus the rampant physician network formation activity that's very obvious in the Boston market, really demonstrates that providers can effectively collaborate under existing antitrust laws when they are working to the benefit of consumers.

On the other hand, we're concerned that the proposed legislation would make it more difficult to combat genuinely anticompetitive activity. Antitrust laws are designed to promote competition for the benefit of consumers, not to protect particular competitors. The antitrust laws have really been the vehicle for cost containment, and it took strong antitrust laws and enforcement to get to where we are with the development of managed care as an alternative to fee-for-service medicine.

I think you all know about the criminal case that went to the Supreme Court 50 years ago in order to enable one of the earliest HMO's to organize, and while that case is more than 50 years old, after 8 years of front-line experience at Tufts, I know that the opposition hasn't disappeared. Provider resistance remains very real today, and we're very concerned that the proposed legislation rule of reason analysis doesn't distinguish between financially-integrated networks and sham arrangements that don't require sufficient allocation to really get to the kinds of efficiencies and procompetitive statements that we're looking for.

Trying to wrap up quickly, current antitrust laws do distinguish between networks and other joint ventures that are economically integrated from those that are not. Activity that would otherwise

be per se illegal will now be judged under the rule of reason; activity that is normally judged under the per se rule, even under current rules, becomes rule of reason if it's within financially-integrated joint ventures. These ventures truly offer new products and services in an economically-efficient manner because the participants have both material stake in the fate of the venture and incentives to provide high quality and cost-effective care without over-utilization.

The proposed legislation, with its very general criteria regarding operations and funding, applies the rule of reason as long as those very general criteria are met. And we're concerned that that creates a very practical problem because it hinders the ability of health plans such as my own to protect themselves and their members from anticompetitive behavior. Our provider contracting staff has had many opportunities to respond to really blatantly anticompetitive overtures by recommending that the providers seek antitrust counsel. That recommendation carries a lot of weight because the per se violation or threat of per se violation is attached.

Let me conclude. We are very concerned. We are worried that by protecting anticompetitive networks that may well raise prices, reduce services, and limit choices. We don't believe the legislation is necessary if it's intended to encourage legitimate provider networks. Those are already prospering.

Thank you for hearing our views. I'd be happy to answer questions.

[The prepared statement of Ms. Metzger follows:]

PREPARED STATEMENT OF MARGARET METZGER, SENIOR VICE PRESIDENT AND CORPORATE GENERAL COUNSEL, TUFTS ASSOCIATED HEALTH PLAN, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA/AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Good Morning Mr. Chairman and Members of the Committee. My name is Margaret Metzger. I am the Senior Vice President and Corporate General Counsel for Tufts Associated Health Plan. Tufts is headquartered in Massachusetts and is the third largest managed care company in New England. The family of affiliated companies offers: Tufts Health Plan, a health maintenance organization (HMO); Secure Horizons®, Tufts Health Plan for Seniors, a Medicare contracting HMO plan which is a division of Tufts Health Plan; Tufts Total Health Plan, a point-of-service (POS) plan; and Tufts Benefit Administrators, a third party administrator. The Tufts provider network includes 69 hospitals and over 11,000 physicians in private practice. Tufts currently has over 500,000 members in more than 2,800 employer groups.

I am testifying today on behalf of Group Health Association of America/American Managed Care and Review Association (GHAA/AMCRA), the largest national organization of patient care networks. GHAA/AMCRA represents over 1,000 member companies nationwide including health maintenance organizations (HMOs), preferred provider organizations (PPOs), third party administrators (TPAs), and utilization review organizations (UROs). Together these organizations provide quality health care services for over 100 million Americans. On behalf of our members and their enrollees, we appreciate your invitation to testify.

HEALTH CARE NETWORKS PROVIDE QUALITY AND CHOICE FOR CONSUMERS

Our health plans provide high-quality health care at predictable cost to consumers who consistently give our plans positive reviews, which are reflected in high enrollment and renewal rates. Over the last few years managed care enrollment has increased by over 40 percent. Today, over 100 million people are enrolled in managed care arrangements (See Attachment). The vast majority of these individuals chose to enroll in a managed care plan.

What is it about health care networks that makes them attractive to so many people? First, people like the idea that coverage is comprehensive and that they have a variety of plan model types to choose from. In addition, they like the emphasis

that plans place on preventive care services. And they like knowing that providers are carefully selected based on professional qualifications and interest in working within a coordinated care system. All of this is available to consumers at a lower cost than most fee-for-service plans. In fact, an article appearing in the May 1994, edition of the *Journal of the American Medical Association* summarized a comprehensive review of 16 previously published studies from the 1980s and 1990s that examined the quality of care in HMOs compared with that in other settings. The study found that the quality of care in HMOs was better than or equal to the care provided in fee-for-service (FFS) plans on 14 of 17 quality-of-care measures.

ANTITRUST LAWS HAVE ENABLED HEALTH PLANS TO FORM

The topic of this hearing today is important to consumers, our industry, and to the future of health care delivery. The health care marketplace is rapidly changing; GHAA/AMCRA has, and continues to, support competition and choice in the evolving health care marketplace. We believe that the current antitrust laws encourage market development while at the same time protecting consumers. The basic purpose of the antitrust laws and antitrust enforcement in the health care industry, as in other industries, is to promote and preserve competition for the benefit of consumers, not individual competitors. The antitrust laws are neutral in this respect. They do not favor or discriminate against any group of sellers or buyers; they apply equally to everyone.

The antitrust laws and antitrust enforcement have played an historic and special role in the development of managed care as an alternative to fee-for-service medicine for consumers. Antitrust enforcement was directly responsible for enabling the first HMO-type plan to form more than 50 years ago. In 1941, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association (GHA),[1] an early HMO-type plan here in Washington, D.C.[2] In that case, the medical associations initiated disciplinary actions against GHA staff physicians, imposed sanctions against doctors who consulted with GHA physicians, and took various actions against hospitals that granted privileges to GHA doctors—all in an effort to prevent GHA from providing an alternative to fee-for-service practice. Unfortunately, a great deal of similar activity still occurs today.[3]

Antitrust laws continue to benefit health care consumers by removing obstacles to the formation and expansion of alternatives to fee-for-service medicine. For example, challenges have been brought against professional society ethical rules and "self-regulation" that prohibited contracting with managed care plans,[4] denials of hospital privileges to doctors affiliated with HMOs,[5] restraints by dominant fee-for-service payers on physicians affiliating with HMOs,[6] and combinations among providers to force higher reimbursements.[7] The enforcement agencies also have challenged conspiracies to obstruct utilization review programs,[8] and boycotts and other conspiracies to maintain prices or force increases in reimbursements.[9]

Competition has enabled managed care plans and other new forms of health care delivery systems to provide all consumers with high-quality care through alternatives to traditional fee-forservice practice. Competition between health plans, for instance, has encouraged innovation, enhanced quality, and increased efficiency in health care delivery. Similarly, greater use of selective contracting and competitive bidding has generated efficiencies and improved quality, as providers have vied to demonstrate the value and dependability of their services.

EXISTING ANTITRUST LAWS PROMOTE COMPETITIVE, PRO-CONSUMER NETWORKS

Ironically, the same antitrust laws that have enabled provider networks to form are now being accused of *inhibiting* the formation of such networks. Today's health care marketplace demonstrates, however, that existing antitrust laws are effective and continue to benefit consumers by enabling the formation of pro competitive collaborations by providers.

For example, joint ventures among hospitals to purchase, operate or market high technology medical equipment have never been challenged by federal enforcement agencies. Nor have the agencies challenged joint purchasing arrangements among hospitals for services such as data processing.[10] Furthermore, in many states—such as Colorado, Ohio, and Wisconsin—50 percent or more of recent HMO state licenses have been issued to physician hospital organizations (PHOs) and other physician sponsored ventures. Additionally, according to the American Medical Association, in 1994, 77 percent of physicians had a managed care contract.[11]

The antitrust laws also have not inhibited the formation of provider networks and joint ventures. Since 1991, of 36 proposed provider networks that sought approval

from either the Department of Justice or the Federal Trade Commission, all but one was approved.[12] The only proposed network that the FTC disapproved involved an unintegrated preferred provider organization (PPO) in which the participating physicians did not share substantial financial risk. The FTC said that the arrangement appeared to be a horizontal price fixing agreement among competing providers.[13] In addition to these agency reviews, hundreds of physician networks, that did not seek an advisory opinion, were formed under the guidance of the health care antitrust enforcement policy statements issued by the enforcement agencies in September 1994.[14] The provider networks that sought approval are diverse geographically, including both rural and urban markets, and represent a broad range of medical services and specialties. For example:

St. Anthony Medical Center, one of three general acute care hospitals in Rock ford, Illinois proposed subcontracting with physicians and another hospital to offer multi-provider, preferred provider contracts to employers and other third-party payers. The contracts would be non-exclusive, thus permitting the providers to enter into contracts with other providers or third-party payers. The network would enable St. Anthony to provide additional hospital services that it previously could not after, and to refer overflow patients to the other network hospital. Referrals to the other hospital would be limited to 20% of St. Anthony's admissions, and St. Anthony would bear all of the financial risk for such referrals. The Department of Justice approved the proposed network.[15]

Seventeen small and mid-sized clinical laboratories in California proposed forming a network to compete with the three largest laboratories in the state to provide services to large regional and statewide HMOs. The network would limit its size to prevent it from acquiring more than 30% of the laboratory sales volume in any given relevant market, and membership would be non-exclusive so that members could participate in other networks or contract individually with managed care organizations. The members would share significant financial risk through capitation. The Department of Justice approved the proposed network.[16]

A group of dermatologists, plastic surgeons and dermatopathologists in Dade, Broward and Palm Beach counties, Florida, proposed forming a provider network to offer services to third party payers. The network's members would share substantial financial risk through the acceptance of capitated payments, and would be non-exclusive, allowing its members to join other networks. Although the network would represent approximately 44% of board-certified dermatologists in the area, the Department of Justice nevertheless found that it would not likely result in anticompetitive effects. Even though the proposed network fell outside the "safety zones" established in the 1994 Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust ("1994 Statements of Enforcement Policy") issued jointly by the Department of Justice and the Federal Trade Commission,[17] the Department of Justice approved the proposed venture.[18]

A nursing home operator with 14 facilities in northern and eastern Wisconsin proposed joining with nursing home operators in other regions of the state to form a single, statewide, non-exclusive network. The Department of Justice business review letter approving the proposal noted that each of the four network members did not operate nursing home facilities in the local markets served by the other participants and would remain free to offer their services independently of each other at a price to be determined solely by each individual member. The letter also observed that the network would be necessary to allow the operator proposing the network to offer customers across the state access to its services.[19]

Physician Care, Inc. ("PCI"), a non-profit corporation, proposed to establish a provider network in south-central Kentucky offering physician services to self insured employers and other payers. Of approximately 276 physicians practicing in the service area, 71 had become PCI members and 29 more had been accepted for membership but had not signed participation agreements. PCI would be nonexclusive. Physician members would be paid on a capitated basis or a discounted fee-for-service rate, and 20% of their fees would be withheld for distribution among PCI members *if* the group's cost containment and utilization goals were met. The Department of Justice approved the proposal because PCI appeared to be a legitimate, bona tide joint venture in which participants would share substantial financial risk. Further, the letter noted that PCI would offer customers in the service area an additional alternative health care delivery system. The letter also approved of PCI's non-exclusivity provision.[20]

All 85 board-certified dermatologists in South Carolina proposed forming a nonexclusive network to contract with managed care plans for dermatology

services throughout the state, but only for those services that also are performed by other types of physicians. The network would not cover hospital admissions and any procedure that dermatologists perform in more than 30 percent of all cases in a relevant service market. The network members would share substantial financial risk either by accepting capitated rates or by withholding a minimum of 20 percent of fees as a risk pool that would be retained by the network or distributed to its members only if promised efficiency goals are achieved. In approving the plan, the Department of Justice assumed that network members will not exceed 30 percent of the physicians providing any given procedure in any relevant market, and thus would not attain market power or cause anticompetitive effects.[21]

As these examples illustrate, the antitrust laws are not inhibiting the formation of provider networks. Instead, the existing laws are encouraging the formation of a variety of procompetitive provider networks—ventures that are responding to the needs of consumers for flexible, high quality and cost-effective health care. The antitrust laws also are protecting consumers from anticompetitive joint ventures that are nothing more than tightly knit cartels to fix prices, engage in boycotts or market allocation schemes, or restrict market entry to competing providers—all of which would restrict choices and raise prices for consumers.

LEGISLATION IS UNNECESSARY TO ENCOURAGE THE FORMATION OF PROCOMPETITIVE PROVIDER NETWORKS

To the extent that H.R. 2925 is intended to apply the *Rule of Reason* analysis to provider networks that involve substantial financial risk-sharing and create efficiencies, it merely reflects current law. Such pro competitive networks and other such joint ventures already are analyzed under the *Rule of Reason.* The *Rule of Reason* analysis weighs the pro competitive effects and efficiencies created by a joint venture in a relevant market against its potential or actual anticompetitive effects. If the legislation is intended to encourage the formation of such provider networks, it is unnecessary. As discussed above, the existing antitrust laws were largely responsible for the emergence of managed care and other innovative forms of health care delivery.

In addition, the enforcement agencies have taken the extraordinary step of offering specific guidelines on the formation of physician and multi-provider networks.[22] The Federal Trade Commission and the Department of Justice have given more guidance in the health care area than in any other area. Provider networks are not inhibited by current law and do not need a special legislative exemption to enable them to form. In fact, in its 1995 report to Congress, the Physician Payment Review Commission (PPRC) "concluded that the available evidence of problems is not sufficient to warrant creating safe harbors or other exemptions from the antitrust laws for physician-sponsored networks at this time. Amending the antitrust laws is a serious step that should be undertaken only in the face of compelling evidence that change is required. The limited available factual evidence, however, does not currently suggest the widespread existence of problems."[23]

H.R. 2925 WOULD PROTECT ANTICOMPETITIVE PRACTICES AND WOULD PREVENT QUICK ACTION TO PROTECT CONSUMERS

GHAA/AMCRA opposes any policy or legislation that would sanction anticompetitive provider joint ventures or networks. Unfortunately, H.R. 2925, would have precisely this effect. The legislation would apply the *Rule of Reason* to health care provider networks without regard to whether the networks are procompetitive and efficiency enhancing.

Current antitrust law distinguishes between networks and other joint ventures that are economically integrated and those that are not. Participants in integrated joint ventures share substantial financial risk, such as the risk of loss from overutilization (commonly reflected in capitated fees), compensation tied to cost containment goals, all-inclusive fee structures (such as per diem rates) or other such factors—in short, evidence that network participants not only have a material stake in the economic fate of the venture, but have the proper incentives to provide high-quality, cost-effective care. Integrated networks also enable providers to offer new products, such as expanded geographic coverage and additional medical specialty services, in an economically efficient manner. Thus, integration benefits consumers by encouraging the delivery of high-quality health care in the most efficient manner.

These characteristics of pro competitive networks are reflected in the 1994 health care antitrust enforcement policy statements issued jointly by the Department of Justice and the Federal Trade Commission.[24]

H.R. 2925, however, makes no distinction between, integrated networks and sham arrangements established merely to fix prices and reduce competition. For example, the definition of "health care provider network" fails to require that the venture be economically integrated, fails to require substantial financial risk sharing (as previously described), and fails to require that a network create economic efficiencies.[25] The legislation states merely that networks must be organized "for purposes that include providing health care services."[26] Such purposes could include the most serious types of anticompetitive conduct such as price fixing, coercion of third party payers or other purchasers to accept those prices, or boycotts designed to exclude competing providers or other legitimate networks from the market. An example of such anticompetitive conduct was recently highlighted by the Department of Justice. DOJ alleged that in 1986, about 85 percent of the doctors in Buchanan County, Missouri formed St. Joseph's Physicians, Inc. to prevent or delay the development of managed care in the area.

The legislation establishes only general criteria regarding a venture's utilization, internal quality and efficiency reviews, management practices, grievance procedures, and contracting standards.[27] Networks may be funded "in part" by capital contributions from the members, regardless of whether the members share substantial financial risk.[28] In addition, the definition of "health care provider" includes "any individual or entity that is engaged in the delivery of health care. . .", including, presumably, any physician, hospital, nurse, laboratory and other such provider.[29] These definitions and criteria in the legislation ignore many of the essential features of pro competitive networks and potentially sanction the most serious types of anticompetitive conduct.

Under H.R. 2925, the *Rule of Reason* analysis would apply to any health care provider network that meets these general criteria, and almost all collaborative activities by competing providers carried out "for the purpose of providing health care services"—regardless of whether such joint ventures are integrated, provide new services or create pro competitive efficiencies.Thus, unintegrated networks of competing providers who collaborate solely for the purpose of jointly setting fees (price fixing) for the services they offer to health plans or other payers would be subject to the *Rule of Reason*. To stop such illegal conduct—conduct that the Supreme Court has condemned for decades—the Department of Justice and Federal Trade Commission would be prevented from taking prompt, decisive action under the *per se* rule, as they can today, and instead would be forced to evaluate such practices under the more protracted and expensive *Rule of Reason* legal analysis. In effect, H.R. 2925 would restrict the flexibility of the enforcement agencies to address quickly *per se* illegal practices, such as price fixing or group boycotts. It would increase enforcement costs and delay the cessation of harmful practices in the health care market to the detriment of consumers.

Anticompetitive networks and other joint ventures should not be given special legislative standing in the antitrust laws. Unfortunately, H.R. 2925 would do just this. It would give protection to precisely the kinds of conduct that raise costs, reduce services and limit choices for consumers—undermining the consumer protection purposes that are embodied in the antitrust laws.

CONCLUSION

The basic purpose of the antitrust laws is to promote and preserve competition, not to protect individual competitors or particular interests. GHAA/AMCRA urges the Congress to retain this principle in any antitrust legislation it considers.

Strong antitrust laws and vigorous enforcement have enabled managed care and other providers to compete in the health care marketplace for the past 50 years. Competition promotes cost containment, consumer choice and the expansion of managed care and other innovative approaches to health care delivery that benefit consumers. The future of such innovations will depend on the vitally important role of antitrust enforcement.

The proposed antitrust legislation would protect anticompetitive provider networks that raise prices, reduce services and limit choices for consumers. To the extent that it is intended to encourage or sanction legitimate provider networks, it is unnecessary. Such networks already are prospering under current antitrust law and enforcement policies.

GHAA/AMCRA wishes to thank the Chairman and the Committee for this opportunity to present its views. I would be happy to answer any questions that you may have.

ENDNOTES

1. Note: Group Health Association, now Group Health Association/Humana is a member plan of GHAA/AMCRA.

2. *American Medical Association* v. *United States*, 317 U.S. 519 (1943).

3. *See United States* v. *Alston et al.*, 974 F.2d 1206 (9th Cir. 1992); (price fixing conspiracy by dentists, including the submission of identical letters to managed care plans demanding higher fees (held pg se illegal)); *Trauma Associates of Broward County, Inc.*, C–3541, (consent order) 59 Fed. Reg. 63,805 (Dec. 9, 1994)(price fixing by trauma center surgeons); *U.S.* v. *Classic Care Network, Inc.*, 1995, Trade Cases (CCH) ¶ 70,997 (eight hospital conspiracy to resist cost-cutting efforts by HMOs and managed care plans); *United States* v. *Massachusetts Allergy Society*, 1992, Trade Cases (CCH) ¶69,846 (D. Mass. 1992) (conspiracy by allergists to develop a fee schedule and to jointly negotiate with HMOs to obtain higher fees (consent decree)); *United States* v. *Greater Bridgeport IPA. Civil Action No. 592 CU00575 (D. Conn. 1992)* (boycott and refusal to deal with an HMO by an IPA and its member physicians to force the HMO to increase the fees it paid to the IPA (consent decree)); *Southbank IPA, Inc.*, 114 FTC 783 (consent order 1991)(conspiracy by OB/GYNs to force HMO to increase fees paid of services, to drop cost-containment measures).

4. *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982); *American Medical Association* v. *United States*, 317 U.S. 519 (1943); *American Society of Anesthesiologists*, 93 F.T.C. 101 (1979).

5. *See Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital*, 110 F.T.C. 476 (1988). *See also Medical Staff of Holy Cross Hospital*, No. C–3345 (consent order, Sept. 10, 1991); *Medical Staff of Broward General Medical Center*, No. C–3344 (consent order, Sept. 10, 1991).

6. *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *Blue Cross of Washington and Alaska* v. *Kitsap Physicians Service*, 1982–1 Trade Cas. (CCH) ¶ 64,950 (W.D. Wash. 1981).

7. *Association of Independent Dentists*, 100 F.T.C. 518 (1982); *Michigan State Medical Society*, 101 F.T.C. 191 (1983); *United States* v. *Massachusetts Allergy Society*, 1992–1 Trade Cas. (CCH) ¶ 69,846 (E.D. Mass. 1992); *United States* v. *Alston*, 974 F.2d 1206 (9th Cir. 1992).

8. *See Indiana Federation of Dentists* v. *FTC*, 476 U.S. 447 (1986).

9. *See, e.g., American Medical International*, 104 F.T.C. 177 (1984); *Hospital Corporation of America*, 106 F.T.C. 455 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

10. The antitrust laws also are not "chilling" hospital mergers, according to a Department of Health and Human Services study that concluded that (1) there was no empirical evidence to support this assertion; (2) the enforcement agencies had made and are continuing to make a significant effort to educate the health care industry about their enforcement policies; (3) antitrust enforcement policies do not conflict with HHS's policies; and (4) it is not necessary or appropriate on the basis of current enforcement policies to support legislation that would exempt hospital mergers from scrutiny under the antitrust laws. "Report of the Secretary's Task Force on Hospital Mergers," Department of Health and Human Services (Jan. 1993).

11. "Source book of State Managed Care Trends and Federation Initiatives," American Medical Association (1995).

12. Data compiled from a review of Department of Justice business review letters and Federal Trade Commission advisory opinions issued from January 1, 1991 through February 1, 1996.

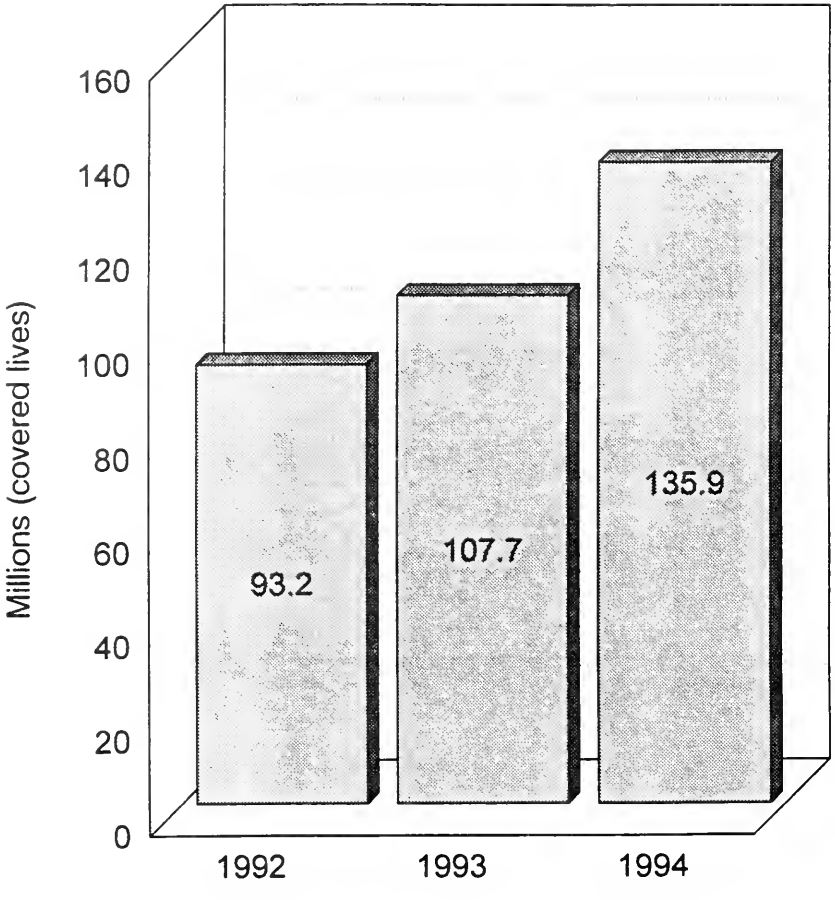
13. The disapproved proposed network involved a proposed PPO in which all members of a state's medical society could participate and in which prices were set at the Bath percentile of fees regularly charged by the participating physicians. In addition, the PPO was officially sponsored by the state medical society. The FTC found that the PPO was not integrated and the physicians did not share substantial financial risk. It involved a horizontal agreement among competing physicians to fix prices. In addition, the FTC concluded that the PPO could attain and exercise market power, given the high level of anticipated physician participation. Physicians would have little incentive to market their services to other plans, particularly given the state medical society's endorsement, and could tacitly agree to offer their services only through the PPO, in effect, negating the non-exclusive physician participation provision of the plan. (*See* Federal Trade Commission Advisory Opinion letter to Paul W. McVay, President, ACMG, Inc. (July 5, 1994).)

14. *See*, "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust," U.S. Department of Justice and the Federal Trade Commission (Sept. 27, 1994) [hereinafter, "1994 Statements of Enforcement Policy"].

15. Department of Justice Business Review Letter to Robert E. Nord, Esq., on behalf of St. Anthony Medical Center (November 8, 1993).
16. Department of Justice Business Review Letter to W. Bradley Tully, Esq., on behalf of Preferred Laboratory Access Network ("PLAN") (Dec. 7, 1995).
17. "The 1994 Statements of Enforcement Policy," *supra,* note 14.
18. Department of Justice Business Review Letter to Melissa J. Fields, Esq., on behalf of Dermnet, Inc. (Dec. 5, 1995).
19. Department of Justice Business Review Letter to Hill haven Corporation (Mar. 29, 1995).
20. Department of Justice Business Review Letter to Physician Care, Inc. (Oct. 28, 1994).
21. Department of Justice Business Review Letter to Dr. Oswald L. Mikell, M.D. (Nov. 1,1995).
22. "1994 Health Care Policy Guidelines," *supra* note 14, Statements 8–9.
23. "Annual Report to Congress," Physician Payment Review Commission (1995).
24. "1994 Health Care Policy Statements," *supra,* note 14.
25. H.R. 2925 2(b)(5).
26. *Id.*
27. *Id.*
28. *Id.*, § 2(b)(5)(B).
29. *Id.* § (b)(3).

Managed Health Care Enrollment

Year-end 1992-94



Source: GHAA/AMCRA Managed Health Care Database

Managed Care Enrollment By State - Year-end 1994

State	Pop. (x1000)	Insured Pop. (x1000)	Total Managed Care Lives	% of total population	% of insured population	State
Alabama	4,219	3,479	535,877	12.7%	15.4%	Alabama
Alaska	606	513	25,443	4.2%	5.0%	Alaska
Arizona	4,075	3,379	2,137,670	52.5%	63.3%	Arizona
Arkansas	2,453	1,995	262,280	10.7%	13.1%	Arkansas
California	31,431	25,020	19,766,235	62.9%	79.0%	California
Colorado	3,656	3,280	1,670,084	45.7%	50.9%	Colorado
Connecticut	3,275	2,861	1,067,042	32.6%	37.3%	Connecticut
Delaware	706	589	164,799	23.3%	28.0%	Delaware
Distnct of Columbia	570	511	335,331	58.8%	65.6%	Distnct of Columbia
Florida	13,953	11,816	5,955,405	42.7%	50.4%	Florida
Georgia	7,055	6,066	2,355,777	33.4%	38.8%	Georgia
Guam	150		81,087	54.1%	N/A	Guam
Hawaii	1,179	1,005	753,942	63.9%	75.0%	Hawaii
Idaho	1,133	980	21,220	1.9%	2.2%	Idaho
Illinors	11,752	10,490	6,352,340	54.1%	60.6%	Illinois
Indiana	5,752	5,355	1,590,659	27.7%	29.7%	Indiana
Iowa	2,829	2,545	993,653	35.1%	39.0%	Iowa
Kansas	2,554	2,201	633,804	24.8%	28.8%	Kansas
Kentucky	3,827	3,268	875,744	22.9%	26.8%	Kentucky
Louisiana	4,315	3,525	1,986,330	46.0%	56.3%	Louisiana
Maine	1,240	1,045	117,097	9.4%	11.2%	Maine
Maryland	5,006	4,414	3,967,893	79.3%	89.9%	Maryland
Massachusetts	6,041	5,259	3,357,844	55.6%	63.8%	Massachusetts
Michigan	9,496	8,495	3,814,981	40.2%	44.9%	Michigan
Minnesota	4,567	4,067	3,826,390	83.8%	94.1%	Minnesota
Mississippi	2,669	2,130	159,063	6.0%	7.5%	Mississippi
Missouri	5,278	4,488	2,474,044	46.9%	55.1%	Missouri
Montana	856	730	22,497	2.6%	3.1%	Montana
Nebraska	1,623	1,472	372,252	22.9%	25.3%	Nebraska
Nevada	1,457	1,284	726,575	49.9%	56.6%	Nevada
New Hampshire	1,137	997	267,511	23.5%	26.8%	New Hampshire
New Jersey	7,904	6,895	2,853,906	36.1%	41.4%	New Jersey
New Mexico	1,654	1,298	627,199	37.9%	48.3%	New Mexico
New York	18,169	15,329	6,371,073	35.1%	41.6%	New York
North Carolina	7,070	5,988	2,436,368	34.5%	40.7%	North Carolina
North Dakota	638	576	57,117	9.0%	9.9%	North Dakota
Ohio	11,102	9,932	4,920,486	44.3%	49.5%	Ohio
Oklahoma	3,258	2,657	701,456	21.5%	26.4%	Oklahoma
Oregon	3,086	2,750	1,902,869	61.7%	69.2%	Oregon
Pennsylvania	12,052	10,727	6,291,651	52.2%	58.7%	Pennsylvania
Puerto Rico	3,807		234,357	6.2%	N/A	Puerto Rico
Rhode Island	997	857	282,329	28.3%	32.9%	Rhode Island
South Carolina	3,664	3,137	410,637	11.2%	13.1%	South Carolina
South Dakota	721	666	37,583	5.2%	5.6%	South Dakota
Tennessee	5,175	4,805	3,495,388	67.5%	72.7%	Tennessee
Texas	18,378	14,352	9,108,342	49.6%	63.5%	Texas
Utah	1,908	1,707	749,732	39.3%	43.9%	Utah
Vermont	580	542	53,638	9.2%	9.9%	Vermont
Virginia	6,552	5,832	1,103,042	16.8%	18.9%	Virginia
Washington	5,343	4,594	2,157,813	40.4%	47.0%	Washington
West Virginia	1,822	1,512	129,064	7.1%	8.5%	West Virginia
Wisconsin	5,082	4,561	2,197,389	43.2%	48.2%	Wisconsin
Wyoming	476	411	0	0.0%	0.0%	Wyoming
Totals	260,341	222,387	135,940,200	43.3%	50.7%	Totals

Source: GHAA/AMCRA Managed Health Care Database

Mr. HYDE. Thank you, Ms. Metzger. Your testimony has been very valuable.

Lastly, Professor Clark Havighurst, the William Neal Reynolds Professor of Law at Duke University Law School. Welcome, Professor Havighurst.

STATEMENT OF CLARK C. HAVIGHURST, WM. NEAL REYNOLDS, PROFESSOR OF LAW, DUKE UNIVERSITY

Mr. HAVIGHURST. Thank you, Mr. Chairman.

As you observed earlier, I've written a lot about the application of the antitrust laws to the health care industry and the medical profession. Indeed, over the years I have been known, I think, as an advocate for aggressive enforcement against doctors. But I recently wrote an article that has yet to be published, but has been circulated some in manuscript form, that criticizes the enforcement agencies for what I called "overregulating physician networks." I've attached a copy of the article to the testimony I prepared and have submitted, and I hope it will get into the record.

Interestingly, the AMA has picked up on that article and has circulated it to a number of people and quoted it widely and has, I think, found some comfort in some of the things I said. And it's of interest as well that a lot of people who have known my earlier work have been surprised to find me taking the doctor's side on a matter of antitrust law. And it, therefore, may be useful for me to try to explain my position here. I'm trying to walk a line somewhere between the agencies and the profession and will end up not endorsing your legislation as such, but endorsing some of the objectives that I think you're trying to achieve.

The issue that I raise in the article is whether the agencies have used the per se rule in such a way as to preclude some potentially efficient arrangements by which doctors might collectively market themselves in this new world of managed care. And I suggested that at least in what I call mature markets—markets where there are a variety of plans available of all kinds and where the purchasers have demonstrated some sophistication and ability to look out for themselves—doctors ought to have a chance to show that any joint selling arrangement they might adopt is not anticompetitive. Such arrangements might yield efficiencies of some kind, either to the doctors themselves or to the purchasers who find it useful to deal with a group as opposed to each doctor one on one. Such arrangements ought therefore to be scrutinized to see whether they pose a net hazard to competition.

Applying the per se rule actually precludes any inquiry as to whether competition is harmed in fact. It simply presumes that harm has occurred. In my article I indicated a concern that the conditions that the agencies insist upon before they will give rule-of-reason treatment to a network are such that the networks are all forced into some rather narrow molds. Specifically, forcing doctors to assume financial risk, which I view as creating some conflict of interests with the patient, is not necessarily the only way in which medical care ought to be provided. It seems to me purchasers large employers, for example—ought to be free—to purchase care and deal with doctors on a fee-for-service basis, to rely on the physicians that are selected to practice efficient medicine, to

scrutinize their practices, and to reward those that are doing well. But it seems to me that we have—perhaps inadvertently to be sure—tended to reduce some of the options that physicians can pursue in marketing themselves.

Now, Mr. Chairman, the issues here aren't easy ones. Each market is different and has to be looked at specifically. I don't think a theoretical answer to the question is possible, and neither I, as an academic lawyer, nor Congress, in its wisdom, is likely to be able to come up with a reliable answer to the questions that the agencies have to deal with. This is a matter that perhaps can't be reduced to statutory language.

Even on the question of whether the per se rule should apply, I would hesitate to write a hard-and-fast prescription of the kind that appears in your bill. In my view at least, the rule of reason should be applied in all restraint-of-trade cases. By that I mean that courts and agencies should use "reason" before they apply per se rules in specific situations. That's how the rule of reason was meant to work. In some cases we have great confidence that there is a real problem of restraint-of-trade. In those cases, we can penalize that conduct without going deeply into everything.

But one doesn't just attach the price-fixing or other per se label without thinking first, without looking at the facts and seeing whether they resemble the earlier cases, and so on. So any legislation that seems to freeze this dichotomy between rule-of-reason and per se cases would, I think, confirm the view that per se rules are rules that we apply unthinkingly instead of rationally—with reason—using our lawyerly skills to decide which cases fit the precedents and which don't.

Chairman Pitofsky of the Federal Trade Commission gave you some assurances yesterday, I believe, that the Commission is rethinking its own use of the per se rule, together with the Justice Department. I would have some confidence that the outcome of their reassessment will address the issues that concern you and will give consumers a fuller range of options than they now have, insofar as that's consistent with protecting competition. I would hope that physician-sponsored networks will be given as much room as is consistent with maintaining competition in the whole market for physician services.

In mature markets where there are sophisticated purchasers and a range of options, doctor-sponsored networks should not be seen to pose huge problems that require the agencies to intervene. The large purchasers in those markets will look at these networks and decide whether to deal with them or not on the basis of whether they look like price-fixers or the efficient providers of good medical care. Purchasers ought to make these decisions, not the antitrust agencies. They ought to be allowed to decide for themselves whether these plans offer quality services at appropriate prices.

I do think there's one issue that one might focus on—namely, how easy it is for a purchaser to extricate himself from a relationship with one of these networks once he enters into it? The problem is that doctor-patient relationships can't be easily severed so that once a network in working with an employer, it might try to raise the doctors' fees—by 20 percent, let's say. The purchaser's options may be limited if his employees are all involved with the doctors

in the network and he can't just go find some other doctors to take care of them.

Although this problem could be worked out ahead of time, there's a lock-in sort of problem here and that the antitrust agencies should be thinking about how these networks, in contracting with purchasers, could preserve the purchasers' right to deal directly with the doctors on a more competitive basis if the networks should try to jack up prices unfairly. This seems to me an issue of a very practical kind that may need attention.

At any rate, I hope that the committee will conclude that what's needed here is oversight and not legislation. I don't think there's anything wrong with the law here. Antitrust law makes very good sense when it's applied thoughtfully and carefully. What we're going through here is a process of rethinking what is called for. It would be unfortunate for Congress to signify in any way that doctors are entitled to special antitrust rules. To send that message would confuse the courts and would give aid and comfort to those in the profession who really are out to try to stop the progress that is being made in bringing effective competition to the health care marketplace.

[The prepared statement of Mr. Havighurst follows:]

PREPARED STATEMENT OF CLARK C. HAVIGHURST, WM. NEAL REYNOLDS PROFESSOR OF LAW, DUKE UNIVERSITY

Mr. Chairman, I am a professor of law at Duke University, where I have taught courses in health care law and policy, antitrust law, and economic regulation since the 1960s. In the early 1970s, I began to publish articles advocating a policy of increased reliance on competition in the financing and delivery of health care. In that connection, I advocated active enforcement of the antitrust laws against physicians and physician organizations even before the Supreme Court finally clarified in 1975, in *Goldfarb* v. *Virginia State Bar,* that the Sherman Act applies to the so-called "learned professions." Indeed, in a friend-of-the-Court brief in the *Goldfarb* case, I urged the Supreme Court to grant the plaintiff's petition for certiorari because of the many benefits that would flow to consumers of health care if physicians had to abide by the Sherman Act as other competitors do. Thus, I have been on record for a long time as believing that antitrust law has an important role to play in policing the health care marketplace. I take some pride in having anticipated that antitrust enforcement would pave the way for a revolution of the kind that is occurring in American health care today.

Over the years, I have written numerous articles on antitrust issues in the health care field. Most recently—and most pertinently for the purposes of this hearing—I have written an article entitled "Are the Antitrust Agencies Overregulating Physician Networks?" I am attaching to this statement the latest prepublication draft of this article (which is soon to appear in the *Loyola Consumer Law Reporter,* published by Loyola University Chicago School of Law), and I hope it will be accepted for the record. As a result of my presentation of an early version of this article at a meeting in Chicago last October, it has been prominently quoted and widely circulated by the American Medical Association in connection with various legislative proposals such as the one this committee is considering today. AMA lawyers apparently found some of my criticisms of how the Sherman Act has been applied to physician network joint ventures compatible with their way of thinking. Because I have long been viewed as a critic of organized medicine and as an uncompromising advocate of antitrust enforcement against medical groups, many observers have been surprised to find the AMA citing my work favorably.

My remarks today are intended to help the committee understand my position and to aid it in deciding whether legislation is needed to ensure that physician sponsored networks receive appropriately sympathetic treatment under the antitrust laws. Although I agree with the AMA that physician networks of certain kinds deserve better treatment than they have recently received, I am not yet persuaded that the needed policy change cannot be achieved through a modification of attitudes in the enforcement agencies. I hope to find in these hearings that the agencies have begun to re-examine their previous position and are no longer locked into an

overly regulatory approach to exercising their prosecutorial discretion with respect to physician networks. There is, in my view, nothing in standard antitrust doctrine or policy that requires the agencies to go nearly as far as they have gone in limiting the freedom of physicians to market themselves in new and efficient ways or in preempting the function of purchasers in deciding which models for financing and delivering health care best balance competing concerns for cost and quality.

The thesis of the attached article and of my remarks today is that the antitrust agencies have been too quick to presume anticompetitive results when physicians organize so-called network joint ventures for the purpose of contracting with competing health plans or with employers purchasing health services for their employees. To be sure, as a species of joint selling agency, a physician network joint venture certainly deserves close antitrust scrutiny, since it may entail some agreement concerning the price and other terms on which otherwise independent competitors sell their services. But unless such a venture qualifies as a sham rather than as a legitimate effort to reduce the marketing and other transaction costs that physicians face in selling their services in the new competitive environment, it is not an appropriate candidate for condemnation under the principle that price fixing is illegal per se. In my view, recent antitrust enforcement policy has given too little credence to the possibility that a physician network controlled by physicians might yield marketing efficiencies that more than offset any loss of competition among the joint venturers themselves. Because I believe that networks designed and controlled by physicians themselves might sometimes offer consumers more desirable products than networks controlled by other interests, I am critical of antitrust policies that permit antitrust enforcers to dictate the nature and character of such plans even when overall market conditions are reliably competitive.

In a joint statement of their enforcement policy toward physician network joint ventures issued in September 1994, the Department of Justice and the FTC specified certain conditions that any physician-sponsored network must meet before they will view it as anything other than a per violation of the Sherman Act. The relevant policy states that physician network joint ventures "will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture *share substantial financial risk* or if the combining of the physicians into a joint venture enables them to *offer a new product* producing substantial efficiencies." (Emphasis added.) These requirements are not laid down merely as conditions that must be met to qualify for a so-called "safety zone" in which private parties are promised freedom from government attack. To be sure, the guideline does delineate two "safety zones"—one for exclusive networks, which are the sole marketing agents for participating physicians, and one for nonexclusive networks, which do not preclude their members from marketing themselves through other networks as well. In each case, the cited conditions, plus a market share screen relating to the percentage of physicians engaged, must be met to satisfy the agencies. The guideline goes on to state (in the quoted language), however, that networks not meeting these requirements, while not necessarily unlawful, can satisfy the rule of reason only if the two stated conditions are met. Although the context of the guideline suggests that the drafters had in mind only networks that failed the market share tests (20 percent for exclusive networks and 30 percent for nonexclusive ones), the guideline is written in such a way that the two conditions apply even to joint ventures representing much smaller percentages of local doctors. Subsequent statements and applications of the guideline by agency personnel confirm that even small joint ventures are expected either to impose financial risks on participating physicians or to integrate their practices so thoroughly as to yield "a new product."

Thus, current enforcement policy declares specific conditions that must be met if any physician network joint venture is to avoid being classified as a violation per se—that is, as absolutely indefensible by reference to conditions in the marketplace, to efficiencies it might achieve, or to other pro competitive features or consequences of the undertaking. To be sure, the policy statement is only a guide to the prosecutors' policy and not a regulatory rule, and one might wonder whether or not enforcement policy is as restrictive in fact as it seems to be on paper. Nevertheless, antitrust counselors have reported that, until recently at least, the agencies took their policy statement at face value. Thus, collaborating physicians have had to be advised that, to avoid a risk of litigation, they must comply with the agencies' dictates until enforcement policy is modified in some authoritative way. In my view, the agencies' conditions are too restrictive and should, for both doctrinal and policy reasons, be relaxed.

The enforcement guidelines put the government on record as conclusively deeming any physician network joint venture of any size to be unlawful unless it is demonstrably something more than a joint selling agency wholesaling the services of the doctors in the group. A group of physicians, of whatever size, would thus be abso-

lutely barred from appointing an agent to negotiate on their behalf with sophisticated purchasers, such as insurers, employers, and other prepaid health plans, if the agent, rather than the individual physicians, had authority to set prices for the group's members. Yet the practical difficulties that individual physicians face in finding secure places in the world of managed care are such that efficiencies in the form of saved transaction costs, not the elimination of competition, may easily be their principal objective in organizing such a sales agency. Purchasers, too, may realize significant cost savings from arrangements that spare them from having to bargain with numerous physicians individually. In my view, a proper application of the rule of reason would allow a physician network a chance to show that pro competitive effects predominate, whether or not the physicians "share substantial financial risk" or "offer a new product." Although many proposed arrangements would undoubtedly fail a rule of reason test, some joint ventures representing significant subsets of practitioners and not satisfying the guideline requirements might be found in particular circumstances to have more positive than negative effects.

The article appended to this statement reviews the legal situation is some detail, concluding that there is no good reason in antitrust doctrine or antitrust policy why the antitrust enforcers should not, in proper cases, be willing to treat physician sponsored networks as joint selling agencies and thus to treat their attendant limitations on price competition as ancillary restraints subject to the usual test of reasonableness. Under what I view as the appropriate analysis, the authorities would give due recognition to the severe practical difficulties that physicians in solo or small group practices face in marketing their services to numerous large buyers. Lacking appreciable business experience and the staff resources necessary to negotiate and keep track of their relationships with multiple payers, physicians should be free, within normal limits imposed by antitrust law, to form and operate joint selling agencies. In mature markets for medical care, purchasers are generally capable of looking out for themselves and should be free to do business with physician networks that do not follow the current prescriptions of the antitrust authorities. In such markets, physicians are more likely to form joint selling agencies as vehicles for competing on a price-discounted basis for particular contracts than to use them as cartelizing devices. Only in cases where the physicians seem truly capable of exercising market power should the agencies continue to insist that joint marketing efforts include cumbersome arrangements—the so-called "messenger model"—designed to remove the appearance of price fixing. In general, the agencies should focus less on form and more on substance than they have been wont to do.

In my view, much of the hostility of the antitrust agencies to physician network joint ventures has resulted in part from their looking backward to the time when it was much more reasonable than it is today to presume that, when physicians collaborate, it is only for anticompetitive purposes—that is, to limit rather than to expand consumers' options. Like many a wayward golf shot, however, the current enforcement policy also suffers from looking ahead, away from the object at hand and toward an intended goal. Thus, the agencies appear to be anticipating where they think the health care marketplace is or should be headed and attempting to steer physician-sponsored networks in that foreordained direction. Thus, their prescription of the form that such networks must take reflects a prejudgment of the way physician services should, and will eventually, be bought and sold in the future health care marketplace. In writing such a prescription, however, the agencies run the risk of substituting their own judgments and preferences for those of purchasers. In other words, the agencies have become regulators, displacing the very marketplace they are charged with protecting. The irony is that the agencies have yet to recognize their own success in bringing real competition into being in American health care or to entrust decisions to the marketplace they have so ably fostered. Indeed, in some markets, they have themselves become the principal remaining obstacle to health care arrangements that some sophisticated purchasers, acting on behalf of consumers, might well find more attractive than the managed-care options currently available.

To be sure, the antitrust agencies are not alone in assuming that all health care will eventually be provided by "capitated" providers or integrated health plans. Many other observers also believe that physicians must bear financial risk if they are to be induced to provide health care efficiently and without the chronic excesses that have characterized much fee-for-service medicine. It is dangerous, however, for regulators to dictate market outcomes on the basis of *a priori* assumptions about what is and what is not efficient or responsive to the needs and preferences of purchasers. In my view, some networks that are nothing more than joint selling agencies, involving no more risk bearing than is implicit in offering any product in a competitive market, may have immediate procompetitive value in their own right and should therefore be good candidates to survive antitrust scrutiny without regard

to the speculative (though probably valid) claim—advanced in the past by AMA officials—that they are also valuable as half-way houses on the way to fuller integration. Another virtue of such plans is that they would avoid regulation as insurers, such as many state insurance commissioners are currently seeking to impose on physician-sponsored plans that accept some explicit financial risk.

The AMA has argued with great conviction that impeding the creation of doctor-controlled plans fosters the unnatural growth of health plans operated by large corporate sponsors, which it alleges are less attuned than physician groups to patient welfare and the quality of care. I agree that antitrust enforcers should not, without good reason to fear anticompetitive effects in the health care market as a whole, deny physician-designed arrangements of all kinds a fair chance to compete against lay controlled entities in finding efficient ways to cope with disease at reasonable cost. In competitive markets, some such arrangements might prove attractive to many consumers. Able to rely on professionalism, collegiality, and consensus rather than exclusively on rules and regulations imposed from the corporate top down, physician-sponsored networks may well prove to have a comparative advantage in finding and implementing cost-saving methods that maintain essential quality and preserve intangible values that are at risk in many of today's managed-care systems.

In any event, putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold. Financial risk creates interest conflicts, diminishes loyalty to patients, and may undermine professionalism, with consequences that some consumers would find objectionable. Not only do the incentives employed in many integrated plans engender *sub rosa* rationing of care that consumers have no way to monitor, but consumers and their agents lack other kinds of reliable information permitting them to compare the overall performance of competing plans. Thus, they have much to worry about in purchasing health care today and might therefore feel safer in dealing with plans that did not put physicians at financial risk. Physician-sponsored joint selling agencies, if they do not dominate their local market, might add usefully to the competitive mix precisely because they do not feature direct financial incentives to withhold care, corporate control of medical practice, or integration and income pooling that lessen productivity incentives. A marketplace lacking arrangements designed by physicians themselves and not by antitrust authorities could easily fail to serve consumers well or to be fully reliable, from the standpoint of society as a whole, as a place for working out the difficult trade-offs with which health care necessarily abounds.

The assumption that competition will eventually induce virtually all Americans to enroll in some form of managed-care organization fails to take account of the fact that nearly 100 million Americans are currently covered by self-insured ERISA plans. This is roughly twice the number who receive their employer purchased benefits through entities that integrate financing and delivery in ways that would satisfy the antitrust authorities in a physician-controlled arrangement. Thus, many large employers do not require either that physician networks assume financial risk or that physicians integrate themselves in some formal fashion. Instead, they have employed either in-house benefit managers or third-party administrators to contract with physicians or physician networks directly at negotiated prices and to work with them, often in highly creative ways, to control costs. Such employers apparently prefer the cost savings achieved through careful selection of physicians and through cooperation with them in addressing cost problems over the savings they might gain by contracting out the business on a capitated basis. Antitrust enforcers should not deny employers the option of dealing with physician-organized joint selling agencies, which they can hold responsible for selecting physicians who provide appropriate care without overcharging for their services. It is simply wrong, legally, for the agencies to insist that, when physicians organize a network joint venture, the only issue is whether the sponsors have either preserved a semblance of price competition among themselves or followed the agencies' prescriptions in allocating risks or integrating their practices. Ironically, the question the agencies should be asking is whether or not the local market features other plans or networks that meet their specified conditions. If a market has matured to this extent, sophisticated purchasers should be allowed to choose for themselves how they want physicians to be organized and compensated for their services.

Having indicated my disagreement with the recent policies of the Department of Justice and the FTC, I want finally to say that, despite the AMA's use of my article to advance their legislative objective, I do not believe that legislation is the best way to solve the problem I have identified. To say that the current policy of the Department of Justice and the FTC toward physician networks is over regulatory is not to say that Congress must step in. Indeed, the problem I identify is not a problem with antitrust law as such, requiring legislative change. Instead, the agencies have

simply made a doctrinal error, adopting a rule of thumb when they should have applied the rule of reason. It is regrettable that this error gives ammunition to organized medicine in its continuing battle for legislative relief from antitrust strictures. Whatever law Congress might write on this subject could easily shelter more than just pro competitive activity by professional groups. It would in any event create unnecessary legal uncertainty and give unfortunate credibility to the medical profession's long-standing argument that doctors are different and should be subject to softer antitrust rules than ordinary mortals.

In the present circumstances, the way is open for the enforcement agencies to give collaborating physicians a chance to demonstrate that their joint ventures pose no ultimate threat to competition, despite their failure in some cases to pass the agencies' objective test. (Indeed, there are already encouraging signs that the FTC, at least, is prepared to weigh the argument that physician joint selling agencies and other networks not satisfying the guidelines' prescriptions do not necessarily pose anticompetitive risks.) Not only would a modest shift in agency policy go far to weaken the AMA's argument for legislation purporting to state new antitrust rules applicable to physician collaboration, but it would do so without bending the law, sacrificing antitrust principles, or authorizing potentially anticompetitive conduct. Most importantly, it would remove an impediment that currently forces innovation in the delivery of medical services into narrow channels, with adverse consequences for the range of consumer choice and possibly also for the quality of care provided.

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November 16, 1995

The Hon. Anne K. Bingaman
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
Washington, D.C.

The Hon. Robert Pitofsky, Chairman
Federal Trade Commission
Washington, D.C.

Dear Anne and Bob,

I am enclosing a draft of a paper strongly criticizing your agencies for being excessively hostile to physician joint selling agencies -- a subspecies of physician network joint ventures. Agency obtuseness on this issue is a serious problem not only because it reflects bad law and bad policy and is distorting market outcomes to the detriment of consumers but also because it is serving to open political doors for organized medicine, which, as always, is seeking congressional relief from the antitrust laws.

The AMA is using an earlier version of my paper to rally support for the provision in H.R. 2425 on physician-sponsored networks. I find it awkward after all these years to be on their side on an antitrust matter, but the issue is not a close one, in my view. Moreover, even if the merits were in doubt, this is a case where political wisdom dictates application of the rule of reason rather than per principles as a way of defusing the doctors' claim that the agencies are acting arbitrarily. The FTC was appropriately circumspect in addressing physician conduct in the 1980s and succeeded in resisting most of the attacks on the application of the antitrust laws to the health care field. (Unfortunately, agency neglect of the doctrinal problems in staff privileges cases was, I think, a major contributor to the climate that produced the regrettable congressional intervention in the Health Care Quality Improvement Act.) The time for such statesmanship has not passed.

I hope you will quickly find a way to acknowledge that conditions in many health care markets warrant a relaxation of earlier vigilance and that physician collaboration will hereafter receive an appropriate hearing in your agencies.

Most sincerely,

Enclosure

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Draft– Nov. 13, 1995

ARE THE ANTITRUST AGENCIES OVERREGULATING PHYSICIAN NETWORKS?

Clark C. Havighurst*

When the antitrust laws were first applied seriously to the medical profession following the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*,[1] a principal objective of antitrust enforcers was to contest organized medicine's control of health care financing. In the ensuing years, most health care markets evolved under antitrust protection so that they now feature a variety of financing entities that are not only independent of professional control but also highly aggressive in forcing physicians to sell their services on competitive terms. Although competition has not yet come to every local market, concerted action by physicians is no longer a ubiquitous obstacle to its emergence. Indeed, in mature markets for medical services, antitrust enforcers may do more harm than good if they continue to view concerted action by physicians with the skepticism that was appropriate in earlier years.

The thesis of this comment is that antitrust enforcers today are too quick to presume anticompetitive results when physicians organize so-called network joint ventures for the purpose of contracting with competing health plans or with employers purchasing health services for their employees. As a species of joint selling agency, a physician network joint venture certainly deserves close antitrust scrutiny since it may entail some agreement concerning the price and other terms on which otherwise independent competitors sell their services. But unless such a venture qualifies as a sham rather than as a legitimate effort to reduce marketing and other transaction costs, it is not an appropriate candidate for condemnation under the venerable principle that price fixing is illegal per se.[2] Yet current antitrust enforcement policy appears to give too little credence to the possibility that a physician network controlled by physicians might yield marketing efficiencies that more than offset any loss of competition among the joint venturers themselves. In

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*William Neal Reynolds Professor of Law, Duke University. The author is grateful to Charles D. Weller of the Ohio bar for calling his attention to the problem addressed in this article, for other insights, and, in particular, for pointing out the extent to which current antitrust policy ignores the special needs and circumstances of self-insured employers as purchasers of physician services.

[1]423 U.S. 886 (1975).

[2]E.g., United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); United States v. Trenton Potteries Co., 273 U.S. 392 (1927).

one of nine joint statements of enforcement policy regarding antitrust issues arising in the health care field, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) have specified certain conditions that any network joint venture must meet before they will view it as anything other than a per violation.[3] These conditions are too restrictive and should, for both doctrinal and policy reasons, be relaxed.

To say that the current policy of the DOJ and the FTC toward physician networks is overregulatory is not to say that Congress or the enforcement agencies should accede to demands by organized medicine that ordinary antitrust principles be bent to accommodate physician collaboration. The problem identified here is not a problem with antitrust law as such. Instead, the agencies have simply made a doctrinal error, adopting a rule of thumb when they should have applied the rule of reason. Regrettably, this error gives added ammunition to organized medicine in its continuing battle for legislative relief from antitrust strictures -- relief that would inevitably shelter more than just procompetitive activity by professional groups.[4] By the same token, giving collaborating physicians a chance to demonstrate that their joint venture poses no ultimate threat to competition, despite its failure to pass the agencies' objective test, would weaken the policy argument for softening antitrust rules applicable to physician collaboration.[5] Moreover, it would do so without sacrificing antitrust principles or authorizing anticompetitive conduct. Most importantly, it would remove an impediment that currently forces innovation in the delivery of medical services into narrow channels, with adverse consequences for the range of consumer choice and possibly also for the quality of care provided.

Origins of Current Enforcement Policy Concerning Physician Collaboration

The successful antitrust campaign against physician control of the financing and delivery of health services in the 1970s and 1980s was one of the great victories

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[3]Statement 8 -- Physician Network Joint Ventures, in U.S. Department of Justice & Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, Sept. 27, 1994, reprinted in 3 Health Law Rptr. (BNA) 1391 (1994).

[4]See text at notes 49-53 infra.

[5]On the appropriateness of accommodating political pressures of this kind in antitrust enforcement and even in antitrust doctrine itself, see infra note 20 and text at notes 52-53.

in the history of antitrust law. Beginning in the 1930s, the medical profession created a panoply of Blue Shield and other profession-controlled health care financing plans that enabled physician interests to dictate the economic conditions of medical practice. To be sure, independent financing programs also existed in the marketplace. But these plans were subject both to legal restrictions imposed at the behest of professional interests and to the threat of coercive boycotts by professional groups, and consequently also played by the profession's preferred rules.[6] In addition, even after Blue Shield and similar plans were freed from direct professional control, many of them protected their dominant market positions by serving local providers as their principal marketing agent. In return for marketing provider services on noncompetitive terms, a dominant Blue plan could count on providers collectively to deny competing plans discounts of the kind the Blues themselves typically enjoyed, to resist incursions by alternative financing and delivery systems, and to stonewall efforts by commercial insurers to introduce competition by selectively contracting with providers.[7]

The health care marketplace began to show signs of competitive life in the 1970s, however, as alternative financing and delivery mechanisms began to get a foothold. In self-defense, physician groups in many local markets organized a second generation of profession-controlled entities. So-called foundations for medical care (FMCs) and individual practice associations (IPAs) served the profession well for a while as effective defenses against both independent health maintenance organizations (HMOs) and innovative purchasing practices by

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[6]See, e.g., Lawrence E. Goldberg & Warren Greenberg, *The Effect of Physician-Controlled Heath Insurance: U.S. v. Oregon State Medical Society*, 2 J. HEALTH POL,. POL'Y & L., Spring 1977 at 48. For examples of provider boycotts and similar restraints aimed at payers, see FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); In re Mich. State Medical Soc'y, 101 F.T.C. 191 (1983).

[7]For cases in which Blue plans acted, not as aggressive purchasers, but as marketing agents for provider cartels (but escaped antitrust penalties because courts failed to recognize the monopolistic character of their conduct), see Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Travelers Ins. Co. v. Blue Cross of Western Pa., 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093) (1973) See generally Clark Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in HEALTH CARE IN AMERICA 221, 245-54 (H. Frech ed. 1988).

conventional health insurers. In the *Maricopa County Medical Society* case,[8] for example, FMCs in two Arizona counties established maximum prices for physician services and performed utilization review for health insurers that agreed to pay physicians under their fee schedules. The apparent purposes of the Arizona doctors in creating the FMCs were to set collectively a limit-entry price for their services (thus making the market less attractive to independent HMOs) and to induce health insurers not to embark on independent paths in procuring physician services on competitive terms. More recently, dominant physician interests have sought to use preferred-provider organizations (PPOs) or other network joint ventures to maintain solidarity in the face of purchasers' new efforts to break the profession's ranks. Antitrust enforcers have been appropriately alert to these collective efforts.[9]

The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s -- particularly in delaying the emergence of corporate middlemen able and willing to act as purchasing agents for consumers in procuring physician services on competitive terms -- was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers.[10] By the same token, the antitrust battles that hastened the breakup of medical cartels paved the way for the revolution that is occurring in American health care today.[11] Indeed, without uncompromising antitrust enforcement against physicians, the nation would have had to wait much longer for private innovations that make providers effectively accountable to consumers for the

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[8]Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

[9]See, e.g., Southbank IPA, Inc., 114 F.T.C. 783 (1991). See also Richard D. Raskin, *Antitrust Issues for Independent Health Care Providers: "Integration" and the* Per Se *Rule*, in ANTITRUST AND EVOLVING HEALTH CARE MARKETS 73 (19) (discussing recent enforcement efforts with respect provider networks); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507 (1994).

[10]See Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

[11]See, e.g., Clark C. Havighurst, The Antitrust Challenge to the Professional Paradigm in Medical Care (Center for Health Admin. Studies, U. of Chicago, 1990); Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986).

cost as well as the quality of medical care.[12] More likely, without antitrust enforcement clearing the way for private innovation, government would have assumed a dominant role in health care, as it has in other countries.

To be sure, the danger of physician collaboration to suppress competitive developments in local markets has not disappeared, and continuing antitrust vigilance is still warranted. Nevertheless, there are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding together. Too many large purchasers -- including Blue Cross and Blue Shield plans finally forced by competition to use their market strength on behalf of consumers rather than providers[13], commercial health insurers, and large self-insured employers -- now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. Selective contracting and discounting of physician fees in return for assured patient load are now common practices. In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options. Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today.

Networks under Today's Enforcement Policy and the Rule of Reason

Although the health care industry is undergoing a remarkable transformation, the one group of players that might develop the most efficient systems for delivering high-quality personal health care at reasonable cost are somewhat constrained in

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[12]Accountability remains a problem in the current market, however. See note 45 infra.

[13]See, e.g., Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc., 784 F.2d 1325, 1337 (7th Cir. 1986) (quoting a 1983 memorandum by a Blue Cross plan proposing a new strategy, novel for the plan and many others like it -- namely, that the plan "use its market position and its control over substantial sums of health care dollars to negotiate lower fees for provider services").

doing so by the way antitrust law is currently applied to their undertakings. Specifically, physicians organizing joint ventures for the purpose of marketing themselves to major purchasers are being forced by unrealistic antitrust standards into arrangements that may serve consumers less well than arrangements that such standards foreclose. The problem lies principally in the insistence by the antitrust enforcement agencies that any physician-controlled network be objectively distinguishable on its face from anticompetitive arrangements appropriately condemned in the past.

The joint DOJ/FTC enforcement policy states that physician network joint ventures "will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture *share substantial financial risk* or if the combining of the physicians into a joint venture enables them to *offer a new product* producing substantial efficiencies."[14] These requirements are not laid down merely as conditions that must be met to qualify for a so-called "safety zone" in which private parties are promised freedom from government attack. To be sure, the guideline does delineate two "safety zones" -- one for exclusive networks, which are the sole marketing agents for participating physicians, and one for nonexclusive networks, which do not preclude their members from marketing themselves through other networks as well. In each case, the cited conditions, plus a market share screen relating to the percentage of physicians engaged, must be met to satisfy the agencies. The guideline goes on to state (in the quoted language), however, that networks not meeting these requirements, while not necessarily unlawful, can satisfy the rule of reason only if the two stated conditions are met. Although the context of the guideline suggests that the drafters had in mind only networks that fail the market share tests (20 percent for exclusive networks and 30 percent for nonexclusive ones), the guideline is written in such a way that the two conditions apply even to very small joint ventures. Moreover, a footnote underscores that the rule of reason will apply only if "the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians who do not share substantial financial risk that fixes the price that each physician will charge." Subsequent statements and applications of the guideline by agency personnel confirm that even very small joint ventures are expected either to impose financial risks on participating physicians or to integrate their practices so thoroughly as to yield "a new product."

Thus, current enforcement policy declares specific conditions that must be

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[14]Supra note 3 (emphasis added).

met if any physician network joint venture is to avoid being classified as a violation per se, making it conclusively indefensible by reference to conditions in the marketplace, to efficiencies it might achieve, or to other procompetitive features or consequences of the undertaking. To be sure, the policy statement is only a guide to the prosecutors' policy and not a regulatory rule, and one might wonder whether or not enforcement policy is as restrictive in fact as it seems to be on paper. Nevertheless, because antitrust counselors report that the agencies are taking their policy statement at face value, collaborating physicians must be advised that, to avoid a risk of litigation, they must comply with the agencies' dictates until enforcement policy is modified in some authoritative way.

The guidelines put the government on record as conclusively deeming any physician network joint venture of any size to be unlawful unless it is demonstrably something more than a joint selling agency wholesaling the services of the doctors in the group. A group of physicians would thus be absolutely barred from appointing an agent to negotiate on their behalf with sophisticated purchasers, such as insurers, employers, and other prepaid health plans, if the agent, rather than the individual physicians, had authority to set prices. Yet the practical difficulties that individual physicians face in finding secure places in the world of managed care are such that efficiencies in the form of saved transaction costs, not the elimination of competition, may easily be their principal objective in organizing such a sales agency. Purchasers, too, may realize significant cost savings from arrangements that spare them from having to bargain with numerous physicians individually. A proper application of the rule of reason would allow a physician network a chance to show that procompetitive effects predominate, whether or not the physicians "share substantial financial risk" or "offer a new product." Although many proposed arrangements would fail a rule of reason test, some joint ventures representing significant subsets of practitioners and not satisfying the guideline requirements might be found in particular circumstances to have more positive than negative effects.

As a doctrinal matter, only certifiably "naked" restraints of trade -- those having no object other than suppression of competition -- are or should be subject to per se rules. To be sure, the Supreme Court's opinion in the *Maricopa* case seemed to say that per se rules may be applied to certain kinds of conduct even though there may be some question concerning the nakedness of the restraint.[15] But the Court's

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[15]E.g., 457 U.S. at ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some.").

method in that case demonstrated the excessiveness of its rhetoric justifying the arbitrary use of per se rules. Indeed, a careful reading of the majority opinion by Justice Stevens reveals that he actually applied the rule of reason (taking what has come to be called a "quick look" at all the circumstances) before finding unsupportable the FMCs' claim that their fixing of maximum prices was procompetitive -- specifically, that it made costs more predictable for both insurers and insureds, thereby lowering the cost and improving the quality of health insurance coverage. Indeed, Justice Stevens showed notable insight in his appraisal of the challenged practice. For example, he observed that, to achieve the arguable efficiencies, "it is not necessary that the doctors do the price-fixing."[16] He thus focused on the availability of a less restrictive, more procompetitive way in which better insurance coverage could be provided -- namely, by having an insurer itself set the fee schedule and contract with those physicians who were willing to abide by it. Since such selective contracting with physicians was practically unheard of at the time (indeed, it was precisely what the doctors hoped to discourage), his prescience was particularly commendable.[17]

Thus, despite what Justice Stevens said in *Maricopa* about having no choice but to apply a per se rule to maximum price fixing, the Court did not in fact find a violation until after it had discredited the physicians' claim that their maximum fee schedules were procompetitive. Thus, Justice Stevens stated that "the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition";[18] such consulting of the record to see whether a presumption of illegality might be successfully rebutted demonstrates that the presumption was not conclusive -- as a per se rule would be. Likewise, the Court said, "It is entirely possible that the potential or actual power of the foundations to dictate the terms of such insurance plans may more than offset the theoretical

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[16]457 U.S. at 352.

[17]At 457 U.S. at , Justice Stevens cited *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), for the proposition that insurers could obtain binding contractual fee commitments from physicians. That case upheld an insurer's selective contracting with low-price pharmacies against an antitrust challenge. Its citation in this context is noteworthy because, at the time, selective contracting and insurer-initiated price competition had not yet emerged in medicine.

[18]457 U.S. at 333.

efficiencies upon which the respondents' defense rests";[19] obviously, the question whether market power offsets efficiencies would not come up if the Court were truly bent on applying a per se rule. Although the *Maricopa* opinion is certainly confusing to anyone who follows Justice Stevens's rhetoric rather than his footwork, the Court's ruling was in no way inconsistent with the generally respected principle that only naked restraints of trade (and, apparently, not all of them[20]) are appropriate candidates for per se treatment.[21]

In any event (and despite the tendency of antitrust lawyers to dichotomize between "per se" and "rule of reason" cases), per se rules are not at war with the rule

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[19]Id. at 354

[20]Neither courts nor commentators have ever made it clear why a per se rule does not apply to all naked restraints, applying instead only to certain categories of such restraints. The best rationale (arguably underlying Justice Stevens's seemingly extreme rhetoric in *Maricopa*, supra note 15) is that, in many imperfect markets, there is more than a negligible chance that a restraint addressed to a matter other than price or output might actually yield an outcome closer to that which would result if the market were efficiently competitive. Wisdom might counsel, of course, against creating a doctrinal loophole for naked restraints of any kind since competitors rarely, if ever, restrain trade solely in the interest of consumers. Nevertheless, a conclusive presumption that concerted action by competitors is always anticonsumer would be politically unwise, especially in professional fields. Possibly for this reason, courts have been "slow to condemn rules adopted by professional associations as unreasonable per se." FTC v. Indiana Federation of Dentists, 476 U.S. 447, (1986). And the enforcement agencies themselves have been circumspect in such matters -- as in the *IFD* case itself, supra, where the FTC fully (though arguably unnecessarily) investigated the dentists' claims that the naked restraint in question enhanced the quality of dental care. Agency and judicial willingness to listen to defenses based on an alleged market failure (even if they rarely accept them) has the virtue of weakening the ability of professional interests to appeal to Congress for antitrust relief. See text at notes 49-53 infra.

[21]In two later cases, the Court appeared to apply per se rules too readily, without even a quick look that would probably have changed the outcome in one case but not the other. See FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411 (1990) (overlooking objection that market power could not be presumed -- as it usually is, implicitly, in price-fixing cases -- solely on the basis of defendants' attempt to fix prices, since defendants had alleged a plausible objective other than restraint of trade), Palmer v. BRG of Georgia, Inc., 498 U.S. 46 (1990) (per curiam) (treating restraint, easily condemnable as overbroad, as a per se violation without regard to its plausible business purpose).

of reason, but are instead products of its application to particular facts.[22] Such rules should therefore never be applied without first applying the rule of reason -- that is, without lawyerlike factual analysis to ensure that the case does indeed call for invoking the policy inherent in past rulings condemning comparable practices as indefensible restraints. The antitrust agencies, however, are apparently unwilling to look at the whole picture in judging physician network joint ventures. Indeed, if one takes the guidelines literally (and there is no reason one should not), a joint venture representing, on a nonexclusive basis, no more than a modest proportion -- say, ten percent -- of community physicians in each specialty would be condemned as a per se violation. Physicians are thus barred by the threat of antitrust attack from forming joint selling agencies that do not meet government specifications. Although antitrust prosecutors are not chartered to wield prescriptive powers, they have in this instance, by publicly committing themselves to exercise their prosecutorial discretion in a particular way, become regulators de facto.

There is no mystery about the source in case law of the agencies' insistence that physician-controlled networks, to escape antitrust challenge, must either impose financial risks on the joint venturers or integrate the doctors' practices so substantially as to "offer a new product." In the *Maricopa* case, the Supreme Court rejected the FMCs' claim that they were engaged in price fixing "only in a 'literal sense'" by stating that "their combination in the form of the foundation does not permit them to sell any different product."[23] The Court went on to distinguish the FMCs from "joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss . . . ."[24] The Court concluded its analysis as follows:

> If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee arrangements disclosed by the record in this case are among independent competing entrepreneurs. They fit

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[22]See Nat'l Soc'y of Professional Engineers v. United States, 435 U.S. 679, (1978) (describing rule of reason and how it yields "two complementary categories of antitrust analysis").

[23]457 U.S. at 356, quoting Broadcast Music, Inc. v. CBS, 441 U.S. 1, (1979).

[24]457 U.S. at 356.

squarely within the horizontal price-fixing mold.[25]

The agencies' position is thus seemingly supported by clear dicta in a Supreme Court opinion (for a four-Justice majority), and might easily carry the day in another court even though *Maricopa* involved a market very different from most of those one finds today. But the agencies' job is not to prosecute every case they might win on the basis of questionable dicta or precedent. It is instead to employ their expertise and fact-finding capability to prevent true restraints harmful to competition and consumer welfare while encouraging arrangements that create efficiencies.

Certainly, risk sharing and integration are appropriate requirements in defining safe harbors for certain physician collaborations. But they should not be made mandatory in all joint ventures by denying noncomplying ones a hearing under the rule of reason even when the parties make a plausible claim that their purpose is procompetitive and that their agreement on prices is ancillary to that purpose. In fact, absence of the features specified by the agencies does not unerringly identify a naked restraint deserving automatic condemnation -- without proof of the parties' anticompetitive purpose, of their power to affect competition in the market at a whole (not merely *inter se*), or of the actual or probable effect of their arrangement. Thus, a correct analysis of a physician-sponsored network falling outside the guidelines' safety zones would walk sensitively through the elements of purpose, power, and effect, condemning it only if there is a probable net harm to competition or if the parties have employed unreasonable means to achieve their legitimate objectives. Such an analysis of physician network joint ventures might sometimes result in a clean bill of health rather than a decision to prosecute.

Physician Networks as Joint Selling Agencies

Physician network joint ventures are best viewed for antitrust purposes, not as naked restraints of trade, but as joint selling agencies (JSAs), a type of arrangement that has not generally been condemned as a per se violation.[26] In a

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[25]Id. at 357.

[26]E.g., Appalachian Coals, Inc. v. United States, 288 U.S. 344 (1933) (treating some very minor and otherwise attainable benefits of joint selling in a difficult market as justifications for allowing a high percentage of sellers of coal to market through a single agent). The *Appalachian Coals* case is generally understood to be an aberration in the law, occasioned by the Great Depression. Nevertheless, even though more recent precedent places a heavy burden on JSAs, e.g., Virginia Excelsior Mills v. FTC, 256 F.2d 538, 539-41 (4th Cir. 1958), elementary principles entitle them to be evaluated under the rule of reason

passage quoted with approval by the Supreme Court in the *NCAA* case, Professor Philip Areeda has observed that "joint buying or selling arrangements are not unlawful per se."[27] Likewise, Professor Lawrence Sullivan has opined that

> some joint arrangements to buy or sell will not be summarily held to be unlawful . . . because summary analysis does not suggest a degree of market power which clearly demands that integration benefits be forbidden because price competition will be reduced. Joint agency cases such as these must be analyzed under the rule of reason, fully blown.
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> . . . . If the proposed selling or buying agency would materially increase concentration and if as a result the balance of forces would shift significantly away from rivalry and toward accord, the arrangement should be rejected as unreasonable. Just as surely, if competition could be expected to continue unabated, or even to improve, the rule of reason will mandate that the market's manner of striving for efficiency not be choked off.[28]

The Supreme Court cited Professor Sullivan's observations with approval in *Broadcast Music, Inc. v. CBS*,[29] overturning a decision condemning per se, as price fixers, two performing-rights societies that jointly marketed musical compositions on behalf of their composer-members. The Court held that the composers, through the societies, were engaged in price fixing only "in a literal sense" and that their pooling of compositions for licensing purposes was "not a 'naked restrain[t] of trade with no purpose except stifling of competition.'"[30]

Despite the favorable treatment of joint selling arrangements in *BMI*,

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if their sponsors' purposes are not obviously anticompetitive.

[27]National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla., 468 U.S. 85, 109 n.39, quoting PHILIP AREEDA, THE "RULE OF REASON" IN ANTITRUST ANALYSIS: GENERAL ISSUES 37-38 (1981) (observing that in some circumstances the power of the combining parties might be so obvious that "the rule of reason [could] be applied [to condemn the joint-selling arrangement] in the twinkling of an eye"). See also 7 PHILIP AREEDA, ANTITRUST LAW ____ (1986)

[28]LAWRENCE SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 104 (1977).

[29]441 U.S. 1 (1979).

[30]Id. at 2, quoting ...

however, that case is the ultimate source of much of the reasoning in the *Maricopa* case that apparently led the DOJ and FTC to insist that physician-controlled networks must either force the doctors to share financial risk or enable them to "offer a new product." To be sure, the Court praised the procompetitiveness of the performing-rights societies in making it easier, in a complex market, for composers to market their music and for users to hire it. But the Court's overall analysis, by emphasizing that the arrangement involved more than joint selling alone, may appear to justify hostility to less integrated physician joint ventures. Thus, the Court stressed that the societies each offered users of copyrighted music a particularly convenient form of blanket license, which it characterized as "to some extent, a different product."[31] Moreover, it went on to say that "to the extent that the blanket license is a different product, [a performing-rights society] is not really a joint selling agency offering the goods of many sellers,"[32] thus implying that a mere JSA would not qualify for rule of reason treatment. The *Maricopa* Court cited this discussion in rejecting the FMCs' claim that they, too, were engaged in price fixing "only in a literal sense."[33]

It is a mistake in judging physician networks, however, for the enforcement agencies to focus so minutely on these two cases and on others blurring the line between naked and ancillary restraints[34] rather than consulting general antitrust principles, under which per se rules apply only to certain categories of the former. In *BMI*, the Court needed to find very strong procompetitive features in the arrangements because the societies, between them, dominated the licensing of musical compositions and were highly vulnerable to condemnation in the absence of a strong business justification.[35] Thus, if all the facts are considered, a physician

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[31]Id. at 21.

[32]Id. at 22.

[33]*Maricopa*, 457 U.S. at 356.

[34]See note 21 supra. See also United States v. Topco Assocs., 405 U.S. 596 (1972) (applying the per se rule condemning market-division agreements to a minor limitation on joint venturers' freedom despite its value in protecting parties against each other's opportunistic conduct and thus in facilitating formation of procompetitive joint venture in the first place). Unfortunately for coherence in the law, this holding, although effectively discredited in Rothery Storage & Van Co. v. Atlas Van Lines, 792 F.2d 210, 227-29 (D.C. Cir. 1986), was cited favorably by Justice Stevens in *Maricopa*, 457 U.S. at ____.

[35]Indeed, the Court should probably have broken up the societies themselves in any

network representing only a fraction of physicians in an area, especially on a nonexclusive basis, might be able to make as persuasive a case for joint marketing as the *BMI* defendants. Certainly the efficiencies they could point to, based on the high transaction costs that both physicians and bulk purchasers would face in creating relationships by individual negotiation and in administering those relationships, would be similar in kind, and probably in magnitude, to the efficiencies achieved by performing-rights societies.

Moreover, a significant fact noted by the Court as favoring application of the rule of reason in the *BMI* case was the retention by the composers of the right to license their respective compositions on an individual basis.[36] As a practical matter, however, that alternative method of marketing was highly inefficient. It also did little to offset the market power of the societies, especially since the composers were not free to license their works through competing agents.[37] Nonexclusive physician networks, on the other hand, would permit physicians not only to service individual patients on a fee-for-service basis but also to join other networks, thus posing much less of a threat to competition. Such nonexclusivity should, in fact, save any network (whatever its size) that exists in a market where large employers and other payers have, and exercise, real opportunities either to organize their own networks or to patronize other existing physician groups. Of course, the enforcement agencies might reasonably require network physicians to show that they are participating in competing ventures in fact, not merely that they are free to do so on paper. In addition, sponsorship of the venture by a local medical society, rather than by a subset of competing physicians, should defeat any claim that it is a procompetitive, rather than a defensive, undertaking.

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event, since as the only two licensors of musical compositions they wielded undue market power and engaged in suspiciously parallel conduct. The private plaintiff, however, for reasons of its own did not seek such relief, asking only for the invalidation of blanket licenses (which served the interests of its competitors more than its own) and not for the restoration of unbridled competition (which would have benefitted its competitors more than itself). See *Broadcast Music*, 441 U.S. at 16-18 (Court's discussion of CBS's theory and desired remedy).

[36]441 U.S. at 20-21, ("The individual composers and authors have [not] agreed not to sell individually in any other market . . . .").

[37]The arrangement was comparable in this respect to the more restrictive ("exclusive") type of physician networks identified in the DOJ/FTC policy statement.

There is no good reason in antitrust doctrine or policy why the antitrust agencies should not, in proper cases, be willing to treat physician-sponsored networks as JSAs and their attendant limitations on price competition as ancillary restraints subject to the usual test of reasonableness. Under the appropriate analysis, the authorities would give due recognition to the severe practical difficulties that physicians in solo or small group practices face in marketing their services to numerous large buyers. Lacking appreciable business experience and the staff resources necessary to negotiate and to keep track of their relationships with multiple payers, physicians should be free, within normal limits imposed by antitrust law, to form and operate JSAs. In mature markets for medical care, purchasers are generally capable of looking out for themselves and should be free to do business with physician networks that do not follow the current prescriptions of the antitrust authorities. In such markets, physicians are more likely to form JSAs as vehicles for competing on a price-discounted basis for particular contracts than as cartelizing devices.

Less Restrictive Alternatives?

To be sure, the evaluation of ancillary restraints of trade does not end with their classification as such. Even if the parties' purposes are unexceptionable, there must still be an inquiry into the probable state of competition if the collaboration is allowed. Such an inquiry begins with an estimate of the parties' market power -- that is, their ability to affect market price and overall output by their collaborative decisions. If the parties turn out to possess market power in fact (even though they do not need such power to accomplish their ostensible procompetitive purpose), the net effect of their collaboration could easily be more harmful than beneficial to consumers.

A case can frequently be resolved, however, without finally balancing procompetitive against anticompetitive effects -- by asking whether the parties could achieve their legitimate purposes in a manner less dangerous to competition. If such a "less restrictive alternative" was available and was not adopted by the collaborators, the antitrust enforcers might conclude either that their purpose was actually anticompetitive (thus justifying application of the per se rule after all) or that, despite their lawful purpose, the parties' choice of the more restrictive method of achieving it can itself be penalized. In reviewing physician-sponsored networks possessing a degree of market power, therefore, antitrust agencies must determine whether the anticompetitive features of the arrangement are reasonable in the sense that they are well-tailored to achieve their procompetitive purposes with minimal harm to competition.

Because the less-restrictive-alternative requirement is an element of a rule of *reason*, it should not used by the antitrust agencies simply as a warrant for closely second-guessing the way the parties have chosen to structure their relationship; thus, it should be invoked only if the methods chosen betray an anticompetitive motive or materially increase the threat to competition. Before antitrust enforcers require a physician joint venture to restructure itself in a way that sacrifices available efficiencies, therefore, they should have substantial reasons to fear that the arrangement jeopardizes competition in the market as a whole. For reasons similar to those already discussed, an agency should not, without at least a quick-look power analysis, invoke the less-restrictive-alternative requirement to force the joint venturers to meet its prescriptions regarding risk-sharing or the nature and extent of their integration. It is not enough to say, as the *Maricopa* Court did, that "it is not necessary that the doctors do the price fixing." Even though an enforcement agency can imagine less restrictive methods by which the doctors could market themselves, it should not require use of such methods unless to do so would avert an unreasonable threat to competition in the larger market.

Reflecting the demands of antitrust authorities, the current practice in forming physician-sponsored networks is to design arrangements that avoid the noncompetitive fixing of prices for the services of the individual physicians in the group. Lawyers for physician JSAs have developed so-called "messenger" models in an effort to obtain some of the efficiencies of joint marketing while preserving a semblance of price competition.[38] Indeed, the apparent frequency with which networks are formed using some kind of messenger mechanism demonstrates that physicians set up JSAs primarily to achieve efficiencies, not to fix prices. It is not obvious why antitrust policy requires that they adopt cumbersome marketing methods that purchasers themselves do not insist upon. The enforcement agencies have uncharacteristically exalted form over substance in their analysis, ignoring valid efficiency considerations that normally would be given due weight.

Messenger arrangements do not so obviously qualify as less restrictive alternatives that every physician-sponsored JSA should be required to use them. To be sure, they are *theoretically* less restrictive than letting the joint venturers agree on price. But because they are cumbersome to operate, they are not equally satisfactory as alternatives for getting the marketing job done. Their use therefore sacrifices some of the efficiency that JSAs can otherwise create. Indeed, antitrust authorities

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[38]See generally Raskin, supra note 9, at 86-91; *Law Firm Warns of FTC's and DOJ's Increased Focus on Messenger Models*, 4 HEALTH LAW RPTR. (BNA) 603.

apparently insist that physician JSAs employ a particularly cumbersome mechanism called the "pure" messenger model. Under these arrangements, the marketing agent must communicate offers back and forth between bulk purchasers and individual doctors without disclosing to the latter the price terms that others are quoting. Because the pure messenger model is unwieldy, some networks employ "modified" messenger arrangements, which may take the form of a standing offer of individual physicians' services on uniform terms that a purchaser is free to accept or reject. Such arrangements have never been approved by enforcement officials, however, and have sometimes been rejected. Thus, if a physician-sponsored network provides neither for risk sharing nor for enough integration to create a "new product," the antitrust authorities will apparently deem it unlawful unless it takes maximum precautions -- at whatever cost in inconvenience to both doctors and purchasers -- to eliminate all price-fixing features. Although it is hard to judge the relative efficiency of all the possible messenger arrangements, the antitrust agencies might somewhat improve the situation by tolerating modified versions whenever competition in the market as a whole is not specifically in danger.[39] The better approach, however, would be to apply the rule of reason.

Insistence on a second-best alternative is appropriate in antitrust enforcement and under the rule of reason only if a specific risk to competition outweighs the efficiencies forgone. To be sure, use of a messenger model should be required in many circumstances, often identifiable with only a "quick look." But in instances where the danger of anticompetitive harm is unclear, a more sensitive evaluation is required. Such an analysis would consider such factors as sponsorship of the JSA by physicians in an aggressive competitive posture rather than in a defensive, anticompetitive one (that is, by interests other than a local medical society); the percentage of competing physicians engaged in the effort; their freedom to participate in competing ventures; their actual participation in other marketing schemes; the sophistication, effectiveness, and preferences of the purchasers with which they deal, and the overall vigor of competition in the market being served. Even if a network was the exclusive marketer for its member doctors, there would still be no threat to competition if the market featured a variety of other plans. In such a mature market,

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[39]It is not known whether anyone has studied the actual operation of various messenger models to see what costs they incur or whether purchasers benefit in fact from the price competition they seemingly preserve. Although the doctrinal basis for doing so would be highly artificial, the agencies might obviate some of the inefficiency by letting joint venturers agree on nonprice terms, using the messenger model only for price terms (which are more amenable to individual negotiation).

purchasers can decide for themselves whether to patronize JSAs in which physicians have not expressly undertaken to share financial risk, to integrate their practices, or to maintain any kind of independent pricing. Indeed, the availability of meaningful purchaser options itself puts the collaborating physicians at risk of contract nonrenewal and should go far toward satisfying government officials that competition is not in danger.[40]

The Danger of Prejudging Market Outcomes

As already demonstrated, the hostility of the antitrust agencies to physician network joint ventures results in part from their looking backward to the time when it was reasonable to presume that physicians collaborated only for anticompetitive purposes. Like many a wayward golf shot, however, the current enforcement policy suffers also from looking ahead, away from the object at hand and toward an intended goal. Thus, the agencies appear to be anticipating where they think the health care marketplace is headed and attempting to steer physician-sponsored networks in that foreordained direction. Thus, their prescription of the form that such networks must take reflects a prejudgment of the way physician services should, and will eventually, be bought and sold in the future health care marketplace. In writing such a prescription, however, the agencies run the risk of choking off (in Professor Sullivan's words) "the market's manner of striving for efficiency."

To be sure, the antitrust agencies are not alone in assuming that all health care will eventually be provided by integrated health plans.[41] Many other observers also believe that either physicians themselves or independent middlemen capable of managing physicians must bear financial risk if physicians are to be induced to provide health care efficiently and without the chronic excesses that have

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[40]Another kind of risk that should reassure antitrust enforcers concerning the compatibility of a JSA with competition in the larger market is the risk of "deselection" faced by individual physicians participating in the network. Although the agencies are reported to take a narrower view, a joint venture might argue that it is offering "a new product" if it reserves, and occasionally exercises, the power to exclude doctors who overuse resources or provide care of doubtful quality. On the other hand, a state "any-willing-provider" law, mandating that a network include any physician willing and able to meet its terms, would eliminate most of this risk. In states where such inclusiveness is mandated by law, the antitrust agencies could reasonably take the position that any joint venture should satisfy their requirements with respect to risk-sharing or integration.

[41]See, e.g., Greaney, *supra* note 9.

characterized much fee-for-service medicine. It is dangerous, however, for regulators to dictate market outcomes on the basis of *a priori* assumptions about what is and what is not efficient or responsive to the needs and preferences of purchasers.[42] Current antitrust enforcement policy with respect to physician networks is an exercise of prosecutorial discretion that, in attempting to provide guidance to the industry, has become overly regulatory and prescriptive, foreclosing options that might attract followers in a competitive market.

The American Medical Association (AMA), in advocating greater freedom for physicians to create their own networks, has been somewhat careful about challenging directly the conventional view that physicians will ultimately either be put under managed-care arrangements operated by third parties or be organized in competing groups with explicit individual or collective incentives to control costs. Thus, the AMA has sought to persuade antitrust enforcers that physicians need more freedom to collaborate only so that they can take incremental steps toward fuller integration or can explore new methods of payment without having to take the plunge all at once.[43] Citing physicians' lack of the capital, experience, and management skills necessary to organize a fully integrated plan, the physician group argues that physicians need an opportunity to test the waters and to evolve gradually toward full-blown integration of their practices. Observing that simple networks and management service organizations (MSOs) could either serve as building blocks for larger plans to incorporate in their systems or evolve into physician-sponsored entities capable of bearing financial risks or offering "new products," it advocates antitrust relief that would facilitate physician experimentation with new ways of organizing themselves. This article argues more explicitly than does the AMA that some JSAs may have immediate procompetitive value in their own right and should therefore survive antitrust scrutiny without regard to the speculative (though probably valid) claim that they are also valuable as half-way houses on the way to fuller integration. Whereas the AMA hopes for some legislative relaxation of antitrust requirements, agency application of the rule of reason would alone be enough to

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[42]Cf. Jeff C. Goldsmith, *The Illusive Logic of Integration*, HEATLHCARE FORUM J., Sept.-Oct. 1994, p. 26 (questioning the benefits of much of the organizational integration sweeping the health care industry).

[43]See generally Letter from James S. Todd, M.D., Executive Vice President, AMA, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, May 11, 1994 (discussing antitrust issues addressed by certain legislative proposals).

give physicians all the freedom of action that is compatible with effective competition.

The AMA has also argued that impeding the creation of doc or-controlled plans fosters the unnatural growth of health plans operated by large corporate sponsors, which it alleges are less attuned than physician groups to patient welfare and the quality of care. Although granting legislative relief to physician collaboration would be a serious policy error,[44] antitrust enforcers should not, without good reason, deny physician-designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at reasonable cost. In competitive markets, some such plans might prove attractive to many consumers. Able to rely on professionalism, collegiality, and consensus rather than exclusively on rules and regulations imposed from the corporate top down, physician-sponsored plans should have a comparative advantage in finding and implementing cost-saving methods that maintain essential quality and preserve intangible values that are at risk in many of today's managed-care systems.[45]

In any event, putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold. Financial risk creates interest conflicts, diminishes loyalty to patients, and may undermine professionalism, with consequences that some consumers would find objectionable. Not only do the incentives employed in many integrated plans engender *sub rosa* rationing of care that consumers have no way to monitor, but consumers and their agents lack other kinds of reliable information permitting them to compare the overall performance of competing plans. Thus, they have much to worry about in purchasing health care today and might therefore feel safer in dealing with plans that did not put physicians at financial risk.[46]

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[44]See text at notes 49-53 infra.

[45]One physician sophisticated in health policy and generally appreciative of the role of antitrust law in medicine has argued that doctors must have a larger role in decision making and management if health care quality is not to suffer in the brave new world of managed care, "gatekeepers," and capitation. See Robert A. Berenson, *Do Physicians Recognize Their Own Best Interests?*, HEALTH AFFAIRS, Spring 1994, p. 185.

[46]The author has recently argued at length that the failure of health plans to write subscriber contracts saying anything meaningful about the degree to which the plan and its providers will ration services and balance health benefits against costs is a severe impediment both to offering consumers meaningful options in the marketplace and to

Physician-sponsored JSAs, if they do not dominate their local market, might add usefully to the competitive mix precisely because they do not feature direct financial incentives to withhold c_re, corporate control of medical practice, or integration and income pooling that lessen productivity incentives. A marketplace lacking health plans designed by physicians alone (and not by antitrust authorities) could easily fail to serve consumers well or to be fully reliable, from the standpoint of society as a whole, as a place for working out the difficult trade-offs with which health care necessarily abounds.

One consequence of the current and emerging problems with managed care could be a rising tide of regulation. Already, a combination of physician criticism, rumor, unverified consumer complaints, and occasional press reports of beneficial care denied is causing increasing skepticism and critical comment about the new generation of health plans. This discontent could easily ripen into a further backlash of regulation and litigation. Although designed to protect consumers, such legal developments would raise health plan costs and limit the ability of plans to adopt innovations responsive to the wishes of consumers and their agents. Indeed, overregulation is already a problem in many states, and only the fortuitous presence of the federal Employee Retirement Income Security Act (ERISA) as a barrier to intrusive state regulation and judicial oversight of employee benefit plans[47] has permitted the market to make as much progress as it has toward bringing costs under appropriate control. ERISA is under constant challenge, however, and may eventually give way as a defense against heavy-handed state regulators. For federal antitrust authorities to mandate risk sharing that in turn invites either relaxation of ERISA preemption or new state regulatory controls could be highly destructive of the market's ability to achieve efficiency.

In this connection, it should be noted that the National Association of Insurance Commissioners has recently declared its members' intention to treat any network of physicians that carries any degree of financial risk as an insurer requiring state licensure as such.[48] Thus, the antitrust requirement that physician-sponsored

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holding providers and plans accountable for complying with any but a generally applicable (poorly defined but relatively expensive) standard of care. See CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

[47]29 U.S.C. § 1001 et seq. (19). See, e.g., Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that ERISA preempts state mandated-benefit laws); Pilot Life Ins. Co. v. Dedeaux, U.S. (1987) (holding that ERISA preempts state law remedies for bad faith in administration of employee health benefits plans).

[48]See *NAIC Bulletin to Address Application of Insurance Laws to Provider Groups*,

networks be structured to impose financial risks on physicians is driving such plans directly into the arms of state insurance regulators. State insurance regulation would increase the difficulty of creating new network joi .t ventures, would raise their costs, and would limit their ability to meet purchaser needs and expectations, thus undermining the efficiencies that such networks might otherwise achieve. Physician JSAs, on the other hand, would escape such regulation and would thus greatly enhance the freedom of self-insured employers and other purchasers to obtain the services they require without encountering the delays, obstacles, and costs that state regulators impose.

The assumption that competition will eventually induce virtually all Americans to enroll in some form of managed-care organization fails to take account of the high degree to which American employers have elected to bypass intermediaries and to do business with providers directly. Nearly 100 million Americans are currently covered by self-insured ERISA plans. This is roughly twice the number who receive their employer-purchased benefits through entities that integrate financing and delivery in ways that would satisfy the antitrust authorities in a physician-controlled arrangement. To be sure, there are some markets such as California where the market penetration by conventional HMOs and managed-care organizations is impressive, but there are many others (large parts of the Middle West, for example) where competition has operated for some time without inducing employers to rely heavily on corporate middlemen or integrated or risk-bearing physician networks. In these markets, many large employers do not require either that physician networks assume financial risk or that physicians integrate themselves in some formal fashion. Instead, they have employed either in-house benefit managers or third-party administrators who contract with physicians or physician networks directly at negotiated prices and work with them, often in highly creative ways, to control costs. Such employers apparently prefer the cost savings achieved through careful selection of physicians and through cooperation with them in addressing cost problems over the savings they might gain by contracting out the business on a capitated basis or by forcing physicians to accept lower fees. Antitrust enforcers should not deny employers the option of dealing with physician JSAs, which they can hold responsible for selecting physicians who provide appropriate care without overcharging for their services.

Self-insured employers should therefore be free to work directly with

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HEALTH LAW RPTR. (BNA) 1177 (discussing NAIC bulletin issued Aug. 10, 1995). See also *Storm Warning*, HEALTH SYSTEMS REV. (Federation of Am. Health Systems), Sept.-Oct. 1995, pp. 26-37 (series of articles discussing state insurance regulation of provider networks).

physician-designed JSAs and not forced instead either to form their own networks or to hire independent entities to assume risk, to manage care, or to form fully integrated health plans. Such entities naturally expect to profit both from investing the employer's advance payments and, most importantly, from economizing on the provision of health care to employees and their families. Many employers might prefer to eliminate the middleman and to take direct responsibility for both the cost and the quality of medical care that their employees receive. In this effort, physician networks organized by physicians themselves could be valuable allies. Antitrust enforcers are simply wrong to insist that, when physicians organize a network joint venture, the only issues are whether the sponsors have either preserved a semblance of price competition among themselves or followed the agencies' prescriptions in allocating risks or integrating their practices.

A Pretext for Congressional Intervention?

Agency obtuseness on the issue addressed in this article comes at a particularly inopportune time -- as Congress is considering major reforms of the Medicare program. The version of the reform legislation that passed the House of Representatives in the Fall of 1995 included two provisions relating to antitrust law applicable to physicians. One would have explicitly required application of the rule of reason rather than a per se rule to "physician-sponsored networks" (PSNs) contracting with "physician-sponsored organizations" (PSOs) to deliver Medicare services under a PSO's capitation contract with the government.[49] Thus, the House bill opted for letting physicians deal with "MedicarePlus" contractors through JSAs to the same extent that, under the analysis in this article, physicians could employ JSAs in dealing with ERISA plans and other private or public purchasers. The need for the House provision would therefore be obviated if the antitrust agencies were to relax the policy criticized in this article. Indeed, that outcome would be highly preferable to a legislative fix precisely because it would extend to physician networks of all kinds, not just to those organized to serve Medicare beneficiaries. In addition, it is always preferable to solve problems in the administration of antitrust law by shaping doctrines to promote competition better rather than by turning to Congress.

A more troubling provision in the House bill would have created a sweeping antitrust exemption for so-called "medical self-regulatory entities,"[50] rolling back twenty years of painstaking development (since *Goldfarb*) of antitrust principles applicable to concerted action by professional groups. Physician interests have long

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[49]H.R. 2425, 104th Cong. 1st Sess. § 15201 (1995).

[50]Id. at § 15221.

contended that antitrust enforcers underestimate their motives in taking collective action in the marketplace. The agencies have successfully (and wisely) maintained, however, that the law requires the uncompromising maintenance of competition in professional fields, even when professionals can plausibly claim that their anticompetitive actions are motivated by concern for the public interest.[51] Thus, the antitrust movement has successfully brought to bear in medicine the wholesomely objective principle -- which the House bill would have converted to an impractical, and much too forgiving, subjective test -- that parties with a conflict of interests ought never to exercise coercive powers that are subject to anticompetitive abuse. Experience under the antitrust laws since the 1970s has generally vindicated the premise that competitive markets are preferable to professional control precisely because they are more hospitable to innovations responsive to consumer interests.

Unfortunately, unwise administration of the antitrust laws, either by the agencies or by the courts, invites Congress to intervene on behalf of politically powerful physician interests and to enact confusing, possibly overbroad correctives or destructive immunities like the ones in H.R. 2425.[52] The agency policy discussed in this article is thus doubly unwise. In addition to being wrong as a matter of antitrust doctrine, it may prove a political disaster. Precisely because it has been based more on hostility toward physicians and suspicions about their motives than on reasoned application of antitrust policy, it has given medical interests a wedge with which to get Congress into the act, creating the potential for legislation virtually repealing antitrust law as it affects organized medicine. Antitrust is ultimately a

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[51]E.g., FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986); National Society of Professional Engineers v. United States, 435 U.S. 679 (1978). But see note 20 *supra*.

[52]Congress last modified the application of antitrust law to the health care industry -- also at the behest of organized medicine -- in the Health Care Quality Improvement Act of 1986. 42 U.S.C. §§ 11101-51 (19) Because courts had been unable to find in antitrust doctrine any reasonable and expeditious basis for distinguishing between meritorious and nonmeritorious private antitrust challenges to staff privileges decisions in hospitals, see, e.g., Patrick v. Burget, U.S. (1988). Congress felt compelled to provide qualified antitrust immunity for hospital-based peer-review (and other similar professional) activities. On the other hand, if courts (perhaps with wise and balanced guidance from the antitrust agencies) had focused their efforts on distinguishing between actions of hospitals themselves and actions of medical staffs empowered by hospitals finally to decide the fate of their competitors, there would probably have been no need for congressional intervention. See Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1108-42.

political enterprise on which turns the fate of competition in the economy as a whole.[53] If competition is not to be undercut by congressional tinkering, antitrust enforcement must reflect astute political judgment. An overly aggressive trust-busting mentality, such as the attitudes manifested by the agencies toward physician-sponsored JSAs, can easily have political repercussions harmful to competition in health care.

Conclusion

This article has argued that Americans are currently being denied access -- by antitrust authorities, of all people -- to a variety of doctor-sponsored physician networks that could perform useful services for some purchasers in some health care markets. In particular, the current policy of antitrust enforcers, in requiring all such networks to meet certain organizational or financial requirements, neglects at least three realities. One is that self-insured ERISA plans have very different needs than other purchasers of health care and that physician networks are capable of responding directly to these needs. Second, the antitrust agencies fail to recognize the heavy regulatory burdens and litigation threats facing the kinds of health plans they visualize as the wave of the health care future; precisely because ERISA plans and physician JSAs both escape many of these burdens, they may be jointly capable of efficiencies that are difficult for other plans to achieve. Finally, the antitrust agencies seem trapped in a time warp that keeps them fearful of physician conspiracies that are much less likely to prosper -- and thus to be attempted -- today than in an earlier era.

The Sherman Act's rule of reason was designed specifically to ensure that antitrust authorities consult the realities of actual markets in making judgments about whether competition is in jeopardy or is operating in healthy though possibly unpredictable ways. Conscientious antitrust analysis should enable the DOJ and FTC to recognize, often with only a "quick look," whether specific physician joint ventures or joint selling arrangements are more likely to suppress competition or to serve efficiently the needs of both their members and sophisticated purchasers, especially large employers and their employees. The threat that current enforcement policy poses to all physician network joint ventures that fail to meet the agencies' own prescriptions should be removed, either by a new policy statement or by an official clarification prominently announced. It would be a terrible reflection on the performance of the antitrust agencies if Congress had to put them on the correct doctrinal path in evaluating physician networks.

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[53]See note 20 supra.

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WRITER'S DIRECT NUMBER
312-853-4719

February 21, 1996

Kirk B. Johnson, Esq.
Sr. Vice President and General Counsel
American Medical Association
515 N. State Street
Chicago, IL 60610

Re: Antitrust Enforcement Statements

Dear Kirk:

The following information, describing the facts surrounding a managed care provider network I represent, is intended to illustrate how the current enforcement posture of federal antitrust enforcement agency representatives has impeded the development of managed health care organizations desired by the health plan sponsors.

In a medium-sized city in the Midwest, the managed care market is dominated by two payors: a Blue Cross HMO and another HMO owned by a large HMO system. The balance of the health benefit plan market consists largely of self-funded benefit plans sponsored by mid-sized employers, and plans insured under traditional indemnity coverage.

Two of the city's hospitals and a number of physicians desire to form a managed care organization. The provider representatives met with the representatives of the two HMOs to discuss a capitation relationship or other form of risk assumption relationship, but were informed that neither HMO desired such a relationship with a provider organization. Therefore, there is no current market for the assumption of risk from HMOs.

The self-funded employers would like the providers to propose a payment methodology that would enable the employer sponsored benefit plans to reduce costs, have access to a reasonably large provider panel, but would not threaten the ERISA pre-emption from state insurance law mandates currently enjoyed by the plans. The employers have requested that the providers organize themselves and develop an initial discounted fee-for-service

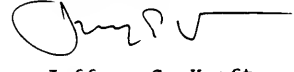
approach to pricing. The employers have no basis for proposing a specific approach to pricing.

As regards any self-funded benefit plan that might desire the assumption of risk by the provider network, the state insurance department has announced its position that a provider network that accepts underwriting risk directly from employer sponsored benefit plans through capitation or other forms of risk sharing must be licensed as an insurance company or HMO in that jurisdiction.

At present, the providers' effort to respond to the employers' request for a discounted fee-for-service proposal has been thwarted by statements by federal antitrust regulators to the effect that, in the absence of substantial risk sharing, a provider network cannot propose, initiate, or suggest a fee schedule to payors requesting such action. For the reasons stated above, risk assumption by the provider network is not feasible.

I hope that the foregoing example is of benefit in describing the impact of current regulatory positions.

Sincerely,



Jeffrey G. Kraft

The InterStudy Competitive Edge
5.2

Part II:
HMO Industry Report
Reporting data as of January 1, 1995

September 1995

CHANGES IN THE HMO INDUSTRY

Acquisitions and Mergers

Third Quarter 1994

- **Foundation Health Corporation** (Rancho Cordoba, CA) acquired **Intergroup Healthcare Corporation** with health plans in Arizona and Utah
- **Health Systems International, Inc.** (Van Nuys, CA) acquired M.D. Enterprises, operator of **M.D. Health Plan** (North Haven, CT)
- **MEDICA** (MN) merged with **HealthSpan**, a hospital system, to form a subsidiary of Allina, a holding company.
- **United Healthcare Corporation** (Minneapolis, MN) acquired **GenCare HealthSytems** (St. Louis, MO).

Fourth Quarter 1994

- Advantage Health Plan of Ohio and West Virginia (OH) merged with Advantage Health Plan of Pennsylvania.
- As part of an enrollment trade, **CIGNA HealthCare, Inc.** acquired **Principal Health Care of Ohio, Inc** (renamed CIGNA HealthCare of Ohio) and **Principal Health Care, Inc.** acquired **CIGNA HealthCare of Kansas/Missouri-Wichita/Salina** (renamed Principal Health Care of Kansas City, Inc - South Central Kansas Division).
- **Foundation Health Corporation** (Rancho Cordoba, CA) **acquired Southern Colorado Health Plan** and **CareFlorida Health Systems**
- **HMO of Wisconsin Insurance Corporation**, affiliated with the Blue Cross and Blue Shield Association, merged with **U-Care HMO, Inc.**, affiliated with the University of Wisconsin Hospital, to form Unity Health Plans Insurance Corporation, which was purchased by United Wisconsin Services
- **HMO Maine** merged with **Blue Cross and Blue Shield of Maine**, which now consolidates the enrollment of both plans
- **Humana, Inc.** (Louisville, KY) acquired CareNetwork, operator of **Wisconsin Health Organization Insurance Corporation** (Milwaukee) The Milwaukee health plan is now listed as Humana Health Care Plans (Milwaukee)
- **Physician Corporation of America** (Miami, FL) acquired **Southeast Health Plan**, a PPO, which was renamed PCA Health Plans of Alabama, Inc

First Quarter 1995

- **Blue Cross and Blue Shield of Kansas City** purchased the medical contracts of **BMA SelectCare, Inc.** (Kansas City, MO).

- **Gulf Health Plans HMO** merged with **Health Partners of Alabama HMO** to form Gulf Health Plans HMO, Inc. Separate listings for the two health plans are still maintained in this issue of the directory.

- **Harvard Community Health Plan** (Brookline, MA) and **Pilgrim Health Care, Inc.** (Norwell, MA) agreed to merge to form Harvard Pilgrim Health Care, based in Dedham, Massachusetts.

- In a joint venture, **Metropolitan Life Insurance Company** and **Travelers Group** formed **MetraHealth Companies,** a national managed care firm based in Hartford, Connecticut.

Second Quarter 1995

- Tennessee-based **Coventry Corporation** acquired Virginia-based **Southern Health Management** and Florida-based **HealthCare USA.**

- **Healthsource, Inc.** (Hooksett, NH) agreed to acquire the assets of **Central Massachusetts Health Care Inc.**

- **Healthsource, Inc.** also acquired the group health business of Provident Life and Accident Insurance Company of America, which includes **Provident Health Care Plans, Inc.** Provident's HMOs are located in the southeastern states of Georgia, North Carolina, South Carolina, and Tennessee.

- **Pacificare of Washington** acquired **Pacific Health Plans** (WA).

- Pacificare Health System Inc.'s subsidiary **Pacificare of California** acquired Priority Health Service's subsidiary **ValuCare** (Fresno, CA).

- **Physicians Plus Insurance Company** (Madison, WI) and Emphesys Financial Group Inc.'s subsidiary **Employers Health Insurance Company** (Green Bay, WI) agreed to merge their HMO operations into a single, regional organization named Physicians Plus Emphesys Insurance Corporation.

- **Trigon Blue Cross Blue Shield of Virginia** (Richmond) established a joint venture with Tidewater Health Care (Tidewater, VA) to combine membership in Trigon's HealthKeepers and HMO Virginia in the Tidewater area with Tidewater's Priority Health Plan.

- **United HealthCare** (Minneapolis, MN) agreed to acquire **MetraHealth Companies** [See First Quarter 1995].

- WellCare Management Group Inc., parent of **WellCare of New York Inc.**, agreed to acquire **Managed Care Administrators** (NY). MCA, which provides primary care health services to Medicaid beneficiaries, manages PrimeCare of New York and PrimeCare of Brooklyn and Queens.

- **Wellpoint Health Networks** (Woodland Hills, CA) agreed to merge with **Health Systems International** (Van Nuys, CA).

HMO Directory Updates

- The listing for **Aetna Health Plans of Louisiana, Inc.** now consolidates the enrollment of both of its Louisiana plans.

- **CIGNA Health Care of California, Inc.** (Glendale) now consolidates the enrollment of **CIGNA Private Practice Plan** (Glendale, CA) in a mixed-model HMO.

- **Educators Health Care** (UT), which ceased offering an HMO product, no longer appears in this directory.

- The listing for **FHP, Inc. (California)** now includes the enrollment of **TakeCare Health Plan, Inc.** (CA).

- The listing for **FHP Health Plan of Ohio, Inc.** now includes the enrollment of TakeCare Health Plan of Ohio, Inc.

- The listing for **FHP of Colorado, Inc.** now consolidates the enrollment of both FHP of Colorado health plans, including the former TakeCare Health Plans, Inc.

- **Garden State Health Plan** (NJ), whose membership is currently limited to Medicaid only, no longer appears in this directory.

- **Harvard University Group Health Program** (MA), which offers its HMO product only to affiliates of Harvard University, no longer appears in this directory.

- The listing for **Humana Health Care Plans (Kentucky)** now consolidates the enrollment of its Lexington and Louisville markets.

- The listing for **Humana HealthCare Plans of Alabama** now consolidates the enrollment of its Huntsville and Montgomery markets.

- The listing for **Humana Medical Plan, Inc. (Daytona)** now consolidates the enrollment of its Daytona and Jacksonville markets.

- The listing for **Kaiser Permanente Medical Care Program (Northeast Region)** now consolidates the enrollment of the **Kaiser Foundation Health Plan of Massachusetts** and the **Kaiser Foundation Health Plan of New York.**

- Enrollment in the California markets of **MetraHealth** is now listed separately under **MetLife HealthCare Network of California, Inc. - San Francisco** and **MetLife HealthCare Network of California, Inc. - Los Angeles**.

- Enrollment in the Florida markets of **MetraHealth** is now listed separately under **MetLife HealthCare Network of Florida, Inc. - Miami, MetLife HealthCare Network of Florida, Inc. - Orlando, and MetLife HealthCare Network of Florida, Inc. - Tampa.**

- Enrollment in the Ohio markets of **MetraHealth** is now listed separately under **MetLife HealthCare Network of Ohio, Inc. - Cincinnati, MetraHealth Care Plan of Ohio, Inc. - Cleveland, and MetraHealth Care Plan of Ohio, Inc. - Columbus.**

- The listing for **MVP Health Plan, Inc.** (NY) now consolidates in one listing the enrollment of all of its markets.

- The listing for **PacifiCare Health Systems** now consolidates the enrollment of its Oklahoma City and Tulsa markets.

- Enrollment in the Jacksonville, Orlando, and Tampa markets of **Principal Health Care, Inc.** is now listed separately for each market.

- The listing for **United HealthCare of Ohio, Inc.** now includes the enrollment of **Western Ohio Health Care Plan.**

Terminations

- **Complete Health of Florida, Inc.**

- **Greater Wisconsin Rapids Health Protection Plan**

- **MetLife Health Care Management Corporation** (Westport, CT)

New York Times 6/27/95

MERGER TO CREATE LARGEST COMPANY FOR HEALTH PLANS

INDUSTRY CONSOLIDATING

United Healthcare to Acquire Metrahealth in the Trend to More Managed Care

By MICHAEL QUINT

One of the nation's largest operators of health maintenance organizations, the United Healthcare Corporation, agreed yesterday to buy Metrahealth, a more traditional health insurance company with 10 million customers. The new company would be the nation's largest provider of health care plans.

The deal will mean that millions of people accustome to the freedoms allowed by old-fashioned health plans will now get their insurance from a company that has made its reputation by offering more restrictive health plans. And the merger continues a move toward larger health care companies that are in a better position to offer lower prices because they have the size to demand lower prices from doctors and hospitals.

Metrahealth, based in McLean, Va., was created just last year from a merger of the health insurance businesses of Metropolitan Life and Travelers. Fewer than 5 percent of its customers belong to health maintenance organizations, which tightly control the list of doctors to whom their members can go and the treatments those doctors provide, while another 18 percent are in H.M.O.'s that provide some freedom to select doctors outside the plan. More than half of Metrahealth's customers are still in traditional insurance plans offered by employers.

United Healthcare, based in Minnetonka, Minn., provides full medical coverage for nearly 4 million people and specialty coverage such as mental-health services for 27 million more. It has grown into one of the nation's biggest H.M.O. companies by moving into Midwestern and Southeastern cities and offering health plans particularly to workers at medium-sized or small companies and in government jobs. (A rival company with a similar name, U S Healthcare, is already a strong competitor in the Northeast.)

With the $1.65 billion deal for Metrahealth, United Healthcare will invade the Northeast, Southwest and West Coast, and rural America. Among the employers offering Metrahealth plans are 40 of the nation's largest companies, as well as tens of thousands of smaller ones. Metrahealth also offers policies to individuals.

Some of the people covered under Metrahealth's old plans may choose to join United Healthcare health maintenance organizations already up and running in their city, or to be organized soon. Health maintenance organizations are an attractive business because when run right they can charge lower prices than traditional health plans but still earn a higher profit.

But many other people do not want to belong to a health maintenance organization, at least not yet. United Healthcare will offer these people other kinds of health plans. For example, United Healthcare's fastest-growing product is an H.M.O. that aims to offer members some of the freedom of choice of a traditional plan. Members can choose any doctor, including those not on the H.M.O. list, if they pay extra for the privilege.

H.M.O.'s, which collect a flat fee in exchange for meeting a person's medical needs, have won an increasing share of the health insurance business in recent years, much of it at the expense of traditional insurers like Metropolitan Life or Travelers.

Dr. William L. McGuire, chief executive at United Healthcare, noted that even when the health plan of choice was something other than a health maintenance organization, his company could apply the lessons it had learned through its H.M.O.'s about the most efficient medical treatments and cost controls.

Kennett L. Simmons, the chief executive at Metrahealth, said the new company must do more than repeat the strategy of the last 10 years when H.M.O.'s grew and prospered by attracting customers from traditional insurance plans. In the future, he said, health care companies will become more skilled at applying their knowledge about medical treatments to customers outside the H.M.O.'s.

The challenge, said Thomas Pyle, a senior health care adviser to the Boston Consulting Group, is for companies like United Healthcare to keep records that enable them to identify the best course of treatment for different ailments, and be confident enough in their judgment to dictate procedures that doctors will follow.

News of the merger was well received on Wall Street, where United Healthcare stock was unchanged at $43 a share, while other companies specializing in H.M.O.'s were down sharply as some said profits would be lower than Wall Street analysts had forecast.

"This merger will provide access to millions of Metrahealth customers who were seeking managed care arrangements for their health insurance that Metrahealth could not provide as quickly or as efficiently as United Healthcare," said Margot L. Vignola, an analyst at Merrill Lynch. For United Healthcare, she noted, the merger provides access to thousands of companies, including many in the Fortune 500.

Ms. Vignola agreed with United Healthcare executives who said the merger would increase the company's earnings per share, and added that "the new United Healthcare will be in a position to grow more rapidly than either company could have by itself."

James W. McLane, head of the health care business at Aetna Life and Casualty, the nation's third-largest health care company, said the merging of two of his competitors "reinforces our strategy of offering corporations a wide variety of options," from H.M.O.'s to traditional insurance. He noted that about 65 percent of employees were covered by some form of managed care plan, up from 28 percent early this decade.

The owners of Metrahealth elected to be paid in different ways. Travelers, whose chairman, Sanford I. Weill, has said he wanted out of the health care business, is taking $831 million in cash, and may collect $175 million more if Metrahealth meets an earnings goal of nearly $200 million this year.

Continued on next page

Metropolitan Life is keeping closer ties to United Healthcare, taking a package of $296 million in cash and $500 million worth of preferred stock that is convertible into United Healthcare common stock at $49.48 per share. Apart from eventually owning about 5 percent of United Healthcare's common stock, Metropolitan and United Healthcare have agreed to market each other's products.

Metropolitan may also collect $175 million more in both 1996 and 1997 if Metrahealth's business meets unspecified earnings targets. Travelers sold to Metropolitan its right to collect half the 1996 and 1997 bonus payments for $35 million.

Health Care Giant

Profile for Metrahealth companies and United Healthcare for the three months ended March 31

	METRAHEALTH COMPANIES	UNITED HEALTHCARE	COMBINED
FINANCIAL DATA (in millions)			
Revenue	$1,010.0	$1,069.7	$2,079.7
Net income	$ 40.0	$ 89.4	$ 129.4
MEMBERSHIPS (in millions)			
HMO	0.45	2.47	2.92
POS*	1.89	1.33	3.22
PPO†	2.55	0.20	2.75
Indemnity	5.25	minor	5.25
Total	**10.14**	**4.00**	**14.14**

*Point of service HMOs allow enrollees to consult non-HMO doctors
†Preferred provider organizations of doctors who accept discounted fees

Source: Company reports

GOP Disputes Need For Surgeon General

4/27/95 Chicago Sun-Times

By Marlene Cimons

WASHINGTON—Does America need a national "family doctor"?

With the battle over surgeon general nominee Henry W. Foster Jr. ending in defeat for President Clinton, Republicans on Capitol Hill are expected to escalate their efforts to do away with the job entirely, stirring fierce debate over the role of the nation's top doctor.

Has the job of surgeon general become so political and so divisive that it has outlived its usefulness? A surgeon general has no real policymaking authority, and his or her effectiveness rests largely on strength of personality and determination to press public health issues.

Many administration officials and their congressional allies say the job is vital. "The surgeon general is the health conscience of the nation," said a senior administration health official who requested anonymity.

But the Senate's fiscal 1996 budget resolution calls for eliminating the position, and some House conservatives are urging their budget conferees to accept the Senate language. Republicans in particular tend to believe the job has become largely symbolic and therefore obsolete.

Despite the uncertainty, the White House is expected to begin searching for a new nominee, and many public health officials say they intend to fight to save the position. The last surgeon general, Jocelyn Elders, was dismissed by Clinton for making what he felt were inappropriate public comments about masturbation.

Although the surgeon general operates with a small budget and staff, the position has a rich and colorful history. It dates back 125 years, when Congress established a "supervising surgeon," later renamed surgeon general.

The office has had its landmark moments. In 1964 Surgeon General Luther Terry issued a report linking smoking to lung cancer. In the Reagan and Bush administrations Surgeon General C. Everett Koop launched a campaign against tobacco and AIDS.

The "reinventing government" blueprint endorsed by Clinton and Vice President Al Gore calls for diminishing the power of the government's only other high-ranking health official, the assistant secretary of health. That assistant secretary, typically a physician, oversees the Public Health Service and signs off on all public health policy decisions. Under the Clinton-Gore proposal, the job would be reduced to an advisory staff position.

In the Marketplace

Mergers And Acquisitions

Wilson Administration Approves Wellpoint/HSI Merger, With $3 Billion Donation To Charity

SACRAMENTO, Calif.—In a long-anticipated announcement, the Department of Corporations approved Sept 7 **Blue Cross of California**'s public benefit plan; the recapitalization of its for-profit **Wellpoint Health Networks Inc.** subsidiary; and the merger of Wellpoint and **Health Systems International**

When completed, the merger and related transactions will create the nation's largest publicly traded managed care company, with more than 4 7 million medical members and annual revenues of approximately $6 billion. Wellpoint and HSI shareholders vote on the merger this fall—majority shareholder BCC has indicated it will vote in favor of the transaction—and the merger is expected to be completed by the end of the year, BCC Chairman and Chief Executive Officer Leonard D. Schaeffer said in a statement

State-Approved Plan Includes $3 Billion Endowment

According to a Sept. 7 press release issued by BCC, the public benefit plan—filed with the DOC on Sept 15, 1994 and now approved by the state—calls for BCC to sell its commercial assets to Wellpoint for up to $235 million. Wellpoint to recapitalize and to declare and pay a dividend of $1.2 billion to BCC and Wellpoint's public shareholders, Wellpoint to combine with HSI, and BCC to donate all its remaining assets, including the cash from Wellpoint and the stock it receives in the merged company, to two newly established independent charitable foundations

The new foundations will have a total charitable endowment of $3 billion—the sixth largest in the nation, according to the DOC—which reimburses Californians for BCC's years of tax-free nonprofit operation The foundations will be responsible for donating five percent of their assets each year to programs and activities to expand access to quality health care for under-served Californians

"The Wilson administration's actions create a new wealth of resources to answer the health care needs of Californians for generations to come," Gary Mendoza, DOC commissioner, said in a statement

The DOC's approval, issued under the Knox-Keene Health Care Service Plan Act, is the final major regulatory hurdle necessary for BCC and HSI to move forward with their proposed merger

The merger already has been approved by HSI's, BCC's, and Wellpoint's boards of directors, BCC's advisory directors, and the board of HSI's majority shareholder, the **California Wellness Foundation**. In addition, the Blue Cross and Blue Shield Association has approved use of the Blue Cross name and mark for the company—an issue of contention between BCBSA and the state (1 MACR 212, 8/30/95). Consumers Union, initially opposed to the merger claiming Blue Cross would use the endowment for lobbying and public relations, now endorses the merger since the agreement bars these uses. The agreement also limits Blue Cross to picking a minority of directors for foundation boards, giving Commissioner Mendoza a limited veto over its picks.

The merged company will be based in Woodland Hills, marketing in California and seven other states.□

Mergers And Acquisitions

Northern California Alliance Will Create Area's Second Largest Health System

SACRAMENTO, Calif.—**California Healthcare System** and **Sutter Health Plan** will affiliate by December, creating northern California's second biggest doctor-and-hospital system after **Kaiser Foundation Health Plan Inc.**

California Healthcare President and Chief Executive Officer Quentin Cook and Sutter President and Chief Executive Officer Van Johnson signed an Aug. 29 letter of intent to consolidate their not-for-profit firms. Johnson becomes president and chief executive officer and Cook vice chairman of the resulting $2-billion-plus company; Kaiser has more than twice these assets

Sacramento-based Sutter has seven physician groups totaling about 737 doctors, 18 acute care hospitals with a total of 2,630 beds, six long-term care facilities with almost 630 beds, and numerous outpatient specialty sites. Sutter also has majority ownership of the health maintenance organization **Omni Healthcare**, with nearly 187,000 enrollees. The company has more than 17,000 employees and more than $1 billion in assets and covers about 415,000 people.

California Healthcare has four San Francisco Bay Area hospitals totaling 2,580 beds and affiliated physician groups totaling about 1,931 doctors It has about 8,900 employees and more than $900 million in assets and covers about 325,000 people.

The consolidated company will offer coverage in 23 of California's 58 counties. Each company will name seven board directors

Human resources consultant Glenn Smith at Watson Wyatt Worldwide in San Francisco predicts this new company will set a national precedent for managing the health care market □

hospital until the legal issues are resolved. It also "implicitly raises questions about how the mayor's advisors have developed" their plans to privatize the public hospital system "with many major decisions made behind closed doors." Queens Hospital Advisory Board Chair Rory Lancman said, "Ever since the Mayor announced his plans [2/95], we have politely requested information and inclusion in the decision-making process and we have been ignored. This is a big win even though it is a first little baby step."

REAX: HHC Board Chair/Giuliani special health pc'icy advisor Maria Mitchell said that the restraining order would not affect the mayor's plans. She added that Giuliani administration officials had planned to meet with the advisory board "anyway." She said that the advisory board's request to see a sales memorandum before it is released "was misplaced since the [10/95] offering plan ... would be revised many times before a buyer was found" (Rosenthal, 9/29).

===== INSIDE THE INDUSTRY =====

*9 INDUSTRY WRAP-UP: CAREMARK BUYS DIVISION OF CIGNA

CAREMARK INTERNATIONAL Inc. "pushed further into the fast-growing physician-practice-management field" by announcing 9/28 that it would acquire CIGNA MEDICAL GROUP, a Southern California managed care group of the CIGNA Corporation (Miller, W.S. JOURNAL, 9/29). According to Caremark officials, the deal would make the company the "nation's largest manager of physician practices in prepaid health plans." The deal, which is subject to federal approval, is expected to be completed by the end of the year (REUTERS/N.Y. TIMES, 9/29). Caremark, which recently left the home-infusion business, "has made it clear that it wants to be a player in the emerging" physician-practice-management field (Miller, 9/29).

STILL MAKING MONEY: While HMOs and hospitals "have lagged in 1995," the stocks of large prescription manufacturers and medical device makers have fared well. The medical products sector saw a 41% increase this year, medical instruments "have gained 51%" and the drug companies are up about 41%, according to INVESTOR'S BUSINESS DAILY. The positive results can be attributed to several factors, including the demise of the Clinton health plan, industry mergers and the development of new products. "The question now is whether Medicare reform could again clip some health care stocks." Industry analysts are divided on "the eventual effect on the industry." Volpe, Welty & Co. analyst Ann Logue said, "We're at the mercy of the politicians and that's one of the things that caused the volatility in (some) stocks." Bear, Stearns & Co.'s Frederick Wise noted that "any time a large reimburser is going to cut costs, you can't argue that that's positive. There are fewer dollars to be spread around" (Hamilton, 9/29).

BIOTECH BUSINESS: The "volatile" biotech industry got "another upward push" 9/27 after GLAXO WELLCOME and British BIOTECH announced that they have signed a licensing agreement for an oral treatment for arthritis. Glaxo Wellcome will fund development of Biotech's drug in exchange for worldwide marketing rights (Green, FINANCIAL TIMES, 9/28).

IMPLANT UPDATE: Plaintiffs' negotiators in the breast implant suit (see AHL 8/31) have "unanimously rejected" the most recent offer by former implant manufacturers. The rejection increases the likelihood that the judge involved in the case will allow the women to opt out of the global settlement and pursue cases on an individual basis. People close to the situation said talks are expected to continue (W.S. JOURNAL, 9/27).

tion drug formularies, medical outcome studies, and disease management programs, he added.

There will be tremendous pressure on PBMs to differentiate themselves from competitors, with those offering a broader array of health care services the likely winners, Barberi said.

Among the likely trends for PBMs are more performance-based networks, a big shift from rebate to outcome-based formularies, and "connectivity," or the electronic linking of laboratories, pharmacies, and physicians.

"Everyone's looking at information technology," Barberi said.

There also will be great pressure on PBMs to provide proof—and even guarantees—that their services are working. "Companies want report cards on everybody—even consultants," Barberi told the audience. He predicted that this trend toward "benchmarking" would remain a major factor for PBMs for the next couple of years.

As with other areas of the rapidly changing health care industry, the inevitable consolidation within the PBM industry will give those able to successfully differentiate themselves a larger share of the market, Barberi suggested.

Consolidation among employer purchasers and intermediary control of increasingly large blocks of business by managed care operations are the major points of tension for the pharmacy industry, Barberi explained. Inevitably, those trends will erode pharmaceutical companies' margins and effectively "lock out" some products, he predicted.

Financial Incentives Plus Education Plus Authority

As employers and HMOs look more closely at the net cost-benefit of certain drugs, marketing strategies based upon rebates are likely to diminish. At the same time, plans will adopt more closed or at least restricted formularies, as well as more incentives for patients and health care providers to use one drug over another, Barberi predicted.

In fact, a recent in-depth study by Booz Allen found that PBMs generally have had little success in altering prescription drug behavior of either patients or physicians, in large part because their plans did not have strong enough incentives to effect such change, Beever explained.

The study, which surveyed 57 companies with some 30 million covered lives, found that plan design was a critical variable in determining the effectiveness of a PBM, with financial incentives a major factor in whether a PBM was able to alter behavior or shift market share for a given drug, Beever said.

However, employers often fail to give the PBMs the authority needed to really make a difference, Beever added.

Many have only voluntary incentives for formularies, for instance, and few are willing to significantly narrow down the retail network of pharmacies available to plan participants, he pointed out. The study did find that those plans calling for a differential copayment for [illegible] were more successful in altering behavior [illegible] drug groups, he added.

The key may be a combination of financial incentives and education—of patients, physicians, and pharmacists—but that would require more employer support for PBM intervention, Beever said.

For now, however, the study found that few if any major PBMs have the ability to greatly influence either the market share of a given drug or the behavior of patients, he added. □

Mergers And Acquisitions

Columbia/HCA Eyes Non-Profit Hospitals To Further Expand Managed Care Network

NEW ORLEANS—**Columbia/HCA Healthcare Corp.** is eyeing not-for-profit hospitals as its main acquisition target to expand its managed care network, a top executive said Oct. 20.

A key part of this strategy will be acquiring teaching and university hospitals, which Columbia/HCA says brings "prestige" to its networks. It can "operate [a teaching hospital] more like a business" to keep costs down, corporate general counsel Stephen Braun told an American Bar Association health law forum.

Teaching hospitals "bring prestige. They've got great names, do high-tech things," Braun said. And, he added, they "can bring added value if you get them to operate more like a business and less like a school."

With its focus on not-for-profit and teaching hospitals, Braun said the firm still expects to expand its managed care networks by acquiring between 25 and 40 hospitals a year. Braun added, though, that acquiring not-for-profit and teaching hospitals will take a lot more time than the multi-facility public hospital acquisitions that fueled Columbia/HCA's growth from an initial 12 facilities to 330 today.

The addition of not-for-profits and teaching hospitals to Columbia/HCA's managed care network also is forcing changes in the management structures of the acquired facilities. More boards of directors are being formed for the subsidiaries, Braun said, even though Columbia/HCA continues to insist on being the managing partner.

Braun added that "99 percent" of the time when Columbia/HCA acquires a facility, "we're going to do asset deals" as opposed to stock transfers, particularly when not-for-profits are involved. "Most sellers don't want your promissory note. Most sellers want cash."

Another acquisition attorney, Robert Zimmerman, told BNA that not-for-profit and teaching hospitals are attracting the interest of firms like Columbia/HCA because they represent a largely untapped source of the nation's existing health care infrastructure as industry consolidation makes property increasingly scarce. □

In Brief

HUMANA ACQUIRES SOUTH FLORIDA CLINICS A stock purchase agreement has been signed by **Humana Inc.** to acquire certain subsidiaries of **Coastal Physician Group Inc.**

Columbia may buy into the insurance business

Columbia/HCA Healthcare Corp. is considering acquiring all or part of Cleveland-based Blue Cross and Blue Shield of Ohio, according to a report published last week.

The *Akron* (Ohio) *Beacon Journal* said unidentified sources confirmed that the Nashville, Tenn.-based hospital chain is conducting a "due diligence" review with Ohio's largest health insurer.

Hospital companies

Neither the Blues nor Columbia would confirm that a deal is in the works.

Such a move would mark a departure for Columbia, the nation's largest for-profit hospital chain. Columbia President and Chief Executive Officer Richard Scott repeatedly has said the company does not intend to compete with insurers, which are its customers.

Entering the insurance business proved problematic for several provider organizations including, Humana, a Louisville, Ky.-based company that ended up splitting its insurance and hospital businesses into separate companies.

Peter G. Reibold, president of Columbia's Ohio division, issued a statement that said, "We have been open to discussions with a variety of organizations."

Blues spokesman David Buckel called the article "rumors." He said the insurer had no comment beyond a statement to employees.

The company told workers that: "For some time now, we have had discussions with many companies. To date, we have made no decisions."

For a sale to be completed, the Blues would have to switch to for-profit status, which would require approval from the state.

A purchase of the insurer would further alter the balance among healthcare providers in northeast Ohio.

In November, Columbia bought a 50% share of Sisters of Charity of St. Augustine Health System, which includes St. Vincent Charity Hospital in Cleveland, Timken Mercy Medical Center in Canton and St. John West Shore Hospital in the Cleveland suburb of Westlake. Columbia also owns a diagnostic center and a surgery center in a Cleveland suburb.

Also, the Blues has several deals with hospitals, including a for-profit venture with Meridia Health System in Cleveland.

Under the venture, the four-hospital system owns a 12% stake in the Super Blue HMO.

COLUMBIA/HCA
Healthcare Corporation

A Meridia spokeswoman said the system has no involvement in the reported negotiations.

The Blues also has affiliations with Saint Luke's Medical Center in Cleveland and Riverside Hospital in Toledo.

Both affiliations give the Blues power in hospital governance.

—Mary Chris Jaklevic and Sandy Lutz with Associated Press reports

Fla. rejects Columbia's CON request

Florida regulatory officials denied Columbia HCA Healthcare Corp.'s application to build a new 100-bed hospital in Naples, Fla.

A Columbia official in Fort Myers said the investor-owned company will appeal the decision and resubmit a modified certificate-of-need application to the state in February.

"The state doesn't want competition in Collier County (Naples)," said Chuck Hall, president of Columbia's Southwest Florida division in Fort Myers. Naples, which is about 20 miles south of Fort Myers, is served by one hospital, 354-bed Naples Community Hospital.

A spokeswoman for the state Agency for Health Care Administration, which denied the CON request, said Columbia didn't show there was a need for another hospital in the area.

Naples Community had a 1994 occupancy rate of 65%.

"Columbia said there is a need for (a facility to serve) indigent-care and Medicaid patients, but they didn't show in their application that they would meet that need," said agency spokeswoman Sally Berger. "They didn't show that (Naples Community) is not meeting that need."

Hall maintained that the state also ruled against Columbia because it is a for-profit chain.

"They said we don't provide as much community benefits (as not-for-profit hospitals)," he said. "We didn't see any evidence to substantiate the state's claims)."

In its proposal, Columbia offered to reduce its licensed beds by 50 and transfer 100 from the Fort Myers area, where it owns three hospitals, to the proposed hospital. The hospital would cost $30 million to build, he said.

The last hospital approved in Florida was in 1990 when Hospital Corporation of America won a seven-year CON battle to build 120-bed Gulf Coast Hospital in Fort Myers. Columbia now owns Gulf Coast.

"We weren't surprised by the decision," Hall said. "We recognize this is a lengthy process."

Meanwhile, the state agency also approved a CON application from Atlanta-based Vencor to reopen financially troubled Physicians Community Hospital in St. Petersburg as a long-term-care hospital. Physicians Community, formerly a privately owned, for-profit facility, has been closed for more than a year.

The agency also denied a CON request by Seminole (Fla.) Hospital and Women's Center to convert itself to a long-term-care hospital.

Columbia is expected to acquire Seminole from Community Health Systems later this month.

—Jay Greene

WellPoint to buy Mass. insurer

Rebounding from its scuttled merger with Health Systems International, Woodland Hills, Calif.-based WellPoint Health Networks signed an agreement to acquire the group life and health subsidiary of Massachusetts Mutual Life Insurance Co. for $380 million.

Combining with the Springfield, Mass.-based unit would create the second-largest for-profit managed-care company, with annual revenues of almost $4 billion and nearly 4 million enrollees. The combination would be half as big as Minneapolis-based United Healthcare Corp., which has $8 billion in revenues and 8 million enrollees.

It is WellPoint's first major foray outside California and sets the stage for other alliances in the HMO's expansion strategy. The deal is expected to close by the end of March.

It makes good on the promise by WellPoint and Blue Cross Chairman and CEO Leonard Schaeffer—made at the time of the proposed merger with HSI—to take the HMO nationwide. Blue Cross is WellPoint's majority owner. Massachusetts Mutual's large indemnity business allows WellPoint to offer a range of managed-care choices to employers in 50 states, with a goal of eventually converting them to HMOs.

Under Schaeffer, Blue Cross itself evolved from being mostly an indemnity company in the mid-1980s to the point where almost all its enrollees are now in some form of managed care.

"But the HMO product is not the end-all," said a WellPoint spokesman. "Our focus is on the fact that members want choice." That will appeal to employers' benefits managers who want to offer "a full spectrum" of healthcare products, said David Blume, co-managing director of Andersen Consulting's health management practice in Hartford, Conn.

Besides their group health products, WellPoint and its acquisition have "a huge dental business, which is just now getting into managed care," Blume said. WellPoint's move is similar in strategy to United's acquisition last year of MetraHealth Cos., most of whose enrollees are still in indemnity plans.

Buying a plan with indemnity enrollees is a lot cheaper than acquiring an HMO, Blume said. WellPoint is paying $38 per enrollee, while companies buying HMOs have paid over $1,000 per enrollee, he said.

Blue Cross of California said it would file another plan within three weeks showing how it will meet its charitable obligations under state law in converting to for-profit status.

—Louise Kertesz

Columbia hires ad agency to put name on nation's lips

"Columbia" soon may become embedded in the minds of consumers who previously hadn't recognized the name of the nation's largest healthcare provider.

Last week, Columbia/HCA Healthcare Corp. tapped the Martin Agency, Richmond, Va., to handle its multimillion-dollar national name-recognition account. Although published reports have estimated the campaign's worth at more than $10 million, Columbia spokeswoman Eve Hutcherson said it's too early to say how much the campaign will cost.

Although the Nashville, Tenn.-based company is the nation's largest healthcare provider and 10th-largest employer, it has little name recognition because nearly all its hospitals have different names. That will change by mid-year, when the names of its 335 hospitals will be changed to contain the word "Columbia," Hutcherson said. In some markets, such as Dallas-Fort Worth, the transition is already under way.

"This is an opportunity for Columbia to be the first in the healthcare business to create a national brand name," said John Adams, Martin's chairman and president.

Columbia's only previous push to gain national name recognition was about a year ago when the company ran a 30-second television spot that featured Columbia's president and chief executive officer, Richard Scott. When asked whether Scott would play a similar role in the branding campaign, Adams said there had been "preliminary conversation" about it, but that a decision had not yet been made.

Because healthcare is perceived to be a market-by-market business, efforts to create national brand names have been limited in the past. In the late 1980s, Humana promoted its name as a national brand and put it on all its hospitals. The difference is that Humana was only one-third the size of Columbia.

VHA, an Irving, Texas-based alliance of more than 1,000 not-for-profit hospitals, also did some brand advertising in a limited way in the late 1980s.

Martin said his agency recognizes that healthcare is a local business, but will try to leverage the benefits of Columbia's national scope. He said Columbia will push the message that it brings lower healthcare costs, which can contribute to quality improvements.

"Our job is to bring that essentially revolutionary message to the constituencies of Columbia," Adams said.

The brand-name campaign will couple with other Columbia efforts to gain consumer recognition. The chain publishes a quarterly magazine, *One-Source*, that goes to more than 3 million households. It also has a World

Continued on p 12

Michael Marcotte

Columbia CEO Richard Scott appeared in national TV spots early last year.

HealthSouth to take lead in ambulatory sector

HealthSouth Corp. isn't content with its title as the largest rehabilitation chain in the nation. Soon it also will take the helm of the outpatient surgery center market.

HealthSouth will acquire Surgical Care Affiliates in a stock swap worth an estimated $1.2 billion, or $28.21 per share, the companies announced last week. The deal, expected to close early in 1996, will make HealthSouth the leader of the fragmented but rapidly growing ambulatory surgery sector.

Joel C. Gordon, SCA's chief executive officer, has a $44 million stake in the deal. He and his family currently hold about 1.6 million shares of SCA, according to the company's proxy statement. Gordon will join the HealthSouth board of directors and serve as a consultant for five years. "His insight and his vision will be very good for this growing company," said Richard M. Scrushy, CEO of Birmingham, Ala.-based HealthSouth.

The merger will help make HealthSouth attractive to insurers, managed-care companies and large employers that want to buy surgical and rehabilitation services on a national basis.

Nashville, Tenn.-based SCA, the largest independent operator of outpatient surgery centers, had been aggressively looking for a partner. SCA operates 67 facilities in 24 states. In April 1994, Dallas-based Medical Care America spurned its hostile takeover bid, a proposed $950 million stock swap.

Scrushy

HealthSouth has been on a blistering acquisition pace. In August, it agreed to acquire Sutter Surgery Centers for $38 million in stock. In June, the company completed its $155 million merger with Surgical Health Corp. And a month before that, it closed on its $215 million acquisition of NovaCare's rehabilitation facilities.

Each share of SCA will be traded for 1.22 shares of HealthSouth. If HealthSouth's stock rises above $28 per share or falls below $22 per share, the exchange ratio could be adjusted. The transaction is considered a pooling of interests and should be tax-free. It's subject to approval by shareholders and the Federal Trade Commission.

After the merger, HealthSouth will have 122 surgery centers, 400 outpatient rehabilitation centers, 77 rehabilitation hospitals, and five medical centers operating in 42 states.

Working together the combined company could add as many as 20 outpatient surgery facilities in the next 12 to 15 months, Scrushy said.

"There is a lot of upside potential for our company putting these two together. Our surgery-center margins are less than half of what their (SCA) margins are. If we implement their systems, we could bring our margins up."

Scrushy envisions 200,000 new admissions to HealthSouth's outpatient network. "A large number of patients in our rehab system go through surgery," he said. Some 20% of SCA's surgeries are orthopedic. If those cases can be captured for HealthSouth's rehabilitation business, "it would add $30 million immediately in incremental revenue. At a 50% margin that will add $15 million to earnings."

In 1994, HealthSouth reported net income of $53.2 million on revenues of $1.3 billion. SCA earned $29.6 million on revenues of $238.9 million. Combined, the two companies expect revenues of more than $2 billion.

Scrushy said the merger will help the company adapt to the push to move more Medicare patients into manageo-

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[forthcoming in LOYOLA CONSUMER LAW REPORTER]
[Final Prepublication Draft--Feb. 22, 1996]

ARE THE ANTITRUST AGENCIES OVERREGULATING PHYSICIAN NETWORKS?

Clark C. Havighurst*

When the antitrust laws were first applied seriously to the medical profession following the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*,[1] a principal objective of antitrust enforcers was to contest organized medicine's control of health care financing. In the ensuing years, most health care markets evolved under antitrust protection so that they now feature a variety of financing entities that are not only independent of professional control but also highly aggressive in forcing physicians to sell their services on competitive terms. Although competition has not yet come to every local market, concerted action by physicians is no longer a ubiquitous obstacle to its emergence. Indeed, in mature markets for medical services, antitrust enforcers may do more harm than good if they continue to view concerted action by physicians with the skepticism that was appropriate in earlier years.

The thesis of this comment is that antitrust enforcers today are too quick to presume anticompetitive results when physicians organize so-called network joint ventures for the purpose of contracting with competing health plans or with employers purchasing health services for their employees. As a species of joint selling agency, a physician network joint venture certainly deserves close antitrust scrutiny since it may entail some agreement concerning the price and other terms on which otherwise independent competitors sell their services. But unless such a venture qualifies as a sham rather than as a legitimate effort to reduce marketing and other transaction costs, it is not an appropriate candidate for condemnation under the venerable principle that price fixing is illegal per se.[2] Yet current antitrust enforcement policy appears to give too little credence to the possibility that a physician network controlled by physicians might yield marketing efficiencies that more than offset any loss of competition among the joint venturers themselves. In one of nine joint statements of enforcement policy regarding antitrust issues arising in the health care field, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) have specified certain conditions that any network joint venture must meet before they will view it as anything other than a per violation.[3]

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[1] 423 U.S. 886 (1975).

[2] E.g., United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); United States v. Trenton Potteries Co., 273 U.S. 392 (1927).

[3] Statement 8 -- Physician Network Joint Ventures, in U.S. Department of Justice & Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, Sept. 27, 1994, reprinted in 3 Health Law Rptr (BNA) 1391 (1994).

These conditions are too restrictive and should, for both doctrinal and policy reasons, be relaxed.

To say that the current policy of the DOJ and the FTC toward physician networks is overregulatory is not to say that Congress or the enforcement agencies should accede to demands by organized medicine that ordinary antitrust principles be bent to accommodate physician collaboration. The problem identified here is not a problem with antitrust law as such. Instead, the agencies have simply made a doctrinal error, adopting a rule of thumb when they should have applied the rule of reason. Regrettably, this error gives added ammunition to organized medicine in its continuing battle for legislative relief from antitrust strictures -- relief that would inevitably shelter more than just procompetitive activity by professional groups.[4] By the same token, giving collaborating physicians a chance to demonstrate that their joint venture poses no ultimate threat to competition, despite its failure to pass the agencies' objective test, would weaken the policy argument for softening antitrust rules applicable to physician collaboration.[5] Moreover, it would do so without sacrificing antitrust principles or authorizing anticompetitive conduct. Most importantly, it would remove an impediment that currently forces innovation in the delivery of medical services into narrow channels, with adverse consequences for the range of consumer choice and possibly also for the quality of care provided.

Origins of Current Enforcement Policy Concerning Physician Collaboration

The successful antitrust campaign against physician control of the financing and delivery of health services in the 1970s and 1980s was one of the great victories in the history of antitrust law. Beginning in the 1930s, the medical profession created a panoply of Blue Shield and other profession-controlled health care financing plans that enabled physician interests to dictate the economic conditions of medical practice. To be sure, independent financing programs also existed in the marketplace. But these plans were subject both to legal restrictions imposed at the behest of professional interests and to the threat of coercive boycotts by professional groups, and consequently also played by the profession's preferred rules.[6] In addition, even after Blue Shield and similar plans were freed from direct professional control, many of them protected their dominant market positions by serving local providers as their principal marketing agent. In return for marketing provider services on noncompetitive terms, a dominant Blue plan could count on providers collectively to deny competing plans discounts of the kind the Blues themselves typically enjoyed, to resist incursions by alternative financing and delivery

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[4]See text at notes 50-54 infra.

[5]On the appropriateness of accommodating political pressures of this kind in antitrust enforcement and even in antitrust doctrine itself, see infra note 20 and text at notes 53-54.

[6]See, e.g., Lawrence E. Goldberg & Warren Greenberg, *The Effect of Physician-Controlled Heath Insurance: U.S. v. Oregon State Medical Society*, 2 J. HEALTH POL., POL'Y & L., Spring 1977 at 48. For examples of provider boycotts and similar restraints aimed at payers, see FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); In re Mich. State Medical Soc'y, 101 F.T.C. 191 (1983).

systems, and to stonewall efforts by commercial insurers to introduce competition by selectively contracting with providers.[7]

The health care marketplace began to show signs of competitive life in the 1970s, however, as alternative financing and delivery mechanisms began to get a foothold. In self-defense, physician groups in many local markets organized a second generation of profession-controlled entities. So-called foundations for medical care (FMCs) and individual practice associations (IPAs) served the profession well for a while as effective defenses against both independent health maintenance organizations (HMOs) and innovative purchasing practices by conventional health insurers. In the *Maricopa County Medical Society* case,[8] for example, FMCs in two Arizona counties established maximum prices for physician services and performed utilization review for health insurers that agreed to pay physicians under their fee schedules. The apparent purposes of the Arizona doctors in creating the FMCs were to set collectively a limit-entry price for their services (thus making the market less attractive to independent HMOs) and to induce health insurers not to embark on independent paths in procuring physician services on competitive terms. More recently, dominant physician interests have sought to use preferred-provider organizations (PPOs) or other network joint ventures to maintain solidarity in the face of purchasers' new efforts to break the profession's ranks. Antitrust enforcers have been appropriately alert to these collective efforts.[9]

The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s -- particularly in delaying the emergence of corporate middlemen able and willing to act as purchasing agents for consumers in procuring physician services on competitive terms -- was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers.[10] By the same token, the antitrust battles that hastened the breakup of medical cartels paved the

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[7]For cases in which Blue plans acted, not as aggressive purchasers, but as marketing agents for provider cartels (but escaped antitrust penalties because courts failed to recognize the monopolistic character of their conduct), see Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); Travelers Ins. Co. v. Blue Cross of Western Pa., 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093) (1973). See generally Clark Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in HEALTH CARE IN AMERICA 221, 245-54 (H. Frech ed. 1988).

[8]Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

[9]See, e.g., Southbank IPA, Inc., 114 F.T.C. 783 (1991). See also Richard D. Raskin, *Antitrust Issues for Independent Health Care Providers: "Integration" and the* Per Se *Rule*, in ANTITRUST AND EVOLVING HEALTH CARE MARKETS 73 (19) (discussing recent enforcement efforts with respect provider networks); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507 (1994); John J. Miles, Provider-Controlled Networks, Market Power, and Price Fixing (National Health Lawyers Ass'n, Managed Care Law Institute, Chicago, Dec. 4-6, 1995).

[10]See Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

way for the revolution that is occurring in American health care today.[11] Indeed, without uncompromising antitrust enforcement against physicians, the nation would have had to wait much longer for private innovations that make providers effectively accountable to consumers for the cost as well as the quality of medical care.[12] More likely, without antitrust enforcement clearing the way for private innovation, government would have assumed a dominant role in financing and regulating health care, as it has in other countries.

To be sure, the danger of physician collaboration to suppress competitive developments in local markets has not disappeared, and continuing antitrust vigilance is still warranted. Nevertheless, there are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding together. Too many large purchasers -- including Blue Cross and Blue Shield plans finally forced by competition to use their market strength on behalf of consumers rather than providers,[13] commercial health insurers, and large self-insured employers -- now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. Selective contracting and discounting of physician fees in return for assured patient load are now common practices. In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options. Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today.

Networks under Today's Enforcement Policy and the Rule of Reason

Although the health care industry is undergoing a remarkable transformation, the one group of players that might develop the most efficient systems for delivering high-quality personal health care at reasonable cost are somewhat constrained in doing so by the way antitrust law is currently applied to their undertakings. Specifically, physicians

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[11]See, e.g., Clark C. Havighurst, The Antitrust Challenge to the Professional Paradigm in Medical Care (Center for Health Admin. Studies, U. of Chicago, 1990); Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986).

[12]Accountability remains a problem in the current market, however. See note 46 infra.

[13]See, e.g., Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc., 784 F.2d 1325, 1337 (7th Cir. 1986) (quoting a 1983 memorandum by a Blue Cross plan proposing a new strategy, novel for the plan and many others like it -- namely, that the plan "use its market position and its control over substantial sums of health care dollars to negotiate lower fees for provider services").

organizing joint ventures for the purpose of marketing themselves to major purchasers are being forced by unrealistic antitrust standards into arrangements that may serve consumers less well than arrangements that such standards foreclose. The problem lies principally in the insistence by the antitrust enforcement agencies that any physician-controlled network have objective features that make it distinguishable on its face from anticompetitive arrangements appropriately condemned in the past.

The joint DOJ/FTC enforcement policy states that physician network joint ventures "will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture *share substantial financial risk* or if the combining of the physicians into a joint venture enables them to *offer a new product* producing substantial efficiencies."[14] These requirements are not laid down merely as conditions that must be met to qualify for a so-called "safety zone" in which private parties are promised freedom from government attack. To be sure, the guideline does delineate two "safety zones" -- one for exclusive networks, which are the sole marketing agents for participating physicians, and one for nonexclusive networks, which do not preclude their members from marketing themselves through other networks as well. In each case, the cited conditions, plus a market share screen relating to the percentage of physicians engaged, must be met to satisfy the agencies. The guideline goes on to state (in the quoted language), however, that networks not meeting these requirements, while not necessarily unlawful, can satisfy the rule of reason only if the two stated conditions are met. Although the context of the guideline suggests that the drafters had in mind only networks that fail the market share tests (20 percent for exclusive networks and 30 percent for nonexclusive ones), the guideline is written in such a way that the two conditions apply even to very small joint ventures. Moreover, a footnote underscores that the rule of reason will apply only if "the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians who do not share substantial financial risk that fixes the price that each physician will charge." Subsequent statements and applications of the guideline by agency personnel confirm that even very small joint ventures are expected either to impose financial risks on participating physicians or to integrate their practices so thoroughly as to yield "a new product."

Thus, current enforcement policy declares specific conditions that must be met if any physician network joint venture is to avoid being classified as a violation per se, making it conclusively indefensible by reference to conditions in the marketplace, to efficiencies it might achieve, or to other procompetitive features or consequences of the undertaking. To be sure, the policy statement is only a guide to the prosecutors' policy and not a regulatory rule, and one might wonder whether or not enforcement policy is as restrictive in fact as it seems to be on paper. Nevertheless, because antitrust counselors report that the agencies are taking their policy statement at face value, collaborating physicians must be advised that, to avoid a risk of litigation, they must comply with the agencies' dictates until enforcement policy is modified in some authoritative way.

The guidelines put the government on record as conclusively deeming any physician network joint venture of any size to be unlawful unless it is demonstrably something more than a joint selling agency wholesaling the services of the doctors in the group. A group of physicians would thus be absolutely barred from appointing an agent

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[14]Supra note 3 (emphasis added).

to negotiate on their behalf with sophisticated purchasers, such as insurers, employers, and other prepaid health plans, if the agent, rather than the individual physicians, had authority to set prices. Yet the practical difficulties that individual physicians face in finding secure places in the world of managed care are such that efficiencies in the form of saved transaction costs, not the elimination of competition, may easily be their principal objective in organizing such a sales agency. Purchasers, too, may realize significant cost savings from arrangements that spare them from having to bargain with numerous physicians individually. A proper application of the rule of reason would allow a physician network a chance to show that procompetitive effects predominate, whether or not the physicians "share substantial financial risk" or "offer a new product." Although many proposed arrangements would fail a rule of reason test, some joint ventures representing significant subsets of practitioners and not satisfying the guideline requirements might be found in particular circumstances to have more positive than negative effects.

As a doctrinal matter, only certifiably "naked" restraints of trade -- those having no object other than suppression of competition -- are or should be subject to per se rules. To be sure, the Supreme Court's opinion in the *Maricopa* case seemed to say that per se rules may be applied to certain kinds of conduct even though there may be some question concerning the nakedness of the restraint.[15] But the Court's method in that case demonstrated the excessiveness of its rhetoric justifying the arbitrary use of per se rules. Indeed, a careful reading of the majority opinion by Justice Stevens reveals that he actually applied the rule of reason (taking what has come to be called a "quick look" at all the circumstances) before finding unsupportable the FMCs' claim that their fixing of maximum prices was procompetitive -- specifically, that it made costs more predictable for both insurers and insureds, thereby lowering the cost and improving the quality of health insurance coverage. Indeed, Justice Stevens showed notable insight in his appraisal of the challenged practice. For example, he observed that, to achieve the efficiencies claimed, "it is not necessary that the doctors do the price-fixing."[16] He thus focused on the availability of a less restrictive, more procompetitive way in which better insurance coverage could be provided -- namely, by having an insurer itself set the fee schedule and contract with those physicians who were willing to abide by it. Since such selective contracting with physicians was practically unheard of at the time (indeed, it was precisely what the doctors hoped to discourage), his prescience was particularly commendable.[17]

Thus, despite what Justice Stevens said in *Maricopa* about having no choice but

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[15]E.g., 457 U.S. at ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some.").

[16]457 U.S. at 352.

[17]At 457 U.S. at , Justice Stevens cited *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), for the proposition that insurers could obtain binding contractual fee commitments from physicians. That case upheld an insurer's selective contracting with low-price pharmacies against an antitrust challenge. Its citation in this context is noteworthy because, at the time, selective contracting and insurer-initiated price competition had not yet emerged in medicine.

to apply a per se rule to maximum price fixing, the Court did not in fact find a violation until after it had discredited the physicians' claim that their maximum fee schedules were procompetitive. Thus, Justice Stevens stated that "the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition";[18] such consulting of the record to see whether a presumption of illegality might be successfully rebutted demonstrates that the presumption was not conclusive -- as a per se rule would be. Likewise, the Court said, "It is entirely possible that the potential or actual power of the foundations to dictate the terms of such insurance plans may more than offset the theoretical efficiencies upon which the respondents' defense rests";[19] obviously, the question whether market power offsets efficiencies would not come up if the Court were truly bent on applying a per se rule. Although the *Maricopa* opinion is certainly confusing to anyone who follows Justice Stevens's rhetoric rather than his footwork, the Court's ruling was in no way inconsistent with the generally respected principle that only naked restraints of trade (and, apparently, not all of them[20]) are appropriate candidates for per se treatment.[21]

In any event (and despite the tendency of antitrust lawyers to dichotomize between

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[18]457 U.S. at 333.

[19]Id. at 354

[20]Neither courts nor commentators have ever made it clear why a per se rule does not apply to all naked restraints, applying instead only to certain categories of such restraints. The best rationale (arguably underlying Justice Stevens's seemingly extreme rhetoric in *Maricopa*, supra note 15) is that, in many imperfect markets, there is more than a negligible chance that a restraint addressed to a matter other than price or output might actually yield an outcome closer to that which would result if the market were efficiently competitive. Wisdom might counsel, of course, against creating a doctrinal loophole for naked restraints of any kind, since competitors rarely, if ever, restrain trade solely in the interest of consumers. Nevertheless, a conclusive presumption that competitor cooperation aimed at limiting some aspect of competition in the market as a whole is always anticonsumer would be politically unwise, especially in professional fields. Possibly for this reason, courts have been "slow to condemn rules adopted by professional associations as unreasonable per se." FTC v. Indiana Federation of Dentists, 476 U.S. 447, (1986). And the enforcement agencies themselves have been circumspect in such matters -- as in the *IFD* case itself, supra, where the FTC fully (though arguably unnecessarily) investigated the dentists' claims that the naked restraint in question enhanced the quality of dental care. Agency and judicial willingness to listen to defenses based on an alleged market failure (even if such defenses are rarely accepted) has the virtue of weakening the ability of professional interests to appeal to Congress for antitrust relief. See text at notes 50-54 infra.

[21]In two later cases, the Court appeared to apply per se rules too readily, without even a quick look that would probably have changed the outcome in one case but not the other. See FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411 (1990) (overlooking objection that market power could not be presumed -- as it usually is, implicitly, in price-fixing cases -- solely on the basis of defendants' attempt to fix prices, since defendants had alleged a plausible objective other than restraint of trade); Palmer v. BRG of Georgia, Inc., 498 U.S. 46 (1990) (per curiam) (treating restraint, easily condemnable as overbroad, as a per se violation without regard to its plausible business purpose).

"per se" and "rule of reason" cases), per se rules are not at war with the rule of reason, but are instead products of its application to particular facts.[22] Such rules should therefore never be applied without first applying the rule of reason -- that is, without lawyerly factual analysis to ensure that the case does indeed call for invoking the policy inherent in past rulings condemning comparable practices as indefensible restraints. The antitrust agencies, however, are apparently unwilling to look at the whole picture in judging physician network joint ventures. Indeed, if one takes the guidelines literally (and there is no reason one should not), a joint venture representing, on a nonexclusive basis, no more than a modest proportion -- say, ten percent -- of community physicians in each specialty would be condemned as a per se violation. Physicians are thus barred by the threat of antitrust attack from forming joint selling agencies that do not meet government specifications. Although antitrust prosecutors are not chartered to wield prescriptive powers, they have in this instance, by publicly committing themselves to exercise their prosecutorial discretion in a particular way, become regulators de facto.[23]

There is no mystery about the source in case law of the agencies' insistence that physician-controlled networks, to escape antitrust challenge, must either impose financial risks on the joint venturers or integrate the doctors' practices so substantially as to "offer a new product." In the *Maricopa* case, the Supreme Court rejected the FMCs' claim that they were engaged in price fixing "only in a 'literal sense'" by stating that "their combination in the form of the foundation does not permit them to sell any different product."[24] The Court went on to distinguish the FMCs from "joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss . . . ."[25] The Court concluded its analysis as follows:

> If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee arrangements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely within

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[22]See Nat'l Soc'y of Professional Engineers v. United States, 435 U.S. 679, (1978) (describing rule of reason and how it yields "two complementary categories of antitrust analysis").

[23]Other have observed the increasingly regulatory character of antitrust enforcement -- not only in the health care field. See, e.g., Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, 486-89; Thomas E. Kauper, *The Justice Department and the Antitrust Laws: Law Enforcer or Regulator?*, in 1 THE ANTITRUST IMPULSE: AN ECONOMIC, HISTORICAL AND LEGAL ANALYSIS 435 (Theodore P. Kovaleff ed., 1994). The Greaney article, although observing the agencies' regulatory role in health care, does not observe the particular instance of overregulation that is the subject this article. Indeed, Greaney raises a quite different (and equally valid) concern -- namely, the possibility that "assumption of financial reisk by physicians will trump most concerns about anticompetitive risks." Greaney, supra, at 479 n.57.

[24]457 U.S. at 356, quoting Broadcast Music, Inc. v. CBS, 441 U.S. 1, (1979).

[25]457 U.S. at 356.

the horizontal price-fixing mold.[26]

The agencies' position is thus seemingly supported by clear dicta in a Supreme Court opinion (for a four-Justice majority), and might easily carry the day in another court even though *Maricopa* involved a market very different from most of those one finds today. But the agencies' job is not to prosecute every case they might win on the basis of questionable dicta or precedent. It is instead to employ their expertise and fact-finding capability to prevent true restraints harmful to competition and consumer welfare while encouraging arrangements that create efficiencies.

Certainly, risk sharing and integration are appropriate requirements in defining safe harbors for certain physician collaborations. But they should not be made mandatory in all joint ventures by denying noncomplying ones a hearing under the rule of reason even when the parties make a plausible claim that their purpose is procompetitive and that their agreement on prices is ancillary to that purpose. In fact, absence of the features specified by the agencies does not unerringly identify a naked restraint deserving automatic condemnation -- without proof of the parties' anticompetitive purpose, of their power to affect competition in the market at a whole (not merely *inter se*), or of the actual or probable effect of their arrangement. Thus, a correct analysis of a physician-sponsored network falling outside the guidelines' safety zones would walk sensitively through the elements of purpose, power, and effect, condemning it only if there is a probable net harm to competition or if the parties have employed unreasonable means to achieve their legitimate objectives. Such an analysis of physician network joint ventures -- which could often be completed with only a "quick look" -- might sometimes result in a clean bill of health rather than a decision to prosecute.

Physician Networks as Joint Selling Agencies

Physician network joint ventures are best viewed for antitrust purposes, not as naked restraints of trade, but as joint selling agencies (JSAs), a type of arrangement that has not generally been condemned as a per se violation.[27] In a passage quoted with approval by the Supreme Court in the *NCAA* case, Professor Philip Areeda has observed that "joint buying or selling arrangements are not unlawful per se."[28] Likewise, Professor

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[26]Id. at 357.

[27]E.g., Appalachian Coals, Inc. v. United States, 288 U.S. 344 (1933) (treating some very minor and otherwise attainable benefits of joint selling in a difficult market as justifications for allowing a high percentage of sellers of coal to market through a single agent). The *Appalachian Coals* case is generally understood to be an aberration in the law, occasioned by the Great Depression. Nevertheless, even though more recent precedent places a heavy burden on JSAs, e.g., Virginia Excelsior Mills v. FTC, 256 F.2d 538, 539-41 (4th Cir. 1958), elementary principles entitle them to be evaluated under the rule of reason if their sponsors' purposes are not obviously anticompetitive.

[28]National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla., 468 U.S. 85, 109 n.39, quoting PHILIP AREEDA, THE "RULE OF REASON" IN ANTITRUST ANALYSIS: GENERAL ISSUES 37-38 (1981) (observing that in some circumstances the power of the combining parties might be so obvious that "the rule of reason [could] be applied [to condemn the joint-selling arrangement] in the twinkling of an eye"). See also 7 PHILIP AREEDA, ANTITRUST LAW ____ (1986).

Lawrence Sullivan has opined that

> some joint arrangements to buy or sell will not be summarily held to be unlawful . . . because summary analysis does not suggest a degree of market power which clearly demands that integration benefits be forbidden because price competition will be reduced. Joint agency cases such as these must be analyzed under the rule of reason, fully blown.
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> . . . . If the proposed selling or buying agency would materially increase concentration and if as a result the balance of forces would shift significantly away from rivalry and toward accord, the arrangement should be rejected as unreasonable. Just as surely, if competition could be expected to continue unabated, or even to improve, the rule of reason will mandate that the market's manner of striving for efficiency not be choked off.[29]

The Supreme Court cited Professor Sullivan's observations with approval in *Broadcast Music, Inc. v. CBS*,[30] overturning a decision condemning per se, as price fixers, two performing-rights societies that jointly marketed musical compositions on behalf of their composer-members. The Court held that the composers, through the societies, were engaged in price fixing only "in a literal sense" and that their pooling of compositions for licensing purposes was "not a 'naked restrain[t] of trade with no purpose except stifling of competition.'"[31]

Despite the favorable treatment of joint selling arrangements in *BMI*, however, that case is the ultimate source of much of the reasoning in the *Maricopa* case that apparently led the DOJ and FTC to insist that physician-controlled networks must either force the doctors to share financial risk or enable them to "offer a new product." To be sure, the Court praised the procompetitiveness of the performing-rights societies in making it easier, in a complex market, for composers to market their music and for users to hire it. But the Court's overall analysis, by emphasizing that the arrangement involved more than joint selling alone, may appear to justify hostility to less integrated physician joint ventures. Thus, the Court stressed that the societies each offered users of copyrighted music a particularly convenient form of blanket license, which it characterized as "to some extent, a different product."[32] Moreover, it went on to say that "to the extent that the blanket license is a different product, [a performing-rights society] is not really a joint selling agency offering the goods of many sellers,"[33] thus implying that a mere JSA would not qualify for rule of reason treatment. The *Maricopa* Court cited this discussion in rejecting the FMCs' claim that they, too, were engaged in price fixing "only in a literal sense."[34]

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[29]LAWRENCE SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 104 (1977).

[30]441 U.S. 1 (1979).

[31]Id. at 2, quoting ...

[32]Id. at 21.

[33]Id. at 22.

[34]*Maricopa*, 457 U.S. at 356.

It is a mistake in judging physician networks, however, for the enforcement agencies to focus so minutely on these two cases and on others blurring the line between naked and ancillary restraints[35] rather than consulting general antitrust principles, under which per se rules apply only to certain categories of the former. In *BMI*, the Court needed to find very strong procompetitive features in the arrangements because the societies, between them, dominated the licensing of musical compositions and were highly vulnerable to condemnation in the absence of a strong business justification.[36] Thus, if all the facts are considered, a physician network representing only a fraction of the physicians in an area, especially on a nonexclusive basis, might be able to make as persuasive a case for joint marketing as the *BMI* defendants. Certainly the efficiencies they could point to, based on the high transaction costs that both physicians and bulk purchasers would face in creating relationships by individual negotiation and in administering those relationships, would be similar in kind, and probably in magnitude, to the efficiencies achieved by performing-rights societies.

Moreover, a significant fact noted by the Court as favoring application of the rule of reason in the *BMI* case was the retention by the composers of the right to license their respective compositions on an individual basis.[37] As a practical matter, however, that alternative method of marketing was highly inefficient. It also did little to offset the market power of the societies, especially since the composers were not free to license their works through competing agents.[38] Nonexclusive physician networks, on the other hand, would permit physicians not only to service individual patients on a fee-for-service basis but also to join other networks, thus posing much less of a threat to competition. Such nonexclusivity should, in fact, save any network (whatever its size) that exists in a market where large employers and other payers have, and exercise, real opportunities either to organize their own networks or to patronize other existing physician groups. Of course,

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[35]See note 21 supra. See also United States v. Topco Assocs., 405 U.S. 596 (1972) (applying the per se rule condemning market-division agreements to a minor limitation on joint venturers' freedom despite its value in protecting the parties against each other's opportunistic conduct and thus in facilitating formation of the procompetitive joint venture in the first place). Unfortunately for coherence in the law, this holding, although effectively discredited in Rothery Storage & Van Co. v. Atlas Van Lines, 792 F.2d 210, 227-29 (D.C. Cir. 1986), was cited favorably by Justice Stevens in *Maricopa*, 457 U.S. at ____.

[36]Indeed, the Court should probably have broken up the societies themselves in any event, since as the only two licensors of musical compositions they wielded undue market power and engaged in suspiciously parallel conduct. The private plaintiff, however, for reasons of its own did not seek such relief, asking only for the invalidation of blanket licenses (which served the interests of its competitors more than its own) and not for the restoration of unbridled competition (which would have benefitted its competitors more than itself). See *Broadcast Music*, 441 U.S. at 16-18 (Court's discussion of CBS's theory and desired remedy).

[37]441 U.S. at 20-21. ("The individual composers and authors have [not] agreed not to sell individually in any other market . . . .").

[38]The arrangement was comparable in this respect to the more restrictive ("exclusive") type of physician networks identified in the DOJ/FTC policy statement.

the enforcement agencies might reasonably require network physicians to show that they are participating in competing ventures in fact, not merely that they are free to do so on paper. In addition, sponsorship of the venture by a local medical society, rather than by a subset of competing physicians, should defeat any claim that it is a procompetitive, rather than a defensive, undertaking.

There is no good reason in antitrust doctrine or policy why the antitrust agencies should not, in proper cases, be willing to treat physician-sponsored networks as JSAs and their attendant limitations on price competition as ancillary restraints subject to the usual test of reasonableness. Under the appropriate analysis, the authorities would give due recognition to the severe practical difficulties that physicians in solo or small group practices face in marketing their services to numerous large buyers. Lacking appreciable business experience and the staff resources necessary to negotiate and to keep track of their relationships with multiple payers, physicians should be free, within normal limits imposed by antitrust law, to form and operate JSAs. In mature markets for medical care, purchasers are generally capable of looking out for themselves and should be free to do business with physician networks that do not follow the current prescriptions of the antitrust authorities. In such markets, physicians are more likely to form JSAs as vehicles for competing on a price-discounted basis for particular contracts than as cartelizing devices.

Less Restrictive Alternatives?

To be sure, the evaluation of ancillary restraints of trade does not end with their classification as such. Even if the parties' purposes are unexceptionable, there must still be an inquiry into the probable state of competition if the collaboration is allowed. Such an inquiry begins with an estimate of the parties' market power -- that is, their ability to affect market price and overall output by their collaborative decisions. If the parties turn out to possess market power in fact (even though they do not need such power to accomplish their ostensible procompetitive purpose), the net effect of their collaboration could easily be more harmful than beneficial to consumers.

A case can frequently be resolved, however, without finally balancing procompetitive against anticompetitive effects -- by asking whether the parties could achieve their legitimate purposes in a manner less dangerous to competition. If such a "less restrictive alternative" was available and was not adopted by the collaborators, the antitrust enforcers might conclude either that their purpose was actually anticompetitive (thus justifying application of the per se rule after all) or that, despite their lawful purpose, the parties' choice of the more restrictive method of achieving it can itself be penalized. In reviewing physician-sponsored networks possessing a degree of market power, therefore, antitrust agencies must determine whether the anticompetitive features of the arrangement are reasonable in the sense that they are well-tailored to achieve their procompetitive purposes with minimal harm to competition.

Because the less-restrictive-alternative requirement is an element of a rule of *reason*, it should not used by the antitrust agencies simply as a warrant for closely second-guessing the way the parties have chosen to structure their relationship; thus, it should be invoked only if the methods chosen betray an anticompetitive motive or materially increase the threat to competition. Before antitrust enforcers require a physician joint venture to restructure itself in a way that sacrifices available efficiencies, therefore, they should have substantial reasons to fear that the arrangement jeopardizes

competition in the market as a whole. For reasons similar to those already discussed, an agency should not, without at least a quick-look power analysis, invoke the less-restrictive-alternative requirement to force the joint venturers to meet its prescriptions regarding risk-sharing or the nature and extent of their integration. I is not enough to say, as the *Maricopa* Court did, that "it is not necessary that the doctors do the price fixing." Even though an enforcement agency can imagine less restrictive methods by which the doctors could market themselves, it should not require use of such methods unless to do so would avert an unreasonable threat to competition in the larger market.

Reflecting the demands of antitrust authorities, the current practice in forming physician-sponsored networks is to design arrangements that avoid the noncompetitive fixing of prices for the services of the individual physicians in the group. Lawyers for physician JSAs have developed so-called "messenger" models in an effort to obtain some of the efficiencies of joint marketing while preserving a semblance of price competition.[39] Indeed, the apparent frequency with which networks are formed using some kind of messenger mechanism demonstrates that physicians set up JSAs primarily to achieve efficiencies, not to fix prices. It is not obvious why antitrust policy requires that they adopt cumbersome marketing methods that purchasers themselves do not insist upon. The enforcement agencies have uncharacteristically exalted form over substance in their analysis, ignoring valid efficiency considerations that normally would be given weight.

Messenger arrangements do not so obviously qualify as less restrictive alternatives that every physician-sponsored JSA should be required to use them. To be sure, they are *theoretically* less restrictive than letting the joint venturers agree on price. But because they are cumbersome to operate, they are not equally satisfactory as alternatives for getting the marketing job done. Their use therefore sacrifices some of the efficiency that JSAs can otherwise create. Indeed, antitrust authorities apparently insist that physician JSAs employ a particularly cumbersome mechanism called the "pure" messenger model. Under these arrangements, the marketing agent must communicate offers back and forth between bulk purchasers and individual doctors without disclosing to the latter the price terms that others are quoting. Because the pure messenger model is unwieldy, some networks employ "modified" messenger arrangements, which may take the form of a standing offer of individual physicians' services on uniform terms that a purchaser is free to accept or reject. Such arrangements have never been approved by enforcement officials, however, and have sometimes been rejected. Thus, if a physician-sponsored network provides neither for risk sharing nor for enough integration to create a "new product," the antitrust authorities will apparently deem it unlawful unless it takes maximum precautions -- at whatever cost in inconvenience to both doctors and purchasers -- to eliminate all price-fixing features. Although it is hard to judge the relative efficiency of all the possible messenger arrangements, the antitrust agencies might somewhat improve the situation by tolerating modified versions whenever competition in the market as a whole is not specifically in danger.[40] The better approach, however, would be to

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[39]See generally Raskin, supra note 9, at 86-91; *Law Firm Warns of FTC's and DOJ's Increased Focus on Messenger Models*, 4 HEALTH LAW RPTR. (BNA) 603.

[40]It is not known whether anyone has studied the actual operation of various messenger models to see what costs they incur or whether purchasers benefit in fact from the price competition they seemingly preserve. Although the doctrinal basis for doing so

apply the rule of reason.

Insistence on a second-best alternative is appropriate in antitrust enforcement and under the rule of reason only if a specific risk to competition outweighs the efficiencies forgone. To be sure, use of a messenger model should be required in many circumstances, often identifiable with only a "quick look." But in instances where the danger of anticompetitive harm is unclear, a more extensive evaluation is required. Such an analysis would consider such factors as sponsorship of the JSA by physicians in an aggressive competitive posture rather than in a defensive, anticompetitive one (that is, by interests other than a local medical society); the percentage of competing physicians engaged in the effort; their freedom to participate in competing ventures; their actual participation in other marketing schemes; the sophistication, effectiveness, and preferences of the purchasers with which they deal, and the overall vigor of competition in the market being served. Even if a network was the exclusive marketer for its member doctors, there would still be no threat to competition if the market featured a variety of other plans. In such a mature market, purchasers can decide for themselves whether to patronize JSAs in which physicians have not expressly undertaken to share financial risk, to integrate their practices, or to maintain any kind of independent pricing. Indeed, the availability of meaningful purchaser options itself puts the collaborating physicians at risk of contract nonrenewal and should go far toward satisfying government officials that competition is not in danger.[41]

The Danger of Prejudging Market Outcomes

As already demonstrated, the hostility of the antitrust agencies to physician network joint ventures results in part from their looking backward to the time when it was reasonable to presume that physicians collaborated only for anticompetitive purposes. Like many a wayward golf shot, however, the current enforcement policy suffers also from looking ahead, away from the object at hand and toward an intended goal. Thus, the agencies appear to be anticipating where they think the health care marketplace is headed and attempting to steer physician-sponsored networks in that foreordained direction. Thus, their prescription of the form that such networks must take reflects a prejudgment of the way physician services should, and will eventually, be bought and sold in the future

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would be highly artificial, the agencies might obviate some of the inefficiency by expressly letting joint venturers agree on nonprice terms, using the messenger model only for price terms (which may be more amenable to individual negotiation).

[41]Another kind of risk that should reassure antitrust enforcers concerning the compatibility of a JSA with competition in the larger market is the risk of "deselection" faced by individual physicians participating in the network and subject to periodic "profiling" of their practice patterns. Although the agencies are reported to take a narrower view, a joint venture might argue that it is offering "a new product" if it reserves, and occasionally exercises, the power to exclude doctors who overuse resources or provide care of doubtful quality. On the other hand, a state "any-willing-provider" law, mandating that a network include any physician willing and able to meet its terms, would diminish the risk of deselection. In states where such inclusiveness is mandated by law, the antitrust agencies could reasonably take the position that any joint venture should satisfy their requirements with respect to risk sharing or integration.

health care marketplace. In writing such a prescription, however, the agencies run the risk of choking off (in Professor Sullivan's words) "the market's manner of striving for efficiency."

To be sure, the antitrust agencies are not alone in assuming that all health care will eventually be provided by integrated health plans.[42] Many other observers also believe that physicians must bear financial risk if they are to be induced to provide health care efficiently and without the chronic excesses that have characterized much fee-for-service medicine. It is dangerous, however, for regulators to dictate market outcomes on the basis of *a priori* assumptions about what is and what is not efficient or responsive to the needs and preferences of purchasers.[43] Current antitrust enforcement policy with respect to physician networks is an exercise of prosecutorial discretion that, in attempting to provide guidance to the industry, has become overly regulatory and prescriptive, foreclosing options that might attract followers in a competitive market. It should after all be the province of purchasers, not the antitrust authorities, to decide whether a particular incentive arrangement achieves the right balance between spending and economizing.

The American Medical Association (AMA), in advocating greater freedom for physicians to create their own networks, has been somewhat careful about challenging directly the conventional view that physicians will ultimately either be put under managed-care arrangements operated by third parties or be organized in competing groups with explicit individual or collective incentives to control costs. Thus, AMA officials have sought to persuade antitrust enforcers that physicians need more freedom to collaborate only so that they can take incremental steps toward fuller integration or can explore new methods of payment without having to take the plunge all at once.[44] Citing physicians' lack of the capital, experience, and management skills necessary to organize a fully integrated plan, the AMA argues that physicians need an opportunity to test the waters and to evolve gradually toward full-blown integration of their practices. Observing that simple networks and management service organizations (MSOs) could either serve

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[42]See, e.g., Greaney, *supra* note 9.

[43]Although it is often assumed that fee-for-service practice is inherently inefficient, physician practice styles may be changing as physicians become more accountable for their competitive performance (see note 41 supra), as cost-consciousness becomes pervasive, and as changes in the prevailing standard of care reduce legal pressures to overtreat patients. Indeed, efficient practices have often been observed in some multispecialty groups treating patients under traditional indemnity insurance. See also Jeff C. Goldsmith, *The Illusive Logic of Integration*, HEALTHCARE FORUM J., Sept.-Oct. 1994, p. 26 (questioning the presumed benefits of much of the organizational integration sweeping the health care industry).

[44]See generally Letter from James S. Todd, M.D., Executive Vice President, AMA, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, May 11, 1994 (discussing antitrust issues addressed by certain legislative proposals). See also Edward B. Hirshfeld, *Antitrust Reform and Physician Groups*, in HEALTH CARE ANTITRUST: A MANUAL FOR CHANGING PROVIDER ORGANIZATIONS ¶¶1000-89 (Thomas Campbell & Daniel D. McDevitt eds., 1995) (authored by the AMA's Vice President Health Law).

as building blocks for larger plans to incorporate in their systems or evolve into physician-sponsored entities capable of bearing financial risks or offering "new products," it advocates antitrust relief that would facilitate physician experimentation with new ways of organizing themselves. This article argues more explicitly than does the AMA that some JSAs may have immediate procompetitive value in their own right and should therefore survive antitrust scrutiny without regard to the speculative (though probably valid) claim that they are also valuable as half-way houses on the way to fuller integration. Whereas the AMA hopes for some legislative relaxation of antitrust requirements, agency application of the rule of reason would alone be enough to give physicians all the freedom of action that is compatible with effective competition.

The AMA has also argued that impeding the creation of doctor-controlled plans fosters the unnatural growth of health plans operated by large corporate sponsors, which it alleges are less attuned than physician groups to patient welfare and the quality of care. Although granting legislative relief to physician collaboration would be a serious policy error,[45] antitrust enforcers should not, without good reason, deny physician-designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at reasonable cost. In competitive markets, some such plans might prove attractive to many consumers. Able to rely on professionalism, collegiality, and consensus rather than exclusively on rules and regulations imposed from the corporate top down, physician-sponsored plans should have a comparative advantage in finding and implementing cost-saving methods that maintain essential quality and preserve intangible values that are at risk in many of today's managed-care systems.[46]

In any event, putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold. Financial risk creates interest conflicts, diminishes loyalty to patients, and may undermine professionalism, with consequences that some consumers would find objectionable. Not only do the incentives employed in many integrated plans engender *sub rosa* rationing of care that consumers have no way to monitor, but consumers and their agents lack other kinds of reliable information permitting them to compare the overall performance of competing plans. Thus, they have much to worry about in purchasing health care today and might therefore feel safer in dealing with plans that did not put physicians at financial risk.[47] Physician-sponsored JSAs, if they do not

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[45]See text at notes 50-54 infra.

[46]One physician sophisticated in health policy and generally appreciative of the role of antitrust law in medicine has argued that doctors must have a larger role in decision making and management if health care quality is not to suffer in the brave new world of managed care, "gatekeepers," and capitation. See Robert A. Berenson, *Do Physicians Recognize Their Own Best Interests?*, HEALTH AFFAIRS, Spring 1994, p. 185.

[47]The author has recently argued at length that the failure of health plans to write subscriber contracts saying anything meaningful about the degree to which the plan and its providers will ration services and balance health benefits against costs is a severe impediment both to offering consumers meaningful options in the marketplace and to holding providers and plans accountable for complying with any but a generally applicable (poorly defined but relatively expensive) standard of care. See CLARK C. HAVIGHURST,

dominate their local market, might add usefully to the competitive mix precisely because they do not feature direct financial incentives to withhold care, corporate control of medical practice, or integration and income pooling that lessen productivity incentives. A marketplace lacking arrangements designed by physicians themselves and not by antitrust authorities could easily fail to serve consumers well or to be fully reliable, from the standpoint of society as a whole, as a place for working out the difficult trade-offs with which health care necessarily abounds.

One consequence of the current and emerging problems with managed care could be a rising tide of regulation. Already, a combination of physician criticism, rumor, unverified consumer complaints, and occasional press reports of beneficial care denied is causing increasing skepticism and critical comment about the new generation of health plans. This discontent could easily ripen into a further backlash of regulation and litigation. Although designed to protect consumers, such legal developments would raise health plan costs and limit the ability of plans to adopt innovations responsive to the wishes of consumers and their agents. Indeed, overregulation is already a problem in many states, and only the fortuitous presence of the federal Employee Retirement Income Security Act (ERISA) as a barrier to intrusive state regulation and judicial oversight of employee benefit plans[48] has permitted the market to make as much progress as it has toward bringing costs under appropriate control. ERISA is under constant challenge, however, and may eventually give way as a defense against heavy-handed state regulators. For federal antitrust authorities to mandate risk sharing that in turn invites either relaxation of ERISA preemption or new state regulatory controls could be highly destructive of the market's ability to achieve efficiency.

In this connection, it should be noted that the National Association of Insurance Commissioners has recently declared its members' intention to treat any network of physicians that contracts with an employer to assume any degree of financial risk as an insurer requiring state licensure as such.[49] Thus, the antitrust requirement that physician-sponsored networks be structured to impose financial risks on physicians is driving such plans directly into the arms of state insurance regulators. State insurance regulation would increase the difficulty of creating new network joint ventures, would raise their costs, and would limit their ability to meet purchaser needs and expectations, thus undermining the efficiencies that such networks might otherwise achieve. Physician JSAs, on the other hand, would escape such regulation and would thus greatly enhance the freedom of self-insured employers and other purchasers to obtain the services they require without

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HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

[48]29 U.S.C. § 1001 et seq. (19). See, e.g., Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that ERISA preempts state mandated-benefit laws); Pilot Life Ins. Co. v. Dedeaux, U.S. (1987) (holding that ERISA preempts state law remedies for bad faith in administration of employee health benefits plans).

[49]See *NAIC Bulletin to Address Application of Insurance Laws to Provider Groups*, HEALTH LAW RPTR. (BNA) 1177 (discussing NAIC bulletin issued Aug. 10, 1995). See also *Storm Warning*, HEALTH SYSTEMS REV. (Federation of Am. Health Systems), Sept.-Oct. 1995, pp. 26-37 (series of articles discussing state insurance regulation of provider networks).

encountering the delays, obstacles, and costs that state regulators impose.

The assumption that competition will eventually induce virtually all Americans to enroll in some form of managed-care organization fails to take account of the fact that nearly 100 million Americans are currently co ered by self-insured ERISA plans. This is roughly twice the number who receive their employer-purchased benefits through entities that integrate financing and delivery in ways that would satisfy the antitrust authorities in a physician-controlled arrangement. To be sure, there are some markets such as California where the market penetration by conventional HMOs and managed-care organizations is impressive, but there are many others (large parts of the Middle West, for example) where competition has operated for some time without inducing employers to rely heavily on corporate middlemen or integrated or risk-bearing physician networks. In these markets, many large employers do not require either that physician networks assume financial risk or that physicians integrate themselves in some formal fashion. Instead, they have employed either in-house benefit managers or third-party administrators to contract with physicians or physician networks directly at negotiated prices and work with them, often in highly creative ways, to control costs. Such employers apparently prefer the cost savings achieved through careful selection of physicians and through cooperation with them in addressing cost problems over the savings they might gain by contracting out the business on a capitated basis. Antitrust enforcers should not deny employers the option of dealing with physician JSAs, which they can hold responsible for selecting physicians who provide appropriate care without overcharging for their services.

Self-insured employers should therefore be free to work directly with physician-designed JSAs and not forced instead either to form their own networks or to hire independent entities to assume risk, to manage care, or to form fully integrated health plans. Such entities naturally expect to profit both from investing the employer's advance payments and, most importantly, from economizing on the provision of health care to employees and their families. Many employers might prefer to eliminate the middleman and to take direct responsibility for both the cost and the quality of medical care that their employees receive. In this effort, physician networks organized by physicians themselves could be valuable allies. Antitrust enforcers are simply wrong to insist that, when physicians organize a network joint venture, the only issue is whether the sponsors have either preserved a semblance of price competition among themselves or followed the agencies' prescriptions in allocating risks or integrating their practices. Ironically, the question they should ask is whether the market features *other* plans that meet the agencies' conditions. Once a market has matured to this extent, purchasers should be allowed to choose for themselves how they want physicians to be organized and compensated for their services.

An Invitation for Congressional Intervention?

Agency obtuseness on the issue addressed in this article comes at a particularly inopportune time -- as Congress is considering major reforms of the Medicare program. The version of the reform legislation that passed the House of Representatives in the Fall of 1995 included two provisions relating to antitrust law applicable to physicians. One would have explicitly required application of the rule of reason rather than a per se rule to "physician-sponsored networks" (PSNs) contracting with "physician-sponsored organizations" (PSOs) to deliver Medicare services under a PSO's capitation contract with

the government.[50] Thus, the House bill opted for letting physicians deal with "MedicarePlus" contractors through JSAs to the same extent that, under the analysis in this article, physicians could employ JSAs in dealing with ERISA plans and other private or public purchasers. The need for the House provision would therefore be obviated if the antitrust agencies were to relax the policy criticized in this article. Indeed, that outcome would be highly preferable to a legislative fix precisely because it would extend to physician networks of all kinds, not just to those organized to serve Medicare beneficiaries. In addition, it is always preferable to solve problems in the administration of antitrust law by refining doctrine so that it better promotes competition rather than by turning to Congress.

A more troubling provision in the House bill would have created a sweeping antitrust exemption for so-called "medical self-regulatory entities,"[51] rolling back twenty years of painstaking development (since *Goldfarb*) of antitrust principles applicable to concerted action by professional groups. Physician interests have long contended that antitrust enforcers misconstrue their motives in taking collective action in the marketplace. The agencies have successfully (and wisely) maintained, however, that the law requires the uncompromising maintenance of competition in professional fields, even when professionals can plausibly claim that their anticompetitive actions are motivated by concern for the public interest.[52] Thus, the antitrust movement has successfully brought to bear in medicine the wholesomely objective principle -- which the House bill would have converted to an impractical, and much too forgiving, subjective test -- that parties with a conflict of interests ought never to exercise coercive powers that are subject to anticompetitive abuse. Experience under the antitrust laws since the 1970s has generally vindicated the premise that competitive markets are preferable to professional control precisely because they are more hospitable to innovations responsive to consumer interests.

Unfortunately, unwise administration of the antitrust laws, either by the agencies or by the courts, invites Congress to intervene on behalf of politically powerful physician interests and to enact confusing, possibly overbroad correctives or destructive immunities like the ones in H.R. 2425.[53] The agency policy discussed in this article is thus doubly

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[50]H.R. 2425, 104th Cong. 1st Sess. § 15021 (1995).

[51]Id. at § 15221.

[52]E.g., FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986); National Society of Professional Engineers v. United States, 435 U.S. 679 (1978). But see note 20 *supra*.

[53]Congress last modified the application of antitrust law to the health care industry -- also at the behest of organized medicine -- in the Health Care Quality Improvement Act of 1986. 42 U.S.C. §§ 11101-51 (19). Because courts had been unable to find in antitrust doctrine any reasonable and expeditious basis for distinguishing between meritorious and nonmeritorious private antitrust challenges to staff privileges decisions in hospitals, see, e.g., Patrick v. Burget, U.S. (1988), Congress felt compelled to provide qualified antitrust immunity for hospital-based peer-review (and other similar professional) activities. On the other hand, if courts (perhaps with wise and balanced guidance from the antitrust agencies) had focused their efforts on distinguishing between actions of hospitals themselves and actions of medical staffs empowered by hospitals finally to decide the fate of their

unwise. In addition to being wrong as a matter of antitrust doctrine, it may prove a political disaster. Precisely because it has been based more on hostility toward physicians and suspicions abou' their motives than on reasoned application of antitrust policy, it has given medical interests a wedge with which to get Congress into the act, creating the potential for legislation virtually repealing antitrust law as it affects organized medicine. Antitrust is ultimately a political enterprise on which turns the fate of competition in the economy as a whole.[54] If competition is not to be undercut by congressional tinkering, antitrust enforcement must reflect astute political judgment as well as sound legal and economic analysis. An overly aggressive trust-busting mentality, such as the attitudes manifested by the agencies toward physician-sponsored JSAs, can easily have political repercussions harmful to competition in health care.

Conclusion

This article has argued that Americans are currently being denied access -- by antitrust authorities, of all people -- to a variety of doctor-sponsored physician networks that could perform useful services for some purchasers in some health care markets. In particular, the current policy of antitrust enforcers, in requiring all such networks to meet certain organizational or financial requirements, neglects at least three realities. One is that self-insured ERISA plans have very different needs than other purchasers of health care and that physician networks are capable of responding directly to these needs. Second, the antitrust agencies fail to recognize the heavy regulatory burdens and litigation threats facing the kinds of health plans they visualize as the wave of the health care future; precisely because ERISA plans and physician JSAs both escape many of these burdens, they may be jointly capable of efficiencies that are difficult for other plans to achieve. Finally, the antitrust agencies seem trapped in a time warp that keeps them fearful of physician conspiracies that are much less likely to prosper -- and thus to be attempted -- today than in an earlier era.

The Sherman Act's rule of reason was designed specifically to ensure that antitrust authorities consult the realities of actual markets in making judgments about whether competition is in jeopardy or is operating in healthy though possibly unpredictable ways. Conscientious antitrust analysis should enable the DOJ and FTC to recognize, often with only a "quick look," whether specific physician joint ventures or joint selling arrangements are more likely to suppress competition or to serve efficiently the needs of both their members and sophisticated purchasers, especially large employers and their employees. The threat that current enforcement policy poses to all physician network joint ventures that fail to meet the agencies' own prescriptions should be removed, either by a new policy statement or by an official clarification prominently announced. It would be a terrible reflection on the performance of the antitrust agencies if Congress had to put them on the correct doctrinal path in evaluating physician networks.

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competitors, there would probably have been no need for congressional intervention. See Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1108-42.

[54]See note 20 supra.

Mr. HYDE. Thank you, Professor, very much.

Without objection, the full statements of all witnesses today will be entered into the record. We will now have a period of questioning, and I first yield to the distinguished ranking minority member, the gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman.

I welcome the witnesses and I align myself with Ms. Metzger and Ms. McKay with great enthusiasm. With Professor Havighurst there were parts that were really swell, Professor. [Laughter.]

You lost me on a couple of curves in the road, but then I've been out of law school for a little while, and we welcome your contribution here today.

Dr. Dickey, you are my prime witness at this panel. I only wish you were by yourself. Are you aware of the New York Times' observations about the AMA's relationship with the Speaker of the House in connection with the Medicare reform bill that was passed out of the House in October?

Dr. DICKEY. I am, Representative.

Mr. CONYERS. Yes, the Sunday, October 15, 1995, editorial which was rather raw. It's starts off, "Bribes for Doctors" and goes on from there, and I would be interested to hear your reaction to it in some other panel where I have more than 5 minutes and I will be around after this hearing. I'll be working here at least for the balance of 1996.

In that editorial they suggested that they gave out three concessions to the AMA in exchange for their support for the Gingrich health care bill. And the first was to soften proposed cuts in fees that doctors can charge patients to stay in fee-for-service coverage. And the second one was to cap malpractice awards at ridiculously low levels. And the third one was Mr. Gingrich agrees to ease antitrust laws for the ostensible purpose of permitting doctors and hospitals to create their own health care plans in competition with traditional insurance companies. You're familiar with those three charges leveled in that editorial, aren't you?

Dr. DICKEY. Yes, I am.

Mr. CONYERS. Would you care to make any brief comments about those three charges, please?

Dr. DICKEY. I would suggest that I'll try not to believe any more in the newspapers about the Congressmen running for reelection this year than they believe about what is said about the AMA. Unfortunately, papers don't always report what happens.

Mr. CONYERS. I see.

Dr. DICKEY. We've worked hard with both sides of the aisle to identify the concerns we have with Medicare that make it a program that does not serve your constituents, my patients, the best. There were no deals.

Mr. CONYERS. Excuse me. Let's just focus on the editorial, and here's what I'm trying to get at. Is it not correct that the first concession was to soften proposed cuts and fees that doctors can charge for patients to stay on fee-for-service coverage? Maybe that's justifiable. But isn't that true?

Dr. DICKEY. The charge was made. The actual discussions were that——

Mr. CONYERS. I said, isn't that true?

Dr. DICKEY. No, sir.

Mr. CONYERS. OK. Let's go to the next one. Was there a concession to cap malpractice awards?

Dr. DICKEY. A concession? There was discussion of what's needed in liability reform. There were no concessions that I'm aware of.

Mr. CONYERS. OK. So that's inaccurate, too?

Dr. DICKEY. The issues we brought forward——

Mr. CONYERS. I said, so that's inaccurate, too?

Dr. DICKEY. That's correct.

Mr. CONYERS. OK. Then that the Speaker agreed to ease antitrust laws for the ostensible purpose of permitting doctors to create their own health plans, is that true?

Dr. DICKEY. We suggested a need——

Mr. CONYERS. Is it true? I've got 2 minutes.

Dr. DICKEY. Mr. Conyers, if you're asking me if the editorial is true, the answer is, no, sir.

Mr. CONYERS. This item I just read to you, is that true?

Dr. DICKEY. As a concession, no.

Mr. CONYERS. I didn't say "concession" for that one.

Dr. DICKEY. As a tradeoff, no. As an important issue to patients, yes.

Mr. CONYERS. OK, all right. Let me ask you about a letter that you and five other doctors signed to Speaker Gingrich dated July 28, 1995. I have a copy of it, if you'd like to refer to it specifically. Would you like a copy?

Dr. DICKEY. Yes, sir. I don't remember it verbatim.

Mr. CONYERS. Sure. The operative paragraph that I would like to refresh you on is committee jurisdiction. This is you advising the Speaker of the House of Representatives, an 18-year Member of Congress: "Committee jurisdiction need not be an obstacle to a comprehensive Medicare reform package. Antitrust issues should be resolved through the Republican leadership's task force, designed to deal with cost-cutting issues."

That's great advice to the Speaker of the House. I'm sure he needed that guidance, and, apparently, he followed it, didn't he?

Dr. DICKEY. Yes, sir.

Mr. CONYERS. Yes, he did. Well, thank you. We have one area of agreement here in the course of our few minutes together. Because that antitrust reform was included in the reconciliation bill without ever going before the Judiciary Committee, isn't that true?

Dr. DICKEY. I believe that's true.

Mr. CONYERS. Yes, I believe so, too, because we never had a hearing, a markup, or a vote. And then I came to the Rules Committee, and Chairman Solomon, friendly fellow from New York, decided that we didn't need to discuss antitrust in the bill going before the floor, so there was no provision made for it there. There were a few other allowed amendments, but that was not one of them. And so then we came to the floor and there was this huge antitrust issue that we are now discussing that had never been before anybody in the House; we had never had a chance to say one word on it. And I presume that was a result of your precise and very pointed advice to the Speaker about how to handle the procedural method of our antitrust law. Why did you want to do it that way?

Dr. DICKEY. Congressman, we were simply attempting to find ways to address the concerns with Medicare. Now this was one suggestion. We're pleased the Speaker took it, but we don't presume to either get everything we request listened to or to change the policies and procedures of the House. We simply respond when given an opportunity.

Mr. CONYERS. Well, you changed the procedures very much. You took subject matter out of our jurisdiction, and not only out of our jurisdiction, it didn't go into anybody else's. It never got debated in the House of Representatives until after the Senate kicked this bill back, and now we're having hearings on it. Don't you think we should have had these hearings before we had the provision included in the bill that we never got a chance to discuss, just a simple procedure?

Dr. DICKEY. I'm pleased to be here to have the hearings now. We felt that it was——

Mr. CONYERS. I said, in answer to my question, don't you think we should have done this before, rather than after?

Dr. DICKEY. I don't honestly have an opinion on how the process gets through the House, sir.

Mr. CONYERS. Well, then why did you make this recommendation that it skip the House?

Dr. DICKEY. Because the issue was very important that we have the issue as part of the Medicare reconciliation.

Mr. CONYERS. Must have been pretty important to skip 435 people from getting any discussion about it. But you've been very helpful, Dr. Dickey, and I appreciate your response, and I thank the chairman for allowing me a few extra moments.

Dr. DICKEY. Thank you.

Mr. HYDE. The gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman.

A ranking member is a hard act to follow on something like this. I'll try to be as exciting as he was.

Professor Havighurst, many doctors are concerned about limits on their ability to get together and negotiate fee reimbursements with health insurance companies or managed care groups. Would you explain what collective actions may be taken by physicians in these negotiations that do not run afoul of the antitrust laws independent of the guidelines?

Mr. HAVIGHURST. It is my sense that physicians acting individually as independent competitors have a hard time finding their places in this new world. They have to have contracts with lots of different purchasers, insurers, employers, and so on, and some collective action in making and maintaining these contracts probably is efficient. So I start with the proposition that some collective action is permissible. But it should not be caused to the point where they can exercise what we call market power, where they represent such a large portion of the business in the market that there isn't effective competition.

But I think appointing an agent to help you negotiate a contract with an employer or a large purchaser can itself be efficient and procompetitive and ought not to be condemned as a per se violation. And that's the essential starting point for my objection to the policies that have been in place for the last couple of years, which

say that doctors who form a network to negotiate for contracts necessarily violate the law unless they also share some financial stake in the overall performance of the group, or have integrated their practices in such a way that they can be characterized as offering a different product than their own separate services.

I thought that the conditions imposed by the agencies for relaxing the per se rule were too restrictive and leave out some potential efficiencies that should be recognized. Because all physicians networks can make a claim that the doctors are collaborating for procompetitive, efficiency-enhancing purposes, they all ought to be entitled to hearing under the rule of reason. Now sometimes you can apply the rule of reason very quickly. For example, if you see 80 percent of the doctors forming a network, it takes no time to conclude that's too big. We don't have to spend a lot of time collecting market data; we just say that's more market power than the group should exercise.

But if the group is small—say, 10 percent of the doctors in each specialty—I wouldn't see a threat to competition, especially if there are other plans in the market that are integrated, that do involve putting doctors at risk. This just adds to the mix in the marketplace and the purchasers can choose what they want to buy. And it seems to me that's where the decisions ought ultimately to be made, not by the antitrust agencies deciding which products are acceptable for offering in the marketplace. Unless they have a good reason to believe that competition would be harmed, I think they ought to let most anything try to fly.

Mr. MOORHEAD. You know, as I talk to people at home and at various places, doctors and others, one of the major concerns is that our medical profession is changing so rapidly. Many people because of costs at the hospital and the—are forced into HMO's whether they want to be or not. This legislation's goal, basically, is to make the total field more competitive and allow individual doctors to make it on their own with help from other people that are around. I know my own doctor just quit practicing medicine because he felt that there were so many strings on him that he couldn't compete in this atmosphere any more.

What can we do that meets the pleasure of the legal profession, the HMO's, and the medical profession that will make the field a little more even, so that people in the medical profession can compete, those that are independent and have had their lone practitioner offices for a long time?

Ms. Dickey, can you answer that?

Dr. DICKEY. Well, what we have suggested is that we again loosen the unreasonable constraints so that physicians can come together. It's important to note that a physician in general rarely has a single plan or a single contract, and so even if 50 percent of the physicians participate in a given plan, they may only have 3 percent of the patients under that plan. So what we would like to do is have the opportunity for physicians to come together and offer another choice, and many of those choices would be the opportunity to integrate into a network even as they keep their offices in the manner that you're used to going to see that office.

We think the same kinds of enforcement could occur that exists under today's rules; if there is a violation, if there's a boycott, if

there's overt price fixing, you could still go in and utilize the antitrust regulations as they currently exist. The problem is today that the rules have been so narrowly defined that many physicians are afraid to even talk about ways to come together, except for these very narrow definitions that Professor Havighurst has referred to. So there is a halfway in between, if you will, that will allow physicians to continue to practice, that will be a competitive advantage, more choice for patients, and at the same time not lead to price fixing, boycotting, and those kinds of behaviors.

Mr. MOORHEAD. I see my time is up, but I'd like Ms. Metzger to have a chance to make a comment.

Ms. METZGER. I would respond briefly. I think we would be very concerned that collective action without the kinds of forces—integration, risk sharing, or procompetitive efficiencies, the things that genuinely will assure that they don't lead to over utilization—that collective action without those indicia really are an invitation to mischief, and that it would be unfortunate and potentially disadvantageous. I guess we don't see the field as uneven as others do. Our view is that physicians have many choices, that the plans have to be competitive or employers won't choose them, and that plans are only as successful as they are attractive to employers and to individual members. And we think that in many cases that means broad provider networks. Certainly in our market that's the case, but we don't see the uneven balance in negotiating.

Mr. HYDE. The gentlelady from Colorado, Ms. Schroeder.

Ms. SCHROEDER. Thank you, Mr. Chairman. And Mr. Chairman, I'm going to be a sexist today, if you don't mind.

I was reading Ms. McKay's testimony and my past flashed in front of me, because I used to do pro bono work in Colorado before I got elected, and one of the things I was trying to do was get breast examinations on Indian reservations and the Ob/Gyn's would not allow nurses to do that. So we had a real problem. So as I came across your written testimony, the issue about physician boycotts against nurse anesthetists vis-a-vis the epidural blocks for women in labor in some of the rural areas, I would like for you to go through that for my colleagues, because if you are a woman in labor in a rural area, you might want to know about this unintended consequence of the antitrust law.

Ms. MCKAY. The situation that you speak of was in Montana and in Wyoming, and women were unable to obtain epidural blocks for pain management while giving childbirth because the hospital had contracted with a group of anesthesiologists. These are not terribly financially rewarding procedures because you put the block in and you have to monitor the patient for many hours before the baby is born. And the anesthesiologists were unwilling to provide the service. There were nurse anesthetists in the area that very much wanted the opportunity to provide the service, the patients wanted it, but they were boycotted and held out of the marketplace to provide this service.

And it was only use of the antitrust laws and the per se analysis that this was allowed to be set straight. Had there not been a per se analysis, and this had to be considered only under a rule of reason, it would have taken years to correct this situation so that the

women in Montana and in Wyoming could have their epidural blocks for child birth.

Ms. SCHROEDER. And, actually, those are situations that arose in rural areas but could arise anywhere?

Ms. MCKAY. They could arise anywhere, yes, they could.

Ms. SCHROEDER. Because the anesthesiologist doing one of these during child labor could be on call for a very long time. And what you're saying is that your hourly rate drops as labor increases.

Ms. MCKAY. That's correct. And nurse anesthetists, sort of our forte is long hours of monitoring our patients. We're with the patients from the time they go to sleep until they awaken. Unlike our physician colleagues, we're not in a supervisory role, so we're very comfortable with that role of staying with the patient and monitoring throughout the long labor process.

Ms. SCHROEDER. Well, I just hope all of my colleagues think about being in labor in Casper and finding out, guess what, we have no pain relief for you because the Congress changed the antitrust law.

Dr. Dickey, I wanted to ask you——

Mr. HYDE. Would the gentlelady yield?

Ms. SCHROEDER. Yes, I would.

Mr. HYDE. The gentlelady knows that pain builds character, doesn't she?

Ms. SCHROEDER. Mr. Chairman, I'm not sure in that situation. We could try a uterus transplant.

Mr. HYDE. We would never deny anesthesia or pain killers to anybody, gentlelady.

Ms. SCHROEDER. Good. Thank you, sir.

Dr. Dickey, one of the concerns I have about the $250,000 cap on noneconomic damages are damages to young women's reproductive systems. I find it rather harsh to say that that's not as valuable as somebody's ability to make a paycheck. And we really are. Because I have always found that loss of fertility or loss of your reproductive organs is one of the most important things that can happen to you. And that troubles me a lot. I think it does a lot of women. I understand noneconomic damages in a lot of places, but for reproductive loss, that to me is very serious, be it male or female. And I just wonder if the AMA has thought about that, if that really is the AMA's position, that your reproductive organs, be they male or female, are not worth as much as your ability to make a corporate paycheck?

Dr. DICKEY. If I may, first of all, I want to say that I think the kind of boycott that we're describing would continue to be illegal even under the legislation that is proposed; that boycotts are not an exception we are asking for. We don't think boycotts should occur, and whether they are boycotts against a select group or whether they are boycotts against a sector of the economy. Now in terms of the——

Ms. SCHROEDER. Well, maybe we should ask the law professor because I think what Ms. McKay was saying is, when you change it from per se to rule of reason, you're talking about a lot longer period of time to work it all out. And that may be what we're talking about. Meanwhile, if you're in labor, you're not really interested in a decision that will come down 5 years later.

Dr. DICKEY. Well, you're right. I had three babies and called the anesthesiologist first. I understand.

In terms of the $250,000 cap, I think taking care of my patients that there are many losses that can occur that it's very hard to put a set amount of money on. And part of the issue is there are some losses we can't make whole, whether we're talking about $250,000 or half a million, or three-quarters of a million dollars, but we have to look in terms of what this lottery mentality does to cost and process of medicine for all patients, and that does leave us, I think, with some concern, whether it's a loss of reproductive capacity or perhaps the loss of a limb.

But when we try to look at the system, what we've discovered is that we do damage in terms of spending excessive amounts of money for defensive medicine, in terms of physicians who refuse to participate in some parts of care delivery for fear of being sued, and where there has been a cap placed, though at times it's hard to, certainly no amount of money will replace the inability to have a family. The good of having a cap, so there's some predictability to it, is then shared with all patients.

Ms. SCHROEDER. I guess I just don't understand—why not a cap on pay then, too, if you're going to do that. Because if you're rich and you're getting a big paycheck, you continue to win and everybody else is considered de minimis, because with inflation this will soon be de minimis, I fear.

Mr. HYDE. I dislike—is the gentle lady through?

Ms. SCHROEDER. Sure.

Mr. HYDE. I didn't want to cut her off. OK.

The gentleman from Pennsylvania, Mr. Gekas.

Mr. GEKAS. Thank you. I was sitting back in awe and inspired by the gentleman from Michigan who nailed you to the wall, Ms. Dickey, on the nefarious editorial of the New York Times and the daring letter that the AMA sent to the Speaker making suggestions about the Medicare package. He was an astounding cross examiner because he has said to you that the New York Times, which is the bible to him for this inquiry, pointed out evil on the part of those who would talk to the Speaker about proposed changes in Medicare. I would wonder if he is, in the same context, defending the insurance companies.

The gentleman from Michigan, who has for years pounded against insurance companies over the years, is by implication, is he not, defending the insurance executives in this context? Or is he against them, too? And maybe I'll see you afterwards after I get some questions from Ms. Dickey.

Mr. CONYERS. I haven't asked you to yield yet.

Mr. GEKAS. Don't.

Mr. CONYERS. Will you yield? Will the gentleman yield? [Laughter.]

Mr. GEKAS. I will in time, but let me pose a question.

For instance, in the letter, this terrible letter, in daring to express your opinions and concerns, you have said that the AMA is also concerned regarding press reports about a plan that would put insurance executives in control, rather than patients and their physicians. That, to me, is a concern that many people, including patients, have expressed over the years. So in making some of these

expressions of concern to the Speaker, you are, in effect, in your minds at least, warding off some of the pressures that the insurance executives have put on and trying to advance the cause of patients. Is that a fair reading of that?

Dr. DICKEY. I think it's an excellent reading.

Mr. GEKAS. Then by implication that letter that you have sent to him, and being criticized by the New York Times, puts the gentleman from Michigan and the New York Times on the side of insurance executives. If we are to take everything you say as law that he wants to condemn, then that is a fair conclusion that I can draw.

Because I went to a different law school at a different time from the gentleman from Michigan, who is a close friend of mine—or he was up until now—I still am his friend.

Mr. CONYERS. Will the gentleman yield?

Mr. GEKAS. Yes, I'll yield. And then I'll ask for an extension of time.

Mr. CONYERS. It's ironic how you went straight to the heart of the weakness of my presentation and aligned me on the side of these multinational, worldwide, global, money-grabbing insurance companies. I was afraid somebody would discover this, and sure enough you did. But wouldn't it have been nicer for this discussion that Dr. Dickey gave this advice to the Speaker of the House to have appeared, instead of in an ex parte letter, that it would have come forward at a hearing like this where we could have all been on record?

Mr. GEKAS. Seizing back my time——

Mr. CONYERS. That was a question.

Mr. GEKAS. Were you aware that there was antitrust discussion during the Democrat-controlled Congress during the Clinton failed health care policy?

Dr. DICKEY. Numerous times in the last decade, sir.

Mr. GEKAS. And during that time, did you get any satisfaction from the Democratic leadership or from the gentleman from Michigan or others on the Judiciary Committee on a possible—or at least investigation of the possibility of loosening the choke of antitrust legislation?

Dr. DICKEY. In fact, our extensive conversations have led us here to this meeting to say we're not getting there through the regulatory process; can we please look at a legislative solution?

Mr. GEKAS. And you complained in the letter, not complained, but expressed concerns about the look-back provisions——

Dr. DICKEY. Yes, sir.

Mr. GEKAS [continuing]. About the education provisions, about price controls. How dare you try, as a representative of the medical association, speak to those issues? You're supposed to sit back and just take whatever this Congress throws at you on whatever whims we Members of Congress may have in that.

I wanted to ask you or Ms. McKay one question, but I guess my yielding has hurt me a little bit.

Mr. HYDE. No, go ahead.

Mr. GEKAS. One thing I don't understand. The nurse anesthetist who works at "X" hospital, is that individual an independent contractor or an employee of the hospital?

Ms. MCKAY. It can be either. There are CRNA's who compete directly, because they are independent contractors, and there are CRNA's who are hospital employees as well.

Mr. GEKAS. So a nurse anesthetist could bid against a anesthesiologist for a particular position, is that correct?

Ms. MCKAY. Yes, and we're very willing to compete like that. We need a level playing field to be able to do that. And because many times we feel that we've been the victims of price fixing and boycotts such as what I've described to you this morning, we feel that weakening the antitrust laws would make it impossible for us——

Mr. GEKAS. Aren't you saying to me something I'm missing, that in establishing your fee, the nurse anesthetist fee for working at the hospital, that that price is not fixed, it's not a general price established by nurse anesthetists?

Ms. MCKAY. No, it's not. If you're an independent contracting CRNA, you bid for the contract for the best price.

Mr. GEKAS. So if you have a bid against you by an anesthesiologist, that's price fixing if it's a lower bid?

Ms. MCKAY. No, but in many instances in the hospital discussions that we've had in Minnesota, hospitals were unwilling to accept a bid from a CRNA group. And all of these four hospitals where CRNA's were displaced from hospital employment, CRNA's formed groups and tried to submit a bid to the hospital and they were precluded from even bidding. The contract was given exclusively.

Mr. GEKAS. Well, I would defend your right to have that considered, but I thought you were saying that even in the face of the competitive bidding, if they chose a lower price figure, that that was price fixing per se.

Ms. MCKAY. There's no argument that nurse anesthetists are the lower cost providers in the field of anesthesia.

Mr. GEKAS. Are you saying then that in these instances that you quote that the anesthesiologists were getting the contract even though their prices were higher?

Ms. MCKAY. Yes, that's precisely what I'm saying. Anesthesiologists make four, five, six times as much money as a nurse anesthetist makes, and we felt that it did not make common sense to replace a nurse anesthetist, who is a lower cost provider, by awarding exclusive contracts to anesthesiologists, compelling us to be employees of our closest competitor. We don't feel that that is in the consumers' best interest; we feel that in the long run that will increase the prices.

Mr. HYDE. Has the gentleman exhausted his line of inquiry?

Mr. GEKAS. Yes, I'm exhausted, period.

Mr. HYDE. All right, thank you.

The gentleman from California, Mr. Berman.

Mr. BERMAN Thank you, Mr. Chairman.

I would like to follow up a little bit more with Ms. McKay because I was a little unclear about the relationship of the legislation to the problem you're discussing. You're talking about a series of practices in Minnesota essentially where you feel, and make a very plausible case, it sounds like sort of unfair competition and improper kinds of leverage to, in a sense, keep you from performing

your services in your traditional way or nurse anesthetists sort of led by the anesthesiologists. That's happening now?

Ms. MCKAY. Yes, it is.

Mr. BERMAN Under existing law?

Ms. MCKAY. Yes, it is. My only point, and the point that I've made in my testimony, is that the very best protection that nurse anesthetists have had is the antitrust laws, including the per se analysis. At the time we filed our lawsuit, virtually every hospital in the Twin Cities area was considering terminating their CRNA employees and compelling them to become employees of the anesthesiologists. After we have filed our lawsuit, that's been limited to four hospitals. Others have taken a wait-and-see attitude. And we feel that if you weaken the antitrust laws so we don't have an avenue for swift enforcement, that would be to our detriment. In fact, I think it would be to the detriment of all nonphysician providers as they try and compete.

Mr. BERMAN Swift enforcement, meaning the application of the per se rule.

Ms. MCKAY. Yes. As swift as that is.

Mr. BERMAN You can establish some conduct and then once they find that it violates the antitrust laws, then they enjoin it and compensate you for it. The hospitals stopped—once you filed your lawsuit.

Ms. MCKAY. And I think it was the threat that they might also see that kind of action if they proceeded. I think that the antitrust laws with the per se analysis, as it stands, is a very big deterrent to anticompetitive behavior. And I think to relax those laws you might see many more instances of anticompetitive behavior. The mere existence of them might prevent that some.

Mr. BERMAN Professor, speak to this. This sounds like, to the extent there is something about this bill that is going to change antitrust laws in a way that will allow that kind of activity to happen more readily, that seems like a bad idea. Could you respond?

Mr. HAVIGHURST. Yes. I don't know the Minnesota situation precisely; I've heard about it a little bit before this, but a boycott, if that's what was going on, where all the hospitals would agree to no longer deal with CRNA's, would be a per se violation. I don't see that this statute would change that. Even if one did apply the rule of reason, one could do it pretty quickly. There's no procompetitive justification for such an agreement. One would very quickly arrive at the conclusion that it's unlawful.

My problem with the bill is not that it would necessarily change significantly how we analyze any particular transaction, but I think it sends a message that somehow special rules ought to apply in the health care field or to doctors, and that Congress must have meant to change something. Some court may therefore think a more relaxed or softer antitrust rule is called for. It doesn't seem to me that that would be in the public interest. I don't know that that would happen, but I would think that the law, as it stands today, leaves plenty of room for distinguishing anticompetitive from the procompetitive collaboration.

Mr. BERMAN There's an interesting connection between this issue, which was presented earlier in the context of the Clinton comprehensive health care package and now again with the chair-

man's bill, and labor law. Labor unions are exempt from antitrust laws. To the extent that physicians are viewed as employees as opposed to independent professionals, they are allowed a certain greater level of concerted activity and working together in seeking to maximize their leverage.

I wonder to what extent in this particular situation they want one part of that tradeoff without the other part, because in some fashion there is nothing inherently wrong with physicians trying to take action to maximize their income or work rules on how they deliver medical care as long as it doesn't pose an unfair competition and end up with sort of moving it away from the marketplace.

Mr. HAVIGHURST. Well, the rule now is that, unless they are actually employees in the literal and explicit sense, they are subject to the antitrust laws. If they are employees, they could get some protection under labor laws and under the labor exemption in the Clayton Act.

Mr. HYDE. The gentleman's time has expired. Do you mind? Thank you.

The gentleman from Virginia.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Ms. Dickey, I'm stunned. My understanding is that you and five other practicing physicians wrote a letter to the Speaker of the House of Representatives after legislation had progressed beyond the committee level. Are you the first people ever to do that in the history of this Congress?

Dr. DICKEY. I certainly hope not.

Mr. GOODLATTE. I certainly suspect not, too. In fact, I get letters all the time from my constituents who write to the Speaker and send me copies. Let me encourage you to keep on doing that. In fact, you have a right to do that, and that right is defined in the first amendment of the U.S. Constitution.

Dr. DICKEY. Thank you.

Mr. GOODLATTE. I am surprised that the gentleman from Michigan would attack that right, but be that as it may.

Mr. CONYERS. Would the gentleman yield?

Mr. GOODLATTE. I will.

Mr. CONYERS. Thank you. I'm not attacking her right to petition the Congress. I'm questioning her suggesting how we could keep this out of the jurisdiction of the committee upon which you serve, which she succeeded in doing.

Mr. GOODLATTE. Let me follow on that further. Is that the first time to your knowledge that such efforts have taken place? Did that ever take place when Mr. Foley was Speaker of the House, that suggestions were made that legislation should be changed beyond the committee process so there would be change before a bill went to the floor? It seems to me that was done at the request of the President of the United States during the budget process in 1993.

Dr. DICKEY. We have taken many opportunities to address legislation at every level of its investigation, and had it come to a hearing, we would have been delighted to be here. At that point, we were past the hearing stage and still felt this was an appropriate issue.

Mr. GOODLATTE. So you've done that in a bipartisan way. You've not only done that with the current Speaker of the House, but with previous Speakers, and to the best of our knowledge, that's been done over the last previous 40 years with a great many Democratic Speakers by a great many individuals and organizations concerned that legislation coming through the Congress take into account their concerns before it is brought to the floor for a vote.

Dr. DICKEY. I suspect we've written more Democratic Speakers than Republican Speakers, sir.

Mr. GOODLATTE. I suspect that's true in your and my lifetime. Let me thank you and your organization for the support of my legislation, which I think is separate from this entire antitrust issue, but is also geared toward making sure that health care services are available to more people by assuring physicians and nurses, and others who provide free services, are not exposed to what could be an intolerable risk for any one individual to be exposed to, at the same making available to low income people, people who are above the level that qualify them from Medicaid, but often cannot afford health insurance, and I thank you for that support.

Ms. McKay, two questions for you. I'm not sure how much work in the free clinic area nurse anesthetists do, but nurses in general do a great deal of work. Do you have any thoughts on that legislation?

Ms. MCKAY. The legislation for volunteers? Actually, there are many nurse anesthetists that provide volunteer anesthesia in a lot of different areas and, yes, we would support your legislation.

Mr. GOODLATTE. Wonderful. Good.

Let me ask you one question in the antitrust area as well. Would the outcome of the matter that you referred to—and, by the way, I support expanded efforts for nurses of all specialties and practices to be able to provide services where that's economical to do so—would the outcome have been different if you had a rule-of-reason test under our antitrust laws and had been proceeding the same way you did, instead of a per se rule?

Ms. MCKAY. Well, obviously, I'm not attorney so I'm probably not the best person to ask. My understanding is that proceeding under a rule of reason would be much more costly and much more time-consuming because we would have years of discovery and production of expert witnesses, and markets and submarkets to prove. So my understanding is, yes, it would be perhaps a different outcome. The other thing is that antitrust cases are very, very expensive. To add more expense and more time to that, I think that you would find that it would become very difficult for individuals to bring antitrust cases.

Mr. GOODLATTE. Not being an attorney, if you have some background from the attorneys who are involved in that case or anything you would like to submit to us, I would like to see their arguments as to why this same outcome could not have been achieved with a rule-of-reason test, which is certainly intended to protect the very right that you were referring to.

Ms. MCKAY. OK.

Mr. GOODLATTE. Thank you.

Mr. HYDE. I thank the gentleman.

And the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

I had a couple of questions, one for Ms. Dickey about defensive medicine. Well, let me just ask it this way: you're suggesting that physicians are performing services that are not medically indicated?

Dr. DICKEY. No, we're talking about that grey area, particularly in today's marketplace, where from the prospective end I have all kinds of pressures to cut as close to the margin as I can in terms of doing only what's absolutely necessary, but, retrospectively, I have to answer for all of those things that might have changed the outcome, that might have changed my decisionmaking. So defensive medicine is doing those things that are in the margin of grey that says, Is it worth the cost to do another test? Will it increase my ability to diagnose?

And there's a new Stanford study, which we'll provide to the committee, that indicates that that costs us some $50 billion in tests that are not unindicated, but simply that some people would suggest to you the test costs more than the increase that it adds to the diagnostic process.

[The information follows:]

Exhibit 5

forthcoming, Quarterly Journal of Economics

Do Doctors Practice Defensive Medicine?*

Daniel Kessler and Mark McClellan

* We would like to thank Randall Bovbjerg, David Genesove, Jerry Hausman, Paul Joskow, Lawrence Katz, W. Page Keeton, Gary King, A. Mitchell Polinsky, George Shepherd, Frank Sloan, seminar participants at Michigan, Northwestern, and NBER, and two anonomous referees for advice, assistance, and helpful comments. Jeffrey Geppert and Mohan Ramanujan provided excellent research assistance. Funding from the Harvard/MIT Research Training Group in Positive Political Economy, the John M. Olin Foundation, and the National Institute on Aging is greatly appreciated. All errors are our own.

Abstract

"Defensive medicine" is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies many times greater than the costs of compensating malpractice claimants. To obtain empirical evidence on this question, we analyze the effects of malpractice liability reforms using data on all elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990. We find that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications. We conclude that liability reforms can reduce defensive medical practices.

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Introduction

The medical malpractice liability system has two principal roles: providing redress to individuals who suffer negligent injuries, and creating incentives for doctors to provide appropriately careful treatment to their patients [Bell 1984]. Malpractice law seeks to accomplish these goals by penalizing physicians whose negligence causes an adverse patient health outcome, and using these penalties to compensate the injured patients [Danzon 1985]. However, considerable evidence indicates that the current malpractice system is neither sensitive nor specific in providing compensation. For example, the Harvard Medical Practice Study [1990] found that sixteen times as many patients suffered an injury from negligent medical care as received compensation in New York State in 1984. And, in any event, the cost of compensating malpractice claimants is not an important source of medical expenditure growth: compensation paid and the costs of administering that compensation through the legal system account for less than one percent of expenditures [OTA 1993].

The effects of the malpractice system on physician behavior, in contrast, may have much more substantial effects on health care costs and outcomes, even though virtually all physicians are fully insured against the financial costs of malpractice such as damages and legal defense expenses. Physicians may employ costly precautionary treatments in order to avoid nonfinancial penalties such as fear of reputational harm, decreased self-esteem from adverse publicity, and the time and unpleasantness of defending a claim [Charles, Pyskoty, and Nelson 1988; Weiler et al. 1993].

On one hand, these penalties for malpractice may deter doctors and other providers from

putting patients at excessive ris. of adverse health outcomes. On the other hand, these penalties may also drive physicians to be too careful -- to administer precautionary treatments with minimal expected medical benefit out of fear of legal liability -- and thus to practice "defensive medicine." Many physicians and policymakers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for a substantial portion of the explosive growth in health care costs [Reynolds, Rizzo, and Gonzalez 1987; OTA 1993, 1994]. The practice of defensive medicine may even have adverse effects on patient health outcomes, if liability induces providers either to administer harmful treatments or forego risky but beneficial ones. For these reasons, defensive medicine is a crucial policy concern [Sloan, Mergenhagen, and Bovbjerg 1991].

Despite this policy importance, there is virtually no direct evidence on the existence and magnitude of defensive medical practices. Such evidence is essential for determining appropriate tort liability policy. In this paper, we seek to provide such direct evidence on the prevalence of defensive medicine by examining the link between medical malpractice tort law, treatment intensity, and patient outcomes. We use longitudinal data on all elderly Medicare recipients hospitalized for treatment of a new heart attack (acute myocardial infarction, or AMI) or of new ischemic heart disease (IHD) in 1984, 1987, and 1990, matched with information on tort laws from the state in which the patient was treated. We study the effect of tort law reforms on total hospital expenditures on the patient in the year after AMI to measure intensity of treatment. We also model the effect of tort law reforms on important patient outcomes. We estimate the effect of reforms on a serious adverse outcome that is common in our study

population: mortality within one year of occurrence of the cardiac illness. We also estimate the effect of tort reforms on two other common adverse outcomes related to a patient's quality of life: whether the patient experienced a subsequent AMI or other cardiac illness requiring hospitalization in the year following the initial illness.

To the extent that reductions in medical malpractice tort liability are associated with decreases in intensity but not with increases in adverse health outcomes, medical care for these health problems is defensive – that is, doctors supply a socially excessive level of care due to malpractice liability pressures. Put another way, tort reforms that reduce liability also reduce inefficiency in the medical care delivery system to the extent that they reduce health expenditures that do not provide commensurate benefits. We assess the magnitude of defensive treatment behavior by calculating the cost of an additional year of life or an additional year of cardiac health achieved through treatment intensity induced by specific aspects of the liability system. If liability-induced precaution results in low expenditures per life saved relative to generally accepted costs per life of other medical treatments, then the existing liability system provides incentives for efficient care; but if liability-induced precaution results in high expenditures per life saved, then the liability system provides incentives for socially excessive care. Because the precision with which we measure the consequences of reforms is critical, we include all U.S. elderly patients with heart diseases in 1984, 1987, and 1990 in our analysis.

The first section of the paper discusses the theoretical ambiguity of the impact of the current liability system on efficiency in health care. For this reason, liability policy should be guided by empirical evidence on its consequences for "due care" in medical practice. The second section reviews the previous empirical literature. Though the existing evidence on the

effectiveness of alternative liability rules has provided considerable insights, direct evidence on the crucial effects of the tort system on physician behavior is virtually nonexistent. The third section presents our econometric models of the effects of liability rules on treatment decisions, costs, and patient outcomes, and formally describes the test for defensive medicine used in the paper. We identify liability effects by comparing trends in treatment choice, costs, and outcomes in states adopting various liability reforms to trends in those that did not; we also review a number of approaches to enriching the model, assisting in the evaluation of its statistical validity and providing further insights into the tort reform effects. The fourth section discusses the details of our data, and motivates our analysis of elderly Medicare beneficiaries for purposes of assessing the costs of defensive medicine. The fifth section presents the empirical results. The sixth section discusses implications for policy, and the last section concludes.

I. Malpractice Liability and Efficient Precaution In Health Care

In general, malpractice claims are adjudicated in state courts according to state laws. These laws require three elements for a successful claim. First, the claimant must show that the patient actually suffered an adverse event. Second, a successful malpractice claimant must establish that the provider caused the event: the claimant must attribute the injury to the action or inaction of the provider, as opposed to nature. Third, a successful claimant must show that the provider was negligent. Stated simply, this entails showing that the provider took less care than that which is customarily practiced by the average member of profession in good standing, given the circumstances of the doctor and the patient [Keeton et al. 1984]. Collectively, this three-part test of the validity of a malpractice claim is known as the "negligence rule."

In addition to patient compensation, the principal role of the liability system is to induce doctors to take the optimal level of precaution against patient injury. However, a negligence rule may lead doctors to take socially insufficient precaution, such that the marginal social benefit of precaution would be greater than the marginal social cost; or, it may lead doctors to take socially excessive precaution -- that is, to practice defensive medicine – such that the marginal social benefit of precaution would be less than the marginal social cost [Farber and White 1991]. The negligence rule may not generate socially optimal behavior in health care because the private incentives for precaution facing doctors and patients differ from the social incentives. First, the costs of accidents borne by the physician differ from the social costs of accidents. Because malpractice insurance is not strongly experience rated [Sloan 1990], physicians bear little of the costs of patient injuries from malpractice; however, physicians bear significant uninsured expenses in response to a malpractice claim, such as the value of time and emotional energy spent on legal defense [OTA 1993: 7]. Second, patients and physicians bear little of the costs of medical care associated with physician precaution in any particular case because most health care is financed through health insurance and because physicians may not be perfect agents for the managers of the organizations in which they practice [McClellan 1995]. Generally, insured expenses for drugs, diagnostic tests, and other services performed for precautionary purposes are much larger than the uninsured cost of the physician's own effort. Third, physicians only bear substantial costs of accidents when patients file claims, and patients may not file a malpractice claim in response to every negligent medical injury [Harvard Medical Practice Study 1990].

The direction and extent of the divergence between the privately and socially optimal levels of precaution depends in part on states' legal environments. Although the basic

framework of the negligence rule applies to most medical malpractice claims in the United States, individual states have modified their tort law to either expand or limit malpractice liability along various dimensions over the past 30 years. For example, several states have imposed caps on malpractice damages such that recoverable losses are limited to a fixed dollar amount, such as $250,000. These modifications to the basic negligence rule can affect both the costs to physicians and the benefits to patients from a given malpractice claim or lawsuit, and thereby also affect the frequency and average settlement amount ("severity") of claims. We use the term *malpractice pressure* to describe the extent to which a state's legal environment provides high benefits to plaintiffs and/or high costs to physicians (Malpractice pressure can be multidimensional.)

If the legal environment creates little malpractice pressure and externalized costs of medical treatment are small, then the privately optimal care choice may be below the social optimum. In this case, low benefits from filing malpractice claims and lawsuits reduce nonpecuniary costs of accidents for physicians, who may then take less care than the low cost of diagnostic tests, for example, would warrant. However, if the legal environment creates substantial malpractice pressure and externalized costs of treatment are large, then the privately optimal care choice may be above the social optimum: privately chosen care decisions will be defensive. For example, increasing technological intensity (with a reduced share of physician effort costs relative to total medical care costs) and increasing generosity of tort compensation of medical injury would lead to relatively more defensive medical practice.

Incentives to practice defensively may be intensified if judges and juries impose liability with error. For example, the fact that health care providers' precautionary behavior may be ex

post difficult to verify may give them the incentive to take too much care [Coot r and Ulen 1986, Craswell and Calfee 1986]. Excessive care results from the all-or-nothing nature of the liability decision: small increases in precaution above the optimal level may result in large decreases in expected liability.

Because privately optimal behavior under the basic negligence rule may result in medical treatment that has marginal social benefits either greater or less than the marginal social costs, the level of malpractice pressure that provides appropriate incentives is an empirical question. In theory, marginal changes to the negligence rule can either improve or reduce efficiency, depending on their effects on precautionary behavior, total health care costs, and adverse health outcomes. Previous studies have analyzed effects of legal reforms on measures of malpractice pressure, such as the level of compensation paid malpractice claimants. To address the potentially much larger behavioral consequences of malpractice pressure, we study the impact of changes in the legal environment on health care expenditures to measure the marginal social cost of treatment induced by the liability system, and the impact of law changes on adverse health events to measure the marginal social benefit of law-induced treatment. As a result, we can provide direct evidence on the efficiency of a baseline malpractice system and, if it is inefficient, identify efficiency-improving reforms.

II. Previous Empirical Literature

The previous empirical literature is consistent with the hypothesis that providers practice defensive medicine, although it does not provide direct evidence on the existence or magnitude of the problem. One arm of the literature uses surveys of physicians to assess whether doctors

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practice defensive medicine [Reynolds, Rizzo, and Gonzalez 1987; Moser and Musaccio 1991; OTA 1994]. Such physician surveys measure the cost of defensive medicine only with further untestable assumptions about the relationship between survey responses, actual treatment behavior, and patient outcomes. Although surveys indicate that doctors believe that they practice defensively, surveys only provide information about what treatments doctors say that they would administer in a hypothetical situation; they do not measure behavior in real situations.

Another body of work uses clinical studies of the effectiveness of intensive treatment [Leveno et al. 1986; Shy et al. 1990]. These studies find that certain intensive treatments which are generally thought to be used defensively have an insignificant impact on health outcomes. Similarly, clinical evaluations of malpractice control policies at specific hospitals have found that intensive treatments thought to serve a defensive purpose are "overused" by physicians [Masters et al. 1987]. However, this work does not directly answer the policy question of interest: does intensive treatment *administered out of fear of malpractice claims* have any effect on patient outcomes? Few medical technologies in general use have been shown to be ineffective in all applications, and the average effect of a procedure in a population may be quite different from its effect at the margin, for example in the additional patients who receive it because of more stringent liability rules [McClellan 1995]. Evaluating malpractice liability reforms requires evidence on the effectiveness of intensive treatment in the "marginal" patients.

A third, well-developed arm of the literature estimates the effects of changes in the legal environment on measures of the compensation paid and the frequency of malpractice claims. Danzon [1982, 1986] and Sloan, Mergenhagen, and Bovbjerg [1989] find that tort reforms that

cap physicians' liability at some maximum level or require awards in malpractice cases to be offset by the amount of compensation received by patients from collateral sources[1] reduce payments per claim.[2] Danzon [1986] also finds that collateral-source-rule reforms and statute-of-limitations reductions reduce claim frequency. Based on data from malpractice insurance markets, Zuckerman, Bovbjerg, and Sloan [1990] and Barker [1992] find similar results: Zuckerman, Bovbjerg, and Sloan find that caps on damages and statute-of-limitations reductions reduce malpractice premiums, and Barker finds that caps on damages increase profitability.

Despite significant variety in data and methods, this literature contains an important unified message about the types of legal reforms that affect physicians' incentives. The two reforms most commonly found to reduce payments to and the frequency of claims, caps on damages and collateral source rule reforms, share a common property: they *directly* reduce expected malpractice awards. Caps on damages truncate the distribution of awards; mandatory collateral source offsets shift down its mean. Other malpractice reforms that only affect malpractice awards *indirectly*, such as reforms imposing mandatory periodic payments (which require damages in certain cases to be disbursed in the form of annuity that pays out over time) or statute-of-limitations reductions, have had a less discernable impact on liability and hence on malpractice pressure.

However, estimates of the impact of reforms on frequency and severity from these analyses are only the first step toward answering the policy question of interest: do doctors practice defensive medicine? Taken alone, they only provide evidence of the effects of legal reforms on doctors' incentives; they do not provide evidence of the effects of legal reforms on doctors' behavior. Identifying the existence of defensive treatment practices and the extent of

inefficie t precaution due to legal liability requires a comparison of the response of costs of precaution and the response of losses from adverse events to changes in the legal environment.

A number of studies have sought to investigate physicians' behavioral response to malpractice pressure. These studies generally have analyzed the costs of defensive medicine by relating physicians' actual exposure to malpractice claims to clinical practices and patient outcomes [Rock 1988; Harvard Medical Practice Study 1990; Localio et al. 1993; Baldwin et al. 1995]. Rock, Localio et al., and the Harvard Medical Practice Study find results consistent with defensive medicine; Baldwin et al. do not. However, concerns about unobserved heterogeneity across providers and across small geographic areas qualify the results of all of these studies. The studies used frequency of claims or magnitude of insurance premiums at the level of individual doctors, hospitals, or areas within a single state over a limited time period to measure malpractice pressure. Because malpractice laws within a state at a given time are constant, the measures of malpractice pressure used in these studies arose not from laws but from primarily unobserved factors at the level of individual providers or small areas, creating a potentially serious problem of selection bias. For example, the claims frequency or insurance premiums of a particular provider or area may be relatively high because the provider is relatively low quality, because the patients are particularly sick (and hence prone to adverse outcomes), because the patients had more "taste" for medical interventions (and hence more likely to disagree with their provider about management decisions), or because of many other factors; the sources of the variation in legal environment are unclear and probably multifactorial. All of these factors are extremely difficult to capture fully in observational datasets, and could lead to an apparent but noncausal association between measured malpractice pressure and treatment

decisions or outcomes.

Thus, while previous analyses have provided a range of insights about the malpractice liability system, they have not provided direct empirical evidence on how malpractice reforms would actually affect physician behavior, medical costs, and health outcomes.

III. Econometric Models

Our statistical methods seek to measure the effects of changes in an identifiable source of variation in malpractice pressure influencing medical decision making -- state tort laws -- that is not related to unobserved heterogeneity across patients and providers. We compare time trends across reforming and nonreforming states during a seven-year period in inpatient hospital expenditures, and in outcome measures including all-cause cardiac mortality as well as the occurrence of cardiac complications directly related to quality of life. We model average expenditures and outcomes as essentially nonparametric functions of patient demographic characteristics, state legal and political characteristics, and state- and time-fixed-effects. We model the effects of state tort law changes as differences in time trends before and after the tort law changes. We test for the existence and magnitude of defensive medicine based on the relationship of the law-change effects on medical expenditures and health outcomes.

While this strategy fundamentally involves differences-in-differences between reforming and nonreforming states to identify effects, we modify conventional differences-in-differences estimation strategies in several ways. First, as noted above, our models include no potentially restrictive parametric or distributional assumptions about functional forms for expenditures or health outcomes. Second, we do not model reforms as simple one-time shifts. Malpractice

reforms might have more complex, longer-term effects on medical practices for a number of reasons. Law changes may not have instantaneous effects because it may take time for lawyers, physicians, and patients to learn about their consequences for liability, and then to reestablish equilibrium practices. Law changes may affect not only the static climate of medical decision making, but also the climate for further medical interventions by reducing pressure for technological intensity growth. Thus, the long-term consequences of reforms may be different from their short-term effects. By using a panel dataset including a seven-year panel, our modeling framework permits a more robust analysis of differences in *time trends* before and after adoption.

We use a panel-data framework with observations on successive cohorts of heart disease patients for estimating the prevalence of defensive medicine. In state s = 1...S during year t = 1...T, our observational units consist of individuals I=1...N_{st} who are hospitalized with new occurrences of particular illnesses such as a heart attack. Each patient has observable characteristics X_{ist}, which we describe as a fully-interacted set of binary variables, as well as many unobservable characteristics that also influence both treatment decisions and outcomes. The individual receives treatment of aggregate intensity R_{ist}, where R denotes total hospital expenditures in the year after the health event. The patient has a health outcome O_{ist}, possibly affected by the intensity of treatment received, where a higher value denotes a more adverse outcome (O is binary in our models).

We define state tort systems in effect at the time of each individual's health event based on the existence of two categories of reforms from a maximum-liability regime: direct and indirect malpractice reforms. Previous studies, summarized in Section II, found differences

between these types of reforms on claims behavior and malpractice insurance premiums (Section IV below discusses our reform classification in detail). We denote the existence of direct reforms in state s at time t using two binary variables L_{1st}: L_{1st}=1 if state s has adopted a direct reform at time t, and L_{2st}=1 if state s has adopted an indirect reform at time t.

We first estimate linear models of average expenditure and outcome effects using these individual-level variables. The expenditure models are of the form

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}\phi_m + v_{ist} , \qquad (1)$$

where θ_t is a time fixed-effect, α_s is a state fixed-effect, X_{ist} is a fully-interacted vector of binary variables describing observable individual characteristics, W_{st} is a vector of variables describing the legal-political environment of the state over time, β and γ are vectors of the corresponding average-effect estimates for the demographic controls and additional state-time controls, L_{st} is a two-dimensional binary vector describing the existence of malpractice reforms, ϕ_m is the two-dimensional average effect of malpractice reforms on growth rate, and v_{ist} is a mean-zero independently-distributed error term with $E(v_{ist} | X_{ist}, L_{st}) = 0$. Because legal reforms may affect both the level and the growth rate of expenditures, we estimate different baseline time trends θ_t for states adopting reforms before 1985 (which were generally adopted before 1980) and nonadopting states. Our dataset includes essentially all elderly patients hospitalized with the heart diseases of interest for the years of our study, so that our results describe the actual average differences in trends associated with malpractice reforms in the U.S. elderly population. We report standard errors for inferences about average differences that might arise in potential populations (e.g., elderly patients with these health problems in other years). Our model

assumes that patients grouped at the level of state and time have similar distributions of unobservable characteristics that influence medical treatments and health outcomes. Assuming that malpractice laws affect malpractice pressure, but does not directly affect patient expenditures or outcomes, then the coefficients ϕ identify the average effects of changes in malpractice pressure resulting from malpractice reforms.

To distinguish short-term and long-term effects of legal reforms, we estimated less restrictive models of the average effects of legal reforms that utilize the long duration of our panel. These "dynamic" models estimate separate growth rate effects ϕ_{md} based on time-since-adoption:

$$R_{ist} = \theta_t + \alpha_s + X_{ist}\beta + W_{st}\gamma + L_{st}d_{st}\phi_{md} + v_{ist} \qquad (2)$$

where we include separate short-term average effects ϕ_{m0} and long-term average effects ϕ_{m1}. We estimate the short-term effect of the law (within two years of adoption) ϕ_{m0} by setting $d_{st0}=1$ for 1985-87 adopters in 1987 and 1988-90 adopters in 1990, and we estimate the long-term effect (three to five years since adoption) ϕ_{m1} by setting $d_{st1}=1$ for 1985-87 adopters in 1990.

The estimated average effects ϕ_{md} in these models form the basis for tests of the effects of malpractice reforms on health care expenditures and outcomes, and thus for tests of the existence and magnitude of defensive medicine. In all of these models, there is strong evidence of defensive medicine if, for direct or indirect reforms m, $\phi_{md}<0$ in our models of medical expenditures and $\phi_{md}=0$ in our models of health outcomes. In other words, if a state law reform is associated with a reduction in the growth rate of intensive treatment use and does not adversely affect the growth rate of adverse health outcomes through its impact on treatment

decisions, then malpractice pressure is too high from the perspective of social welfare and defensive medicine exists. More generally, defensive medicine exists if the effect of malpractice reforms on expenditures is "large" relative to the effect on health outcomes. Thus, in the results that follow, we test both whether expenditure and outcome effects of reforms differ substantially from zero, as well as the ratio of expenditure to outcome effects.

The power of the test for defensive medicine depends on the statistical precision of the estimated effects of law reforms on outcomes; consequently, we evaluate the confidence intervals surrounding our estimates of outcome effects carefully.[3] It is not feasible to collect information on *all* health outcomes that may matter to some degree to individual patients. Instead, our tests focus on important health outcomes, including mortality and significant cardiac complications, which are reliably observed in our study population. Because the cardiac complications we consider reflect the two principal ways in which poorly-treated heart disease would affect quality of life (e.g., through further chest pain symptoms or through impaired cardiac function), estimates of effects on these health outcomes along with mortality would presumably capture any substantial health consequences of malpractice reforms.

We estimated additional specifications of our models to test whether reform adoption is not in fact correlated with unobserved trends in malpractice pressures or patient characteristics across the state-time groups. One set of specification tests was based on the inclusion of random effects for state-time interactions or the use of Huber-White standard error corrections to account for any important error correlations arising after accounting for state and time effects, i.e., within state-time cells.[4]

Another set of specification tests involved evaluating a range of variables W_{it}

summarizing the political and regulatory environment in each state at each point in time, to test whether various factors that might influence reform adoption influence our estimates of reform effects on either expenditure or health outcomes. Since the main cause of the tort reforms that are the focus of our study was nationwide crisis in all lines of commercial casualty insurance, it is unlikely that endogeneity of reforms is a serious problem [Priest 1987; Rabin 1988]. However, Campbell, Kessler, and Shepherd [1996] show that the concentration of physicians and lawyers in a state and measures of states' political environment are correlated with liability reforms, and Danzon [1982] shows that the concentration of lawyers in a state are correlated with both the compensation paid to malpractice claims and the enactment of reforms.[5] Consequently, we control for the political party of each state's governor, the majority political party of each house of each state's legislature, and lawyers per capita in all of the regressions.[6]

A third set of specification tests relied on other tort reforms enacted in the 1980s which would not be expected to have much impact on malpractice liability cases in the elderly during the time frame of our study. However, these reforms might be correlated with relevant malpractice reforms, for example if general concerns about liability pressures in all industries led to broad legal reforms. If such reforms were correlated with included reforms, then our estimates might overstate the impact of the malpractice law reforms that we analyze.

Although results from the malpractice-claim studies discussed above suggest that these omitted reforms are unimportant relative to reforms with a more direct effect on awards, we investigate the validity of our assumption of no omitted variable bias by estimating the impact of reforms to states' statutes of limitations. Statutes of limitations are most relevant in situations involving latent injuries; malpractice arising out of AMI in the elderly would involve an injury

the adverse consequences of which would appear before any statute of limitations would exclude an injured patient. Nonetheless, statutes of limitations are the potentially most important reform not included in our study (23 states shortened their statutes of limitations between 1985 and 1990, and Danzon [1986] found shorter statutes of limitations to reduce claims frequency). If our models are correctly specified, then statute of limitations reforms should have no effect on the treatment intensity and outcome decisions that we analyze; if omitted variable bias is a problem, however, statute of limitations reforms may show a significant estimated effect.

Finally, because all of our specifications control for fixed differences across states, they do not allow us to estimate differences in the baseline levels of intensive treatment and adverse health outcomes. Thus, we also estimate additional versions of all of our models with region effects only, to explore baseline differences in treatment rates, costs, and outcomes across legal regimes.

IV. Data

The data used in our analysis come from two principal sources.[7] Our information on the characteristics, expenditures, and outcomes for elderly Medicare beneficiaries with heart disease are derived from comprehensive longitudinal claims data for the vast majority of elderly Medicare beneficiaries who were admitted to a hospital with a new primary diagnosis (no admission with a either health problem in the preceding year) of either acute myocardial infarction (AMI) or ischemic heart disease (IHD) in 1984, 1987, and 1990. Data on patient demographic characteristics were obtained from the Health Care Financing Administration HISKEW enrollment files, with death dates based on death reports validated by the Social

Security Administration. Measures of total one-year hospital expenditures were obtained by adding up all reimbursement to acute-care hospitals (including copayments and deductibles not paid by Medicare) from insurance claims for all hospitalizations in the year following each patient's initial admission for AMI or IHD. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers) in the year following the patient's initial admission. Cardiac complications included rehospitalizations within one year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure. Treatment of IHD and AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of heart failure requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequences. The programming rules used in the data set creation process and sample exclusion criteria were virtually identical to those reported in McClellan and Newhouse [1995a , 1995b].

We analyze cardiac disease patients because the choice of a particular set of diagnoses permits detailed exploration of the health and treatment consequences of policy reforms. Cardiac disease and its complications are the leading cause of medical expenditures and mortality in the United States. A majority of AMIs and IHD hospitalizations occur in the elderly, and both mortality and subsequent cardiac complications are relatively common occurrences in this population. Thus, this condition provides both a relatively homogeneous set of patients and outcomes (to analyze the presence of defensive medicine with reasonable clinical detail), and medical expenditures are large enough and the relevant adverse outcomes common enough that the test for defensive medicine can be a precise one. Furthermore, because AMI is

essentially a more severe form of the same underlying illness as is IHD, we can assess whether reforms affect more or less severe cases of a health problem differently by comparing AMI to IHD patients.

In addition, cardiovascular illness is likely to be sensitive to defensive medical practices. In a ranking of illnesses by the frequency of and payments to the malpractice claims that they generate, AMI is the third-most prevalent and costly, behind only malignant breast cancer and brain-damaged infants [PIAA 1993]. AMI is also distinctive because of the severity of medical injury associated with malpractice claims: conditional on a claim, patients with AMI suffer injury that rates 8.2 on the National Association of Insurance Commissioners nine-point severity scale, the second-highest severity rating of any malpractice-claim-generating health problem [PIAA 1993]. Cardiovascular illnesses and associated procedures also include 7 of the 40 most prevalent and costly malpractice-claim-generating health problems [PIAA 1993].

We focus on elderly patients in part because no comparable longitudinal microdata exists for nonelderly U.S. patient populations. However, there are other advantages to concentrating on this population. Several studies have documented that claims rates are lower in the elderly than in the nonelderly population, presumably because losses from severe injuries would be smaller given the patients' shorter expected survival [Weiler et al. 1993]. This hypothesis suggests that physicians are least likely to practice defensively for elderly patients; thus, treatment decisions and expenditures in this population would be the least sensitive to legal reforms. Similarly, relatively low baseline incentives for defensive practices and the relatively high frequency of adverse outcomes in the elderly implies that this population can provide the most sensitive tests for adverse health effects of reforms. These considerations suggest that

analysis of elderly patients provides a lower bound on the costs of defensive medicine. In any event, trends in practice patterns over time have been similar for elderly and nonelderly patients (e.g., intensity of treatment have increased dramatically and survival rates have improved for both groups, National Center for Health Statistics [1994]); thus, we would expect the findings for this population to be qualitatively similar to results for the nonelderly, were such a longitudinal empirical analysis possible.

Table 1 describes the elderly population with AMI and IHD from the years of our study. Between 1984 and 1990, the elderly AMI population aged slightly and the share of males in the IHD population increased slightly, but the characteristics of AMI and IHD patients were otherwise relatively stable. The number of AMI patients in an annual cohort declined slightly (from 233,000 to 221,000) while the number of IHD patients increased (from 357,000 to 423,000). Changes in real hospital expenditures in the year following the AMI or IHD event were dramatic, for example, one-year average hospital expenditures for AMI patients rose from $10,880 in 1984 to $13,140 in 1990 (in constant 1991 dollars), a real growth rate of around 4 percent per year. These expenditure trends are primarily attributable to changes in intensity; because of Medicare's "prospective" hospital payment system, reimbursement given treatment choice for Medicare patients actually declined during this period. This growth in expenditures and treatment intensity was associated with significant mortality reductions, from 39.9 percent to 35.3 percent for AMI patients (with the bulk of the reduction coming after 1987) and from 13.5 percent to 10.8 percent for IHD patients (with the bulk coming before 1987). However, the AMI survival improvements -- but not the IHD improvements -- were associated with corresponding increases in recurrent AMIs and in heart failure complications. This underscores that the role of

changes in intensity versus other factors – as well as any role of changes in liability -- in all of these trends is difficult to identify directly.

Second, building on prior efforts to collect information on state malpractice laws (e.g., Sloan, Mergenhagen, and Bovbjerg [1989]), we have compiled a comprehensive database on reforms to state liability laws and state malpractice-control policies that contain information on several types of legal reforms from 1969 to 1992.[8] The legal regime indicator variables are defined such that the level of liability imposed on defendants in the baseline is at a hypothetical maximum.[9]

Eight characteristics of state malpractice law, representing divergences from the baseline legal regime, are summarized in Table 2A. We divide these eight reforms into two groups of four reforms each: reforms that directly reduce malpractice awards and reforms that only reduce awards indirectly. "Direct" reforms include reforms that truncate the upper tail of the distribution of awards, such as caps on damages and the abolition of punitive damages, and reforms that shift down the mean of the distribution, such as collateral-source rule reform and abolition of mandatory prejudgment interest. "Indirect" reforms include other reforms that have been hypothesized to reduce malpractice pressure but only affect awards indirectly, for instance through restricting the range of contracts that can be enforced between plaintiffs and contingency-fee attorneys. As discussed in Section II above, we chose this division because the previous empirical literature generally found the impact of direct reforms to be larger than the impact of indirect reforms on physicians' incentives through their effect on the compensation paid and the frequency of malpractice claims. Each of the observations in the Medicare data set was matched with a set of two tort law variables that indicated the presence or absence of direct

or indirect malpractice reforms at the time of their initial hospitalization.

Table 2B contains the effective dates for the adoption of direct and indirect reforms for each of the 50 states. The table shows that a number of states have implemented legal reforms at different times. For example, 13 states never adopted any direct reforms, 23 states adopted direct reforms between 1985 and 1990, and 18 states adopted direct reforms 1984 or earlier (adoptions plus nonadoptions exceed 50 because some states adopted both before and after 1985). Similarly, 16 states never adopted any indirect reforms, 22 states adopted indirect reforms between 1985 and 1990, and 18 states adopted indirect reforms 1984 or earlier. Adoption of direct and indirect reforms is not strongly related; 16 states that never adopted reforms of one type have adopted reforms of the other.

V. Empirical Results

Table 3 previews our basic difference-in-difference (DD) analysis by reporting unadjusted conditional means for expenditures and mortality for four patient groups, based on the timing of malpractice reforms. Expenditure levels in 1984 (our base year) were slightly higher in states passing reforms between 1985-87 and lower in states passing reforms between 1988-90. Baseline mortality rates were slightly lower for AMI and higher for IHD in the 1985-87 reform states, and conversely for the 1988-90 reform states. Thus, overall, reform states looked very similar to nonreform states in terms of baseline expenditures and outcomes. States with earlier reforms (pre-1985) had slightly higher base year expenditures but similar base year mortality rates. The table shows that expenditure growth in reform states was smaller than in nonreform states during the study years; altogether, growth was two to six percent slower in the

reform compared to the nonreform states for AMI, and trend differences were slightly greater for IHD. Though mortality trends differed somewhat across the state groups, mortality trends on average were quite similar for reform and nonreform states. These simple comparisons do not account for any differences in trends in patient characteristics across the state groups, do not account for any effects of other correlated reforms, and do not readily permit analysis of dynamic malpractice reform effects. Nonetheless, they anticipate the principal estimation results that follow.

Table 4 presents estimates of a standard DD specification of the effects of tort reforms between 1985 and 1990 on average expenditures and outcomes for AMI; that is, no dynamic reform effects are included. In this and subsequent models, we include fully-interacted demographic effects -- for patient age (65-69, 70-74, 75-79, 80-89, 90-99), gender, black or nonblack race, and urban or rural residence -- and controls for contemporaneous political and regulatory changes described previously. For each of the four outcomes -- one-year hospital expenditures, mortality, and AMI and CHF readmissions -- two sets of models are reported. The first set includes complete state and year fixed effects. The second set, intended to illustrate the average differences of states that had adopted reforms before our study began as well as the sensitivity of the results to a more complete fixed-effect specification, includes only time and region effects. As described in Section II, both specifications are linear, the dependent variable in the expenditure models is logged, all coefficient estimates are multiplied by 100 and so can be interpreted as average effects in percent (for expenditure models) or percentage points (for outcomes models), and the standard errors are corrected for heteroskedasticity and grouping at the state/zip-code level.

The estimates of average expenditure growth rates in both specifications are substantial, showing an increase in real expenditures of over 21 percent between 1984 and 1990. The estimated DD effects show that expenditures declined by 5.3 percent relative to nonreform states in states that adopted direct reforms. The corresponding DD estimate of the effect of indirect reforms, 1.8 percent, is positive but small; these reforms do not appear to have a substantial effect on expenditures. In the region-effect models, the estimated DD reform effects are slightly larger but qualitatively similar. States that adopted reforms prior to our study period had 1984-1990 growth rates in expenditures that were slightly larger, by around 3 percent. The region-effect model shows that these states as a group also had slightly higher expenditure levels in 1984. Because these states generally adopted reforms at least five years before our panel began, our results suggest that direct reforms do not result in relatively slower expenditure growth more than five years after adoption. However, lack of a pre-adoption baseline for and adoption-time heterogeneity among the early-adopting states, as well as the sensitivity of the early-adopter/nonadopter differential growth rates to alternative specifications (as discussed below), makes interpreting estimates of differential early-adopter/nonadopter growth rates as a long-term effect problematic. And, in any event, in no case would the differential 1984-1990 expenditure growth rate between adopters and nonadopters offset the difference-in-difference "levels" effect; in total, malpractice reforms always result in a decline in cost growth of at least 10 percent.

The remaining columns of Table 4 describe the corresponding DD estimates of reform effects on AMI outcomes. Mortality rates declined but readmission rates with cardiac complications increased during this time period, confirming the results of Table 1. Outcome trends were very similar in reform and nonreform states; the cumulative difference in mortality

and cardiac-complication trends was around 0.1 percentage points. These small estimated mortality differences are not only insignificantly different from zero; they are estimated rather precisely as well. For example, the upper 95 percent confidence limit for the effect of direct reforms on one-year mortality trends between 1984 and 1990 is 0.65 percentage points. Coupled with the estimated expenditure effect, the expenditure/benefit ratio for a higher-pressure liability regime is over $500,000 per additional one-year AMI survivor in 1991 dollars; even a ratio based on the upper-bound mortality estimate translates into hospital expenditures of over $100,000 per additional AMI survivor to one year.[10] The estimates in the corresponding region-effect models are very similar. Indirect reforms were also associated with estimated mortality effects that were very close to zero. Results for outcomes related to quality of life -- that is, rehospitalizations with either recurrent AMI or heart failure -- also showed no consequential effects of reforms. In this case, the point estimates (upper bound of the 95 percent confidence interval) for the estimated effect of direct reforms were -0.18 (0.22) percentage points for AMI recurrence and -0.07 (0.29) percentage points for the occurrence of heart failure. Again, compared to the estimated expenditure effects, these differences are not substantial.

Table 5 presents estimated effects of malpractice reforms on IHD expenditures and outcomes, with results qualitatively similar to those just described for AMI. IHD expenditures also grew rapidly between 1984 and 1990. Direct reforms led to somewhat larger expenditure reductions for IHD (9.0 percent) and indirect reforms were again associated with relatively smaller increases in expenditures (3.4 percent). The effects of reforms on IHD outcomes are again very small: the effect of direct reforms on mortality rates was an average difference of -0.19 percentage points (95 percent upper confidence limit of 0.11), and the effects on

subsequent occurrence of AMI or heart failure hospitalizations were no larger.[11] Estimates from the models with region effects were very similar. Thus, direct liability reforms appear to have a relatively larger effect on IHD expenditures, without substantial consequences for health outcomes.

As we noted in Section III, the simple average effects of liability reforms estimated in the DD specifications of Tables 4 and 5 may not capture the dynamic effects of reforms. Table 6 presents results from model specifications that estimate reform effects less restrictively. In these specifications, we use our seven-year panel to estimate short-term and long-term effects of direct and indirect reforms on expenditures and outcomes, to determine whether the "shift" effect implied by the DD specification is adequate. The models retain our state and time fixed effects.[12]

We find the same general patterns as in the simple DD models, but somewhat larger effects of malpractice reforms three to five years after adoption compared to the short-term effects. In particular, Table 6 shows that direct reforms lead to short-term reductions in AMI expenditures of approximately 4.0 percent within two years of adoption, and that the reduction grows to approximately 5.8 percent three to five years after adoption. This specification also shows that the positive association between indirect reforms and expenditures noted in Table 4 is a short-term phenomenon; the long-term effect on expenditures is approximately zero.[13]

As in Table 4, both direct and indirect reforms have trivial effects on mortality and readmissions with complications, both soon and later after adoption. For example, the average difference in mortality trends between direct-reform and nonreform states is -0.22 percentage points (not significant) within two years of adoption, with a 95 percent upper confidence limit of 0.4 percentage points. At three to five years, the estimated effect is 0.12 percentage points (not

significant) with a 95 percent upper confidence limit of 0.76 percentage points. These point estimates translate into very high expenditures per reduction in adverse AMI outcomes.

The results for the corresponding model of IHD effects over time are presented in the right half of Table 6. Direct reforms are associated with a 7.1 percent reduction in expenditures by two years after adoption (standard error 0.5) and an 8.9 percent reduction by five years after (standard error 0.5).[14] In contrast, mortality trends for states with direct reforms do not differ significantly by two years (point estimate of -0.15 percentage points, 95 percent upper confidence limit 0.19) or five years after adoption (point estimate -0.11 percentage points, 95 percent upper confidence limit 0.23). Direct reforms also have no significant or substantial effects on cardiac complications, either immediately or later. Indirect reforms are again associated with small positive effects on expenditure growth (3.1 percent within two years), but these effects decline over time to a relatively trivial level (1.4 percent at three to five years). Indirect reforms are also associated with slightly lower mortality rates and slightly higher rates of cardiac complications, but the size of these effects are very small (e.g., the upper limit of the 95 percent confidence interval around the estimated effect of indirect reforms three to five years after adoption is 0.47 percentage points for AMI recurrence and 0.30 percentage points for heart failure occurrence). Thus, the pattern of reform effects for IHD is again qualitatively similar to that for AMI, with direct reforms having a somewhat larger effect on expenditures.

Taken together, the estimates in Tables 4 through 7 consistently show that the adoption of direct malpractice reforms between 1984 and 1990 led to substantial relative reductions in hospital expenditures during this period -- accumulating to a reduction of more than five percent for AMI and nine percent for IHD by five years after reform adoption -- and that these

expenditure effects were n t associated with any consequential effects on mortality or on the rates of significant cardiac complications.

We estimated a variety of other models to explore the robustness of our principal results. We tested the sensitivity of our results to alternative assumptions about the excludability of state/time interactions. One set of tests reestimated the models with random state/time effects, to determine whether correlated outcomes at the level of state/time interactions might affect our conclusions. Our estimated effects of reforms did not differ substantially or significantly with these methods. Using the model presented in Tables 4 and 5, the estimated difference-in-difference effect of direct reform on expenditures for AMI patients, controlling for random state/time effects, is -4.9 percent (standard error 2.1); for indirect reform, the estimated effect is -0.6 percent (standard error 2.0). The estimated DD effect of direct reform on mortality for AMI patients, controlling for random state/time effects, is 0.15 percentage points (standard error 0.32); for indirect reform, the estimated effect is -0.19 percentage points (standard error 0.32). Similar results obtained for IHD patients: direct reform showed a negative and statistically significant effect on expenditures with an insubstantial and precisely estimated effect on mortality, and indirect reform showed no substantial effect on either expenditures or mortality. Estimated differential 1984-1990 expenditure growth rates between early-adopters and nonadopters were insignificant in the random effects specification. For AMI patients, the differential growth rate for early adopters of direct reforms is 0.61 percent (standard error 3.1); for early-adopters of indirect reforms, the differential growth rate is 0.61 percent (standard error 2.3). For IHD patients, the differential growth rate for early adopters of direct reforms is -1.9 percent (standard error 3.0); for early adopters of indirect reforms, the differential growth rate is

-3.2 percent (standard error 2.2). Another related diagnostic involved estimating the models with Huber-White [1980] corrections for state/time grouped errors instead of corrections for zip-code/time grouped errors. Standard errors corrected for state/time grouping were greater than those corrected for zip-code/time grouping but less than those obtained under the random effects specification.

Although they did have a statistically significant influence on expenditures in some models, the broad set of political and regulatory environment controls that we used did not change our results substantially. Using the models presented in Tables 4 and 5 but excluding controls for the regulatory and legal environment, the estimated DD effect of direct reforms on expenditures for AMI patients is -9.1 percent (standard error 0.44); for indirect reforms, the estimated DD effect is 3.3 percent (standard error 0.40). In addition, the difference in 1984-1990 growth rates between early-reforming and nonreforming states changes sign from positive to negative for states enacting direct reforms before 1985 (3.1 percent with legal environment controls (Table 4), -3.1 percent without them); the difference in growth rates for states enacting indirect reforms before 1985 remains about the same (2.76 percent with legal environment controls (Table 4), 3.5 percent without them). These two specification checks, taken together, underscore the points made by Tables 4 and 5. Direct reforms reduce expenditure growth without increasing mortality; indirect reforms have no substantial effect on either expenditures or mortality; and differential 1984-1990 expenditure growth rates for early-adopting states are not robust estimates of the long-term impact of reforms.

Finally, we reestimated the models in Tables 4 and 5 including controls for statute-of-limitations reforms. Statute-of-limitation reforms have a very small positive effect on

expenditures and no effect on mortality, which is consistent with their classification as a indirect reform. Using the models presented in Tables 4 and 5, statute-of-limitations reforms are associated with a 0.96 percent increase in expenditures for AMI patients (standard error 0.46), and a 0.003 percentage point increase in mortality (standard error 0.28). Inclusion of statute-of-limitation reforms did not substantially alter the estimated DD effect of either direct or indirect reforms: for AMI patients, the estimated effect of direct reforms went from -5.3 percent (Table 4) to -5.5 percent, and the estimated effect of indirect reforms remained constant at 1.8 percent (Table 4).

To explore the sources of our estimated reform effects more completely, we estimated additional specifications that analyzed effects on use of intensive cardiac procedures such as cardiac catheterization, that used alternative specifications of time-since-adoption and calendar-year effects, and that estimated the effects of each type of tort reform separately (see Table 2A). These specifications produced results consistent with the simpler specifications reported here for both AMI and IHD. Specifically, reforms with a determinate, negative direct impact on liability led to substantially slower expenditure growth, somewhat less growth in the use of intensive procedures (but smaller effects than would explain the expenditure differences, suggesting less intensive treatments were also affected), and no consequential effects on mortality.

VI. Policy Implications

We have developed evidence on the existence and magnitude of "defensive" medical practices by studying the consequences of reforms limiting legal liability on health care expenditures and outcomes for heart disease in the elderly. These results provide a critical

extension to the existing empirical literature on the effects of malpractice reforms. Previous studies have found significant effects of direct reforms on the frequency of and payments to malpractice claims. Because the actual costs of malpractice litigation comprise a very small portion of total health care expenditures, however, these litigation effects have only a limited impact on health care expenditure growth. To provide a more complete assessment of malpractice reforms, we have studied their consequences for actual health care expenditures and health outcomes. Our study is the first to use exogenous variation in tort laws not related to potential idiosyncrasies of providers or small geographic areas to assess the behavioral effects of malpractice pressure. Thus, our analysis fills a crucial empirical gap in evaluating the U.S. malpractice liability system, because the effects of malpractice law on physician behavior are both a principal justification for current liability rules and potentially important for understanding medical expenditure growth.

Our analysis indicates that reforms that directly limit liability -- caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral-source rule reforms -- reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear. The effects appear to be somewhat smaller for actual heart attacks than for a relatively less severe form of heart disease (IHD), for which more patients may have "marginal" indications for treatment. In contrast, reforms that limit liability only indirectly – caps on contingency fees, mandatory periodic payments, joint-and-several liability reform, and patient compensation funds -- are not associated with substantial effects on either expenditures or outcomes, at least by several years after adoption. Neither type of reforms led to any consequential differences in mortality or the

occurrence of serious complications. As we described previously, the estimated expenditure/benefit ratio associated with direct reforms is over $500,000 per additional one-year survivor, with comparable ratios for recurrent AMIs and heart failure. Even the 95-percent confidence bounds for outcome effects are generally under one percentage point, translating into over $100,000 per additional one-year survivor. While it is possible that malpractice reforms have had effects on other outcomes valued by patients, this possibility must be weighed against the absence of any substantial effects on mortality or the principal cardiac complications that are correlated with quality of life. Thus, the results indicate that liability rules that are more generous in terms of award limits are a very costly approach to improving health care outcomes.

Approximately 40 percent of patients with cardiac disease were affected by direct reforms between 1984 and 1990. Based on simulations using our effect estimates, we conclude that if reforms directly limiting malpractice liability had been applied throughout the United States during this period, expenditures on cardiac disease would have been around $450 million per year lower for each of the first two years after adoption and close to $600 million per year lower for each of years three through five after adoption, compared with nonadoption of direct reforms.

While our panel is relatively lengthy for a DD study, it is not long enough to allow us to reach equally certain conclusions about the long-term effects of malpractice reforms on medical expenditure growth and trends in health outcomes. Plausible *static* effects of virtually all policy factors cannot explain more than a fraction of expenditure growth in recent decades [Newhouse 1992], and we have also documented that outcome trends may be quite important. Whether policy changes such as malpractice reforms influence these long-term trends through effects on

the environment of technological change in health care is a critical issue. Do reforms have implications for trends in expenditures and outcomes long after they are adopted, or do the trend effects diminish over time? Preliminary evidence on this question from early-adopted (pre-1985, mostly pre-1980) reforms suggest that long-term expenditure growth is not slower in states that adopt direct reforms; on the other hand, subsequent growth does not appear to offset the expenditure reductions that occur in the years following adoption. Moreover, we found no evidence that direct reforms adopted from 1985-1990 had smaller effects in states that had also adopted direct reforms earlier, suggesting that dynamic malpractice policies may produce more favorable long-term expenditure/benefit trends. In any event, our conclusions about long-term effects are speculative at this point, given the absence of baseline data on expenditures and outcome trends in reform states. Follow up evaluations of longer-term effects of malpractice reforms should be possible within a few years, and might help confirm whether liability reforms have any truly lasting consequences for expenditure growth or trends in health outcomes.

Hospital expenditures on treating elderly heart disease patients are substantial -- over $8 billion per year in 1991 -- but they comprise only a fraction of total expenditures on health care. If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms could lead to expenditure reductions of well over $50 billion per year without serious adverse consequences for health outcomes. We hope to address the generalizability of our results more extensively in future research. More detailed studies using both malpractice claims information and patient expenditure and outcome information, linking the analysis of the two policy justifications for a malpractice liability system, should be particularly informative. Such studies could provide more direct evidence on

how liability rules translate into effects on particular kinds of physician decisions with implications for medical expenditures but not outcomes. Thus, they may provide more specific guidance on which specific liability reforms -- including "nontraditional" reforms such as no-fault insurance and mandatory administrative reviews -- will have the greatest impact on defensive practices without substantial consequences for health outcomes.

Our evidence on the effects of direct malpractice reforms suggests that doctors do practice defensive medicine. Given the limited relationship between malpractice claims and medical injuries documented in previous research, perhaps our findings that less malpractice liability does not have significant adverse consequences for patient outcomes but does affect expenditures are not surprising. To our knowledge, however, this is the first direct empirical quantification of the costs of defensive medicine.

VII. Conclusion

We have demonstrated that malpractice liability reforms that directly limit awards and hence benefits from filing lawsuits lead to substantial reductions in medical expenditure growth with no appreciable consequences for important health outcomes, including mortality and common complications of the diseases we studied. We conclude that fostering appropriate provider incentives for quality care is not a reasonable justification for the current malpractice liability system for elderly patients with cardiac disease. Thus, direct liability limitations appear to be an effective policy reform for improving the efficiency of the U.S. health care system.

TABLE I: AVERAGE HEALTH CARE COSTS, OUTCOMES, AND DEMOGRAPHIC CHARACTERISTICS FOR AMI AND IHD POPULATION

	AMI Population		
	1984	1987	1990
1-Year Mortality	39.9	38.8	35.4
1-Year AMI Re-admit	10.9	11.4	14.6
1-Year Heart Failure Re-admit	9.6	10.1	11.0
1-Year Total Hospital Expenditures	$10,881	$11,996	$13,140
Mean Age (Standard Deviation)	75.6 (7.0)	75.9 (7.2)	76.1 (7.3)
Female	48.5	49.6	49.6
Black	5.1	5.4	5.5
Rural	29.4	30.3	30.3
Sample Size	232,768	227,360	220,550
	IHD Population		
	1984	1987	1990
1-Year Mortality	13.5	11.6	10.6
1-Year AMI Re-admit	5.5	4.7	4.3
1-Year Heart Failure Re-admit	7.8	6.9	7.7
1-Year Total Hospital Expenditures	$10,638	$11,187	$12,515
Mean Age (Standard Deviation)	74.6 (6.9)	74.3 (6.8)	74.3 (6.8)
Female	55.2	53.4	51.4
Black	5.7	5.7	5.8
Rural	30.6	30.4	29.7
Sample Size	356,717	372,871	381,222

Notes: Hospital Expenditures in 1991 Dollars. Outcome measures and demographic characteristics except age in percentage points.

TABLE IIA: LEGAL REFORMS USED IN ANALYSIS

Reform	Description of Reform	Predicted Impact on Liability
Caps on damage awards	Either noneconomic (pain and suffering) or total damages payable are capped at a statutorily-specified dollar amount	Direct
Abolition of punitive damages	Medical malpractice defendants are not liable for punitive damages under any circumstances	Direct
No mandatory prejudgment interest	Interest on either noneconomic or total damages accruing from either the date of the injury or the date of filing of the lawsuit is not mandatory	Direct
Collateral-source rule reform	Total damages payable in a malpractice tort are statutorily reduced by all or part of the dollar value of collateral source payments to the plaintiff	Direct
Caps on contingency fees	The proportion of an award that a plaintiff can contractually agree to pay a contingency-fee attorney is capped at a statutorily-specified level	Indirect
Mandatory periodic payments	Part or all of damages must be disbursed in the form of an annuity that pays out over time	Indirect
Joint-and-several liability reform	Joint and several liability is abolished for noneconomic or total damages, either for all claims or for claims in which defendants did not act in concert	Indirect
Patient compensation fund	Doctors receive government-administered excess malpractice liability insurance, generally financed through a tax on malpractice insurance premiums	Indirect

Table IIB: Chronology of Legal Reforms*

State	Year Effective Direct Reform	Indirect Reform	State	Year Effective Direct Reform	Indirect Reform
Alabama	1987	1987	Montana	1987	
Alaska	1976, 1986	1988	Nebraska	1960, 1976	1976
Arizona		1988	Nevada		
Arkansas			New Hampshire	1986	
California	1975	1975, 1986	New Jersey	1987	1972, 1976
Colorado	1986	1986, 1988	New Mexico	1976	1976, 1987
Connecticut	1985	1986	New York	1967, 1984	1970, 1985
Delaware		1976	North Carolina		
Florida	1976, 1986	1980, 1985	North Dakota	1987	1987
Georgia			Ohio	1975	1988
Hawaii	1986		Oklahoma		1953, 1978
Idaho	1987, 1990	1986, 1987	Oregon	1975, 1987	1975**, 1987
Illinois	1976, 1985	1985	Pennsylvania		1975
Indiana	1975	1975, 1985	Rhode Island	1976	
Iowa	1975		South Carolina		1976
Kansas	1986, 1988	1974, 1976	South Dakota	1976	1988
Kentucky			Tennessee	1975	1975
Louisiana	1975, ***	1975, 1984	Texas	1977	
Maine	1989	1985, 1988	Utah	1985, 1986	1985, 1986
Maryland	1986		Vermont		1970
Massachusetts	1986, ***	1986	Virginia	1974	
Michigan	1986	1981	Washington	***	1986
Minnesota	1986		West Virginia	1986	
Mississippi			Wisconsin	1986	1975, 1986
Missouri	1986	1986	Wyoming		1986, 1987

Notes: * - Except prejudgment interest. Montana imposed prejudgment interest in 1985. No other states repealed or imposed prejudgment interest 1985-1990. The following states imposed mandatory prejudgement interest effective before 1984: AK, CO, IA, LA, ME, MA, NH, NJ, NC, OK, RI, UT, WV.

** - Oregon repealed in 1987 those indirect reforms effective as of 1975.

*** - Common law effective before 1984 prohibits punitive damages.

Table III: Hospital Expenditures and Mortality Outcomes in States With and Without Direct Reforms, AMI and HID Patients, 1984-1990

	1-Year Total Hospital Expenditures					1-Year Mortality				
	1984	1987	1990	1984-87 %Change	1984-90 %Change	1984	1987	1990	1984-87 Change	1984-90 Change
					AMI					
States without Direct Reforms	$10,194	$11,810	$12,618	15.9%	23.8%	40.2%	39.1%	35.7%	-1.1%	-4.5%
States with Direct Reforms in Effect Before 1985	$10,513	$11,722	$13,022	11.5%	23.9%	40.1%	39.0%	35.4%	-1.1%	-4.7%
States Enacting Direct Reforms Effective Between 1985 and 1987	$11,304	$12,595	$13,186	11.4%	16.6%	39.5%	38.6%	35.3%	-0.9%	-4.2%
States Enacting Direct Reforms Effective Between 1988 and 1990	$8,960	$9,865	$10,925	10.1%	21.9%	41.9%	39.2%	35.7%	-2.7%	-6.2%
					HID					
States without Direct Reforms	$9,439	$10,859	$12,083	15.0%	28.0%	14.1%	12.0%	11.0%	-2.1%	-3.1%
States with Direct Reforms in Effect Before 1985	$10,331	$11,064	$12,505	7.1%	21.0%	13.5%	11.7%	10.7%	-1.8%	-2.8%
States Enacting Direct Reforms Effective Between 1985 and 1987	$10,527	$11,315	$12,300	7.5%	16.8%	13.8%	11.6%	10.5%	-2.2%	-3.3%
States Enacting Direct Reforms Effective Between 1988 and 1990	$9,241	$9,623	$11,421	4.1%	23.6%	14.1%	12.3%	11.5%	-1.8%	-2.6%

Note: Hospital Expenditures in 1991 Dollars.

Table IV: Effects of Tort Reforms on Expenditures and Outcomes of Acute Myocardial Infarction, Difference-in-Difference Specification

	State- and Time-Fixed Effects				Region- and Time-Fixed Effects			
Variable	1 Year Hospital Expenditures	1-Year Mortality	1 Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Difference-in-Difference Effects of Reforms								
Direct Reforms	-5 30	0 07	0 18	-0 07	-6 71	0.05	-0.31	-0.14
	(0 47)	(0 29)	(0 20)	(0.18)	(0.46)	(0 28)	(0.19)	(0.18)
Indirect Reforms	1.81	-0 13	-0 04	-0 02	3.37	0.10	-0 09	0.14
	(0 46)	(0 28)	(0 19)	(0.18)	(0.43)	(0 26)	(0.18)	(0.16)
Baseline 1984-1990 Growth Rate								
	21 01	-5 46	5 02	0.99	22.64	-5.51	4.78	1.10
	(0.70)	(0 46)	(0 32)	(0.29)	(0.76)	(0 44)	(0.31)	(0.28)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	3 08	0 36	-1 60	0.43	1.24	0 17	-1.25	0.25
	(0.77)	(0 47)	(0 32)	(0.30)	(0.73)	(0.44)	(0.31)	(0.28)
Indirect Reforms	2 76	-0 57	0 52	-0 28	4.88	-0 45	0.56	-0.16
	(0.50)	(0 30)	(0 21)	(0.19)	(0.49)	(0.30)	(0.21)	(0.19)
Differential 1984 Level, States with pre-1985 Reforms								
Direct Reforms					4.97	-0.89	-0 08	0 21
					(0.57)	(0.34)	(0.23)	(0.21)
Indirect Reforms					1.75	-0.12	0 12	0 32
					(0 40)	(0.24)	(0.17)	(0.15)

Notes: Heteroskedasticity consistent standard errors allowing for zip code/time grouping in parentheses. Hospital Expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

Table V: Effects of Tort Reforms on Expenditures and Outcomes of Ischemic Heart Disease, Difference-in-Difference Specification

Variable	State- and Time-Fixed Effects				Region- and Time-Fixed Effects			
	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Difference-in-Difference Effects of Reforms								
Direct Reforms	-9.02	-0.19	-0.20	-0.12	-10.02	0.05	-0.19	-0.03
	(0.45)	(0.15)	(0.10)	(0.12)	(0.44)	(0.15)	(0.10)	(0.12)
Indirect Reforms	3.42	-0.42	0.24	0.19	4.06	-0.61	0.23	0.10
	(0.44)	(0.15)	(0.10)	(0.12)	(0.40)	(0.14)	(0.09)	(0.11)
Baseline 1984-1990 Growth Rate								
	17.16	-2.78	-0.84	-0.92	18.56	-2.91	-0.98	-1.00
	(0.75)	(0.25)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	-1.41	0.33	-0.39	0.56	-3.06	0.42	-0.21	0.61
	(0.76)	(0.26)	(0.17)	(0.21)	(0.73)	(0.25)	(0.16)	(0.20)
Indirect Reforms	-1.04	-0.32	0.11	-0.29	0.87	-0.31	0.01	-0.22
	(0.47)	(0.16)	(0.11)	(0.13)	(0.46)	(0.16)	(0.11)	(0.13)
Differential 1984 Level, States with pre-1985 Reforms								
Direct Reforms					6.88	-0.66	-0.34	-0.61
					(0.57)	(0.19)	(0.13)	(0.15)
Indirect Reforms					2.71	-0.24	-0.19	-0.01
					(0.38)	(0.13)	(0.09)	(0.10)

Notes: Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping in parentheses. Hospital expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

Table VI: Effects of Tort Reforms on Expenditures and Outcomes
Time-Since-Adoption Specification

	AMI, State- and Time-Fixed Effects				HID, State- and Time-Fixed Effects			
Variable	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit	1-Year Hospital Expenditures	1-Year Mortality	1-Year AMI Readmit	1-Year HF Readmit
Time-Since-Adoption Effects of Reforms								
Adopted 1985 to 1990, within the past 2 years or less								
Direct Reforms	-3 95	-0 22	-0 25	-0.29	-7.08	-0.15	-0.17	-0.23
	(0 52)	(0 31)	(0 22)	(0.20)	(0.49)	(0.17)	(0.11)	(0.13)
Indirect Reforms	1.71	0 10	-0 32	-0 01	3.09	-0.24	0.21	0.31
	(0.48)	(0 29)	(0 20)	(0.18)	(0.46)	(0.15)	(0.10)	(0.12)
Adopted 1985 to 1990, within the past 3 to 5 years								
Direct Reforms	-5 80	0 12	0 19	0.03	-8.88	-0.11	-0.16	0.08
	(0 53)	(0 32)	(0 22)	(0.21)	(0.50)	(0.17)	(0.11)	(0.14)
Indirect Reforms	-0 14	-0 23	0 06	-0.12	1.43	-0.70	0.21	-0.00
	(0.58)	(0.35)	(0.24)	(0.23)	(0.55)	(0.19)	(0.13)	(0.15)
Baseline 1984-1990 Growth Rate								
	21.54	-5.51	4.84	0.94	17.11	-2.91	-0.98	-1 00
	(0.72)	(0.47)	(0.33)	(0.30)	(0.77)	(0.27)	(0.20)	(0.20)
Differential 1984-1990 Growth Rate, States with pre-1985 Reforms								
Direct Reforms	3.54	0.39	-1.56	0.47	-0.53	0.37	-0.35	0.67
	(0.77)	(0.47)	(0.32)	(0.30)	(0.76)	(0.26)	(0.17)	(0.21)
Indirect Reforms	3.20	-0.52	0.49	-0.25	-0.42	-0.24	0.13	-0.22
	(0.51)	(0.31)	(0.21)	(0.20)	(0.48)	(0.16)	(0.11)	(0.13)

Notes: Heteroskedasticity-consistent standard errors allowing for zip-code/time grouping in parentheses. Hospital expenditures in 1991 dollars. Coefficients from 1-year hospital expenditures model *100 from regressions in logarithms; Coefficients from outcome models in percentage points. All models include controls for the regulatory/legal environment and patient demographic characteristics. Baseline growth rate calculated at the sample average level of regulatory/legal environment characteristics.

References

Barker, D.K., "The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis," Journal of Health Politics, Polic, and Law XVII (1992): 143-161.

Baldwin, L.M., et al., "Defensive Medicine and Obstetrics," JAMA CCLXXIV (1995): 1606-1610.

Bell, P.A., "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability," Syracuse Law Review XXXV (1984): 939-993.

Campbell, T.J., D.P. Kessler, and G.B. Shepherd, "Liability Reforms' Causes and Economic Impacts," in The Mosaic of Economic Growth, Landau, R. et al. (ed.) (Stanford, CA: Stanford University Press, 1996).

Charles, S.C., C.E. Pyskoty, and A. Nelson, "Physicians on Trial - Self-Reported Reactions to Malpractice Trials," The Western Journal of Medicine CXLVIII (1988): 358-360.

Cooter, Robert D. and Ulen, Thomas S., "An Economic Case For Comparative Negligence," New York University Law Review LXI (1986): 1067-1110.

Craswell, Richard and Calfee, John, "Deterrence and Uncertain Legal Standards," Journal of Law, Economics, and Organization II (1986): 279-303.

Cutler, D.M. and McClellan, Mark, "What is Technological Change?" Harvard Mimeo (1995).

Danzon, P.M., "The Frequency and Severity of Medical Malpractice Claims," RAND R-2870-ICJ/HCFA (1982).

Danzon, P.M., Medical Malpractice: Theory, Evidence, and Public Policy (Cambridge, MA: Harvard University Press, 1985).

Danzon, P.M., "New Evidence on the Frequency and Severity of Medical Malpractice Claims," RAND R-3410-ICJ (1986).

Farber, H.S. and White, M.J., "Medical Malpractice: An Empirical Examination of the Litigation Process," RAND Journal of Economics XXII (Summer 1991): 199-217.

Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report of the Harvard Medical Practice Study to the state of New York (Cambridge, MA: The President and Fellows of Harvard College, 1990).

Keeton, W.P., et al., Prosser and Keeton on Torts, 5th. ed., (St. Paul, MN: West Publishing Co., 1984).

Leveno, K.J., et al., "A Prospective Comparison of Selective and Universal Electronic Fetal Monitoring in 34,995 Pregnancies," The New England Journal of Medicine CCCXV (1986): 614-619.

Localio, A.R., et al.,"Relationship Between Malpractice Claims and Cesarean Delivery," JAMA CCLXIX (1993): 366-373.

Masters, S.J., et al., "Skull X-Ray Examinations After Head Trauma: Recommendations by a Multidisciplinary Panel and Validation Study," New England Journal of Medicine CCCXVI (1987): 84-91.

McClellan, Mark, "Why Do Hospital Costs Keep Rising? Hospital Reimbursement, Hospital Production and the Puzzles of Medicare's Prospecuve Payment System", Harvard Mimeo (1994).

McClellan, Mark, "Uncertainty, Health Care Technologies, and Health Care Costs," American Economic Review LXXXV (1995): 38-44.

McClellan, Mark and Newhouse, Joseph P., "The Marginal Benefits of Medical Treatment Intensity: Acute Myocardial Infarction in the Elderly," NBER Working Paper (1995a).

McClellan, Mark, and Newhouse, Joseph P., "The Marginal Costs and Benefits of Medical Technology: Acute Myocardial Infarcuon," Journal of Econometrics, forthcoming (1995b).

Moser, J. and R. Musaccio, "The Cost of Medical Professional Liability in the 1980s," Medical Practice Management (Summer 1991): 3-9.

National Center for Health Statistics, Health United States, (Washington, DC: U.S. Government Printing Office, 1994).

Newhouse, J.P., "Medical Care Costs: How Much Welfare Loss?" Journal of Economic Perspectives VI (1992): 3-22.

Physician Insurers Association of America (PIAA), Data Sharing Reports (1993).

Priest, George L., "The Current Insurance Crisis and Modern Tort Law," Yale Law Journal XCVI (1987): 1521-1589.

Rabin, Robert L., "Some Reflections on the Process of Tort Reform, San Diego Law Review XXV (1988): 13-48.

Reynolds, R.A., J.A. Rizzo, M.L. Gonzales, "The Cost of Medical Professional Liability," JAMA CCLVII (1987): 2776-2781.

Rock, S.M., "Malpractice Premiums and Primary Cesarian Section Rates in New York and Illinois," Public Health Reporter CVIII (1988): 459-468.

Shy, K.K., et al., "Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants," The New England Journal of Medicine CCCXXII (1990): 588-593.

Sloan, F.A., "Experience Rating: Does It Make Sense for Medical Malpractice Insurance?" American Economic Review LXXX (1990): 128-133.

Sloan, F.A., P.M. Mergenhagen, and R.R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," Journal of Health Politics, Policy and Law XIV (1989): 663-689.

U.S. Congress, Office of Technology Assessment, Impact of Legal Reforms on Medical Malpractice Costs, OTA-BP-H-119, (Washington, DC: U.S. Government Printing Office, 1993).

U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H-602, (Washington, DC: U.S. Government Printing Office, 1994).

Weiler, P.C., et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (Cambridge, MA: Harvard University Press, 1993).

White, H., "A Heteroskedasticity-Consistent Covariance Matrix Estimator and a Direct Test for Heteroskedasticity," Econometrica XLVII (1980): 817-838.

Zuckerman, S., R.R. Bovbjerg, and F. Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry XXVII (1990): 167-182.

Endnotes

1. Reforms requiring collateral-source offset revoke the cor mon-law default rule which states that the defendant must bear the full cost of the injury suffered by the plaintiff, even if the plaintiff were compensated for all or part of the cost by an independent or "collateral" source. Under the common-law default rule, defendants liable for medical malpractice always bear the cost of treating a patient for medical injuries resulting from the malpractice, even if the treatment were financed by the patient's own health insurance. Either th: plaintiff enjoys double recovery (the plaintiff recovers from the defendant and his own health insurance for medical expenses attributable to the injury) or the defendant reimburses the plaintiff's (subrogee) health insurer, depending on the plaintiff's insurance contract and state or federal law. However, some states have enacted reforms that specify that total damages payable in a malpractice tort are to be reduced by all or part of the value of collateral source payments.

2. Estimates of the impact of reforms on claim severity vary over time and across studies. Based on 1975-1978 data, Danzon [1982: 30] reports that states enacting caps on damages had 19 percent lower awards, and states enacting mandatory collateral source offsets had 50 percent lower awards. Based on 1975-1984 data, Danzon [1986: 26] reports that states enacting caps had 23 percent lower awards, and states enacting collateral source offsets had 11 to 18 percent lower awards. Based on 1975-1978 and 1984 data, Sloan, Mergenhagen, and Bovbjerg [1989] find that caps reduced awards by 38 to 39 percent, and collateral source offsets reduced awards by 21 percent.

3. Again, because all elderly patients with serious heart disease during the years of our study are included, this consideration applies only to extending the results to other patient populations.

4. Of course, if such state-time specific effects exist, there is no reason to expect that they would be normally distributed; normality assumptions in error structures generally have not performed

well in models of health expenditures and outcomes. However, incorporating such random effects permits us to explore the robustness of our estimation methods to possible state-time specific shifts.

5. According to Danzon [1982, 1986], urbanization is a highly significant determinant both of claim payments to and the frequency of claims and of the enactment of tort reforms; we control for urbanization at the individual level as discussed below.

6. Although we did not include controls for the number of physicians per capita in the reported results because of concerns regarding the exogeneity of that variable, results conditional on physician density are virtually identical. We include both a current- and a one-year-lagged effect to account for the possibility that past political environments influence current law.

7. Data on lawyers per capita for 1980, 1985, and 1988 are from The Lawyer Statistical Report (Chicago, IL: The American Bar Foundation, 1985, 1991). Intervening years are calculated by linear interpolation. Data on state political environments are courtesy of Gary King.

8 Our data set is partially derived from Campbell, Kessler, and Shepherd [1996].

9 The baseline is defined as the "negligence rule" without any of the liability-reducing reforms studied here and with mandatory prejudgment interest.

10 That is, (.053*$13,140)/.0065=$107,000 using the 95% upper bound of the estimated mortality effect and (.053*$13,140)/.0007= $1,000,000 using the actual DD estimate. Both of these ratios are very large; the difference in absolute magnitude of the two estimates results from the denominator being very close to zero.

11. Because we were concerned that reforms might affect the rate of IHD hospitalization as well as outcomes among patients hospitalized, we estimated models analogous to the specifications reported using population hospitalization rates with IHD as the dependent variable. We found no significant or substantial effects of either direct or indirect reforms on IHD hospitalization

rates.

12. Models with region effects on ', analogous to the right half of Tables 4 and 5, again showed very similar effect estimates.

13. We also estimate separate time-trend effects for early-reform (pre-1984) states. This approach may permit the development of some evidence on "long-term" effects of reforms on intensity growth rates; as noted previously, we find no evidence for such effects. Of course, our lack of a pre-adoption baseline for the early-adopting states precludes DD identification and makes the long-term conclusion more speculative. A follow up study using more recent expenditure and outcome data would provide more convincing evidence on effects beyond five years.

14. In contrast to AMI, the slower rate of expenditure growth between 1984 and 1990 for early-reform states (see Table 5) suggests that reforms may have longer-term effects on slowing IHD expenditure growth.

Mr. SCOTT. And what would patients want you to do? Would they want you to be careful and diagnose to the best of your ability, or not?

Dr. DICKEY. The patients want me to do everything reasonable and possible to do, but particularly in today's market of managed care, they want me to do only what's absolutely necessary. I saw a patient yesterday——

Mr. SCOTT. No, now wait a minute. You're talking about two different things. The HMO wants you to cut it to the bone; the patient wants good health care.

Dr. DICKEY. That's right, yes, sir.

Mr. SCOTT. And, but for the liability exposure, you would be cutting it to the bone, not providing the good health care. Is that what you're saying?

Dr. DICKEY. That's right. I'm caught from both ends.

Mr. SCOTT. Well, then some patients would thank God for a liability system because, but for that, they wouldn't be getting good health care. Now there's another, outside of the grey area, where people blame what is outright fraud on the liability case, where services are performed that are not medically indicated, charge the patient, make some money, and blame it on the lawyers.

Dr. DICKEY. That's fraud, not defensive medicine, Mr. Scott, and we don't support that. It's that questionable extra ultrasound, it's the, Do I really need an MRI?

Mr. SCOTT. That might save a patient's life.

Dr. DICKEY. Well, when there's any feeling on my part that it might save the patient's life, we do the test first and talk to the payor afterwards.

Mr. SCOTT. And the liability system helps balance it so that the patient is protected. And if you remove that counterweight——

Dr. DICKEY. We don't want to remove that. What we want to do is make the liability system function as a counterweight, but not function in a system that actually encourages me to do far more than science today says I absolutely have to do. It's a balance.

Mr. SCOTT. And, without that balance, the only force would be from the HMO trying to cut it to the bone, so that you would not be performing as good health care, as you would like to, because there's no countervailing weight. I think we've made the point on that.

Dr. DICKEY. OK.

Mr. SCOTT. Mr. Havighurst, Ms. McKay has talked about the time and effort it takes to make the case when you're dealing with the rule of reason versus the per se. How much more time is involved in making the case when you're dealing with rule of reason? Because it seems to me that by the time you went through all the studies and everything, you'd never get there.

Mr. HAVIGHURST. In recent years we've begun to recognize in antitrust law that we frequently apply the rule of reason pretty quickly. Professor Areeda, who wrote the major treatise in the field said, at some point, that you can sometimes apply the rule of reason sometimes in the twinkling of an eye. We also speak about a "quick look," with which one can easily see that there's an awful lot of market power being exercised and very little likelihood any efficiency is going to achieved.

Mr. SCOTT. Let me ask you another question because our time is running out. I don't mean to cut you off.

Mr. HAVIGHURST. On her facts, a real boycott could probably be penalized pretty quickly. I don't think it would drag things out unduly. On the other hand, under legislation of the kind we have here, a court might think it's required to do a lot more than we currently do in applying the rule of reason.

Mr. SCOTT. Do other professions, like lawyers, do they need the same kind of rule-of-reason liberalization? Accountants, architects?

Mr. HAVIGHURST. I wouldn't think so. I think we're doing pretty well under the current rules in all areas, except that I think the agencies have perhaps misconstrued, misapplied the per se rule in a very specific set of cases with respect to physician networks. But I don't think this a problem in the law in general as it applies to the professions. I think under the rule of reason we could deal with most cases expeditiously.

Ms. METZGER. Mr. Chairman, could I respond on bare bones medicine for 1 minute?

Mr. HYDE. Yes, ma'am.

Ms. METZGER. It seems to me that patients and HMO's both want high quality, cost-effective care. And plans that can't work collaboratively with doctors to figure out what is good medicine aren't going to be successful in the long run.

Mr. HYDE. Thank you very much.

The distinguished gentleman from Indiana, Mr. Buyer.

Mr. BUYER. Mr. Chairman, I'd like to note that I find no offense at all in Mr. Conyer's line of questioning. I don't find any offense in that line of questioning, and this is my second term here as a Member of this Congress, and I'd share with the American public that I came to this Congress after one party domination and control that left this institution very closed, mismanaged, and undemocratic. It may have been efficient because its Members didn't get to participate and deals were always cut in the back room, which I find obnoxious to my conscience. So I don't find offense in the line of questioning.

I am amused, though, whenever senior Democrats, who have benefited by that arrogance of power over the years, somehow now feel that they need to rein in the light of day. I'm amused by that, because right now the Congress is an open process, far different from what I lived through for 2 years. It's open, it's dynamic, and it's deliberative and it's democratic, and it's one that the American people can be proud of. So I guess I find no offense, but am yet amused.

May I—let me ask you a question, Dr. Dickey. Yesterday we had testimony from the Chairman of the Federal Trade Commission about the guidelines on the issues of fairness. I'm one that, when I look at this, I'm not so anxious to give someone, one particular sector in our society, a particular benefit, and I recognize some of the concerns that are happening in health care and its integration. Are you working with the Chairman of the FTC with regards to his testimony yesterday about going through a rework of the guidelines? Are you working closely with them?

Dr. DICKEY. Congressman, we've been working with the FTC for almost a decade. In fact, Assistant Attorney General Bingeman

suggested she was going to erect a statue to our general counsel in his persistence in attempting to change the interpretations applied. So we've been working with them a long time; we just haven't accomplished much.

Mr. BUYER. All right.

Dr. DICKEY. And that's why we have some concerns.

Mr. BUYER. Yesterday he almost left this committee with the impression that there is going to be this rapid progress. He turned on the caution light and said, please, please don't give us this legislation; just wait until you see what I can produce. What do you feel? What was your sense from that?

Dr. DICKEY. I've been active in the AMA for 15 years. I have 3 or 4 more years at an officer level that I might serve. I fear that his definition of rapid won't be here before I finish my time at the AMA, at least from past experience. That's why we had to come to Congress to say clarification by you will mean that it's not just this individual who, by the way, said that his written remarks spoke for the agency, but his oral remarks he couldn't assure you spoke for the entire agency. We need a bit more predictability for physicians in this very rapidly changing marketplace; we've not been able to get that in negotiating with the agencies themselves. We feel that we need a legislative clarification, so we can offer better choice to patients.

Mr. BUYER. I have the sense that many would like—we like this inducement to move to these private, cooperative initiatives, and as we're asking doctors to do the very same thing, and if in fact do so under particular guidelines, does it not subject you to treble damages if in fact the suit were successful?

Dr. DICKEY. Absolutely. If we participate in price fixing, if we participate in boycott, if we participate in anticompetitive behavior, we will still be subject to not only treble damages, but to criminal penalties as well. All we're asking is to have the same application. No other industry is asked the kinds of shared risk, closely defined by FTC as capitation and only capitation. No other industry is asked what percentage of participants, in our case 30 percent of physicians in an area. I come from a town of 150,000 where there are 12 pediatricians, but it happens that they're in two groups of six. That means that if I attempted to put together an integrated network, I would be in violation of FTC guidelines because by definition I either have no pediatricians or I have 50 percent of pediatricians.

So no other agency has the kinds of interpretations that have been placed on physicians. We're just asking the same rules as everyone else.

Mr. BUYER. Ma'am, I didn't come from a town of 150,000; I came from a town of about 150 people. Life's pretty simple. And when life's pretty simple, we also understand the word "fairness." So, in the words of fairness, as I'm sitting here, and I will repeat, I'm not so anxious to give particular change to doctors in our society. I try to look at all the other options that are out there that are necessary. But at the same time the word "fairness" keeps coming back to me.

And I look at this and say that we've got insurance companies and other health care businesses that get to bring doctors in and

form networks, and they can have an almost unlimited potential there as they form an integration, horizontal and vertical. Correct?

Dr. DICKEY. That's right. Correct. They can have 90 percent of physicians; they can have 100 percent of a particular specialty participating.

Mr. BUYER. Ms. McKay, that can't make you very happy, right?

Ms. MCKAY. Well, that's an interesting point. We feel in the case in Minnesota, the anesthesiologists are not the only ones who are being sued for antitrust violations, and that we have also gone after one of the major health care networks because we feel they have participated in excluding us and boycotting us from the system.

Mr. BUYER. May I follow up with this, Mr. Chairman?

Mr. HYDE. Yes, you may.

Mr. BUYER. I just wanted to make sure, though, that if in fact we have insurance companies and the other businesses that are permitted to do vertical and horizontal integration, but doctors, somehow, if they move to network, are treated differently under the guidelines. So the word "fairness" comes to me. I would be more apt to say that, yes, you should all be treated the same. And can that be done without the heavy hand of Congress? So that's my question to you. Do you feel, and have a sense, that that will be able to be achieved with the chairman of the FTC and your coordination and cooperation with the Department of Justice? That's my last question.

Dr. DICKEY. Our sense after the last decade, Congressman, is that it cannot be achieved by negotiating with the agency itself; that we need the balance, the clarification if you will, of Congress, to tell them what you're looking for, and that is that fairness that you're talking about. And we don't think we can get it simply by negotiating further with a group that we've literally lined their conference rooms with paper from the negotiations and moved nowhere.

Ms. METZGER. May I speak to that as well?

Mr. HYDE. The gentlelady, Ms. Metzger, wants to comment.

Ms. METZGER. Mr. Chairman, we would like to respond on the issue of fairness because we think that what we're talking about are fundamentally different relationships. It's like comparing apples and oranges.

On the one level, when you're talking about nonintegrated individual physicians creating joint ventures, it's a horizontal integration. When you're talking about health plans or other payors contracting with physicians who are suppliers, it's a vertical relationship. And the rules that apply horizontally apply across industries, and the rules that apply vertically apply equally across industries. If a venture were created by physicians, a horizontal venture that fit within the guidelines, that would not preclude them from contracting vertically with other physicians.

So I think that this focus on fairness is very misplaced; and that within existing guidelines things apply equally, so that we would hope there would be no need for legislative change. If there is some room within the FTC for further review, that may well be appropriate, but we would really challenge the need for legislative change.

Mr. HYDE. We have two more questioners for this panel, and I would, before I forget it, suggest that we may wish to submit written questions to the panel and solicit your cooperation in answering them, if you would. Very good.

The next gentleman is Mr. Bryant from Tennessee.

Mr. BRYANT of Tennessee. Thank you, Mr. Chairman.

I would direct my question to the entire panel. I have 5 minutes and I want to ask each one of you to answer it, if I could.

There are many of us in Congress who favor reforms such as this physicians service network or PSN's. The concerns that I hear consistently back in my district are that we need some relief from antitrust laws if the PSN's are indeed to be effective. And, again, there are many of us who want to see these as an option out there along with the traditional coverages. Would each one of you, in less than a minute each, because I only have 5 minutes, answer the question? Is it possible to have an effective physician's network without some regulatory relief, particularly in the antitrust area? Is it possible to have an effective PSN without some relief in antitrust law?

And if you would just say yes or no first; if it's no, then I don't really need an answer. But if it's yes, would you tell us how we could work around this. Less than a minute each.

Mr. HAVIGHURST. I don't think we need the legislation to achieve effective networks. There is a need, however, to identify those networks that may be so effective that they restrain trade and limit competition and choice, raise prices, and limit consumers' options in the marketplace. We don't want that kind. The agencies, I think, are dedicated to trying to identify those networks that are procompetitive, that are a useful addition to the market, and those that are trying to limit choice and raise prices.

Mr. BRYANT of Tennessee. So your answer would be no?

Mr. HAVIGHURST. Right.

Mr. BRYANT of Tennessee. OK, thank you.

Ms. Metzger.

Ms. METZGER. My answer would be yes. It would be based on the existence of many such networks currently, and the fact that they are continuing to form, the fact that the market is highly competitive and the fact that I think it's really ironic that the very laws, if you step back, that enabled the formation of alternative delivery systems today as an option in lieu of fee-for-service medicine are now being considered to be impediments to further development. And we just don't see that antitrust relief is needed. It's happening all the time in our market, and, in fact, we think competition is fair, competition is neutral, antitrust laws protect competition and consumers, not individual competitors, and I guess if there's a problem, I question whether they're getting adequate counsel.

Mr. BRYANT of Tennessee. Thank you. Thank you for your concise answers, also; I appreciate that.

Ms. MCKAY. I would respond also that, yes, it is possible for these networks to flourish without changes in the legislation. I'm from Minnesota, and in Minnesota we have a very excellent example in Mayo Clinic of a group of physicians that have networked for years and have been very effective in providing effective care in our State.

I would also like to point out, just briefly, that when we talk about competition in the health care market, it's not just limited to competition between the physician and the health care plan. There are other health care providers besides physicians. And to take action that might increase competition between physicians and health care plans, but would have the exact opposite effect on nonphysician providers, I think would be counterproductive. Thank you.

Mr. BRYANT of Tennessee. Thank you, Ms. McKay.

Dr. Dickey, you can have the rest of the time.

Dr. DICKEY. Wonderful. I would say if what you're looking for is an effective system, then the answer is we need legislation. We do have networks that are formed today; approximately 6 percent of the networks out there are physician networks. I think that speaks to the need for some legislative reform because networks that form today are of a particular type and very small. They must have less than 30 percent of the physicians in the area and less than 30 percent of any given specialty. They must capitate. Even though the rules say they only have to share risks, those plans that have gone forward and asked, as Montana did, for significant fee withhold, are not approved. And so capitation is the only risk adjustment that the FTC has agreed to let go forward.

So, though there are plans, they're extraordinarily small in number and they have to meet particular guidelines in order for physician, or more importantly, provider-sponsored networks, because there are nonphysician providers who do a superb job that ought to also have the opportunity to compete in the marketplace, but we need to have the opportunity to compete under the same rules. If you have good quality assurance, good utilization review, and some shared risk, but not necessarily narrowly-defined shared risk, you can come together and offer a product and see if it can compete.

Even while we're struggling to put together very small physician networks, we're watching national conglomeration of massive insurance networks which are not held to the same questions that a physician network would be held by. So we're simply asking I think the same thing I hear Ms. McKay asking: judge us all by the same set of rules. And in order to do that, we appear to need legislation.

Mr. BRYANT of Tennessee. Thank you.

Thank you, Mr. Chairman.

Mr. HYDE. Thank you, Mr. Bryant.

The distinguished gentleman from Ohio, Mr. Chabot.

Mr. CHABOT. I thank the chairman.

Because I had two other committee meetings going on at the same time, I wasn't able to hear all the testimony here this morning. I will make sure that I review all of your testimony and review your remarks with my staff as well. In the interest of time, I'll yield back the balance of my time and thank the witnesses for their input to Congress today.

Mr. HYDE. Well, I thank the gentleman, and I want to thank this panel for a very helpful contribution—spirited, informative, and we're going to chew on it. We will send you written questions, if you would be kind enough to answer them. Thank you very much for your contribution.

Now we have a made a decision to go ahead with panel three rather than take time out for lunch and attenuate this hearing. I think we can finish this in a reasonable time and not impinge on your normal lunch, so we'll bring on panel three.

Our final panel today consists of several witnesses who are involved in charitable medical care. First, we have Sister Christine Bowman on behalf of the Catholic Health Association. Sister Christine is a hospital administrator and a registered nurse. She currently serves as vice chairman of the board and director of community relations at Saint Anne's Maternity Home in Los Angeles.

Also with us today is Ms. Chris Franklin, vice president of the National Office of Volunteers of the American Red Cross. Ms. Franklin was appointed vice president in August 1994.

Mr. John Graham is here today on behalf of the American Society of Association Executives and the National Coalition for Volunteer Protection. Mr. Graham is the CEO of the nonprofit American Diabetes Association. We welcome you here today.

Mr. CONYERS. Mr. Chairman.

Mr. HYDE. The gentleman from Michigan.

Mr. CONYERS. Mr. Chairman, may I submit a statement with reference to this panel?

Mr. HYDE. You certainly may.

Mr. CONYERS. Thank you very much.

[The statement of Mr. Conyers follows:]

STATEMENT OF HON. JOHN CONYERS, JR., CONCERNING VOLUNTEER LIABILITY

At the outset I would like to clarify my understanding of how the volunteer liability bills before use would impact state law.

The Goodlatte bill clearly preempts State malpractice laws for medical volunteers in cases of negligence. The bill reads, and I quote, "the provisions of this section shall preempt any State law." [Section 2(c)]

As for the Porter bill, although up front it states it should not be construed to preempt state law, it goes on to make it difficult for the states to do anything but change their laws. It offers cash inducements to the States to enact laws which restrict victim rights. It could cost the U.S. approximately $28 million per year—every year—to comply with these obligations (according to Department of Health and Human Services statistics). And the bill offers no similar cash incentives to protect victims—for example for asking charities to adopt risk management techniques or assume liability from their volunteers.

Mr. HYDE. Thank you.

We are ready to proceed, Ms. Franklin. If you'd pull the microphone in? That's it.

STATEMENT OF CHRISTINE G. FRANKLIN, VICE PRESIDENT, NATIONAL OFFICE OF VOLUNTEERS, AMERICAN RED CROSS

Ms. FRANKLIN. Thank you very much. I'm Chris Franklin, vice president, National Office of Volunteers, American Red Cross, and again, thank you, Mr. Chairman, for inviting the American Red Cross to testify on volunteer tort liability protection. We greatly appreciate the fact that you seek to further the cause of voluntary action and are also studying and seeking to remedy some of the problems that we in the non-for-profit sector face in the accomplishment of our mission.

The purpose of our testimony today is to articulate the importance which the American Red Cross attaches to protecting individual volunteers acting in good faith from tort liability exposure. We

strongly believe that a society which encourages volunteerism and benefits from it, owes volunteers a positive volunteer experience. Such an experience cannot be achieved without a comprehensive support structure of which tort liability protection must be an integral part.

Surely, we should not expect that, in return for their generosity of spirit, volunteers be asked to put their savings, their family's future, and their peace of mind at risk. To foreclose that possibility is a moral imperative that keeps volunteerism from becoming exploitative. It is also a realistic assessment of what is necessary to maintain volunteerism as a viable resource today and into the 21st century.

In accordance with its volunteer philosophy, the American Red Cross assumes fully what it considers to be its corporate and moral responsibility of providing tort liability coverage to the American Red Cross staff, both paid and volunteer, through its own insurance program. We do not maintain separate coverage for volunteers; it's all one and the same program. The American Red Cross, as described in our written testimony, engages 1.4 million volunteers and 32,200 paid staff in its work, which is an average ratio of 45 volunteers to every paid staff. One-third of our 1,582 chapters are all-volunteer chapters.

The basis for our tort liability policy is the principle of supervision and control. We assume liability as an organization for those situations where we are in a position to control work conditions and work performance, and thus minimize risk. Those volunteers who are referred by the Red Cross to other organizations, such as military hospitals, for example, are not provided American Red Cross tort liability coverage since, once the referral process is completed, these volunteers come under the control and supervision of other organizations.

The American Red Cross has supported Congressman John Porter's bill, H.R. 911, the Volunteer Protection Act, since it was first introduced in 1988. And we continue our support of Congressman Porter's bill, which encourages States to enact the kind of comprehensive volunteer protection legislation which we favor.

The American Red Cross also supports S. 1435, the Volunteer Protection Act of 1995, recently introduced in the Senate by Senator Mitch McConnell. We support these bills which focus on immunizing volunteers but not the organizations for which they work even though neither of them would significantly reduce the tort liability exposure of the American Red Cross.

We, nevertheless, stand behind these volunteer protection initiatives because, one, passage of volunteer protection legislation by the Congress would be a vital reaffirmation of the Nation's commitment to and appreciation of volunteerism, and, two, passage of this legislation would assist those charitable and volunteer dependent service agencies, which are unable themselves to extend liability protection to their volunteers, to attract and retain volunteers.

Much is spoken annually in praise of volunteerism, but few actions are undertaken in its support. As a matter of fact, some new, necessary but, nevertheless, burdensome requirements are constantly being placed on volunteers. Criminal background checks and IRS expense deductibility requirements come to mind. But

there comes a point when the risks and complications of volunteering may outweigh the desire to serve and minimize the satisfaction of serving. By enacting volunteer protection legislation, the Congress can demonstrate that the Nation's support for voluntary action is expressed not only through speeches and awards, but also through helpful and vigorous public policy.

Thank you.

[The prepared statement of Ms. Franklin follows:]

PREPARED STATEMENT OF CHRISTINE G. FRANKLIN, VICE PRESIDENT, NATIONAL OFFICE OF VOLUNTEERS, AMERICAN RED CROSS

My name is Chris Franklin and I am Vice President, National Office of Volunteers of the American Red Cross. Thank you, Mr. Chairman, for inviting the American Red Cross to testify on volunteer tort liability protection. We greatly appreciate the fact that you seek to further the cause of voluntary action not only by encouraging and showing interest and respect for our work, but also by studying and seeking to remedy some of the problems we in the nonprofit sector face in the accomplishment of our mission.

BACKGROUND

The American Red Cross is a volunteer organization in a very special sense of that word. The work force of the American Red Cross is comprised of 1.4 million volunteers and 32,200 paid staff. Almost one third of our 1582 chapters are all-volunteer chapters. Throughout our organization, volunteers undertake senior-level and middle-level management tasks, assume supervisory and training responsibilities, and deliver client services that include—among many others—disaster relief, disaster damage assessment, provision of biomedical services, the teaching of first aid, safety, and HIV/AIDS prevention courses, and a wide range of services to vulnerable populations: the ill, the elderly, the young, and the handicapped. The American Red Cross is governed by an all-volunteer Board of Governors at the national level and all-volunteer boards at the community level.

The above figures and the history of the Red Cross tell the same story. Our volunteers are not merely extension of paid staff or in any sense supplementary workers. As a matter of fact, until the early 1900's the American Red Cross operated with no paid staff at all, and it wasn't until 1950 that the presidency of the organization became a paid position. Thus volunteers *are* the Red Cross, by a 43:1 ratio, and without them we would quite literally cease to exist. Consequently, when we speak of tort liability issues affecting volunteers, we are speaking of issues that directly affect our ability to provide the services on which so many rely in time of war, in time of disaster, and in the emergencies of our daily lives.

INTERNAL RED CROSS VOLUNTEER TORT LIABILITY POLICY

Before I articulate our public policy position on volunteer tort liability and the legislation you are considering today, I would like briefly to describe our internal policy on volunteer protection. It may be stated as follows:

In all Red Cross administered programs, we assume fully what we consider to be our corporate and moral responsibility of providing tort liability coverage to American Red Cross staff, both paid and volunteer, through our own insurance program. We do not maintain separate coverage for volunteers. It is all one and the same program. Volunteers and paid staff are treated in identical fashion for questions of individual and corporate liability because volunteers perform the same work as paid staff, are held to the same high standards as paid staff, and run the same risks as paid staff.

The basis for our tort liability policy is the principle of supervision and control. We assume liability as an organization for those situations where we are in a position to control work conditions and work performance and can thus minimize risk. The way we minimize risk and provide quality assurance for both paid and volunteer staff is by: Appropriate assignment, rigorous training, adequate supplies, equipment, information and assistance, careful and on-going supervision, and periodic evaluation.

However, there is a group of Red Cross volunteers to whom the above does not necessarily apply. We refer to this group as "brokered" volunteers. These volunteers receive from the American Red Cross the basic orientation to the organization and to the responsibilities and opportunities of volunteerism, but they give their services

through other organizations and in other settings to which the American Red Cross has referred them. These settings are, for example, military or veterans' hospitals, Department of Defense schools overseas, Indian reservations, or Public Health Service shelters.

In these cases, the Red Cross does not provide the volunteers with its tort liability coverage because, once the referral process is completed and the volunteers report to work, they come under the direct control, supervision, and authority of another organization. For these volunteers, the American Red Cross seeks to negotiate the assumption of tort liability coverage by the organizations in charge of the programs in which they work. In this connection, and as an example, I would like to mention that in September of 1990 the Administrative Law and Government Relations Subcommittee of this Committee was very helpful to us in securing a Memorandum of Understanding from the Defense and Justice Departments that guaranteed federal tort liability protection to Red Cross volunteers who serve in military hospitals and—clinics.

AMERICAN RED CROSS PUBLIC POLICY POSITION ON VOLUNTEER PROTECTION

The American Red Cross has since 1988 supported Congressman John Porter's bill, H.R. 911, the Volunteer Protection Act, and the general principle of legislated volunteer protection. We continue our support of Congressman Porter's bill. It encourages states to enact the kind of comprehensive volunteer protection legislation which we favor and which was well described in the Model Volunteer Protection Bill developed by the Bush administration.

The American Red Cross also supports S. 1435, the Volunteer Protection Act of 1995, recently introduced in the Senate by Senator Mitch McConnell. The two bills are not in conflict. While the Porter bill would encourage states to act and provides them with certain guidelines, the McConnell bill actually would legislate volunteer protection. It would give volunteers tort liability immunity at the federal level and against claims of federal law as well as against state statutes and common law. It would preempt state law in case of conflict, but it would not prevent states from legislating creatively in this area and setting their own standards of volunteer protection.

For the American Red Cross, neither of the two bills would significantly reduce our national organization's tort liability exposure. That is because the bills would immunize volunteers acting in good faith, but not the organization for which the volunteers work. Thus enactment of these bills' provisions will have no impact on the Red Cross which already assumes tort liability responsibility for its volunteers.

The reason we nevertheless stand full square behind these volunteer protection initiatives is twofold:

Passage of volunteer protection legislation by the Congress would be a vital reaffirmation of the nation's commitment to, and appreciation of, volunteerism; and

Passage of this legislation would assist other charitable and volunteer dependent service agencies, which are unable themselves to extend liability protection to their volunteers, to attract and retain volunteers

A great deal of words are spoken annually in praise of volunteerism, but very few actions are undertaken in its support. As a matter of fact, many new (necessary but nevertheless burdensome) requirements are constantly being placed on volunteers. Criminal background checks and IRS expense deductibility requirements come to mind, but there are others. There comes a point when the risks and complications of volunteering may outweigh the desire to serve and minimize the satisfaction of serving. By enacting volunteer protection legislation, the Congress can demonstrate that the nation's support for voluntary action is expressed not only through speeches and awards but also through helpful and vigorous public policy.

In closing, I would like to refer again to the volunteer philosophy which determines our own volunteer policy and practices. We believe that those who encourage volunteerism and benefit from volunteers, in this case the society at large as well as individual organizations, must be willing to accept the costs and responsibilities properly associated with volunteer involvement. While, obviously, we do not owe volunteers a paycheck or a pension, we do owe them a positive volunteer experience. That cannot be achieved without a comprehensive support structure of which tort liability protection must be an integral part. Surely, we should not expect that, in return for their generosity of spirit, volunteers be asked to put their savings, their families' future, and their peace of mind at risk. To foreclose that possibility is a moral imperative that keeps volunteerism from becoming exploitative. It is also a realistic assessment of what is necessary to maintain volunteerism as a viable resource today and into the 21st century.

Mr. HYDE. Thank you very much.
Sister Bowman.

STATEMENT OF SISTER CHRISTINE BOWMAN, O.S.F., ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Sister BOWMAN. Good morning.

My name is Sister Christine Bowman and I am a Franciscan Sister of the Sacred Heart, currently ministering at Saint Anne's Maternity Home in Los Angeles in Congressman Becerra's district. I thank you for this opportunity to testify and for holding these hearings.

I am pleased to be here today to speak on behalf of the Catholic Health Association to support Congressman Goodlatte's bill and that of Mr. Porter. These bills will help free clinics recruit physicians and other health care volunteers. The legislation is a small but important step for encouraging the development of voluntary free medical clinics and improving the access to health care for the working poor. There are four points I wish to make before this committee.

The Catholic Health Association, first, strongly supports both of these bills. Second, free clinics are a local, effective community response to the plight of the uninsured. Third, fear of liability deters volunteerism among health care professionals at free clinics. Fourth, the Goodlatte and Porter bills encourage volunteerism without taking away the rights of the most vulnerable. Let me share with you my personal story of establishing a free clinic.

In 1992, I helped to found HealthReach, a clinic for the medically underserved in Waukegan, Lake County, IL, in the district of John Porter. The clinic was an outstanding example of community involvement. For example, our two major businesses, Abbott Laboratories and Baxter International, completely renovated and outfitted the clinic. And nearly every community organization was involved, including Catholic Charities, local churches, the Illinois Nurses Association, United Way of Lake County and the Lake County Health Department. HealthReach and the more than 200 free clinics throughout the country provide a valuable service.

A good example of this is the story of a 28-year-old male Hispanic and his 23-month-old son, who presented at the clinic with an active case and history of seizures. The father was working at two separate jobs that earned him only $314 a week for a family of six. Because of HealthReach, they received extensive neurological testing, medications, and treatment that successfully controlled their seizure disorder. This allowed the father to return to the work force and, further, enabled him to attend the city college to improve his work skills.

This free service was available only because of volunteers. Unfortunately, in our litigious society, health care volunteers fear lawsuits. Worries about liability were the No. 1 concern expressed by our prospective physician volunteers. To illustrate, an obstetrician/gynecologist from Florida expressed interest in volunteering at HealthReach during an extended stay in Illinois, but was concerned about liability. The HealthReach director shared with him the Illinois law providing protection for medical volunteers. He sent

the information to his lawyer who ultimately determined that the physician had protection. Because of this legislation, he continues to volunteer on his visits to Illinois.

Mr. Goodlatte's and Mr. Porter's bills are positive approaches to dealing with liability. We know that volunteer liability protection contributes to the increase in the number of free clinics. For example, in the 10 years prior to passage of similar legislation in Virginia, there were only two free clinics. Today there are 29. While we know what these bills do, it is important to understand what they do not do. They do not take away the patient's right to sue the clinic or the physician in cases of gross negligence or willful misconduct. The bills offer liability protection which encourages the establishment of free clinics and broadens the access to health care. Rather than losing the right to sue, the patient is given the opportunity to choose access to health care.

In conclusion, the Catholic Health Association believes that free clinics can be a low-cost, community-based approach to improving access to basic health care for uninsured persons. But free clinics need volunteers to survive. And the threat of lawsuits is a strong disincentive to volunteering, especially for physicians. We applaud the insight of Mr. Goodlatte and Mr. Porter in initiating these bills. Their legislation will reduce a barrier to volunteers and encourage the establishment of free clinics.

Thank you.

[The prepared statement of Sister Bowman follows:]

PREPARED STATEMENT OF SISTER CHRISTINE BOWMAN, O.S.F., ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Good afternoon. My name is Sister Christine Bowman. I am a Franciscan Sister now working at St. Anne's Maternity Home in Los Angeles. I am pleased to be here today on behalf of the Catholic Health Association to support legislation that would help free clinics recruit physicians and other health care volunteers. This legislation would be a small but important step toward improving the access of thousands of working, but uninsured families to quality health care.

At a time when the federal government is reducing the growth in health care spending and an ever growing number of people are medically uninsured, we must look for low cost ways communities and voluntary organizations can bring health care to uninsured persons and families.

The federal government has demonstrated its interest and commitment to the issue of providing health care for the disadvantaged in numerous programs over the last fifty years, including Medicaid, the Public Health Service Act and the recently passed Federally Supported Health Centers Assistance Act. As you know, the numbers of uninsured Americans has continued to grow to over 41 million. I know from personal experience that for many working poor families, free clinics can be their only lifeline to health care.

In 1989, I was involved in the establishment of HealthReach, a free clinic in Waukegan, Illinois, a member of the Free Clinic Foundation of America. Working with an assessment group from Saint Therese Medical Center, local parishes, and a number of civic, religious and community leaders, we identified a severe need for primary and preventive health care for medically uninsured persons. We found our county did not offer medical care for working poor families who were uninsured for health care benefits, unable to qualify for Medicaid, and unable to afford the most basic care.

To plan the clinic, we expanded our group to include the health department, other nonprofit hospitals, Catholic Charities, the United Way of Lake County, the Illinois Nurses Association, and area physicians. Local businesses became also involved. As part of Abbott Laboratories' executive management development program, 30 executives from around the world learned how to work together as a team by renovating our clinic in two days. Baxter International sent in a design team and completely outfitted the clinic. This was truly a community effort.

In its first three months of operation, HealthReach saw more than 400 patients, 50 percent Hispanic, 25 percent black and 25 percent Caucasian. Diagnosis ranged from the common cold to acute liver failure. Since HealthReach went into operation, the use of area emergency rooms for non emergency care seems to have decreased.

We know that the clinic is valued by the persons we serve. I remember one evening when an elderly woman came for care and, seeing our sign requesting donations, opened her purse and gave the nurse everything she had: seventeen cents. Of course the nurse said we could not take her last cent, but the woman insisted. "This is very important to me," she said.

The clinic is staffed completely with volunteers, although we now have a paid executive director and two part time nurses on who fill in when we do not have sufficient volunteers. Physicians, nurses, translators, dietitians, social workers form the volunteer pool. Some former patients have also returned to volunteer their time.

The lifeblood of our clinic in Waukegan and all free clinics is volunteers. Unfortunately, in our litigious society, health care volunteers fear lawsuits. Worries about liability were the number one concern raised by our prospective physician volunteers. I have been told that liability issues are the most frequently given reason why physicians hesitate to volunteer in other free clinics throughout the country.

I once asked a physician friend if he could volunteer at HealthReach even one hour a year. He told be he would see charity patients in his office, but he insurance did not cover him in our clinic so he could not volunteer at all.

For free clinics and their volunteers, the risk of lawsuits may be more perception than reality. The Catholic Health Association has not come across a single reported case of a free clinic or a free clinic volunteer being sued.[1] This should not be surprising: free clinics provide primary and preventive care. Under normal circumstances, they do not care for trauma victims, perform surgery, deliver babies, or engage in high risk medical procedures. If specialty care is available, it is usually by referral to a physician in their offices.

Most free clinics do not provide malpractice liability insurance for volunteers because of the prohibitive cost. Like HealthReach they prefer to spend scarce resources in medicines, X-rays, lab and other services directly related to patient care. Yet, the perception of liability is a strong disincentive for many prospective volunteers.

Legislation being considered here today would make great strides in addressing the disincentive to volunteerism encountered by numerous health care professionals throughout the nation. Congressman John Porter has introduced H.R. 911, the Volunteer Protection Act to encourage states to enact legislation granting immunity from personal civil liability to volunteers working for nonprofit groups, such as ours. Congressman Robert Goodlatte's H.R. 2938, the Charitable Medical Care Act of 1996, specifically offers increased protection to health care professionals serving the poor in free clinics.

In addition, three bills have been introduced in the Senate. These bills include:

S. 1435, introduced by Senator Mitch McConnell and companion legislation to Congressman Porter's bill, which would grant immunity from personal civil liability to volunteers working on behalf of nonprofit organizations and government entities.

S. 1217, introduced by Senator Dan Coats, provides that a health care professional who delivers health service to medically under served persons without receiving compensation for the service shall be regarded as an employee of the federal government for purposes of malpractice claims.

S. 1351, introduced by Senator Carol Moseley-Braun and companion legislation to Congressman Goodlatte's bill, which would offer increased liability protection to health care professionals volunteering their time in free clinics.

The Catholic Health Association supports all of these bills. We believe that each, while taking a different approach, would make an important contribution toward eliminating a barrier to volunteering in free clinics.

While each bill would begin to relieve health care professionals' concerns about liability, it is important to realize what these bills would not do. None would take away a patient's ability to sue the clinic itself. None would take away a patient's ability to sue in cases of gross negligence or willful misconduct. We understand the vulnerability of patients in free clinics, and we believe it is critically important that they maintain these legal rights. Yet, the right to sue for negligence is an empty promise if an individual cannot obtain needed health care in the first place. These bills strike the appropriate balance between the needs of volunteers to enable them

[1] A computerized search of State and Federal reported decisions failed to unearth any case in which free clinics or their volunteers were sued for the negligent provision of health care.

to provide care to our most disadvantaged citizens and the needs of patients to insure that they have access to quality care.

Protecting those providing health care services is not an issue of first impression at the state or federal level. All states have passed some form of "Good Samaritan" laws to protect volunteers in an emergency situation. Thus, state governments have already made the determination that the threat of a negligence lawsuit may deter a health care professional from helping someone in need. I believe that we are in an emergency situation with respect to providing services to the uninsured. As their numbers continue to climb and the federal resources dedicated to serving them are reduced, the private sector, in the form of community involvement, must bridge the gap. The legislation advocated by Congressmen Porter and Goodlatte will help to encourage this community and volunteer involvement.

At least ten states have taken steps to protect volunteers in free or non-profit clinics.

These states include, Virginia, Utah, North Carolina, Florida, Kentucky, South Carolina, Iowa Wisconsin, Illinois, and Washington, D.C. Virginia may have enacted the legislation most conducive to the voluntary provision of health care services. Similar to Congressman Goodlatte's legislation, the Commonwealth permits suits against licensed volunteers in free clinics only for an act or omission that resulted from gross negligence or willful misconduct. In addition, similar to Senator Coats' legislation, the Commonwealth may deem volunteers as its agents and then provide their legal defense in the case of a malpractice suit.

The federal government has also taken steps to limit liability in order to maximize the provision of health care services. Just last year, the House and Senate unanimously passed and the President signed into law, the Federally Supported Health Centers Assistance Act of 1995. Basically, the federal government decided to spend its scarce resources on the provision of health care rather than on insurance to defend community health centers from a limited number of negligence suits. Thus, those working at or affiliated with community health centers may be deemed employees of the Public Health Service and may be defended by the federal government in malpractice suits brought against them. This law has the same goal as the legislation being sponsored by Congressmen Goodlatte and Porter—to expand the provision of health care services to the most disadvantaged members of our community.

In conclusion, the Catholic Health Association believes that free clinics can be a low cost, community based approach to improving access to basic health care for uninsured persons. But free clinics need health care volunteers to survive, and the threat of frivolous lawsuits are a strong disincentive to volunteering, especially for physicians. Both Mr. Porter's and Mr. Goodlatte's bills would be helpful in reducing that barrier to volunteers and would encourage the establishment of free clinics. We congratulate both Congressmen on their legislation, and commend the Committee for holding hearings on this important subject.

Mr. HYDE. Thank you very much, Sister.

And now Mr. John H. Graham.

STATEMENT OF JOHN H. GRAHAM IV, CEO, AMERICAN DIABETES ASSOCIATION, ON BEHALF OF THE AMERICAN SOCIETY OF ASSOCIATION DIRECTORS AND THE NATIONAL COALITION FOR VOLUNTEER PROTECTION

Mr. GRAHAM. Thank you, Mr. Chairman and distinguished committee members.

My name is John Graham and I am the chief executive officer of the American Diabetes Association, an organization representing over 1 million volunteers. I'm also here on behalf of the American Society of Association Executives, an organization representing more than 23,500 individuals from more than 11,000 National, State, and local trade and professional associations. As a member of ASAE's board of directors, I can report that these associations are completely dependent upon volunteers who serve their boards and committees and who perform direct service functions.

Because the American Diabetes Association and ASAE represent organizations that rely so heavily on volunteers, we are both found-

ing members of the National Coalition for Volunteer Protection. This coalition was formed in 1987 by over 100 volunteer dependent organizations to enhance awareness of volunteerism and to address the threats of volunteerism to America. The National Coalition for Volunteer Protection continues to coordinate and generate support for the passage of volunteer protection legislation. As of February 1, 1996, the coalition represents over 250 National, State, and local volunteer dependent groups. These groups utilize tens of millions of volunteers.

I thank the committee for conducting this hearing on the critical issue of volunteer protection. More specifically, I am pleased that the committee is considering H.R. 911, the Volunteer Protection Act. This committee must address a number of important issues and I'm heartened that the committee recognizes the degree to which volunteerism has suffered due to liability concerns.

I will focus my testimony on the effect that the liability crisis has had on volunteer participation in charitable organizations and trade associations grouped by the IRS designation of 501(c)(3), (c)(4), and (c)(6). The protection of volunteers is critical because volunteers are withholding their services and because State volunteer protection laws are dangerously inconsistent and discriminatory. But this issue is also critical because of the victims who are citizens who would otherwise provide uncompensated services to society. These victims are volunteers who house and feed the homeless, who treat and support the elderly, and who clothe and care for the poor.

These volunteers provide services which fill gaps in government and private programs for the truly needy, gaps which will no doubt increase over the next decade as both Federal and State governments make fiscal responsibility and balanced budgets the cornerstone of public policy; nonprofit organizations and their volunteers will play an even larger role in helping those in need. It is no coincidence that the issue of protecting volunteers has followed massive increases in both the size and litigation claims and the cost of liability insurance. As the size of the claims rises along with the number of defendants in each lawsuit, insurers point their fingers at the tort system. And, conversely, as liability insurance premiums rise, plaintiffs' attorneys scream for Federal regulation of the insurance industry.

Many states have acted to both protect volunteers from negligence lawsuits and to reduce liability insurance costs for nonprofits. All 50 states have passed laws limiting the liability of directors and officer of nonprofit organizations. About 15 states have properly instituted nonprofit risk management programs and/or risk pools to stabilize liability insurance premiums. Some of these State laws, however, are dangerously limited. For example, Indiana's names fraternity and sorority volunteers.

While each State has different volunteer needs, we firmly support a Federal effort to design consistent and comprehensive guidelines. This problem is not being corrected; rather, it is being exacerbated by States who provide limited liability for select groups of volunteers.

In total, State volunteer protection laws are patchwork and inconsistent and discriminatory. Because of the lack of consistency in

these State laws, volunteer leaders in many States are covered by limited immunity while direct service volunteers remain exposed. This inconsistency is creating a dangerous class system among volunteers. In addition to creating a class system among volunteers, substantially different civil justice standards apply to volunteers conducting identical services for the same organizations in different states. This inconsistency hinders efforts by national volunteer dependent organizations to accurately advise their chapters on volunteer liability and risk management guidelines.

We recognize that H.R. 911 is not a panacea. However, this legislation should help volunteer organizations promote consistent State standards. H.R. 911 should help ameliorate volunteer liability fears, and be they hospital volunteers, little league coaches or drug counselors.

A recent judgment, *Powell* v. *the Boy Scouts of America, et al.* in a personal injury lawsuit in Oregon, illustrates the continuing problem for volunteers. The case involved a youth seriously injured in an activity sponsored by the Sea Explorers. The youth sued the Boy Scouts and his two adult volunteers for negligence. The young man suffered a paralyzing injury in a rough game of touch football while participating in the outing.

At least one adult volunteer knew that the boys were throwing the football around, but neither observed the game in which the injury occurred. The court dismissed the original lawsuit against the Boy Scouts, evidently due to an insufficient nexus between the Boys Scouts and the youth's injury. However, the injured young man filed his lawsuit against the two adult volunteers who participated in the outing. In one of the largest monetary verdicts in Oregon history, the judge found against the two volunteers and held them liable for $7 million. The jury seemingly held the volunteers to a standard of care requiring the constant supervision of the youth in their care, even for the activities which may not warrant such care under other circumstances.

Mr. Chairman, committee members, it's time we stop the blame game. We must design careful and comprehensive solutions to the volunteer liability crisis. It's time to say no to the powerful forces who oppose this bill. We must say yes to those in the front lines, our country's volunteers. The Volunteer Protection Act is greatly needed as part of this solution. Without this legislation, volunteers will continue to withhold their services, nonprofit organizations will not attract and retain quality volunteers, and many social services in America will suffer.

Mr. Chairman, I urge you to report this bill out of your committee as soon as possible. We need this legislation so States will have an incentive in this issue. Literally tens of millions of American volunteers are following this legislation. They will be grateful when you report it out from your committee.

On behalf of those volunteers and on behalf of the volunteer member organizations throughout this country, I thank you for the opportunity to testify and welcome any questions you may have.

[The prepared statement of Mr. Graham follows:]

PREPARED STATEMENT OF JOHN H. GRAHAM IV, CEO, ON BEHALF OF THE AMERICAN SOCIETY OF ASSOCIATION EXECUTIVES AND THE NATIONAL COALITION FOR VOLUNTEER PROTECTION

Mr. Chairman, and distinguished committee members, my name is John H. Graham IV and I appear before this committee on behalf of a variety of organizations. Principally, I am the Chief Executive Officer of the American Diabetes Association, an organization representing over 1 million volunteers.

I am also here on behalf of the American Society of Association Executives (ASAE), an organization representing more than 23,500 individuals from more than 11,000 national, state and local trade and professional associations. As a member of ASAE's board of directors, I can report that these associations are completely dependent upon volunteers who serve on their boards and committees and who perform direct service functions.

Because the American Diabetes Association and ASAE represent organizations that rely so heavily on volunteers, we are both founding members of the National Coalition for Volunteer Protection. This coalition was formed in 1987 by over 100 volunteer-dependent organizations to enhance awareness of voluntarism, and to address the threats to voluntarism in America.

The National Coalition for Volunteer Protection continues to coordinate and generate support for the passage of volunteer protection legislation. As of February 1, 1996, this coalition represents over 250 national, state and local volunteer-dependent groups. These groups collectively utilize tens of millions of volunteers.

I thank the Committee for conducting this hearing on the critical issue of volunteer protection. More specifically, I am pleased that the committee is considering H.R. 911, the *Volunteer Protection Act*. This Committee must address a number of important issues, and I am heartened that the Committee recognizes the degree to which voluntarism has suffered due to liability concerns.

I will focus my testimony on the effect that the liability crisis has had on volunteer participation in charitable organizations and trade associations—groups with the IRS designation of 501(c)(3), (c)(4), and (c)(6).

The protection of volunteers is critical because volunteers are withholding their services and because state volunteer protection laws are dangerously inconsistent and discriminatory. But this issue is also critical because the victims are citizens who would otherwise provide uncompensated services to society. These victims are volunteers who house and feed the homeless, who treat and support the elderly, and who clothe and care for the poor.

These volunteers provide services which fill large gaps in government and private programs for the truly needy—gaps which will no doubt increase over the next decade. As both federal and state governments make fiscal responsibility and balanced budgets the cornerstone of public policy, nonprofit organizations and the volunteers they utilize will play an even larger role.

Nonprofit organizations mobilize volunteers by drawing on their members' special talents to meet social or economic needs. For example, associations unite their members' talents and help alleviate hunger, educate the public about alcohol and drug abuse, promote literacy and other educational programs, find missing children, improve the condition of health care facilities, give eye care to the poor, offer medical aid to the homeless, teach fire safety, and aidm victims of natural disasters. In a 1990 study by the Hudson Institute, which covered 5,500 associations, volunteer time was conservatively estimated to total $3.3 billion per year (time was valued at $10 per hour).

It's no coincidence that the issue of protecting volunteers has followed massive increases in both the size of litigation claims and the cost of liability insurance. As the size of claims rise—along with the number of defendants named in each lawsuit—insurers point their fingers at the tort system. And, conversely, as liability insurance premiums rise, plaintiff's attorneys scream for federal regulation of the insurance industry.

The National Coalition for Volunteer Protection is a relatively tiny player in this massive policy battle. We are funded at a minimal level by volunteer-dependent organizations. We don't have the resources to compete with the trial lawyers or the insurance industry. But we do have the support of millions of American volunteers. We know we can't win this battle with money, so we are working to win through grassroots persistence and volunteers who vote.

Many states have acted to both protect volunteers from negligence lawsuits *and* to reduce liability insurance costs for nonprofits. All fifty states have passed laws limiting the liability of directors and officers of nonprofit organizations. Several states have properly instituted nonprofit risk management programs and/or risk pools to stabilize liability insurance premiums.

Some of these state laws, however, are dangerously limited. For example, Indiana's law names fraternity and sorority volunteers. While each state has different volunteer needs, we firmly support a federal effort to design consistent and comprehensive guidelines for state volunteer liability standards. This problem is not being corrected, rather it is being exacerbated by states who provide limited liability for select groups of volunteers.

We recognize that H.R. 911 is not a panacea; however, this legislation should help volunteer organizations promote consistent state standards. H.R. 911 should help ameliorate volunteer's liability fears—be they hospital volunteers, little league coaches, or drug counselors.

There is little quantitative data which links tort reform to insurance rates. Nevertheless, if this bill is enacted, and if states comply, we will reach the goal of reducing exposure for volunteers. Protecting volunteers should be in everyone's best interest, including the plaintiff's bar as well as the insurance industry.

A 1988 Gallup study offers some insight into the extent of the volunteer liability issue. Since most of the facts regarding volunteer liability have not changed since 1988, we believe that the findings of the study would be similar if undertaken today.

The study, "The Liability Crisis and the Use of Volunteers by Nonprofit Associations," was released by the Gallup Organization in January 1988. The study was sponsored by the American Society of Association Executives and funded by the Gannett Foundation. This study also concentrated on director and officers liability, some revealed very interesting data on the effect of this crisis on direct service volunteers. According to the study:

> Approximately one in ten nonprofit organizations have experienced the resignation of a volunteer due to liability concerns. If this figure were multiplied by the number of nonprofit organizations in America (600,000), then 48,000 volunteers would have been lost during the past few years strictly due to liability concerns. 48,000 is a significant number of volunteers. Remember: *these volunteers resigned.* Resignation is a very drastic measure.
>
> One in six volunteers report withholding their services due to fear of exposure to liability suits. If this figure is applied to the number of nonprofit groups, then as many as 100,000 American volunteers have declined to serve due to fear of exposure to lawsuits. This is an extraordinary figure.

This survey also highlighted the increased cost of liability insurance premiums for associations in recent years. The average reported increase in the past three years is 155%, and one-in-eight organizations report an increase of over 300%, roughly the equivalent of a two-fold increase over 1984 rates.

This study revealed that the extent to which the threat of law suits, and the prohibitive cost of liability insurance, have a negative effect on volunteer participation in charitable organizations and associations. The Gallup study provides hard data which demonstrates the degree to which tax-exempt organizations have been damaged by the liability crisis.

This is not an imaginary problem as opponents of this legislation may suggest; this problem is real problem and it is eroding voluntarism in America. I know from my personal experience as a volunteer leader and as a direct service volunteer that many potential volunteers avoid making a personal commitment to serve nonprofit charitable organizations and associations in order to avoid personal risk.

A recent judgment (*Powell* v. *Boy Scouts of America, et al.*) in a personal injury lawsuit in Oregon illustrates the continuing problem for volunteers. The case involved a youth seriously injured in an activity sponsored by the Sea Explorers. The youth sued the Boy Scouts and its two adult volunteers for negligence. The young man suffered a paralyzing injury in a rough game of touch football while participating in the outing. At least one adult volunteer knew that the boys were throwing a football around, but neither observed the game in which the injury occurred.

The Court dismissed the original lawsuit against the Boy Scouts, evidently due to an insufficient nexus between the Boy Scouts and the youth's injury. However, the injured young man filed his lawsuit against the two adult volunteers who participated in the outing. In one of the largest monetary verdicts in Oregon history, the jury found against the two volunteers and held them liable for $7 million. The jury seemingly held the volunteers to a standard of care requiring the constant supervision of the youth in their care, even for activities which may not warrant such care under other circumstances.[1]

Through the *Volunteer Protection Act,* the two groups which have contributed to this problem—and which have blocked a meaningful, comprehensive solution—will be encouraged to sit down in each state capitol and compromise. This will help stop

[1] Cople III, William J.; "Unfair Lawsuits Threaten Volunteers," *Legal Backgrounder,* Washington Legal Foundation, Vol. 9, No. 45, December 16, 1994

the posturing and stop the distrust. It will also require each group to offer a pint of blood; blood which can be used to revitalize the volunteer spirit in this country.

While we point fingers it's important not to condemn all trial lawyers and all insurers. There are insurance companies which support this legislation even though it may mean lost market share. There are trial lawyers which support this legislation regardless of the fact that their national trade association fervently opposes it.

But we need a vehicle to bring these groups together to negotiate a solution to the problems of volunteer liability.

Mr. Chairman, committee members, it's time we stop the "blame" game. We must design careful and comprehensive solutions to the volunteer liability crisis. It's time to say "no" to the powerful political forces and say "yes" to those on the front lines—our country's volunteers.

The National Coalition for Volunteer Protection was created to promote federal legislation which addresses the volunteer liability issue. We look forward to working with the members of this Committee to complete the design of a fair and balanced bill. We also look forward to working with this Committee to give a jump start to this important legislation. As you are well aware, volunteer protection legislation has been introduced in every Congress since 1987, and each time it has gained significant support from both sides of the aisle—more than 150 Members have cosponsored the bill in each of the last four Congresses.

The *Volunteer Protection Act* is a greatly needed part of the solution. Without this legislation, volunteers will continue to withhold their services, nonprofit organizations will not attract and retain quality volunteers, and many social services in America will suffer. Mr. Chairman, I urge you to report this bill out of your Committee as soon as possible. We need this legislation so states will have an incentive to address this issue.

Additionally, in the House of Representatives the *Volunteer Protection Act* is the best approach for protecting volunteers because it covers all those who volunteer for nonprofit organizations. It does not single out certain types of volunteers for immunity. Volunteers should be treated equally whether they are Boy Scout leaders, Little League coaches, doctors working in free clinics, or whether they are engineers providing services during natural disasters. H.R. 911 would do just that.

Literally tens of millions of American volunteers are following this legislation. They will be grateful when you report it from your committee. On behalf of those volunteers, and on behalf of volunteer-member organizations throughout the country, I thank you for the opportunity to testify today. I welcome any questions you may have.

Mr. HYDE. I thank you, Mr. Graham.

The gentleman from Pennsylvania, Mr. Gekas.

Mr. GEKAS. I thank the Chair.

Ms. Franklin and Mr.—what is it?—Mr. Graham, on the question of volunteers, some 10 years ago when my previous district included the city of Williamsport, where everyone in the world knows Little League championship games are held on an international basis, I met with the board at that time, which included distinguished people in the sports picture as well as volunteers who man and woman the Little League fields throughout the world, really, where an outrageous example of what we're discussing here occurred and was discussed at that meeting.

Namely, the little leaguer who was sent by the coach out to left field, appropriately enough I guess, and as a result of his placing him out there, on a pop fly that went out to his area, the youngster miscalculated and the ball hit him squarely on the head, and, as a result, a massive personal injury suit was instituted against everybody concerned. And that seemed to be egregious enough to have people try to do something about this.

At any rate, at that time I introduced a bill, and, coincidentally, John Porter cosponsored it at that time, which went to that subject—this is 10 years ago now; now we're reaching a stage where maybe we ought to be doing something.

But here's the point that I wanted to make: last year at some time many of the volunteer agencies, perhaps some of your own included, met with our Republican Task Force on Liability and seemed to endorse this feature of our plans to try to limit liability, the Red Cross being one as I recall, Girl Scouts and Boy Scouts being two others.

Yet, within a couple of months we heard rumors, which you may be able to dispell, that the Red Cross was withdrawing and that the Girl Scouts were withdrawing from this coalition that we had put together to try to do something about limiting liability for volunteers. Perhaps the panelists could put the end to such rumors, if they can, or substantiate them. I ask Ms. Franklin first.

Ms. FRANKLIN. I came with a national organization a year and a half ago and I am not familiar with that particular part of our activity, but we do firmly believe that tort liability protection for volunteers is key, not only for ourselves, because, as I said, our own insurance policy covers both paid and volunteer staff, but also on behalf of all of the other organizations that may not be able to afford that kind of policy. So we are here today on behalf of this measure.

Mr. GEKAS. If you wouldn't mind, I would value it if you would check with the office to see if there were some contradictory evidence on the position of the Red Cross and if it changed, how, et cetera. That would be helpful.

Ms. FRANKLIN. I'd be happy to. We will get back to you.

Mr. GEKAS. The same with Mr. Graham.

Mr. GRAHAM. I have no information on the Boys Scouts or the Girl Scouts, but I would happy to find out for you.

I can speak on behalf of the American Diabetes Association and indicate that we are very much supportive of this legislation and always have been for a number of years now.

Mr. GEKAS. All right. Particularly, I do remember a discussion as to the Girl Scouts. I hope it isn't with the cookies, because I'm a regular purchaser of that commodity, but I would appreciate additional information on that because, if there's a waivering of conscience there, then they ought to be a part of what we consider in this.

Mr. GRAHAM. I'll certainly do my best to provide that, sir.

Mr. GEKAS. I have nothing further for the panel, and reluctantly I yield back the balance of my time.

Mr. HYDE. I thank the gentleman.

The distinguished gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Graham, you mentioned the $7 million verdict in the *Boy Scout* case. Was that appealed?

Mr. GRAHAM. I don't have that information. I assume it was.

Mr. SCOTT. So it could have been thrown out?

Mr. GRAHAM. It could have been.

Mr. SCOTT. Do you have any idea how much it would cost to get, for a national organization like the Boy Scouts, to get insurance? I'm sorry.

Mr. GRAHAM. I've just been informed the case has not yet been thrown out. It has been appealed but not thrown out.

Mr. SCOTT. OK. How much would it cost to get insurance for the Boy Scouts to protect them against such suits?

Mr. GRAHAM. I don't know how much it would cost for the Boy Scouts of America, but I can tell you that for the American Diabetes Association it costs us approximately $150,000 a year for officers' and directors' liability, not to even mention other liability coverages we need for special events and activities.

Mr. SCOTT. Does that include your affiliates?

Mr. GRAHAM. Yes. That's just for officers and directors.

Mr. SCOTT. What about volunteers?

Mr. GRAHAM. Officers and directors are volunteers.

Mr. SCOTT. You mentioned in your testimony the groups 501(c)(3), (c)(4), and (c)(6). I think one of the bills just had 501(c)(3). I thought about community action agencies which are in a different area. What are (4) and (6)?

Mr. GRAHAM. 501(c)(4) and (6) organizations would be trade associations or professional associations like the American Medical Association, for example, organizations that are organized around a trade or a profession.

Mr. SCOTT. So, as we consider the legislation, we might want to make sure that everything is covered?

Mr. GRAHAM. The legislation, as I understand it, is for all, all 501(c) organizations.

Mr. SCOTT. OK. Sister Bowman, you indicated, I think in your verbal or other testimony, that no suits had been filed?

Sister BOWMAN. That is correct. To our knowledge, sir, we've not unearthed any specific lawsuit brought about for a volunteer in a free medical clinic offering services pro bono.

Mr. GEKAS. Well, your malpractice insurance ought to be very low then.

Sister BOWMAN. Did you say our insurance must be very low? Well, we count a lot on divine intervention. But it is entirely prohibitive for clinics like HealthReach and the Bradley Free Clinic in Roanoke to be able to afford liability insurance.

Mr. SCOTT. Notwithstanding the fact that no suits have been filed—I think that's an insurance question.

Sister BOWMAN. Assurance or insurance?

Mr. SCOTT. Insurance.

Sister BOWMAN. OK.

Mr. SCOTT. One of the problems that some of us have with the idea is that you are setting up a dual system. Some who go to get health care have the, I think it's assurance, that if there is any negligence, the physician would be responsible. Others who get health care, the physician, for simple negligence, would not be responsible. As I understand it, you assume that the organization would be responsible, and, therefore, the patient isn't paying the price for this immunity. Is that right?

Sister BOWMAN. Correct, the patient is not paying the price for the immunity. If I could proceed with that, the misperception that a physician may be sued, or any other medical volunteers otherwise, is the reality, that is, it's harder to correct a misperception than to change facts. We're dealing here with an access problem. These bills are designed to help ensure access. Sure, no one has ever been sued, but I've worked with these people and the dif-

ference is being able to choose the right to health care. Since there isn't an issue about a suit, these patients are able to get the access to health care that they seek. And this way a patient that has undergone treatment and suffers from wanton misconduct or gross neglect does have the right to sue.

Mr. SCOTT. But if they had gone to another facility to get health care rather being relegated to the only thing they can get, they would have received compensation for simple negligence. If they go to a free clinic and get poor treatment and suffer as a result, I thought I understood your testimony to say that the clinic itself could be liable.

Sister BOWMAN. Yes.

Mr. SCOTT. So that the patient doesn't suffer the burden of having to pay for the malpractice without recourse so long as the clinic itself is liable?

Sister BOWMAN. Yes. As I understand the bill, that could be the case.

Mr. SCOTT. OK. And I think that removes the dual standard because a patient knows when they go to get the service that the service provider is going to be responsible for their actions, and they're not a hapless victim with bills that could be forced on them through malpractice. So the key there is that the organization itself needs to maintain a situation where they are liable. The volunteer would have the immunity.

Sister BOWMAN. If this bill were passed, yes, there would be protection for the volunteer itself. The cost of medical malpractice for volunteers is very expensive. It's not quite so for the clinic.

Mr. SCOTT. Well, if the volunteer had immunity but the clinic were responsible, then we would have covered all of our bases. The volunteer comes in with the immunity. The patient who is a victim of malpractice still has recourse. So that everything works out nicely as long as the clinic has the responsibility.

Mr. HYDE. The gentleman's time has expired.

Mr. SCOTT. Thank you.

Mr. HYDE. The gentleman from Virginia, Mr. Goodlatte. Or had we gone from you first to Mr. Scott?

Mr. GOODLATTE. No. Thank you, Mr. Chairman.

And to clarify what my friend from Virginia has raised, let me make a couple of points: one, the difference between the Porter bill and the Goodlatte bill is that the Porter requires the volunteer organization—and it's broad; it covers all volunteer organizations, not just free clinics—to have insurance in order to qualify. My bill protects the volunteer, does not protect the clinic, but does not require the clinic to have insurance, either. And given the small size and the small amount of assets of some of these clinics, that is a difference, and you correctly point that out.

I'd also point out, however, that this is the law in Virginia that passed into law during your tenure in the Virginia General Assembly. I don't know how you voted on it.

Mr. SCOTT. I think I even voted for it. [Laughter.]

Mr. GOODLATTE. In any event, I'd like to tie the comments from my friend from Pennsylvania to those of my friend from Virginia regarding the insurance issue, because I remember from the debate—I may not have the figures exactly right—but he mentioned

Girl Scout cookies and you mentioned how much it costs. The information that we got was that the Girl Scout Council here in the Washington, DC, had to sell 70,000 boxes of Girl Scout cookies in order to raise the amount of money necessary to pay for their liability insurance just in this particular area.

So it is a very, very serious problem. And I don't know what the experience is of the Girl Scouts, but from my own information from the free clinics in my district, particularly the Bradley Free Clinic which is involved in helping to organize free clinics all over the country through the foundation that is also located in Roanoke, we don't know of any instances, but, as I've indicated before, it's really a problem of who is, as an individual, is going to take the risk to provide the care that's necessary if they might be that one person who gets sued and has the very costly expense of defending the suit even if they are ultimately not found liable or to even face a very large verdict.

And I think the most important point to make here is that we're talking about people who in most instances would not get any other help if they did not have the benefit of free clinics. These are people who do not qualify for government programs for the most part. They are above that income level, but they are just barely above that level, need assistance, and would not get it if we cannot encourage good, decent health providers—doctors, nurses and other people who provide these services—to give of their own free time as Good Samaritans, to help people. And under those circumstances, I think these people deserve that kind of protection.

I'm not sure that light applies to me. I didn't realize I used that much time.

Mr. HYDE. It does apply to thee; however, I'm sure the gentleman is near the close of his questions.

Mr. GOODLATTE. Yes, I have one more.

Ms. Franklin, does the Red Cross have free clinics?

Ms. FRANKLIN. We don't have free clinics per se. Needless to say, when we end up in a disaster situation, we are serving many people, a wide variety of people, with needs. We involve a number of volunteers who come to us with various skills and that happens in a variety of settings.

Mr. GOODLATTE. So my bill may not serve your needs, but Mr. Porter's does, and I would add that I'm a cosponsor of his bill and very much support his. In fact, it may be that some combination of the ideas of the two would be in order.

I thank all of you for your interest in this important issue.

Thank you, Mr. Chairman.

Mr. HYDE. If I might say to my friend from Virginia, the Red Cross is one of the great organizations in the world because during World War II I remember they were there in Manila where I had been sent and I was trying to locate my brother, who was in the Phillipines somewhere, and the Red Cross was right there helping people get together, helping get mail, helping people who were wounded. And they weren't charging a fee. They did wonderful work. Of course, the Franciscan Sisters, the Diabetes Foundation, all of you represent the better side, the better angels of men's nature. The Red Cross was wonderful. I remember them in the years ago.

Well, the distinguished gentleman from New York, Mr. Serrano.

Mr. SERRANO. Thank you, Mr. Chairman.

Let me, first of all, echo the chairman's comments. It's not often that a panel composed of groups and representatives of groups that we can cheer about the work they are always doing, but this is the case today. So I thank you for your support.

And the more I think about this issue and after reading notes last night prepared by staff for this hearing today, I realize that this whole issue of having people volunteer and then find themselves faced in situations which come about simply because they're willing to give up their time is something that we should try to change, to protect them; also I know that in many cases the current situation presents costs that then leave out a lot of people from participating in many of these programs.

I had a situation this weekend where my son was in a basketball tournament, an AAU basketball tournament, and there was a $60 fee, most of which was to protect the volunteers from a broken ankle, or someone hit by a basketball at the wrong time. And as I was paying the fee—by the way it was double elimination; the team didn't do too well, so we paid for about 2 hours work on Sunday, but the intent was correct. [Laughter.]

It dawned on me that a lot of people from the community obviously could not have their child participate that day because it was $60 for the weekend. And if you had the one that got bumped off in two games, it was $60 for a couple of hours.

So I want very much to be supportive of this bill. What I'm asking you is a strange question perhaps: to help me and help us build the argument that Mr. Scott was touching on, that this in fact does not create a double standard for the poor and for certain communities.

The first question that's going to come to me in the South Bronx, which I represent, is, "Oh, wait a minute. So you're saying that because this person is poor he can only get services from volunteers that can be asked to come here but don't have to answer for their deeds, whereas the person who can afford to go there will have full protection." You answered that before, but I want you to elaborate because that's the part that's going to stick with a lot of people when we discuss this bill on the floor.

Sister BOWMAN. I think, if I may begin to answer your question, and I suppose you may be addressing all three of us, I think that there is a responsibility for the volunteer organization to make sure that there is some competency in the volunteers that are providing service for that organization. I can speak for the free medical clinics that there is a built-in mechanism for peer review and quality assurance to make sure that the practitioners practicing within the scope of their license are adequately credentialed and that, particularly through the hospitals with which the physicians are affiliated, that there is an understanding of their quality of work.

In fact, some of the peer reviews that occur in the clinics exceed some of that that I see in acute medical care. And having spent a number of years in that field, I can speak from firsthand experience. I think that's an important point not to be taken lightly.

Secondly, in terms of the volunteers who might be willing in a true altruistic spirit to provide their time, talent, energy, and in a lot of cases financial resources, to expose them, as our friend from the Diabetes Association indicated, is really adding insult to injury. And I believe that those that we invite to participate in our various organizations deserve, at the very least, the amount of protection that these pieces of legislation, not only in the House but in the Senate, may be able to provide for them.

Ms. FRANKLIN. I would like to echo that, if I may. The responsibility does lie on the organization to a large degree in terms of how we select the volunteers, how we orient and train them, the kind of supervision they get, what kind of evaluation they have over a period of time. And so I don't know of any volunteers who come to either fail or create a situation in which the organization or the individuals whom they help would be worse off than when they started. That's usually not the motivation that we find. And I think it does rely, in large measure, on the organization.

Additionally, I would echo what Sister has said in regard to working to the level of credentialing and licensure, where we have nurses in particular who are working in disaster sites or on the Armed Forces emergency services or in our blood services as well. They are always signed, if you will, by a licensed physician and work under that direct guidance. So I think that we have mutual obligations and that may be a part of your answer.

Mr. HYDE. The gentleman from Tennessee.

Mr. BRYANT of Tennessee. Thank you, Mr. Chairman.

I just wanted to commend the volunteers and the work that you do and say that these are two very good bills.

Mr. Graham, if you had a quick comment, otherwise I'll yield back my time after Mr. Graham finishes.

Mr. GRAHAM. I was simply going to make the comment, to further answer your question, that to me there's no downside to this bill. The organizations are still responsible. It's the volunteers who are off the hook. That to me is the upside and I don't see a downside.

Mr. HYDE. I want to thank this very distinguished panel for a great contribution. We will take to heart your testimony. It has helped us. And if we have questions, we'd like to submit them in writing and elicit your cooperation.

Sister BOWMAN. We'd be delighted.

Mr. GRAHAM. Thank you, Mr. Chairman.

Mr. HYDE. Thank you so much.

The hearing is adjourned.

[Whereupon, at 12:22 p.m., the committee adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARINGS

PREPARED STATEMENT OF THE NATIONAL STRUCTURED SETTLEMENTS TRADE ASSOCIATION

The National Structured Settlements Trade Association (NSSTA) is an organization composed of more than 500 members which negotiate and implement structured settlements of tort cases, including medical malpractice actions, involving persons with serious, long-term physical injuries.

In a structured settlement, a voluntary agreement is reached between the parties under which the injured person receives damages in the form of a stream of periodic payments tailored to his or her future medical expenses and basic living needs from a well-capitalized, financially-secure institution. Founded in 1986, the mission of NSSTA is to advance the use of structured settlements as a means of resolving personal injury tort claims, including medical malpractice claims.

NSSTA appreciates the opportunity to submit this statement to the Committee today. NSSTA strongly urges that, as part of any medical malpractice reform legislation considered by the Committee that seeks to expand the use of periodic payment arrangements in malpractice actions by permitting the defendant to unilaterally elect to pay damages on a periodic basis, the defendant correspondingly should be required to provide adequate security to assure that the future damage payments over the next 20 or 30 years or life will indeed be made to the seriously, often permanently injured malpractice victim.

I. PERIODIC PAYMENT ARRANGEMENTS PROVIDE IMPORTANT BENEFITS TO VICTIMS OF MEDICAL MALPRACTICE

Payment of damages in a medical malpractice action in the form of a long-term stream of periodic payments provides important protections to the victim by comparison with a lump sum recovery:

Protection against premature dissipation

A severely-injured person and his or her family often are ill-equipped physically, psychologically, or educationally to handle the financial responsibilities and risks of managing a large lump sum to cover a substantial, ongoing stream of medical expenses, such as for the remainder of a paralyzed child's life.

Tailoring payout to the needs of the particular victim

A periodic payment arrangement offers much greater financial certainty than a lump sum recovery for tailoring the payment of damages to the injured person's ongoing needs for medical expenses, family support, and education.

Avoids shift of responsibility to the Public sector

By avoiding the problem of premature dissipation of a lump sum recovery, the periodic payment mechanism avoids the ultimate shift of liability to care for a severely-injured person to the public sector in the form of Medicaid or other government-subsidized care.

II. ADEQUATE SECURITY NEEDED TO ASSURE FUTURE DAMAGE PAYMENTS TO INJURED CLAIMANTS

Periodic payment arrangements already are in common use today to resolve medical malpractice actions by means of voluntary settlements. Congress has specifically sought to encourage the use of periodic payment settlements in medical malpractice and other tort actions by enacting section 130 of the Internal Revenue Code.

Section 130 of the Internal Revenue Code was adopted as part of the Periodic Payment Settlement Act of 1982 (P.L. No. 97–473) to provide a mechanism under which badly-injured tort victims suffering harm well into the future could receive compensation in the form of a stream of payments from a financially-secure and experienced institution.

In adopting section 130, the clear focus of Congress was on providing maximum financial protection and security for a victim who has suffered serious, long-term physical injuries. Providing compensation to the victim in the form of a long-term stream of payments, such as the remainder of his or her life or 20 or 30 years, meets the injured person's medical and living needs over time and guards against premature dissipation of the recovery by the victim. However, the long-lived nature of the payment stream makes the financial health of the pay or a vital concern to the injured person.

The section 130 qualified assignment mechanism reflects a Congressional recognition of the perils of leaving a badly-injured person exposed to the uncertain financial prospects of a self-insured tortfeasor or a financially-impaired property and casualty carrier over the next 20 or 30 years. The key feature of section 130 is that it permits the obligation to make the stream of payments to the injured person to be transferred, with the victim's consent, from the tortfeasor (or its insurer) to a financially secure institution. Congress expressly mandated in section 130 that the assignee must fund its assigned payment obligation to the injured victim from two of the safest types of investments available—U.S. Treasury obligations or annuities of State licensed and supervised life insurance companies.

Flexibility for future needs of the injured person exists under the section 130 periodic payment arrangement in the form of a payment formula (agreed upon at the time of settlement) that can incorporate cost-of-living adjustments, stepped increases in payments over time, deferred lump sums, and similar features.

To provide even greater financial security to the injured victim, Congress amended section 130 to permit the victim to be given secured creditor status with respect to these high grade funding assets being used by the assignee to make the periodic payments.

Accordingly, the section 130 periodic payment arrangements are widely used today to settle medical malpractice actions.

In other instances, the defendant may choose to purchase and hold the annuity itself as the funding asset for the periodic payments to the victim. This funding asset in the defendant's hands may provide less financial security to the injured claimant than a section 130 periodic payment arrangement, depending on the financial strength of the defendant, because such asset would remain subject to the claims of the defendant's creditors.

III. EXPANDED USE OF PERIODIC PAYMENTS UNDER MEDICAL MALPRACTICE REFORM LEGISLATION—ADEQUATE SECURITY NEEDED TO ASSURE FUTURE DAMAGE PAYMENTS TO INJURED MALPRACTICE VICTIM

Periodic payment arrangements in medical malpractice actions today are most commonly entered into by voluntary arrangement of the parties. In the context of legislative proposals to reform the system for addressing medical malpractice claims, provisions have been included to expand the use of periodic payment arrangements to resolve medical malpractice actions by permitting the defendant unilaterally elect to pay damages on a periodic basis.

For example, medical malpractice reform provisions included as part of the Medicare reform legislation considered by the House Ways and Means and Commerce Committees in the last session provided that the defendant may not be required to pay more than $50,000 in future damages by means of a single, lump sum payment, but instead shall be permitted to make such payments on an appropriate periodic basis as determined by the adjudicating body. (H.R. 2425, Sec. 15312(f)). This proposed periodic payment provision did not expressly require a defendant obligated to make period damage payments 20 or 30 years or more into the future to provide any security to ensure that these decades of future damage payments will be made.

As indicated above, the medical malpractice victims receiving periodic damage payments under current practice have suffered serious, often profoundly disabling, physical injuries. Because of the grave, ongoing nature of their injuries, these victims often are unable to acquire affordable health insurance. They depend very heavily—often entirely—on these periodic payments to fund the substantial, ongoing medical expenses as well as basic living expenses. Under current practice, the periodic payment arrangement is negotiated by the parties at the time of settlement to ensure that the victim does not outlive his or her compensation, as illustrated by the case of malpractice victims who are children requiring care over a remaining

lifespan of 60 years or more. Equally compelling is the need for financial assurance to the victim that these crucial damage payments will be made. Under current practice, the section 130 qualified assignment mechanism adopted by Congress provides that vital financial security.

This need for financial security for the injured victim is even more compelling where the periodic payment arrangement can be mandated at the defendant's direction, rather than by voluntary agreement of the parties as under current practice.

Accordingly, NSSTA strongly urges that, under any provision of medical malpractice reform legislation enabling the defendant to elect to use periodic payments, the injured malpractice victim should be permitted to request that the adjudicating body direct the defendant to financially assure the future payment of such periodic damage amounts by means of a qualified assignment of the periodic payment liability as described in section 130 of the Internal Revenue Code, acquisition of an annuity issued by a state licensed and regulated life insurance company or U.S. Treasury obligations to fund the defendant's future obligation to the victim, or comparable security. In this way, a malpractice victim who has suffered serious, permanent injuries would be protected during the lengthy term over which he or she will receive compensation for those injuries.

CONCLUSION

In summary, any periodic payment provision included as part of medical malpractice reform legislation that would permit the defendant to unilaterally elect use of periodic payments should provide corresponding financial protection for a badly-injured medical malpractice victim by permitting the victim to request that the adjudicating body direct the defendant to undertake a section 130 qualified assignment, to purchase an annuity or Treasury obligations to fund its future damage obligations, or to otherwise assure the future payment of such periodic damage amounts.

STATEMENT OF MURRAY E. FOX, M D.

Mr. Chairman, my name is Murray E. Fox, M.D. I am a co-founder and the medical director of a 240 member Independent Practice Association located in North Texas. I appreciate the opportunity to submit this statement for the Committee on the Judiciary's consideration in its mark-up of H.R. 2925, the Antitrust Health Care Advancement Act of 1996.

Our IPA was incorporated in 1986, and has been providing patient care in North Texas for the last 10 years. Our member physicians provide care under contracts to approximately 250,000 individuals in North Texas. We have physicians in primary care and forty six (46) different specialties, and provide virtually the entire range of physician services available in our geographic area.

A year or so ago, our physicians began discussing the possibility of forming a larger organization to broaden our network, increase our ability to contract for managed care contracts, and prepare our physicians for capitation through education and evaluation of encounter data. We had discussions with hospitals and other entities in the Dallas/Ft. Worth area, but our goal of forming a physician owned and directed network was one we were not willing to sacrifice. We eventually decided to form a new entity which would broaden the geographic coverage of our physicians, making us more attractive to governmental and private payors. We also decided to form a management company which could, on our behalf, negotiate, manage and administer the managed care contracts. Managed care contracts are increasingly complex, and often run 30-40 pages in length. Not only is it cost prohibitive and inefficient for both parties for individual physicians to evaluate and negotiate individual managed care contracts, but individual doctors

simply have no real ability to effectively negotiate contract terms. Sole practitioner negotiations often becomes a "take it or leave it" proposition.

As the committee probably is aware, compiling and assessing outcomes data and expense, utilization, and revenue data on a current basis is critical to successfully competing in the managed healthcare market. We believe forming our own management company will enable us to do so, the result of which will be an enhanced ability to deliver quality patient care efficiently and economically.

Although our physicians are willing and intend to enter into capitation contracts, Texas does not yet have a high penetration of HMO capitation contracts. We realize that it will take some period of time to develop a substantial capitation contract base, and in the meantime we intend to continue developing discounted fee for service contracts.

In attempting to raise funds from prospective members for the new network entities, we have been frustrated with the FTC interpretation of the antitrust laws. As we understand the FTC's position, for those contracts which are not capitation contracts, physicians must share "substantial financial risk" in order to be able to negotiate and perform under those contracts without risk of violating the antitrust laws. The FTC asserts that substantial financial risk amounts to approximately a 20% withhold in the payments that a network receives from each payor. Since the network would already be discounting its services to the insurance companies and HMO's with which it contracts, in order to be more attractive and provide a lower cost alternative for those payors and their insured population, you can understand why the physicians would be very reluctant to withhold an additional 20% of an already limited payment. It has been extremely difficult to convince prospective members of the necessity of this withhold, and

thus we face a Hobson's Choice of putting together a pro-competitive, less costly physician network that will meet the needs of payors and patients (yet potentially facing substantial antitrust exposure), or putting together a "safe" network that does not effectively meet the needs of payors, or is so unattractive from a business standpoint to the physicians that we find it virtually impossible to attract the requisite number of physicians to form a competitive network.

I agree with Congressman Hyde that the current interpretation of the antitrust laws by the Federal Trade Commission and the Department of Justice provide an "arbitrarily narrow definition" of the type of integration that would be permitted by physician networks. Our network is substantially integrated, yet sharing "substantial financial risk" in the fashion proposed by the FTC imposes a substantial burden and puts a severe chill on our ability to attract competent physicians. We support the intent and content of H.R. 2925, and hope that the Committee will pass the legislation substantially in its current form. We also urge the Committee and Chairman Hyde to push for early floor consideration of the legislation so that legislation might be enacted in the current session of Congress.

Finally, Mr. Chairman, let me make it plain that our IPA supports the purposes of the antitrust laws and is not seeking a way to evade the legitimate scope of such laws. We believe, however, that the current narrow interpretation of century old laws by the FTC and the Department of Justice make it very difficult to put together a pro-competitive network of physicians and ancillary health care providers without facing substantial antitrust exposure. We find it ironic - and troubling - that physicians who are trying to provide a less costly, more patient-friendly health care alternative which would have a pro-competitive effect on the North Texas market, could be found to violate the antitrust laws. The consumers want these networks,

the empl yers want the networks, the payors want these networks, and the physicians want to participate in these networks - provided they can do so without incurring unnecessary legal exposure or receiving an arbitrarily low payment amount for their services We believe utilizing a rule of reason analysis for provider sponsored networks will promote their appropriate growth, while preserving the public's interest in the legitimate enforcement of the nation's antitrust laws.

Thank you for the opportunity to present our position to the Committee.

Statement

of the

American Society of Internal Medicine

to the

House Judiciary Committee

on

H.R. 2925, Antitrust Health Care Advancement Act of 1996

for the

Record of the February 27-28, 1996 Hearing

Background

The American Society of Internal Medicine, representing the nation's largest medical specialty, is pleased to submit this statement of support for enactment of the Antitrust Health Care Advancement Act of 1996.

H.R. 2925 would amend antitrust law to permit qualified Health Care Provider Networks (HCPNs) to engage in conduct that would allow them to compete--on the basis of price, quality and service--with other health plans, including insurance-sponsored plans. The bill would allow the following conduct to be evaluated on a case-by-case rule of reason standard:

- exchanges of information between one or more health care providers relating to costs, sales, marketing, profitability, or fees for any health care services if the exchange of such information is solely for the purpose of establishing a HCPN and is reasonably required for such purpose

- the conduct of a HCPN (including any health care provider who is a member of such network and who is acting on behalf of such network) in negotiating, making or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of the health benefit plan and

- the conduct of any such member of such network for the purpose of providing such health care services under such contract.

Such conduct would no longer be deemed illegal per se, but would be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition in properly defined markets.

Current antitrust statutes inhibit the ability of physicians and other "providers" to form networks to compete with HMOs and traditional insurers by considering certain conduct--such as any discussions of price among competitors--to be a "per se" violation. Conduct subject to the per se rule is considered to be automatically illegal, *even though the conduct might have been found to be pro-competitive had the individuals involved had an opportunity to prove that the conduct involved did no harm and in fact, enhanced competition.*

Given that the purpose of antitrust law is to assure that competition is not reduced due to unfair business practices, ASIM believes that it is essential that Congress re-examine and modify antitrust laws that in fact are having the opposite effect of inhibiting competition and innovation in health care delivery. H.R. 2925 would *not* allow physicians and other providers to engage in conduct that unfairly reduces competition, such as price fixing designed to drive up fees or boycotts. Rather, it would simply allow such conduct to be evaluated on the basis of "reasonableness." If the conduct was found to be reasonable--that is, it did not reduce competition or it enhanced competition--it would be permissible. If the conduct was found to be unreasonable and anti-competitive, however, it would be illegal--just as it is under current laws.

Why H.R. 2925 is Needed

What H R. 2925 would do is allow physicians and other providers to make the business decisions needed to compete in the market. Formation of an HCPN typically requires that physicians be able to exchange information on prices, profits, sales and other financial matters that have a direct bearing on whether or not the network will be viable. Because such conduct is today considered to be a per se violation unless the providers in the network fully share in the financial risk of delivering services, many HCPNs are never able to get off the ground. HCPNs also have a legitimate need to negotiate with health benefit plans on the payment schedule for their services and other terms of their contract with the benefit plans. Such negotiations can serve a pro-competitive purpose. For example, the HCPN and the health benefits plan might agree on a fee schedule that undercuts those of competing provider networks. Or the HCPN might negotiate for modifications in the fee schedule that would re-allocate payments toward primary care services, thereby creating incentives for primary care physicians to participate in the plan.

Given the fact that conduct found to be unreasonable and anti-competitive would continue to be illegal, ASIM does not understand the argument proffered by some that enactment of H.R. 2925 would "gut" the antitrust laws and/or drive up costs to businesses and patients. We suspect that the opposition to H.R. 2925 is driven largely by special interest groups that wish to maintain the competitive advantage given to insurance-sponsored organizations under current antitrust laws. They do not want to compete with HCPNs because they fear that HCPNs will be able to deliver higher quality services at lower cost to patients.

Although ASIM strongly believes that the argument that H.R. 2925 would gut the antitrust laws and drive up costs is groundless, we do believe that the insurance industry does have reason to fear that competition from HCPNs would reduce its market share. The reason is that well-run HCPNs can provider better quality of services at lower price than insurer-controlled health plans.

Benefits to Patients of HCPNs

If Congress agrees to modify antitrust and other laws that make it difficult for HCPNs to enter the market to compete fully with insurers, patients and purchasers will be the ones to benefit. HCPNs have the potential of:

1. Providing services at much lower administrative costs than insurer-controlled plans and traditional HMOs. By contracting directly with HCPNs, purchasers can cut out the insurance middleman that drives up costs. Recent reports in the news media have demonstrated how excessive administrative costs incurred by many conventional HMOs--including executive staff salaries that far exceed those of other industries of comparable size--are diverting dollars that could be used to improve service, provide additional benefits, or lower premiums charged to purchasers. Physician-run networks offer the potential of substantially reducing the dollars wasted on administration.

2. Because physicians in HCPNs establish the quality, credentialing, physician performance and utilization review rules, they are far more invested in controlling costs and improving quality than under arrangements where such rules are imposed upon them by insurance companies and non-physician health plan administrators. Conventional HMOs and insurance companies often view the physicians who participate in their plans as adversaries who need to be monitored and controlled, rather than as full partners. As a result, the physicians who participate in those plans do so reluctantly and are not invested in seeing the plan's rules succeed. By comparison, because the participating physicians in HCPNs will themselves make the rules governing clinical decision-making and quality issues, the rules will have credibility with them and the physicians will be personally invested in seeing them succeed.

3. Because HCPNs are typically based in the community that they serve, they are likely to be more responsive to community needs than insurance-controlled health plans that are owned and run by a corporation that is located elsewhere. Patients who receive care from HCPNs know that the doctors and hospitals in those plans are from their own town or city, and therefore would be more likely to put the community's needs above other considerations.

4. Professional ethics will balance cost containment in HCPNs. Conventional HMOs and insurer-controlled health plans control costs by cutting fees and reducing the services provided to patients. While some of the services that are eliminated may be ineffective, marginal or unnecessary services, the potential exists under conventional HMOs and insurer-controlled plans for patients to be denied access to services that would benefit them. This is less likely to be the case with HCPNs, since HCPNs would be run by physicians who are obligated to follow an organized professional code of ethics that would preclude them from imposing rules or risk sharing arrangements that would compromise care.

The bottom line is that well-run HCPNs have the potential to offer better service at lower cost than other health plans. Not all HCPNs, of course, will necessarily be able to provide better care at lower cost than conventional HMOs and insurance companies. But many will, if given the chance to compete in the marketplace. Conventional HMOs and insurance companies will also have an incentive to improve care and lower costs, especially inflated administrative costs, if forced to compete with HCPNs.

Many business groups are already discovering the benefits of contracting directly with HCPNs. The Business Health Care Action Group (Minneapolis) is in the process of initiating a program whereby the employees of companies included in the group would choose among "care systems" run by primary care physicians. The Central Florida Health Care Coalition directly contracts with hospitals and physician networks. According to Coalition President Becky Cheney, "Our [the coalition's] goal is to contract for medical services ourselves and use the plans as third party administrators, not as negotiators . . . because when they negotiate, they take a little bit from us and a little bit from providers." The Houston Health Care Purchasing Organization contracts with 70% of physicians and most area hospitals. Ralph Smith, the organization's President, has been quoted as saying that direct contracting with providers has claimed savings of 35% of health care costs from better quality controls and limiting insurers to

claims processing. Although these initial efforts are promising, antitrust laws and state insurance requirements continue to represent substantial barriers for these and other business groups that wish to contract directly with HCPNs.

Conclusion

Antitrust laws and state insurance requirements that inhibit HCPNs from entering the market must be changed in order to bring about the competition needed to bring about better care at lower cost. Enactment of the Antitrust Health Care Advancement Act of 1996 will be an important step toward achieving this goal.

Controversy Grows Over California Malpractice Cap

■ **Courts:** Doctors seek U.S. version of state's $250,000 limit for pain and suffering. But consumers, lawyers assail 20-year-old law.

By DOUGLAS P. SHUIT
TIMES STAFF WRITER

Kathy Olsen won her medical malpractice suit but ended up feeling like a loser.

Last year, a San Diego jury found that medical negligence was involved in the care given to her son Steven, now 5, care that left him blind and permanently disabled with severe brain damage. In addition to awarding $4.3 million for past and future medical bills, the jury handed down a verdict of $7 million for "pain and suffering." But because of a $250,000 California cap on malpractice awards for pain and suffering, the trial judge reduced the award to that figure, much of which went to pay legal fees.

Olsen, now awaiting the outcome of an appeal of the verdict by the University of California Board of Regents, said she is frustrated by the state's malpractice law. "The law didn't work for us," she said.

She is not the only one who feels that way.

Twenty years after the landmark law putting a monetary "hard cap" on general damages for medical negligence took effect, the state's malpractice system is more controversial than ever.

In recent months, Californians angry with the malpractice system have demonstrated in wheelchairs and on crutches, dumped manure at a congressman's office, testified against organized medicine at legislative hearings in Sacramento and stuffed photos and case histories into a coffin and delivered them to a senator's office.

California's malpractice law also has been pushed to center stage in the national debate over medical negligence. Last year, federal legislation containing a California-type cap was approved by the House of Representatives but was defeated in the Senate. Its chief proponent, the American Medical Assn., said it will try to revive the legislation this year. A similar cap remains part of the Republican "Contract with America," the GOP legislative battle plan.

At the core of the controversy is the California Medical Injury Compensation Reform Act, or MICRA.

Written at the height of a malpractice insurance crisis in the mid-1970s, when premiums were shooting out of sight and doctors were turning away patients, MICRA was devised in large part to protect doctors and hospitals from big jury awards.

Although the law also sharply limits attorney's fees in malpractice cases, most of the controversy stems from the $250,000 cap on general damages, the provision that required the judge in the Olsen case to erase the $7-million jury award.

Juries can be told of judges' discretion about the cap but often are not.

General damages, widely known as

Please see CAP, A15

CAP: State's Landmark Malpractice Limit Is Assailed

Continued from A1

compensation for pain and suffering, are a ratchet category that includes the day-to-day physical and emotional problems that a boy such as Steven Olsen most likely will face now and later in life.

Critics point out that payments for attorneys, court costs and things such as fees for expert witnesses are included within the $250,000 cap. Moreover, they say the cap is not indexed for inflation, and the purchasing power of $250,000 is about a third of what it was two decades ago.

Because general damages are so subjective, they are far more controversial than payouts for economic damages, which may be based solely for future medical costs and loss of earnings.

Doctors and insurance companies say hard caps on pain and suffering and attorney's fees are the fairest and surest way to limit potentially runaway malpractice awards. There are no limits on damages for medical bills and loss of income directly related to patient injuries. If they can be proven, MICRA supporters say.

They also argue that $250,000 is fair compensation for pain and suffering.

"You can never make a person whole even if you shower them with money," said Jay Dee Michael, president of Californians Allied for Patient Protection, an association of doctors, hospitals and insurers organized to defend the malpractice law. "Our goal is to make sure they get adequate compensation for economic loss."

But patients complain that they can't find a lawyer to take their cases because attorneys tell them that only the most egregious cases make money.

One who did find a lawyer is Rosemary Green. The Florida woman's husband died after his lungs were accidentally switched during a transplant operation at UCLA Medical Center. She said she was warned to expect an emotionally draining fight when she filed suit against the university a year ago.

"As time goes on, you feel like the system jerks you around," she said. "I just get angrier."

"The rage this kind of thing engenders is unfathomable until you have lived through it," said Linda D. Ross, a Los Angeles businesswoman turned malpractice activist.

Ross won an arbitration award of $150,000 from Kaiser Permanente in a case that involved the death of her mother. Convinced that her mother's death could have been avoided, Ross had hoped to win a financial judgment large enough to force a change in the procedures that she said contributed to her mother's death. But Ross said she quickly ran up against the pressure of the cap and decided to settle. Still, she continues her fight to change the law by testifying at government hearings, counselling that the award was little more than "a slap on the wrist" for Kaiser.

Kaiser concedes that it erred, but Trischa O'Hanlon, a senior attorney for Kaiser Permanente calls the judgment more than a slap on the wrist. The settlement, she says, triggered an upgrading of training at the Kaiser Foundation Hospital in Fontana where Ross' mother was treated, as well as new procedures imposed to ensure that physicians see needy patients in a timely fashion in the wake of the Ross case, she said.

"This law is an absolute, unmitigated disaster," said San Francisco attorney Robert V. Bakeman. The malpractice specialist said it costs him $100,000 to bring a major malpractice case, which can involve years of litigation, sometimes terrifying expert witnesses and a team of lawyers and researchers. "We have to be extremely selective in the cases we take. I get, on the average, five telephone calls a day, and we accept only five to 10 cases a year."

Before MICRA, attorneys argued fees of 30% to 40% on damage awards as they still are allowed to do in other personal injury suits. Under MICRA, the attorneys can receive a maximum of 15% on awards of more than $200,000.

"I probably take one out of every 30 or 40 cases referred to me," said Woodland Hills attorney Chuck Mazursky. "I really would like to take every case that comes to me that is meritorious, but because of the expense involved and the limited recovery, I have to make an economic decision."

Harvey Rosenfield, a consumer activist who has written a book about the malpractice system, said the cap has produced a profit bonanza for the insurance industry.

During 1990, California malpractice insurance companies, some of them owned by doctors, paid out only 38 cents for every $1 in premiums that they took in, Rosenfield said.

So many people claim to be victims of California's malpractice law that a Los Angeles consumer group, Consumers for Quality Care, began a "casualty of the day" campaign in April that involved releasing a case study each workday that detailed a medical mistake and a person's unhappy brush with the legal system.

The campaign lasted until August, stopping only when the AMA-backed federal legislation failed.

For Kathy Olsen, the law has been a constant irritant, repeatedly rubbing raw the emotional wounds resulting from her son's plight.

Steven, then 2, fell during a family hike. A twig went through his mouth and out his cheek, creating an infection that eventually went to his brain.

Olsen, 39, said she pleaded with the staff at Children's Hospital in San Diego for a CT scan of her son's brain. They refused, and by the time he was tested and doctors discovered the problem, it was too late to prevent permanent brain damage, she argued in her successful suit.

The hospital was not named in the suit. Attorneys for a medical group named in the original suit have settled with her. The University of California Board of Regents which employed one of the physicians who diagnosed Steven, is appealing the judgment. The university contends that its physician exerted a reasonable standard of care.

Today her son's medical problems virtually limit his ability to walk, learn and socialize with other children.

While $4.7 million is a lot, Michael D. Padilla, the San Diego attorney who handled the case for the Olsens, said payments will be spread out over 60 years.

"Steven is going to need every dime of that money if he lives 60 years," Padilla said. "There will be doctors' bills, nursing care, medications to names he will live on. That is all based on economists' projections of what medical costs will be 50 years from now. We have to just hope they are right."

Rosemary Green on behalf of her husband, is filing a malpractice suit that is well above the $250,000 cap. She said she was motivated in part by a desire "to have someone learn from this."

Her husband Frank was suffering from end-stage lung disease when he left his family home in Florida for the transplants that he hoped would change his life.

But his surgeons, by their own admission, "mistakenly" switched Frank Green's new lungs. The left donor lung was put into his right chest cavity. Doctors then said they tried to salvage the situation as best we could" and sewed Green up with the right lung where the left one should have been, according to a medical review of the case.

He died nine days later.

Internal UCLA documents obtained by The Times confirm that a mistake was made but UCLA has denied negligence in its response to the suit and refuses to comment on the case.

"It's such a long, tedious process," said Green, 48, who lives in West Palm Beach. "It's not the money; it's the justice. I want them to own up to what they did and learn from it."

STATEMENT OF HON. ANDY JACOBS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. Chairman, I am pleased to have the opportunity today to submit this statement to the Committee regarding the use of structured settlements in medical malpractice actions.

I have authored a series of measures adopted by Congress over the last decade and a half to encourage the use of structured settlements for tort victims suffering physical injuries, dating back to my sponsorship in 1982 of the Periodic Payment Settlement Act that enacted section 130 of the Internal Revenue Code. This tax code provision enables a badly-injured tort victim, including a medical malpractice victim, to agree to compensation in the form of a series of periodic payments tailored to his or her specific medical and basic living needs and then to have the financial security and protection of receiving those periodic payments from an experienced and strong financial institution.

Mr. Chairman, I have seen firsthand over the course of my longstanding involvement with this issue the benefits that a structured settlement can provide. Families are relieved of the crushing financial burden of caring for a paralyzed loved one for decades into the future. Parents of brain damaged children no longer face the worry of those children's care after the parents are gone. The flexibility with which the periodic payments can be tailored to the individual's needs enables these victims to receive rehabilitation and where feasible education that provide an opportunity for hope for the future.

Since these victims receive their structured settlement payments over a period of as much as several decades or more—particularly in the case of children—it is crucial that these payments be made by a financially experienced and secure institution. That is why the tax code provision requires that the structured settlement payments be funded by annuities from life insurance companies regulated by the state or U.S. Treasury obligations—two of the most secure funding sources available.

I call the Committee's attention to the fact that structured settlements already are in widespread use today to resolve medical malpractice actions. These structured settlements are entered into by voluntary agreements of the parties on the schedules of payments and the funding sources. I understand that medical malpractice reform legislation may come before the Committee and that the legislation may include a periodic payment provision under which the defendant in a malpractice case could elect on its own to make the damage payments on a periodic basis. If that is to be done, it is imperative that the malpractice victim be protected and that adequate security be provided by the defendant to ensure that those decades of payments upon which these victims depend will be made. I believe that a qualified assignment of the periodic payment liability from the defendant to a financially strong institution as defined under Internal Revenue Code section 130 would provide such security, just as it has in the thousands of structured settlements of malpractice cases that have been undertaken in the last decade and a half

Accordingly, I strongly urge the Committee in considering any periodic payment provision as part of medical malpractice reform legislation, to include a requirement that a defendant who chooses to render payment of damages on a periodic basis provide adequate financial assurance to the malpractice victim that the payments will be made.

I would be happy to work with the Committee to address this concern and to build on these years of success in using structured settlements to resolve medical malpractice actions and properly compensate the injured victims.

Thank you, Mr. Chairman.

STATEMENT OF JEANNINE FAUBION, INTERNATIONAL PRESIDENT, GENERAL FEDERATION OF WOMEN'S CLUBS

On behalf of the General Federation of Women's Clubs (GFWC), I would like to express appreciation to Chairman Hyde and the members of the House Judiciary Committee for holding this hearing and affording me the opportunity to submit testimony in support of H.R. 911, the Volunteer Protection Act.

As the International President of GFWC, the world's oldest and largest organization of women volunteers, I speak for nearly 300,000 members across the United States who are concerned that the threat of liability may soon outweigh the benefits of service. Today's hearing on the Volunteer Protection Act of 1995 comes at a time when the nation looks increasingly toward its citizens to meet community needs. In answering this call to action, volunteers must be assured of protection against liability. Volunteering must not be at the risk of personal and family assets.

For more than 100 years, GFWC members have met the most pressing needs of the nation's communities through volunteer service. With its broad-based network of community activists, GFWC has marshalled resources successfully to tackle the issues that affect the lives of women, children and families. In 1994 alone, GFWC clubs reported more than 10 million hours and $17 million donated to approximately 170,000 volunteer projects nationwide. Projects include literacy training and mentoring, child abuse prevention, care of the elderly, environmental education and conservation, substance abuse prevention, support of the arts and more.

As a nation, we must make every effort to encourage more people to give of their time in volunteer service if we are to attempt to meet the growing needs of communities in this country. Particularly as the federal government and state governments look to reduce government services, charities will be looked to for increased participation and efforts. It would indeed be regrettable to lose the talents and energies of even one volunteer to the fear of liability.

An example involving a club in New York demonstrates both the reality of volunteer liability and the effects the perception of the liability threat has on the recruitment of volunteers. A GFWC member in New York agreed to serve as chair for a summer festival, a community tradition, which included a hot air balloon launch. During the festival, an experienced balloonist assisting in the launch stepped into a hole on the field where the launch was taking place, breaking her leg. Subsequently, the injured individual filed suit, naming as defendants the town, the village and the GFWC member serving as festival chair. Fortunately the suit against all parties was eventually dropped. While our volunteer suffered no financial loss, the town lost the enjoyment of the festival for several years, as no one was willing to assume the risk of liability for organizing the event.

To stem the steadily decreasing numbers of volunteers, the Federation joins our colleagues on the National Coalition for Volunteer Protection in supporting enactment of H.R. 911. We look for a national standard of protection addressing and correcting for the sometimes select and narrow protection offered via state legislation. Federal guidelines would provide consistent and comprehensive protection for volunteers while allowing states the flexibility to address needs specific to their own volunteers.

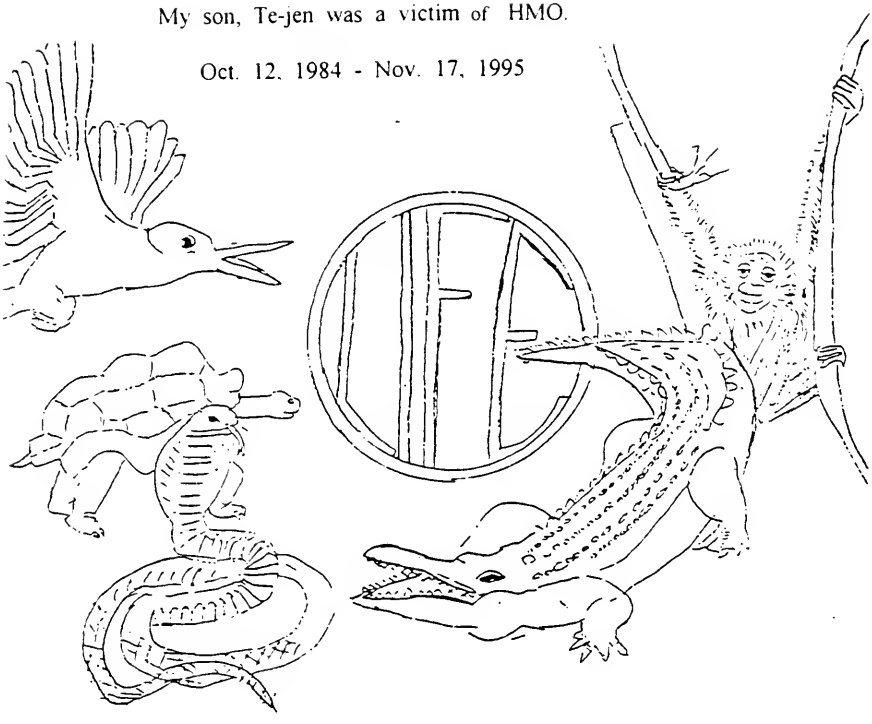
As one of the Federation's legislative priorities, our grassroots membership has mobilized around the passage of the Volunteer Protection Act of 1995. It is our hope that the United States Congress will take the necessary steps to protect American volunteers—protection vitally needed if GFWC is to effectively serve the communities of this country.

The members of GFWC congratulate Representative John Porter for maintaining his commitment to our nation's volunteers. He has brought the volunteer liability issue to the attention of the nation. I hope, as do all our members, that we will see passage of the Volunteer Protection Act during the 104th Congress.

Thank you for the opportunity to submit this testimony.

My son, Te-jen was a victim of HMO.

Oct. 12, 1984 - Nov. 17, 1995



When Te-jen drew this picture, he said:

"Mom I wish everybody can protect wild animal life."

But who respects and protects his little life?

ANOTHER VICTIM! WHEN WILL IT STOP?

My son, Te-jen, was a victim of HMO. He passed away on November 17, 1995. I know there is nothing I can do to bring him back into my arms. The sweet memory of my son still remains clearly in my mind, but that is the only thing that is left — just a memory. **Although I have already lost my child forever, I am writing this letter to prevent further suffering and deaths of more innocent American children. This is my sole purpose and go l.** If I am able to achieve this by helping just one person, then I will know that my son did not die pointlessly. Only then will my heart be at peace.

When Te-jen first became very ill at Denver on a vacation in September, he was sent to Kaiser at Denver by his aunt. The Doctor mistakenly diagnosed him as having mountain sickness. After he came back to the LA on Sept. 30, I took him to Kaiser facility on Sunset Blvd. in LA. He was diagnosed with leukemia. Many things are still unclear to me. Most of those are the actions of my son's pediatric doctor at Kaiser. I still can't understand why he did the things he did. In early November when I found my son started to have blood in his urine, I asked the pediatric doctor to ask an urologist to check my son's kidneys. But he never did. Several days later, he told me that my son's kidneys had failed. I asked him to have dialysis for my son. But he didn't (later I found Kaiser don't have dialysis machine for children). **Why did the Kaiser pediatric doctor have to wait for several days to send my son to the Children's Hospital for dialysis?**

On November 15, before my son was transferred to the Children's Hospital, the pediatric doctor at Kaiser said to me, "Everything is under control! Just his kidneys have failed. We will transfer your son to Children's Hospital for dialysis. After three to five days, everything will be fine and he will come back to Kaiser." But I later found out that this was nothing near the truth. If it were, how come when we arrived at Children's Hospital (which is only one minute's driving distance from the Kaiser), the doctor told me that all of my son's organs had already failed and he would die that night or within 48 hours? **Why did the pediatric doctor at Kaiser not know this? The reason is very simple. It is because the doctor never examined my son thoroughly.** During my son's 37 days staying in the PICU of Kaiser, the pediatric doctor only touched my son once.

That time was on October 3rd, when he wanted to get a catheter into Te-jen's vein, he used an adult size tube, and tried to insert it into my son's right groin. After several crude and unsuccessful attempts, they decided to try the left groin. Again, they forcibly inserted the tube into the left groin. **In the whole process, my son had a lot of pain, and kept asking "Mom, when will it be done?"** I wondered, **If the adult size tube didn't fit into the vein on a little boy's right groin, why would it fit into the vein on his left groin?** But they believed it was successful on the left groin. When they started to process the leuko pheresis, my son felt great pain in his stomach and cried. After I insisted the doctor come for an examination, the resident doctor found from the X-rays that **the tube had stabbed through my son's stomach blood vessel, projected out about two to three inches, and damaged his peritoneum. My son started to bleed.** The resident doctor tried to pull out the tube to get it into the correct position, but he didn't succeed. He said, **"Wait for the pediatric doctor to decide what to do tomorrow ."** From that day on my son had a lot of pain in the area of his stomach where it was wounded by the tube.

In order to permanently keep this tube in the fixed position, **he wanted to put two sutures on my son's leg without using any anesthetic.** I begged and pleaded with him to administer anesthetic first. But he said something that still haunts me. **He said, "Since your child has**

leukemia, he is already going to suffer and face greater pains than this. **If you won't even allow him to withstand this pain, you are spoiling him too much!"** I felt, **What inhumane words he said!** Finally, he gave Te-jen only a little dose of pain killer But my son still had feeling. Te-jen and I asked this doctor to administer a higher dosage of the numbing solution or wait longer But another doctor said, "Just suture it! Don't wait," and then he started to suture him. I will never forget my son's painful scream. I felt helpless and heartbroken that I couldn't help my son The thing that hurt me most was that **my son was tortured and thus suffered a lot of pain. He lost a lot of blood.** The second day when the pediatric doctor came in, **he said it wouldn't work. They then pulled out the tube Why did they have to try use an adult size tube for my son? Why did they let my son suffer two day's pain and ill treatment for an invalid process?** Then they decided to do the Leuko Pheresis manually. I really don't understand **Since they don't have the machine for children, why didn't they transfer my son to Children's Hospital. Or, if they wanted to save money, then why didn't they do it manually at the beginning?** Why didn't they take X-rays before they put in the catheter? They should have to know how far to insert the tube so they wouldn't mistakenly put it into his peritoneum

In early October, my son couldn't pass his urine and we requested several times that the pediatric doctor give him the diuretic drug, 'Lasix'. The doctor said, "That medicine only makes you thirsty Why not drink a lot of water?" The doctor didn't give my son any medicine My son trusted the doctor's words and drank a lot of water, but he felt more uncomfortable and cried The pediatric doctor still didn't give him any care Later on, the Hematology doctor came to check my son and asked the nurse to insert the tube to my son's urinary duct immediately to help release his urine The fact is, 'Lasix' doesn't make patient thirsty, it only helps them to pass urine **Does the doctor have the right to cheat a 10-year-old child, and let him suffer more pain?** Should any humane doctor neglect his patient, thus causing the kidney infection to get worse?

Another thing I still wonder about **How come there is only a resident doctor on call in the Intensive Care Unit from 5:00 PM to 9:00 AM on weekdays and all day on weekends?** One time I saw my son's blood pressure was 28 I begged care for my son, but they told me that I had to wait for the resident doctor After 30 minutes the resident doctor came He didn't know what to do, so he tried to find out from a book In such a critical situation, how long do I have to wait before a doctor decides to arrive and knows what to do?

Once one of my friends visited my son while my son's white blood count was very low My friend saw one patient coughing severely The patient was placed in the open space without partition, just in front of the door to my son's room When my friend asked the child's mother what kind of problem her child had, the mother said the child had pneumonia Why did Kaiser expose my son to the dangerous area while my son wasn't immune from infection? I wonder **why the Kaiser PICU doesn't have isolated rooms for the patients who really need to be protected from getting infection?** Don't they know that the infection would cause the death of Te-jen? After we arrived at Children's Hospital, we saw their facilities **We finally understand that the PICU of Kaiser is not really qualified as an intensive care unit,** because it does not have the capability to do the function of intensive care for patients **We are very regretful and sorrowful that we let my son receive medical treatment at Kaiser. But it was already too late.**

Many times the monitor for my son showed abnormal figures I asked for the attention of the people in the intensive care unit They said that the monitor didn't work correctly **How could they just use the unreliable monitor all the time?**

Te-jen later developed venous stasis and blisters He needed a special bed and a skin specialist to take care of his blood circulation and skin problems But the pediatric doctor didn't request these facilities for my son, until one of my friends who has nursing experience told me to ask for these facilities **Had I not had my friend's suggestion, would the pediatric doctor just let my son suffer many problems without doing anything?**

On November 10, in the morning my son used his gesture to tell me that he couldn't hear out of his right ear In the afternoon he indicated that he couldn't hear out of the left ear Later in the afternoon I tried to communicate with my son by writing He indicated to me that he couldn't see His tears were on his eyes He tried to touch my face. I begged the doctor to do something for my son He told me it was normal, because the medicine caused these problems But I saw my son getting worse day by day After November 12 my son never woke up Why did they never try to find out the real reason which caused these problems? **They know that the California law will protect the hospital and doctor.** Few lawyers like to take this kind of complicated case **Even though my son was tortured and sacrificed his precious life, I can't do anything to the hospital and doctors who do not respect patient's life.** I will never forget my son looking at me with his distressing and irresolute eyes and asking mom to help him Now I only can live with the guilt and grief that I couldn't help my son

I wonder, even though my son had leukemia, does that give the doctor the right to abuse him and cut his life shorter than he should have? Does that give the doctor a reason not to give my son appropriate care and treatment? Would that be true what the Kaiser people told the TV reporters later that Kaiser already gave Te-jen the best treatment? My son loved his life and enjoyed every second of it I tried my best to take care of him, even soaking my hands in very hot water until it hurt my skin, because I wanted to warm his cold hands with my hot hands I know my son fought as hard as he possibly could But in the competition between life and death, sometimes the strong will and spirit of a young boy just isn't enough We needed the doctor's help to save my son's life But in this case we had only unprofessional and negligent help

Although I want to get my point across, I don't want to discredit Kaiser Permanente as a whole There are a few doctors that are very nice and caring They encouraged my son to keep going Therefore, I want to take this opportunity to thank them **Dr. Hiatt, his Surgeon; Dr. Vadakan and Dr. Goodman, his Hematology Doctors; and many nurses that were kind to him.**

In this letter, I have only expressed a few of my hidden pains I hope this letter can urge the relevant organizations to promote the evaluation of the quality of hospitals Let everybody can select the best medical insurance For the benefit of patients, we need a powerful organization to take patients' complaints into actual legal action This organization should be able to track the hospitals' operations and to ensure that proper medical procedures are being followed The medical malpractice of hospitals and doctors should not be immune from the law **The rights of the patients need to be protected so that lives can be saved.**

May God be with my son, Te-jen, and the other victims!

Sincerely,

Susie Chung (805)945-5182

Susie Chung
45217 Saigon Avenue
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WHERE IS THE PATIENT'S RIGHT ?

1. In 1992, I had pain in my breast. I visited my doctor at Kaiser and made a repeated requested for a mammogram. But the doctor rejected my requested. **After I kept asking for two years, finally the doctor reluctantly let me to have a mammogram.**

2. The results of the mammogram and biopsy revealed that I had breast cancer. I had to have surgery of Modified Radical Mastectomy. **The pathology report confirmed that my breast cancer was in stage 2B, with lymph node invasion. I became upset about the delay in diagnosis.** I felt helpless and depressed. I could not help to let my heart calm down. Since I could not release my angry to my doctor, I went to see psychiatrist for help.

3. **To my surprise that the psychiatrist only spent a few minutes with me and treated me as a mental patient.** The psychiatrist called some people to tie me down and sent me to the mental hospital in Los Angeles. They didn't listen my explanation and request at all. My heart hurt seriously. I could never forget this treatment in my life.

4. On July 7, 1995, I went to UCLA for a second opinion. The doctors there told me that I should have had 35 radiation treatments. But the doctor at Kaiser never told me I had that option.

5. **In my family, we have two victims out of three members under medical treatment by Kaiser hospital within one year. Our beloved son, Te-jen, already passed away. How many victims do there have to be before something is done about this?**

6 **I am looking for justice to support the patient's rights.** I feel like an abandoned dog. Who care about us?

Sincerely,

Susie Chung

STATEMENT OF THE GODFREY FAMILY OF QUARTZ HILL, CA

God is my refuge and my strength or I would not be alive to-day, and as such, I have been able to outline my horror story in "HMO RUNS WILD." I know for sure my HMO has no soul, as will you when I have detailed the crimes of this HMO. I am searching to see if my State and my Country has any soul left, or have HMO's sucked it all away, and left no human decency or dignity in America. Perhaps when I finally find an answer, my soul too can be at peace. I am going to detail my story in chapters, so that perhaps America will see the need for immediate action to protect its citizens from [HMO] people like this.

As I begin this project it is 2:20 in the morning, and my mind drifts back to those two years of suffering where I walked the floors, not able to sleep, not able to lie down—sitting propped up to sleep, as I look at my husband unable to lie down today, and hear his labored breathing. I know I will never be able to forget my ordeal, as it is brought to my mind every hour of every day. As my mind drifts back I can see myself going from room to room trying to find a place where I could rest and sleep a little. Every night I would move to the sofa, or to my daughters room where I would cough and everyone would be wok en up. Then I would move into the extra bed in my sons room; I was on the move constantly, not sleeping and constantly coughing. I was like a zombie.

My days were as bad as my nights, and I watched helplessly as my business I had built for eight years slipped away. I had become totally irresponsible and business associates who had known and respected me for years could not tolerate my behavior, as I would be just too sick and I would not show up for assignments repeatedly. Professionals I had known for ten and more years shunned me. I spent my days crying and trying to rationale why someone who had everything to live for was depressed. I had serious mood swings, I also complained to Cigna doctors about this but my complaints were ignored. The constant coughing was an embarrassment, as it wasn't like a cough but like a dog barking. I lost control of urinating, and when I walked I would have to stop and cross my legs to stop from wetting myself. I seriously considered ending my life. Little did I know I was suffering from a very rare tumor that was connected to my nervous system and was causing all these problems.

As a mother and a wife I became non-existent, and this is the part of my life I feel the saddest about as I will never be able to bring back the time I lost with my children. My son was only seven years old and I lost all the joy of his early childhood years. I had just been married a little over two years, and my husband has assumed the role of Mr. Mom. My marriage and my family life was completely shattered. Everything else I lost can be bought back with money, but to repair a family shattered is a much harder task. Almost impossible.

I remember clearly when I went to see the doctor in May. I told him I cannot go on any more; I was physically and mentally exhausted; my back hurt and everything hurt. He put me on disability for six weeks. As I reflect on all my symptoms, I am confident when I say they are either not doctors, or they knew what was wrong with me all the time, and they were going to let me die. How could doctors ignore all my complaints All my hair was falling out, the whole left eyebrow fell completely out, the constant coughing, the repeated phenomena, not to mention the x-rays that showed the tumor. It is unfathomable to me that they did not know I was ill. It is obvious to me that all along they knew what they were doing. Why did they withhold my x-rays, telling me they were lost, and to try to do to me what they did is the first of many criminal acts perpetrated against my family., and should be punishable as such.

Finally I would like to present two theories in this first leg of my journey, either way these people have committed criminal acts. When one has a nodule on a lung, the acceptable treatment is removal or CAT scanning every ninety days. They contend they missed the diagnosis. I contend one of the following:

1. In my medical records they documented a 1½ cm nodule on my right lung. The handwriting that documented this is different from the rest of that medical record. They sent me to an affiliate who placed the problem in the right lung that they said should be checked in 90 days. I contend that they forged my medical records to make it look like they had told me, and in their haste they placed the tumor in the wrong lung. It is also quite evident, had they documented this prior, then they were not providing an acceptable standard of care in the community, by not monitoring it every 90 days. By the way the tumor was in my left lung.

2. My other theory is, with the Cigna Director calling me at home at ten at night to tell me my left lung was fine, and that there was only scarring and

fatty tissue on my right lung, that they were not going to treat me and let me die.

Finally, and with a stroke of strange luck, I was able to obtain all my x-rays. It is strange that when I took these x-rays and CAT scans to independent doctors, I was able to get an immediate diagnosis.

In my mind, and it will probably never change, when a medical provider does not furnish needed life saving treatment, and the patient dies as a result of this, then that provider should be brought before a criminal court as opposed to just facing an administrative review.

Godfrey is unhappy with the care she received at Cigna, where health-care professionals failed to notice a tumor in her lung

Woman upset by failure to notice tumor

y Edmund Sanders
aily News Staff Writer

For two years, Jo Godfrey complained to gna Health Plans of California's North ollywood facility about coughing, breath- g difficulties and fatigue.

The Antelope Valley woman saw more an a dozen doctors, nurses and physician sistants while her problems were diag- sed as bronchitis, pneumonia or stress e was told to stay home and rest.

But in August, the 43-year-old mother of ur complained of a pain in her lung. An -ray revealed a tumor.

Godfrey decided to get a second opinion d she took her X-rays to a non-Cigna ctor.

The Lancaster physician, Dr. Young Ko. firmed the tumor and told Godfrey that as clearly visible on her X-rays dating far back as March 1993.

"This just isn't right," Godfrey sai "I paid my premiums to Cigna to get ta n care of, and I wasn't," she said. "In- ad I had to fight to get proper care."

Officials at Glendale-based Cigna ac- knowledged that doctors did not notice the tumor, but they said Godfrey still has received quality care.

"The care she has received has been timely and provided by appropriate providers," said Stuart Bowne, medical director in Los Angeles for Cigna. "However, we are not suggesting that we couldn't have done better with her."

Cigna has agreed to pay for Godfrey to receive treatment outside of its network of doctors and medical clinics, Bowne said.

"It's hard for some people to accept our fallibility," Bowne said.

"It was not that anything was being ignored," he said. "Hindsight is always a lot better. Our vision gets sharper when we look back with current knowledge."

Cigna recently was cited by the Department of Corporations for deficiencies in quality of care, including evaluating and documenting medical records and lab tests.

According to the department, problems included "deficiencies in continuity of care, medical record incompleteness and lack of communication of abnormal lab tests."

Due to the confidentiality of patient records, it is unknown whether Godfrey's case was among those reviewed by the Department of Corporations.

Bowne said Cigna was committed to resolving problems.

"We're not proud of either of these two things," Bowne said of the state report and Godfrey's case.

Godfrey said her medical charts indicated that the lung nodule was noticed in November 1993, but she said she was not informed of the problem until August.

Last month, Godfrey underwent surgery at a Cigna facility to remove the nodule. She is unsure of her prognosis, she said, because she has refused to go to Cigna facilities since the operation.

On Friday, Godfrey learned that she would be permitted to receive treatment — at Cigna's expense — at the facility of her choice.

She is planning to seek treatment at Cedars-Sinai Medical Center.

"I don't want to go to Cigna any more period," she said.

Quality of care, appointment delays reviewed in audit

Daily News
OCTOBER 2, 1994
SUNDAY
Serving the San Fernando and Neighboring Valleys

By Edmund Sanders
Daily News Staff Writer

In an unusually critical audit of a major health maintenance organization, state regulators are ordering Cigna Health Plans of California to correct "systemic deficiencies" affecting quality of care, handling of patient complaints and excessive delays for medical appointments.

The California Department of Corporations, in a report made public last week, said Glendale-based Cigna had violated at least four key areas of state regulations covering health maintenance organizations.

Among the deficiencies were:

- Lack of recognition of "grossly abnormal lab tests."
- Incomplete medical charts and lack of follow-up care on post-hospital discharges.
- Excessive waiting periods for medical appointments, up to two months at some facilities.
- Failure to properly review and monitor patient complaints.

Cigna officials acknowledge some problems in its quality assurance programs, but attributed some of the negative findings in the department's audit to a lack of communication with state regulators.

"Systems are in place to assure quality of care, but we did not do a good enough job explaining (to regulators) how they operate," said Leslie Margolin, chief counsel for Cigna.

Gary Mendoza, commissioner of the Department of Corporations, said the problems uncovered in the audit were serious and "out of the ordinary," and that staff members brought the matter to his attention two weeks ago for special consideration.

"We are looking into the matter and may be taking additional steps to make sure (Cigna) is in compliance," Mendoza said.

Anthony Iton, a physician and health policy analyst for Consumers Union, said he was most disturbed by the department's finding that Cigna had failed to provide preventive health-care services to some patients.

"That's what HMOs are supposed to be all about," Iton said.

Stuart Bowne, Cigna's medical director for Los Angeles, defended the HMO's quality of care, but said the company already is responding to several of the department's findings.

"The care we provide to our members is very high-quality," Bowne said. "But we've got some deficiencies and we are taking pretty quick action to correct them."

The report faulted Cigna officials for not following up on patient complaints and instead referring them back to the medical

State regulators cite problems in audit of Cigna Health Plans

CIGNA / From Page 1

clinic for response. Beginning next month, complaints will be reviewed by senior company managers on a regular basis, Margolin said.

Margolin also said Cigna will begin new internal enforcement programs to make it easier for patients to schedule appointments more quickly. As it did in previous reports in 1988 and 1990, the department cited Cigna for failing to meet its own internal standards for providing patients with medical appointments in a timely manner.

"We have clear policies, but we need to do aggressive follow-up and self-audits," Margolin said. "We can do a better job and will do a better job."

The problems were identified at several of Cigna's 29 wholly owned medical clinics in Southern California.

Cigna, also known as Ross Loos Healthplan of California, is one of the largest HMOs in the state, covering nearly 600,000 enrollees.

The Corporations Department conducts medical audits of all HMOs on a rotating basis. Under state law, the department must audit every HMO at least once every five years.

The Cigna audit was conducted in June 1993. Regulators conducted on-site inspections, reviewed dozens of patient medical records and interviewed company managers and executives.

Iton said it is unusual for auditors to cite deficiencies because the law gives health plans a chance to correct problems before they are included in the final report released to the public.

Regulators give health plans a preliminary and confidential audit and allow companies 30 days to correct problems or develop plans that address the state's concerns. If regulators are satisfied, the deficiencies are withheld from the final report.

The final report does not specify how many medical records were examined nor does it disclose details of individual cases. It also does not include deficiencies cited by regulators but corrected by health plans within 30 days.

A detailed report, including confidential patient medical records and specific cases reviewed by regulators, was forwarded to Cigna in February. The department found Cigna's response to some of the problems to be inadequate and mentioned those problems in the audit released to the public.

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of its 80,000 members, the American Academy of Family Physicians is pleased to submit this statement for the record of the February 27 hearing on Medical Liability and Antitrust Reforms.

MEDICAL LIABILITY

The American Academy of Family Physicians remains extremely concerned about the impact of the current medical professional liability system on the cost and availability of health care services. Until Congress takes decisive action to realign the incentives created by our tort system, exorbitant medical malpractice insurance premiums and defensive medical procedures will continue to contribute unnecessarily to increased health care costs and reduced access to essential services, particularly in under served areas. The 104th Congress represents the best opportunity in over a decade for enactment of meaningful medical malpractice reforms. Working together, we can pass medical liability reforms that will serve well the needs of physicians and patients.

We spend an extraordinary share the nation's economic resources on resolving tort claims. According to a report by Tillinghast-Towers Perrin, our tort costs as a percentage of GNP are far higher than any other country. We are the only country in the world that allows unlimited compensation for pain and suffering, and we are the only country in the world that allows plaintiff's attorneys an unlimited "take" from the system. These two attributes of the U.S. liability system exert a synergistic upward pressure on both the number of claims filed and the size of jury-awarded damages. According to Jury Verdict Research, the average verdict in health care cases rose 40 percent between 1994 and 1995, from $365,000 to half a million dollars. All told, according to Tillinghast, claims, defensive medical practices and other related expenses rose to $12.69 billion in 1994, up from $8.54 billion in 1990.

Not only is our medical liability system expensive, it is inherently inefficient and unfair. Despite these extraordinary costs to the health care sector—as well as to the legal system, the plaintiff, and the defendant—almost two out of every three medical liability claims nationwide are closed without any payment to the claimant. Moreover, among bona tide victims of medical negligence, all empirical studies confirm that two claimants who have suffered the same injury in the same circumstances will receive wildly different awards. Finally, only 43 cents of every dollar spent in processing and paying claims reaches injured patients. Attorneys' fees account for most of the other 57 cents.

The Academy has long supported legislation to address the medical liability problem without placing limits on a patient's right to be compensated for monetary losses (medical and rehabilitation expenses, additional household expense, lost wages, and so forth) and without reducing the deterrent effect of malpractice liability. Thus, we were particularly pleased to see the following provisions in H.R. 2425, the Medicare Preservation Act of 1995:

A cap of $250,000 on non-economic damages;

Tort reforms that are federally mandated and apply to all states, including: modification of the common law collateral source rule to end the double recovery of damages, allowing periodic payment of future damages over $50,000, limitations on attorneys' contingency fees, and joint and several liability reforms to assign proportionate liability among the defendants in a case;

Statute of limitations, so that a claim must be filed within two years from the date that the alleged injury should reasonably have been discovered;

The Academy also supports an *Alternative Dispute Resolution (ADR)* requirement that would enable courts to quickly resolve meritorious claims and relieve the civil court system of those that are not. As envisioned by the Academy, at the completion of the resolution process, if one of the parties to the dispute chooses to challenge the outcome in court, and the decision rendered in court is less favorable than that in the resolution process, the filing party pays all legal fees. Such a "loser pays" rule is a forceful mechanism for ensuring that only meritorious disputes are brought to the court system.

An essential feature of H.R. 2425 is its cap on non-economic damages. What produces our current system's capricious results—and accounts for a large portion of the system's run-away costs—are jury-awarded damages for "pain and suffering." Such damages are highly subjective, and it is that subjectivity that contributes to much of the unpredictability and inconsistency in awards. Reducing the unpredictability and eliminating the potential for unreasonably high awards would remove some incentive for plaintiffs and their lawyers to "play the lawsuit lottery" and would promote more expeditious settlement of meritorious cases. The Office of Technology Assessment (OTA) concurred in its September, 1993 report, noting that a

reasonable ceiling on damages for pain and suffering is the most effective way to contain medical liability costs.

Reducing uncertainty will also help providers return to a more efficient, economical, and appropriate practice of medicine, with substantial economic benefit society at large. A 1993 Lewin-VHI report estimated that the nation could save $25 billion in health care costs by eliminating the defensive medical practices physicians employ to shield themselves against potential lawsuits. A just-released GAO study concurs that decreases in defensive medical practice would yield substantial national savings. While much attention has been focused on the so-called "high-risk" specialties and procedures, the problem of defensive medicine is pervasive and affects all patients and physicians in all specialties. In a 1992 Gallup poll of generalist physicians, 93 percent said that fear of lawsuits leads them to prescribe tests that are otherwise unnecessary. Eliminating these practices will result in significant savings to the health care sector and the payors, including the public, who support it.

We understand that some advocates question the real potential for savings of the magnitude predicted by Lewin, arguing that "defensive" medical practices have become the accepted standard of care for many clinical conditions and that so long as medical injury compensation remains a tort-based system, physicians will not abandon these practices. However, it is the Academy's strong contention that tests and procedures that are not medically indicated are not only excessively expensive, but are contrary to the physical well being and appropriate medical management of the patient. Every medical test and procedure carries with it a small but statistically measurable risk of adverse reaction or outcome, and the hundreds of thousands of defensive procedures performed by physicians greatly increases the probability that a few patients will suffer needless adverse events.

The Academy concurs that it will take a long time for physicians to adjust their practice patterns once reform is enacted. However, innovations in the health care market place such as managed care and outcomes research will help reduce medically unnecessary services. The Academy notes that critics of reform see in managed care additional opportunities for medical mischief. In a managed care environment, the argument goes, the practice incentives are more likely to result in under treatment, so that the accountability afforded by the medical tort system is more necessary than ever. It is therefore imperative that Congress understand that we are not talking about eliminating liability for medical negligence. On the contrary, there is ample evidence that consumers are already disadvantaged by the current medical malpractice system, and several of the reforms proposed in H.R. 2425 will make it easier for truly injured parties to access the system. What we are talking about is the reduction of incentives for individuals and their lawyers to file truly spurious medical lawsuits on the chance that a sympathetic lay jury might make them millionaires. Experience in California suggests that even when a $250,000 cap on noneconomic damages is in place, patients who file valid claims for severe injuries will still be compensated with large awards.

If Congress is ever to reach agreement on medical liability reform, then it must move beyond the issue of cost to the real issues of access and the consequences of a runaway medical liability system on the availability of critical health care services. In this regard, family physicians bring unique experience to the debate. As the principal providers of health care services to disadvantaged and under served populations, family physicians see daily the contributions of the existing malpractice system to the problems that define these groups.

The availability of obstetric services is a case in point. In rural areas, inner cities, and economically depressed communities—which have been the last to attract qualified medical care providers—a virtual exodus of obstetric providers has occurred. Family physicians are a critical source of obstetric care in these under served areas, providing about two thirds of what rural obstetric services are available. However, the family physicians that deliver such services pay malpractice insurance rates that are considerably higher than those of their counterparts who do not practice obstetrics. Higher rates place an especially difficult burden on rural family physicians, because they generally have fewer obstetric patients among whom to spread the additional cost.

The results are predictable. In a recent survey of AAFP members, 1 out of 4 family physicians who previously provided obstetrical services reported having discontinued those services due to the cost or unavailability of medical liability insurance, while another 10 percent limited the type of obstetrical care they provide. Approximately 62 percent of family physicians have given up obstetrics altogether. As a result, in rural areas pregnant women are unable to deliver at nearby hospitals where the obstetric unit has been shut down for lack of physician coverage, and instead must travel great distances to obtain care. Indigent women are also affected as obstetric providers limit their participation in high risk care or decline to participate

in public programs because reimbursement rates fail to cover liability premium costs. For women who already are statistically less likely to obtain early and regular prenatal care, and who are at considerably greater risk of a poor pregnancy outcome, the medical malpractice problem has exacerbated already chronic access barriers.

At this point, the Academy also wishes to express its support for volunteer protection liability legislation as introduced by Congressman Goodlatte (H.R. 2938) and Congressman Porter (H.R. 911). Such legislation is designed to ensure that licensed medical providers who deliver medical care without compensation at free clinics are not sued for civil liability, except in cases of gross negligence or willful misconduct. Currently, physicians wanting to provide care in free health clinics are discouraged from doing so because it could place their malpractice coverage at risk. Furthermore, retired medical professionals typically do not carry liability coverage and therefore usually cannot volunteer to serve in free health clinics. It seems to us foolish to discourage professionals who are functioning within their scope of competence from rendering a humanitarian service. Moreover, free health clinics provide uninsured individuals with access to primary and preventive health care services without resorting to the costly alternative of emergency room care.

Volunteer protection liability legislation builds upon the tradition of Good Samaritan laws, which exempt volunteers from tort liability for ordinary negligence in rendering emergency aid to an individual. It is Academy policy to support Good Samaritan laws and urge its constituent chapters to seek the enactment of such legislation if it can be constitutionally sustained. All 50 states and the District of Columbia have Good Samaritan laws on the books today. In addition, eight states presently have statutes that offer protection from liability for medical professionals voluntarily providing uncompensated health care: Virginia, Utah, North Carolina, Florida, Kentucky, South Carolina, Iowa, Illinois, and Washington, D.C. We urge the Congress to enact legislation that would extend this protections to medical professionals in all fifty states.

Finally, the Academy would take this opportunity to note its grave concerns about proposals to open the National Practitioner Data Bank to public use. While we understand the impulse to make information about provider competence and claims history available to health care consumers, the fact is that the information contained in the data bank is difficult to interpret accurately and is of little or no predictive value with respect to the quality of care provided by the physicians listed in it. A large number of medical liability settlements reported in the data bank are nuisance suits that were settled by physicians in order to avoid the financial and emotional costs of litigation. That a suit was settled is no indication of the merits of the claim. In cases of actual negligence, studies have found that poor quality of care in any particular instance does not imply incompetence with respect to that condition or procedure. Moreover, the brief descriptions of events contained in the data bank do not permit full understanding of the circumstances of the alleged injury. As the Physician Payment Review Commission states, "Permitting public access to NPDB information would be likely to adversely affect the underlying processes that generate the information. There are anecdotal reports that more physicians are refusing to settle cases in order to avoid being reported to the NPDB. . . . These effects would be greatly exacerbated if the NPDB were opened to the public."

The medical liability reform provisions contained in H.R. 2425, the House-passed Medicare Preservation Act, will help stem the erosion of health care services in rural and other under served communities. In addition, they will spare physicians and patients from the costs and personal tribulations of an overly litigious tort system through lower professional liability insurance premiums and reduced exposure to those unnecessary services ordered for purely defensive reasons. The non-economic damages cap, in particular, will ensure that individuals who are injured as the result of medical negligence will receive full and fair compensation for their expenses while removing incentives to play the lawsuit "lottery."

ANTI-TRUST

The Academy strongly urges Congress to require the Federal Trade Commission and the Department of Justice to adopt an appropriate standard of review for health care provider joint venture activities.

As this Committee is aware, dramatic transformations are occurring in the health care industry. Competition between health plans has stimulated greater patient choice, higher quality, and lower costs. However, some of the nation's more mature managed care markets are witnessing less, rather than more, competition as larger health plans continue to grow, consolidate and merge. In these markets, vigorous

competition could be reignited by the entry of new entities—provider-sponsored organizations—that are able to achieve even greater efficiencies in the financing, organization and delivery of health care services. In highly concentrated managed care markets, employers are beginning to recognize the potential for additional savings, improved quality, and greater patient choice through direct contracting with provider groups. Provider networks have the potential to become a viable competitive alternative to insurance company plans because they substantially eliminate the insurance function's cost and profit centers, thereby adding value to employers' health care premium dollars. Self-insured employers have recognized this potential for years; it is one reason they so vigorously defend their ERISA protections.

Employers are not the only ones who have recognized the potential cost-savings from organized systems of care. Congress, too, has sought to avail itself and its program beneficiaries of the cost-efficiencies produced by managed care plans. Virtually every Medicare reform proposal considered by Congressional committees last year would have offered beneficiaries incentives to enroll in some form of Medicare risk plan. For example, beneficiaries in such plans would often be able to receive benefits above and beyond those provided under Medicare's traditional fee-for-service system while potentially paying less out-of-pocket than fee-for-service enrollees pay. As the Academy has pointed out repeatedly, these incentives may help accelerate enrollment in markets where managed care has penetrated, but they will unfairly penalize beneficiaries who live in markets that do not now and probably never will have a managed care option. The low volume of insurable lives relative to administrative and marketing expense make rural and frontier areas particularly unattractive to most commercial managed care organizations. In these places, locally-grown provider-sponsored organizations could provide beneficiaries with a meaningful alternative to traditional fee-for-service Medicare.

Unfortunately, strict adherence to antitrust doctrine as it has traditionally been applied to medicine will frustrate the development of provider-sponsored organizations in rural areas as elsewhere. In so doing, it will prove counterproductive in efforts to realign the incentives of the health care system in both Medicare and the private sector.

For whatever reason, the antitrust enforcement agencies have always been deeply suspicious of medicine. Whereas collaborative and joint selling activities in other economic sectors are treated according to their net effect on competition in the marketplace, similar activities in the health care sector are simply presumed to be anti-competitive on their face. Moreover, the agencies have in the past been particularly aggressive about investigating health provider joint ventures. As a result providers, and particularly physicians, have been extremely hesitant to experiment with new forms of health care service organization and delivery.

In 1994, the FTC and DOJ attempted to address providers' concerns with a series of policy statements delimiting collaborative activities that would not be challenged under anti-trust laws. Unfortunately, the guidelines specified by the agencies differed little from their existing anti-trust interpretation, and left providers whose activities fell outside the narrowly defined safe-harbors more fearful than ever of being found in violation of the law. Agency surveillance is so zealous, and the consequences of an enforcement action are so severe, that most physicians will not even consider participating in a joint venture-type activity not expressly protected as a safe-harbor.

The net effect has been to forestall organizational innovations in health care that, if implemented, could yield greater benefits, higher quality, and greater satisfaction, all at reduced costs to purchasers and consumers. For example, current FTC and DOJ antitrust enforcement policies restrict approval of non-exclusive provider networks to those which have fewer than 30 percent of the physicians in a market. These restrictions preclude provider networks from acquiring the size and geographic coverage to be attractive to employers and patients. Moreover, they virtually assure that *any* collaborative activity in small rural and frontier areas will exceed the threshold. (Insurance company and HMO networks do not operate under this burden). As a result, physicians and other providers in markets with the most to gain from collaborative, integrative strategies look at their options and conclude that business as usual is the safer course.

In addition, FTC/DOJ's 1994 policy statements require that in order to avoid a challenge of per se anti-competitive conduct, parties to physician joint ventures must share "substantial financial risk." The agencies specify that capitation and fee withhold arrangements will satisfy this test. Although they suggest that other risk-sharing approaches would also be considered, none have been approved. The agencies' policies create *de facto* barriers to legitimate ventures that use other mechanisms for sharing risk, such as the pooling of capital. Equity investments representing "risks of loss as well as the opportunities for profit" were the Supreme Court's

standard in *Mancopa County* for arrangements meriting rule of reason treatment. Even more troubling is that the agencies' prescriptive criterion blunts the ability of purchasers to achieve savings through means other than requiring physician networks to assume financial risk. For example, many ERISA plans have in-house administrators who achieve cost savings through careful selection of providers and through creative mutual cooperation to control costs. Federal anti-trust policy should not deny these employers their preferred strategies by prohibiting physicians from organizing to achieve the employers' goals.

The health care field is evolving so rapidly that it would be impossible for Congress or the enforcement agencies to specify a set of criteria differentiating all permissible, pro competitive behavior from all naked restraints. Any attempt to do so would inevitably curtail innovation in one direction or another, at a time when, more than any other, the purchaser marketplace is seeking new, more efficient models of health care organization. A more appropriate tack is to require the enforcement agencies to apply rule of reason analysis to legitimate provider networks—to weigh the competitive gains against the competitive harms of their individual activities on a case-by-case basis. As long as collaborative activity does not result in decreased competitive benefit to the consumer, the particular manner in which the activity is conducted should not be an issue. If joint ventures can make a plausible claim that their purpose is pro competitive, they should be given a hearing under the rule of reason, period.

Chairman Hyde's Antitrust Health Care Advancement Act of 1996 (H.R. 2925) would accomplish this goal by applying the rule of reason test to legitimate provider networks. Networks engaging in anticompetitive behavior could still be challenged in both criminal and civil court. Under this bill, physician ventures must pass several substantive tests of integration in order to receive rule-of-reason treatment. The network must be organized, operated, and composed of health care providers; be funded in part by members' capital contributions, and have in place a common set of tools including utilization review, quality assurance, coordination of care and a patient grievance process. Most importantly, the network must contract as a group and require all members of the group to provide services for which the network has contracted.

If provider networks are to help stimulate competition in consolidating markets and provide meaningful options for federal program beneficiaries in rural and other places, they must not be unduly constrained by overly restrictive, overly prescriptive federal anti-trust interpretations. The Chairman's Health Care Antitrust Advancement Act would institute a more rational and appropriate mechanism for approaching a highly dynamic industry.

The Academy appreciates the opportunity to submit these comments for the record. We would be please to work with you in any capacity to advance medical liability and anti-trust reforms.

AMERICAN SOCIETY
OF ANESTHESIOLOGISTS

March 6, 1996

The Honorable Henry J. Hyde, Chairman
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, D.C. 20515-6216

Dear Chairman Hyde:

In my capacity as President of the American Society of Anesthesiologists (ASA), I have been provided with a copy of the written testimony of the American Association of Nurse Anesthetists (AANA) presented to your Committee on February 28. The ASA Administrative Council has asked me to respond for the hearing record and I am happy to do so.

The AANA testimony purports to be a statement on behalf of several nonphysician provider organizations in opposition to the principles of H.R. 2925, sponsored by you and Representative Archer, by which the rule of reason would be applied to test the legality under the antitrust laws of exchanges of information in connection with the formation of physician networks. ASA strongly supports this legislation, and during the recent Congressional recess has been active through its key contact physicians in seeking additional sponsors for the bill.

Unfortunately, AANA's principal purpose in appearing before the Committee was not to testify on the merits of your proposed legislation, but to use the hearings as a vehicle for placing on the public record an unprincipled broadside attack on the medical specialty of anesthesiology. Why? Because AANA's leadership desperately needs a scapegoat to explain to its membership, which has historically enjoyed the highest level of income of any of the nurse practitioners, why its members are suddenly confronting fewer and less attractive opportunities to perform their trade.

I will not demean my colleagues in anesthesiology by stooping to respond to the AANA attack. I will note only that the AANA testimony was provided by the immediate past president, who is also the president-elect, of the AANA's Minnesota chapter. A major focus of her statement was the antitrust litigation now pending between that chapter and three hospitals, arising from the decision of the hospitals to terminate employment of CRNAs for economic reasons.

It is interesting to note that the AANA testimony fails to state that most of the terminated Minnesota nurse anesthetists continue to provide services at the hospitals as independent contractors or as employees of anesthesiology groups serving those hospitals under contract. Even more interesting is the fact that notwithstanding the litany of anticompetitive behavior

claimed by AANA to lie behind the hospitals' decisions, a federal appellate court, in dissolving a preliminary order of the trial court, expressed doubt as to the ability of the plaintiffs to prevail on their antitrust claims.

The reality in Minnesota is the reality across the United States. Hospitals are cutting costs wherever possible to make themselves more attractive to managed care organizations. Two of the three Minnesota hospitals reported that they had saved over $1 million by terminating the nurse anesthetists and shifting the risk of their employment to third-party contractors. Many other hospitals, in all parts of the country, are insisting on "clean sweep" provisions in anesthesiology services contracts, assuring themselves that the anesthesiology group will fully cooperate in the hospital's negotiation of managed care contracts or risk losing hospital privileges.

ASA makes no apology for the fact that, based on the medical education and skills of anesthesiologists, nurse anesthetists should provide anesthesia care under the supervision of a physician and, preferably, under the medical direction of an anesthesiologist. This, of course, is an anathema to AANA, the sole political objective of which is to achieve for every nurse anesthetist the right to provide anesthesia care, no matter how complex or dangerous, free from medical supervision. Although ASA regards well-trained nurse anesthetists as valuable members of the anesthesia care team, ASA believes that the independent delivery of anesthesia care by nonphysicians – a state of affairs existing no place else in the Western world – disserves the American people. The AANA attempt to obtain through legislation what anesthesiologists have obtained through medical education and postgraduate training is similarly a disservice to the American people.

If AANA thinks that anesthesiologists or organized anesthesiology are engaged in anticompetitive conduct to the detriment of AANA's members, the courts are always open to hear their complaints, just as the governmental antitrust agencies are always willing to listen. ASA is, of course, aware that in the past decade, AANA inspired an investigation by the Federal Trade Commission into alleged restraints on nurse anesthesia education by organized anesthesiology; curiously, the AANA statement fails to note that the FTC closed that investigation after several years, having failed to find any antitrust violation. With the exception of the Oltz case referred to in the AANA statement, moreover, no court to ASA's knowledge has found that an anesthesiologist or group of anesthesiologists has violated the antitrust laws in relation to practice opportunities for nurse anesthetists.

In short, AANA is seeking an explanation for the changes in the marketplace which are occurring in anesthesia practice. The facts are, indemnity insurers, managed care organizations and government health plans are drastically cutting the amount they will pay for the services of providers, including anesthesia providers – anesthesiologists and nurse anesthetists alike. If AANA were to devote its energy and resources to finding new ways for its members to work in cooperation with anesthesiologists, to respond to these initiatives by improving efficiency and quality, both their members, our members, and this country would be better served.

Once again, Mr Chairman, ASA supports your bill Just as its implementation would facilitate formation of physician groups to compete with managed care delivery systems, so also it would increase the opportunities in the marketplace for nonphysician providers It's too bad AANA doesn't recognize that fact

ASA requests that this statement be included in the record of the hearings

Very truly yours,

Norig Ellison, M D , President

NE:ml
cc The Honorable Bill Archer
Christine S Zambricki, CRNA,President
American Association of Nurse Anesthetists
ASA Board of Directors

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IMMEDIATE PAST PRESIDENT
CHARLES W. BURSON
ATTORNEY GENERAL OF TENNESSEE

October 26, 1995

Honorable Newt Gingrich
Speaker of the House
U.S. House of Representatives
The Capitol
Room H-232
Washington, D.C. 20515-6501

Dear Speaker Gingrich,

As Chair and Vice-Chair of the Antitrust Committee and Chair and Vice-Chair of the Health Care Task Force of the National Association of Attorneys General, (NAAG), we are writing to express our concern about two antitrust provisions included in H.R. 2425, the Medicare Preservation Act of 1995. These provisions, sections 15001 and 15201 of the Act, are unnecessary and could frustrate the cost-containment goals of the Medicare legislation. We urge that these provisions not be included in the final Medicare reform package.

The Attorneys General, as chief law officers of their states, are the primary enforcers of the states' antitrust law and also represent their states and the citizens of their states in federal antitrust litigation. As chief legal officers, the Attorneys General have had and continue to have an important role in the development of national competition policy. We know first-hand that the antitrust laws benefit consumers by protecting competition and promoting efficiency, innovation, low prices, better management and greater consumer choice. Although the Attorneys General, as a group have not had an opportunity to consider this legislation, past NAAG policy positions have consistently opposed both new antitrust exemptions and the weakening of antitrust enforcement standards for specific industries.

Section 15201 of the Act provides an exemption from both state and federal antitrust laws for activity relating to medical self-regulation. We believe that inclusion of this provision is inadvisable. Unfortunately, state Attorneys General have had experience with physicians and other health care providers who have engaged in anticompetitive activities, including physicians' attempts to eliminate competition from HMOs, PPOs and allied health care professionals. For this reason, in a 1993 Resolution, the Attorneys General stated their belief that exempting health care providers from the antitrust laws is undesirable. Nor is the exemption contained in section 15201 necessary. Current antitrust law permits collaborative activities, including standard-setting activities, that benefit the public and do not injure competition.

Section 15001 of the Act provides that certain actions of a provider service network or an individual member of that network shall not be deemed illegal *per se* under either federal or state antitrust law, but shall instead be judged under the "rule of reason." We are concerned

that this relaxation of antitrust standards could lead to higher prices and fewer choices for consumers. Under current law, *per se* treatment is reserved for the most anticompetitive conduct, including horizontal price-fixing. As stated in a 1980 NAAG Resolution, the Attorneys General oppose new industry-specific antitrust standards because present antitrust standards adequately protect the interests of businesses, as well as consumers, by preventing activities that have no pro-competitive justification. More specifically, in the health care area, the Attorneys General believe that competition promotes more affordable health care, development of innovative new delivery systems, and increased information for health care consumers.

Finally, we are concerned about the broad preemption of state antitrust enforcement, particularly in section 1521, which is not limited to protection of activities within the Medicare program. In a 1994 Resolution, the Attorneys General opposed preemption of state antitrust enforcement in the health care area because such preemption erodes state sovereignty and threatens the system of federalism established by the Constitution. Health care is predominately a local industry that varies significantly from state to state. The Attorneys General, as chief law enforcement officers, should continue to be able to prevent anticompetitive behavior within each state.

If you have any questions about our views, please feel free to contact us or Emily Myers, NAAG Counsel for Antitrust and Health at (202) 434-8015.

Very truly yours,

J. Joseph Curran, Jr.
Attorney General of Maryland
Chair, NAAG Antitrust Committee

Pamela Fanning Carter
Attorney General of Indiana
Chair, NAAG Health Care Task Force

Tom Miller
Attorney General of Iowa
Vice-Chair, NAAG Antitrust Committee

Jeffrey L. Amestoy
Attorney General of Vermont
Vice-Chair, NAAG Health Care Task Force

cc: Tom Udall, NAAG President
Members of the Antitrust Committee
Members of the Health Care Task Force

American Hospital Association

One North Franklin
Chicago, Illinois 60606
Telephone 312 422 3000

Fredric J Entin
Senior Vice President and General Counsel
Phone 312 422 2775
Fax 312 422 4603

April 24, 1996

The Honorable Henry J Hyde
Chairman
Committee on the Judiciary
2138 Rayburn Building
Washington, DC 20515

Dear Mr Chairman

I am writing in response to your April 17 letter enclosing a list of questions following up on my testimony before the Committee on the Judiciary regarding "Health Care Reform Issues Antitrust, Medical Malpractice Liability, and Volunteer Liability."

The American Hospital Association does not maintain information regarding specific state malpractice reforms, nor does it maintain information concerning insurance premiums paid by physicians While I am not certain of the precise information which might be maintained it is possible that some of the requested information would be available through the American Medical Association

I am sorry I am not able to be more responsive to your request

Sincerely,

Fredric J Entin
Senior Vice President
and General Counsel

FJE bh

COMMITTEE ON THE JUDICIARY

HEARING ON

"HEALTH CARE REFORM ISSUES:
ANTITRUST, MEDICAL MALPRACTICE LIABILITY,
AND VOLUNTEER LIABILITY"

Tuesday, February 27, 1996
2141 Rayburn House Office Building
9:30 a.m.

QUESTIONS

Please provide information concerning insurance premiums paid by physicians as well as claims paid by insurance companies in the five years prior to and all years subsequent to adoption of malpractice reform and insurance reforms laws in as many states for which data is available (Please note dates of adoption of legal changes.)

Please provide any AMA statistics indicating what impact, if any, medical malpractice changes at the state level have had on the number of obstetricians providing care in rural or lower income communities. Is it true that there were still no obstetricians in California's three most rural counties in 1992 despite the enactment of MICRA in California in 1975?

Law Offices
of
George D. Dikeou

April 30, 1996

The Honorable Henry J. Hyde
Chairman
Congress of the United States
House of Representatives
Committee on the Judiciary
2138 Rayburn House Office Building
Washington, DC 20515-6216

RE: Your Request of April 17, 1996

Dear Chairman Hyde:

I have forwarded your request to the PIAA office in Washington, DC.

With regard to Colorado, I can provide you with the following information:

1. Comprehensive tort reform was enacted in 1988.

2. The attached Premium Rate History by Specialty will demonstrate significant premium rate decreases since 1988 in all specialties except FP/GP, Neurosurgery, Pediatrics and Plastic Surgery.

3. There has been a dramatic reduction is in Ob/Gyn premium rates.

4. The attached news release will establish the basis for tort reform in Colorado.

5. Charts provided to your Committee on the day of testimony indicate what the rates would have been from 1988 forward for certain key specialties, if adjusted only for inflation.

6. In addition, COPIC has returned in excess of $40 million to its policyholders since 1989, further reducing the effective premiums paid.

I would be happy to discuss these issues with your staff.

Very truly yours,

George D. Dikeou

GDD/sra

cc: Larry Smarr
Jerome M. Buckley, M.D.
Larry Thrower

University of Colorado Health Sciences Center
Press Release - Tuesday, February 9, 1988

HIGH INSURANCE COSTS CAUSING OBSTETRICIANS
TO DISCONTINUE DELIVERIES, UCHSC SURVEY SHOWS

DENVER -- A just-completed statewide survey of obstetricians and family physicians who deliver babies indicates that high malpractice insurance costs have caused 21 percent of survey respondents to discontinue the delivery of babies in the past five years.

The survey also indicates that further premium increases will cause 63 percent of physicians still doing obstetrical (OB) work to drop those services. Particularly hard hit will be rural areas. If the trend continues, 42 of Colorado's 63 counties may be left without OB services.

The study, funded by the National Institutes of Health, was conducted by the University of Colorado Health Sciences Center's (UCHSC) Department of Family Medicine in cooperation with the Colorado Department of Health and the Maternal and Child Health Committee of the Colorado Medical Society

Ned Calonge, M.D., UCHSC Department of Family Medicine assistant director of research and principal investigator of the study, said that 19 Colorado counties are or soon will be without medical obstetrical care. "Based on the response of physicians, more will be dropping medical OB care and more counties will be left without such care as premiums increase."

The 918 survey respondents represent more than 76 percent of urban OB care providers and at least 83 percent of rural providers. Also, 92 percent of respondents were Doctors of Medicine, eight percent, Doctors of Osteopathy. Also, 65 percent were family/general practitioners, 31 percent obstetricians/gynecologists, and the balance, related specialties.

The study was released to the Colorado General Assembly and the Governor's Task Force on Medical Liability Tuesday in Denver. Calonge described other conclusions of the study:

-- While 21 percent dropped obstetrics in the past five years, 17 percent dropped such services before that, and another 30 percent reduced OB services. Only 15 percent increased OB services.

-- The three reasons cited as most important in dropping OB services were insurance premium increases, uncertainty about insurance availability and fear of malpractice suits.

-- Of the physicians providing OB care to medically indigent patients and medical patients more than 62 percent said they would drop all OB services if malpractice rates continue to rise.

-- The potential effect of large increases, as compared with modest increases or current premium status, would be that 6,269 Colorado women would have to drive and average of 52 miles to the nearest available medical obstetrical care.

PREMIUM RATE HISTORY BY SPECIALTY

Years 1984 - 1996

Limits: 1 Million/3 Million
Mature Rates
Safety Group
Annual Premiums

Year	Anesthesiology	Emergency Medicine	FP/GP Office Practice	FP/GP Doing OB	General Surgery	Neurosurgery	OB/GYN	Orthopaedic Surgery	Otorhino laryngology	Pediatrics	Plastic Surgery
1984	$11,520	$2,600	$1,440	$3,888	$8,200	$13,680	$13,680	$13,680	$8,200	$1,440	$8,200
1985	$13,760	$3,104	$1,720	$6,164	$9,796	$16,430	$16,340	$16,340	$9,796	$1,720	$9,796
1986	$17,496	$7,000	$2,188	$7,000	$13,124	$19,684	$21,872	$19,684	$13,124	$2,188	$13,124
1987	$21,872	$12,960	$4,056	$12,960	$24,304	$34,652	$42,560	$38,504	$24,304	$4,056	$24,304
1988	$21,448	$15,952	$5,648	$15,952	$31,456	$49,400	$61,904	$49,100	$31,456	$8,648	$31,456
1989	$19,524	$16,004	$5,680	$16,004	$28,524	$56,992	$56,992	$47,008	$28,524	$12,992	$28,524
1990	$16,532	$16,004	$5,680	$16,004	$26,532	$57,008	$52,008	$42,008	$26,532	$9,684	$26,532
1991	$13,232	$13,232	$6,700	$16,168	$24,128	$56,416	$46,444	$36,168	$26,472	$7,872	$26,472
1992	$11,192	$13,232	$6,700	$16,168	$22,956	$49,968	$39,992	$31,952	$26,472	$7,872	$26,472
1993	$9,800	$12,060	$6,132	$11,044	$21,784	$49,384	$34,128	$30,604	$26,472	$7,872	$26,472
1994	$10,252	$11,460	$6,776	$13,264	$21,684	$43,824	$30,580	$26,972	$21,684	$7,976	$30,580
1995	$10,446	$12,391	$7,362	$12,391	$23,411	$47,282	$30,424	$26,534	$20,172	$8,623	$34,632
1996	$10,532	$13,412	$7,984	$13,412	$26,052	$52,388	$30,764	$26,444	$22,448	$9,812	$38,692

American Medical Association
Physicians dedicated to the health of America

Nancy W. Dickey, MD
Chair
Board of Trustees

515 North State Street
Chicago, Illinois 60610

312 464-4466
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June 17, 1996

The Honorable Henry J. Hyde
Chairman, Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Hyde,

I appreciated the opportunity to testify before the Judiciary Committee in February on health care liability and antitrust issues. Attached are my responses to the follow-up questions submitted by the Committee in your April 17, 1996, letter.

Although I testified on behalf of the American Medical Association (AMA), I am aware that the identical questions were submitted to a number of witnesses who appeared during the same hearings, including witnesses for the American College of Obstetricians & Gynecologists (ACOG) and for the Health Care Liability Alliance (HCLA). The AMA helped found and is actively involved in the activities of the HCLA. Some of the information requested by the Committee (medical liability premium data, obstetrics claims data) is more readily available from sources outside the AMA. Where necessary, I have consulted with the ACOG or the other HCLA members in the attempt to provide or direct the Committee to the best available information.

My responses are attached. Please let me know if I can provide any further assistance.

Very truly yours,

Nancy W. Dickey, MD.

Nancy W. Dickey, MD

Enclosures

RESPONSES TO WRITTEN QUESTIONS
COMMITTEE ON THE JUDICIARY HEARING "HEALTH CARE REFORM ISSUES
ANTITRUST, MEDICAL MALPRACTICE, AND VOLUNTEER LIABILITY"

1. **Please provide information concerning insurance premiums paid by physicians as well as claims paid by insurance companies in the five years prior to and all years subsequent to adoption of malpractice reform and insurance reforms laws in as many states for which data is available. (Please note dates of adoption of legal changes.)**

The AMA annually surveys its member and nonmember physicians on a number of socio-economic issues, including liability premiums, since the early 1980s. A summary of our most recent data, extending from 1985 to 1993 is attached. While it documents a number of trends in the insurance market, it does not contain the complete data set requested in this question.

Indeed, it would be very difficult for the AMA or any private sector organization to gather the depth of information requested in this question. Insurance companies competing in the marketplace are reluctant to disclose much of this information. Moreover, the time frame for which information is requested extends back to at least 1970. Since that time there has been a dramatic revolution in the market. Most of the commercial insurers participating in the field in the early 1970s deserted the medical liability market between 1975 and 1980. The market splintered, with the vacuum left by the large commercial insurers filled by approximately 50 to 100 physician and hospital-owned single line insurers, self-insurance trusts, and risk retention groups.

Because of the concerns over proprietary information, it is easier for government or independent researchers to gather this type of data than it is for the AMA, which represents the physician-customers in the market. The most detailed information HCLA is aware of on this subject is a study by the Office of Technology Assessment (OTA) entitled "Impact of Legal Reforms on Medical Malpractice Costs" (September 1993). The OTA Report summarizes the current status of malpractice law reforms in the 50 states and evaluates the best available evidence on the effect of malpractice system reforms on physicians' malpractice insurance premiums. It concludes that two reforms in particular, collateral source rule reform and appropriate limits on non-economic damages, demonstrate the ability to help stabilize insurance premiums. An earlier study by the General Accounting Office, entitled "Medical Malpractice: Insurance Costs Increased But Varied Among Physicians and Hospital's" (September 1986) GAO/HRD86-112, also has substantial data, gathered by a GAO survey of major insurers in every State.

Another source of data is market analysis done by actuarial firms. The College of American Actuaries prepared an analysis in March 1995 of the impact of malpractice reforms on malpractice costs for three states: California, New York and Ohio. Its report also concludes that it is important to have a comprehensive package of reforms noting the specific benefit from a cap on non-economic damages and some form of offset for collateral payments from other sources.

Finally, in October of 1995, the Congressional Budget Office (CBO) reviewed the available data and determined that a comprehensive set of reforms that includes limits on non-economic damages, joint and several liability reform, and collateral source reform, among others, would reduce physician malpractice insurance premiums.

2. **Please provide any AMA statistics indicating what impact, if any, medical malpractice changes at the state level have had on the number of obstetricians providing care in rural or lower income communities. Is it true that there were still no obstetricians in California's three most rural counties in 1992 despite the enactment of MICRA in California in 1975?**

There are no "AMA statistics" on the impact of "medical malpractice changes" at the State level or on the "number of obstetricians" providing care in rural or lower income communities. We assume that the object of this question is whether *tort reform* at the State level has impacted on *the availability of obstetrics services* in rural areas. Much of the obstetrics service in rural areas has always been provided by family practitioners or general practitioners. Hence, evaluating the behavior of these physicians is an important factor in estimating the impact of medical liability exposure and tort reform that ameliorates this exposure.

The most extensive information I am aware of on the subject was compiled by the Institute of Medicine (IOM) in a two volume series entitled, "Medical Professional Liability and the Delivery of Obstetrical Care" published by National Academy Press in 1989. The IOM reports that the delivery of obstetrical care in rural and underserved areas is seriously threatened by professional liability concerns.

In addition, there is a survey by the ACOG on the impact of professional liability on their membership that shows that 1/8 of all board certified ob-gyns have stopped obstetrics because of malpractice risks. ("Professional Liability and Its Effects: Report of a 1992 Survey of ACOGs Membership" (October 1992). I understand that this question has also been directed to their witness, Dr. Joseph Hanss.

With respect to the second part of the question regarding obstetricians practicing in California's rural counties, ACOG's California office reports that there are currently 9 counties in California that do not have a practicing ob-gyn. These include the 3 most rural counties in the State. In 1992, there were about 14 counties without a practicing ob-gyn, which also included the 3 most rural counties in the state. Again, it is likely that most obstetrics services in these counties have historically been provided by family practitioners or general practitioners, as opposed to physicians who specialize in obstetrics.

Medical Professional Liability Claims and Premiums, 1985-1993

By Martin L. Gonzalez

Reform of the medical professional liability system is currently being debated at both the state and federal level. Proposed reforms have included limiting awards for non-economic damages. In this article, trends in claim frequency and cost of insurance premiums are examined using data derived from American Medical Association (AMA) sources. Over the last few years, physicians' liability experiences appear to have moderated in measures of professional liability claim frequency as well as in average premiums. However, more recent trends since 1987 hint at an upturn in physician claims rates. For example:

- The average annual rate of professional liability claims increased from 9.1 per 100 physicians in 1992 to 9.8 per 100 in 1993. However, the increase was not statistically significant. Still, since 1987, the claims rate has increased steadily (a statistically significant finding).
- The percentage of physicians sued decreased slightly from 7.9% in 1992 to 7.8% in 1993. However, the decrease was not statistically significant. Still, the percentage of physicians sued has increased since 1987 (a statistically significant finding).
- Average professional liability premiums increased from $13,800 in 1992 to $14,400 in 1993. However, the increase was not statistically significant.

The information included in this article is derived from the AMA Socioeconomic Monitoring System (SMS) 1984-1994 core surveys of nonfederal patient care physicians, excluding residents. Information reported by respondents to the surveys was weighted to correct for survey nonresponse in order to provide a more accurate estimate of the experience of the entire physician population. Appendices to *Socioeconomic Characteristics of Medical Practice 1995* describe the SMS survey weighting and tabulation methods in detail. Information pertaining to the St. Paul Fire and Marine Insurance Company is from *Physician and Surgeons Update* (June and December 1994 editions).

St. Paul Fire and Marine Insurance Company (hereafter, The St. Paul), the nation's largest commercial medical malpractice carrier, reports that claims frequency among its insureds increased from 14.1 claims per 100 physicians in 1992 to 14.6 claims in 1993. The frequency of claims incurred by St. Paul insureds had declined from the mid-1980s until 1989, when it hit a low of 12.3. Claims frequency continues to be the most critical element affecting The St. Paul's medical liability rate levels. The St. Paul did not increase premium rates in 1993. It should be noted that physicians insured by The St. Paul may not be representative of all physicians practicing in the U.S.

The author is a Senior Research Associate in the American Medical Association's Center for Health Policy Research.

Table 1 **Annual Professional Liability Claims per 100 Physicians, by Specialty and Census Division, 1985-1993**

	1985	1986	1987	1988	1989	1990	1991	1992	1993	Average Annual Rate of Change 1985–1993
All physicians	10.2	9.2	6.7[a]	6.4	7.4	7.7	8.2	9.1	9.8	–0.5
Specialty										
General family practice	5.7	7.0	5.7	6.2	6.6	5.9	5.7	6.0	7.1	2.8
Internal medicine	6.2	5.5	4.5	4.3	5.9	6.2	5.5	7.3	7.0	1.2
Surgery	16.8	15.8	12.7	10.2	11.2	11.5	14.0	15.5	18.0	1.5
Pediatrics	7.2	6.8	4.5	3.7	5.4	9.7	6.4	7.2	4.1	–6.5
Obstetrics/gynecology	25.8	13.0[a]	8.0	15.1[a]	13.5	11.0	11.0	15.6	22.5[a]	–1.7
Radiology	12.8	11.5	8.0	5.2	5.0	8.7	6.1	11.5	9.4	–3.8
Psychiatry	2.9	4.5	1.6	0.6	5.1[a]	2.4	4.0	2.5	4.2	4.7
Anesthesiology	7.5	8.7	4.6	4.0	5.9	5.3	8.2	5.0	2.4	–13.3
Pathology	3.3	1.9	4.0	3.6	2.5	1.5	5.0	3.5	1.0	–8.7
Other	10.4	9.1	5.9	6.7	5.7	7.0	10.4	7.7	6.8	–5.2
Census Division										
New England	7.6	10.1	4.0	8.4	4.0	2.4	4.8	5.6	7.2	–4.7
Middle Atlantic	13.9	12.7	7.8	7.1	7.5	9.6	10.9	12.7	14.5	0.5
East North Central	13.2	10.1	10.5	7.5	10.8	9.5	6.7	8.8	11.5[b]	–1.7
West North Central	9.6	8.6	3.9	4.0	5.9	5.8	6.3	6.4	10.5[b]	1.1
South Atlantic	7.0	7.5	5.6	4.7	4.8	5.7	5.4	5.6	5.8	–2.3
East South Central	5.5	7.3	9.2	6.4	9.0	5.6	9.0	8.4	4.9	–1.4
West South Central	12.4	8.6	6.3	10.4	10.7	11.4	12.1	13.3	12.4	0.0
Mountain	6.2	9.0	4.1	5.0	5.6	8.8	8.8	5.8	7.9	3.1
Pacific	9.3	7.5	5.4	4.4	6.1	7.0	9.5	10.6	9.0	–0.4

Source: 1986-1994 Socioeconomic Monitoring System core surveys. Weights applied to the 1993 survey data have been revised. This may cause the 1992 claims figures to differ from what was reported in the 1994 edition of *Socioeconomic Characteristics of Medical Practice*.

a. Change from previous year statistically significant at $p = .05$.

b. 1987-1993 change statistically significant at $p = .05$.

c. 1985-1993 change statistically significant at $p = .05$.

Trends in Professional Liability Claims

Claim frequency for all physicians was 9.8 claims per 100 physicians in 1993, compared with 9.1 per 100 in 1992 as shown in Table 1. While the claims rate did increase between 1992 and 1993, that increase was not statistically significant. In general, the results indicate a leveling off in the claims rate in contrast to the increases of the early- and mid-1980s. Since 1985, the overall claims rate has declined at an average annual rate of 0.5%. However, the 1993 claims rate was the highest rate since 1985. In addition, physicians experienced a statistically significant increase in their claims rate during the period 1987-1993.

Only anesthesiologists experienced statistically significant declines in their claims rate since 1985. The trend observed with SMS data is supported by data from The St. Paul. Anesthesiologists insured by The St. Paul have recently experienced fewer and less expensive medical liability claims. This trend has prompted a reclassification of the liability risk posed by these anesthesiologists. The reclassification of risk will yield a future rate decrease in liability premiums and is the result of a lowered "class relativity" for anesthesiologists. Class relativity measures the liability risk posed by a given class of medical specialty, as compared to a base group (i.e., family practitioners - no surgery). Improved patient safety brought about by advancements in medical technology and higher standards of risk management and quality assurance resulted in the risk decline, according to The St. Paul.

Regionally, claims per 100 physicians ranged from

Table 2 **Percent of Physicians Incurring Professional Liability Claims, 1985-1993 and in Career, by Specialty and Census Division**

	Percent Incurring Claims Annually									Average Annual Rate of Change, 1985–1993[c]	Percent Incurring Claims in Career, as of 1993
	1985	1986	1987	1988	1989	1990	1991	1992	1993		
All physicians	8.5%	7.6[a]	6.0%	5.8%	6.6[a]	6.6[a]	7.5[a]	7.0	7.8	+1.1	+1.1
Specialty											
General/family practice	5.5	6.3	5.1	5.7	+.9	5.0	5.0	6.2	6.5	+.2	+1.3
Internal medicine	5.4	4.8	+.3	3.8	5.5	5.6	5.5	6.0	6.9	+.1	+2.1
Surgery	13.6	12.3	11.0	8.8	9.9	9.6	12.1	12.5	13.8	+.3	+5.5
Pediatrics	6.0	5.7	3.9	3.5	5.4	7.9	6.0	6.5	8.5	+.7[c]	+2.4
Obstetrics/gynecology	20.0	10.9[a]	6.7[a]	14.1[a]	13.2	9.3	11.1	11.5	17.2[a]	−1.9	+6.0
Radiology	11.2	10.5	6.5	+.3	5.0	8.3	5.7[a]	11.2	7.7	−+.0	+5.4
Psychiatry	2.9	+.1	1.6	0.6	+.4[a]	2.0	+.2	2.5	3.0	0.+	+2.4
Anesthesiology	7.5	8.2	+.2	+.0	5.9	5.3	7.9	5.0	2.+	−1.3.3	+.3.1
Pathology	3.3	1.9	+.9	3.0	2.5	1.5	5.0	2.8	1.0	−.8.7	1.5.7
Other	7.5	7.+	5.7	6.+	5.3	6.+	8.6	7.+	6.0	−2.8	+.0.3
Census Division											
New England	7.2	9.5	+.0[a]	7.+	2.9[a]	2.+	+.5	+.7	5.1	−+.2	2.7.5
Middle Atlantic	11.5	9.7	6.5[a]	6.5	7.+	8.+	10.3	10.0	10.6[a]	−1.0	+5.5
East North Central	10.6	8.3	8.9	6.+	9.3[a]	8.6	5.3	7.5	9.6[a]	−1.2	+1.8
West North Central	7.5	7.8	3.5[a]	+.0	5.0	5.2	5.9	5.8	7.8	1.0	+5.2
South Atlantic	6.3	6.2	5.2	+.5	+.6	+.8	+.6	5.3	5.3	−2.1	+.+.2
East South Central	+.5	5.9	7.8	6.+	7.6	5.2	9.0	8.0	+.1	−1.2	+.8.7
West South Central	10.+	7.8	6.1	8.7	9.6	9.5	10.1	10.6	10.8[b]	0.5	+9.7
Mountain	5.2	7.5	+.1	+.6	5.6	6.2	8.1	+.7	7.2	+.2	+.3.6
Pacific	8.0	6.2	5.2	+.1	5.+	5.9	9.2	9.6	6.6	−2.+	+2.9

Source: 1986-1994 Socioeconomic Monitoring System core surveys. Weights applied to the 1993 survey data have been revised. This may cause the 1992 claims figures to differ from what was reported in the 1994 edition of *Socioeconomic Characteristics of Medical Practice*.

a. Change from previous year statistically significant at $p = .05$.

b. 1987–1993 change statistically significant at $p = .05$.

c. 1985–1993 change statistically significant at $p = .05$.

+.9 in the East South Central states to 14.5 in the Middle Atlantic states. Other regions with above average claims rates were the East North Central (11.5) and West North Central (10.5) states.

The incidence of liability claims is not confined to a small proportion of the physician population. As Table 2 indicates, 40.1% of all physicians have incurred at least one claim during their careers. Over two-thirds of all obstetrician/gynecologists (67.0%) have incurred at least one claim. Across census divisions, physicians in the West South Central states (49.7%) report the highest career percentage. In 1993, 7.8% of all physicians incurred a claim. Obstetrician/gynecologists were most likely to be sued: 17.2% of these specialists incurred a claim in 1993, the highest among the specialties listed. Across census divisions, physicians in the West South Central region (10.8%) were most likely to have incurred a claim in 1993.

Trends in Professional Liability Premiums

Average professional liability insurance premiums, as reported here, embody coverage limits of insurance purchased as well as the price of insurance at those limits. Average premiums paid by self-employed physicians from 1982 to 1993 are shown in Table 3. Premiums rose at an 8.6% average annual rate during this period, increasing from $5,800 in 1982 to $14,400 in 1993. But most of the increase occurred before 1988. In contrast, the average annual rate of inflation was 3.7%, and total practice revenues increased by 7.2% annually over the same

Table 3 **Average Professional Liability Insurance Premiums Paid and Total Practice Revenue of Self-Employed Physicians, 1982-1993**

	Insurance Premiums Paid	Total Practice Revenue	Premiums as a Percent of Revenue
1982	$5.8	$180.0	3.2
1983	6.0	199.3	3.0
1984	8.1	212.2	3.8
1985	10.5	226.8	4.6
1986	12.8	249.5	5.1
1987	15.0	269.9	5.6
1988	15.9	300.7	5.3
1989	15.5	323.7	4.8
1990	14.5	332.4	4.4
1991	14.9	350.8	4.2
1992	13.8	393.4	3.5
1993	14.4	400.9	3.6
1993 net of inflation	9.0	276.8	3.3
Average annual percent increase			
1982-1993	8.6%	7.2	–
1982-1993 net of inflation	4.7	3.7	–

Source: 1982-1993 Socioeconomic Monitoring System core surveys. Weights applied to the 1993 survey data have been revised. This may cause the 1992 premium and revenue figures to differ from what was reported in the 1994 edition of *Socioeconomic Characteristics of Medical Practice*.

a. In thousands of dollars.

b. Based on logs.

Table 4 **Average Professional Liability Premiums Paid (in thousands of dollars) by Self-Employed Physicians, 1985-1993**

	1985	1986	1987	1988	1989	1990	1991	1992	1993	Average Annual Rate of Change 1985-1993
All physicians	$10.5	$12.8	$15.0	$15.9	$15.5	$14.5	$14.9	$13.8	$14.4	4.0
Specialty										
General/family practice	6.8	7.8	8.9	9.4	9.0	7.8	8.1	8.2	7.4	1.1
Internal medicine	5.8	7.1	8.4	9.1	8.2	9.2	8.9	8.6	9.0	5.6
Surgery	16.0	21.3	24.5	26.5	25.8	22.8	22.5	20.9	22.7	4.0
Pediatrics	4.7	6.3	7.1	9.3	7.8	7.8	8.4	7.7	8.6	7.8
Obstetrics/gynecology	23.5	29.4	35.4	35.3	37.0	34.3	34.9	34.0	33.7	4.6
Radiology	8.9	10.4	9.5	12.9	13.3	11.5	21.4	10.1	10.4	2.0
Psychiatry	2.5	3.4	3.8	4.4	6.3	4.5	4.8	4.6	4.1	6.4
Anesthesiology	17.9	20.5	22.9	23.6	21.7	20.8	23.7	17.6	16.7	–0.9
Pathology	3.1	4.4	6.2	4.9	5.5	7.7	5.9	5.8	6.2	9.1[b]
Other	6.0	8.5	8.4	8.5	9.3	9.5	9.3	8.2	10.9	6.6[b]

Source: 1986-1994 Socioeconomic Monitoring System core surveys. Weights applied to the 1993 survey data have been revised. This may cause the 1992 premium figures to differ from what was reported in the 1994 edition of *Socioeconomic Characteristics of Medical Practice*.

a. Change from previous year statistically significant at $p = .05$.

b. Total 1985-1993 change statistically significant at $p = .05$.

Table 5. **Average Professional Liability Premiums Paid and Coverage Limits per Self-Employed Physician, 1993**

	Premiums Paid	Total Coverage Limits	Coverage Limits per Case
	In Thousands	In Millions	
All physicians	$14.4	$2.8	$1.2
Specialty			
General family practice	7.0	2.5	0.9
Internal medicine	9.0	2.8	1.2
Surgery	22.7	2.9	1.2
Pediatrics	8.0	2.4	1.2
Obstetrics gynecology	33.7	3.3	1.7
Radiology	10.4	3.5	1.8
Psychiatry	4.1	2.0	1.2
Anesthesiology	10.7	3.1	1.5
Pathology	6.2	3.1	1.4
Other	10.0	2.6	1.2

Source: 1994 Socioeconomic Monitoring System core survey.

period. Premiums as a percent of total practice revenues increased from 3.5% in 1992 to 3.6% in 1993.

Table 4 presents detailed information on professional liability insurance premiums paid by self-employed physicians between 1985 and 1993. The average premium in 1993 was $14,400. Average professional liability premiums appeared to have moderated since 1988 when premiums peaked at $15,900. Since then premiums have either declined or increased only slightly. Among specialties listed in Table 4, there is some variation in premiums paid. Specialists in obstetrics gynecology paid, on average, the highest professional liability insurance premiums in 1993 ($33,700) while psychiatrists paid the lowest ($4,100). Premiums were up significantly over 1985 for all specialties except general family practice, radiology, and anesthesiology. Among those experiencing statistically significant increases, the average annual growth rate ranged from 4.0% among surgeons to 9.1% for pathologists. Premiums for anesthesiologists declined during the period 1985 to 1993, but the decline was not statistically significant.

Variations in premiums by specialty tend to reflect differences in claims rates. The correspondence, however, is not complete since premiums are affected by the severity of claims, coverage limits, and other factors in addition to claims rates. Table 5 shows 1993 average premium levels and the coverage limits (total and per case) by specialty. The coverage limits are in millions of dollars. There was relatively little variation in coverage limits per case across specialties. Per case limits ranged from $0.9 million (general family practice) to $1.8 million (radiology). Total coverage limits ranged from $2.4 million (pediatrics) to $3.5 million (radiology). For the most part, the higher-risk specialties such as obstetrics gynecology, anesthesiology, and radiology, paid higher premiums and had higher coverage limits. However, surgeons, who had above average premiums, had below average coverage limits.

SMS does not collect information on the severity of claims. However, data from The St. Paul provide recent trend information for St. Paul insureds. According to The St. Paul, claims severity is the average cost of reported claims and reflects the cost of claims that have been paid, claims closed without payment, the estimated value of open claims, and defense costs. The St. Paul reports that severity dropped slightly from $84,500 in 1992 to $83,800 in 1993. Average indemnity payment reflects payments made to plaintiffs on behalf of St. Paul insureds, including the expense of handling and defending claims during a particular calendar year. The average indemnity payment made on medical liability claims (among claims with payments no greater than $200,000) declined from $119,400 in 1992 to $117,500 in 1993. The St. Paul's average indemnity payment, if claim amounts up to $1 mil

lion are included, was $172,300 in 1993, down from $175,800 in 1992

According to SMS data, 97.9% of self-employed physicians paid malpractice premiums in 1993. By specialty, the percentage of physicians with insurance ranged from 98.8% of surgeons to 94.3% of psychiatrists. Still the data indicate that most physicians are not "going bare." An examination of data from 1985 indicate that the percentage of physicians going without insurance has changed little in the past 10 years. The overall average was 97.5% in 1985. There was little change by specialty during this period as well. However, the percentage of obstetricians/gynecologists purchasing insurance declined from 99.0% in 1985 to 96.6% in 1993.

Premiums also varied by geographical area, type of practice, location, and physician age. Tables 43–44, located in the Detailed Statistics section of *Socioeconomic Characteristics of Medical Practice 1995*, provide full breakdowns by these variables.

References

The St. Paul Medical Services. 1994. *Physicians & Surgeons Update*. St. Paul, Minnesota: St. Paul Fire & Marine Insurance Company.

Gonzalez, Martin L., ed. 1995. *Socioeconomic Characteristics of Medical Practice 1995*. Chicago: American Medical Association.

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Ables Lane Dallas, TX 75229 214/243-2272 Fax 214/484-2720

May 4, 1996

The Honorable Henry J. Hyde, Chairman
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, D.C. 20515-6216

Dear Chairman Hyde:

The American Association for Respiratory Care (AARC) is very concerned regarding hearing testimony presented by American Association of Nurse Anesthetists (AANA) during the February 28, 1996 hearing on HR 2925.

The AARC, a 37,000 member association of respiratory care practitioners, strongly objects to the statement made on page 3 of the written testimony which reads:

".....the anesthesia part of the education is very similar for both providers and once they enter the work force, both professionals perform roughly the same services... (4) peri-anesthetic and clinical support functions, such as resuscitation services, acute and chronic pain management, **respiratory care** (emphasis added)....".

The educational training required to provide anesthesia services as performed by a CRNA does not qualify these professionals to perform the all encompassing diagnostics and therapeutics which comprise respiratory care.

Respiratory care is a distinct and discrete health care profession performed under medical direction requiring practitioners to undergo specific and unique education and competency testing. Respiratory care is the diagnostic and therapeutic use of the following: medical gases (excluding anesthetic gases) and administration apparatus, environmental control systems, humidification, aerosols, medications, ventilator support, bronchopulmonary drainage, pulmonary rehabilitation, cardiopulmonary resuscitation and airway management. Furthermore, respiratory care practitioners also educate patients and family caregivers in respiratory care as well as perform assessments on behalf of the attending physician in order to measure patient tolerance and compliance with the respiratory care order.

The educational requirements necessary to become a nurse anesthetist do not qualify these practitioners to perform respiratory care. The AARC believes it is imperative to correct and clarify this issue for the written record.

The American Association for Respiratory Care requests this statement be included in the written record of the hearing.

Sincerely,

Charlie G. Brooks, Jr., MEd., RRT
President

cc. The Honorable Bill Archer
AARC Board of Directors

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ISBN 0-16-052906-9
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