

Connecticut Public Acts

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Bill Number: 1052	
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Committee: Judiciary: 5395-5418, 5432, (5437-5448), 5470, 5479-5480, 5481-5482, 5483-5492, 5495-5513, 5537-5541, 5543-5554, 5555-5588, (5588-5599), 5604-5615, 5639-5650, 5651-5668, 5688-5692, 5696-5708, (5710-5721), (5731-5734), 5741-5744, 5747, 5748, (5749-5754), 5763-5811, 5815-5831, (5832-5920), 5921-5923	360

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Calendar Page 17, Order of the Evening, Calendar
412, File 554, Substitute for S.B. 1052, An Act
Concerning Medical Malpractice, Favorable Report of
the Committees on Judiciary, Insurance, Public Health,
Legislative Management, and Appropriations. Clerk is
in possession of an amendment.

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. Mr. President I move
acceptance of the Joint Committee's Favorable Report
and passage of the bill.

THE CHAIR:

On acceptance and passage, will you remark?

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. Mr. President, I
believe that the Clerk is in possession of LCO 7695.
I ask that it be called and I be granted leave to
summarize.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 7695, which will be designated as Senate
Amendment Schedule "A". It is offered by Senator
McDonald of the 27th District, et al.

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Mr. President, I move adoption of the amendment.

THE CHAIR:

On adoption, will you remark? Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. Mr. President, let me first thank Senator Crisco and Senator Murphy and my colleagues in the House, Representative Lawlor, Representative Fritz, Representative Sayers, and Representative O'Connor, and, in addition, Mr. President, the member, the number of staff members in our nonpartisan Office of Legislative Research and the Legislative Commissioner's Office.

Mr. President, this amendment is the byproduct of an incredible amount of effort on behalf of a number of parties, trying to address a very critical issue in the State of Connecticut.

And that is the malpractice premium increases that have been borne by physicians throughout the state and, in particular, the incredible increases that have taken place over the last couple of years in certain specialties, including OBGYN and neurosurgery, although the experiences that have taken place are not unique to those two specialties.

Mr. President and Members of the Circle, you will recall that this issue is not new to the Chamber, having been before us last year when we passed another comprehensive piece of legislation addressing the tort reform system, the insurance system, and the public health system.

And I am pleased to recall that that legislation was passed in both the House and the Senate on broad bipartisan basis. However, Mr. President, that legislation did meet with a gubernatorial veto, and there was no reform implemented.

This year, Mr. President, we have revisited the issue and approached it as a clean slate, if you will, to see if we could take the best parts of what we passed last year, and to expand on it where possible,

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to make it even better legislation. And I believe what we have before us this evening is that byproduct.

It would perhaps be easiest if I went through the sections of the bill and explained, in summary fashion, what we are trying to achieve here. We have organized this bill so that it is broken into three parts.

The first part deals with tort reform. The second part deals with insurance reform. And the third part deals with public health reform.

I will be happy to explain the tort reform aspects of this legislation, but will, of course, yield to the expertise of Senator Crisco and Senator Murphy for their sections as well, Mr. President.

In Section 1 of the bill, we attempt to address a situation that has been vexing in the provision of legal services to individuals who were involved in wrongful death and personal injury cases.

And in particular, Mr. President, this section arises from the situation where individuals who contract with attorneys, who have contingency fee arrangements, sometimes exceed the statutory

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attorney's fee schedule that currently exists in our law.

We tried to take that law, and also address the decision in the Salerno Case, which essentially said that private individuals have an opportunity, if they wish, to exceed the statutory framework for attorney's fees.

And in this section, Mr. President, we acknowledge that fact, but because of the strong public policy interests we have as a state, we have put parameters around the circumstances under which that statutory formula can be exceeded.

Mr. President, in no circumstance, if the statutory framework that currently exists is going to be exceeded, could an attorney enter into a contingency fee arrangement with a client that would compensate that attorney for more than 33 1/3% of a recovery or judgment.

But in order to, in order to achieve such a waiver, if you will, we would require that the attorney make certain and substantial disclosures to the plaintiff, before any such agreement was entered into.

There would be very clear language informing the individual that he or she has a right to seek other counsel who may or may not be willing to perform the legal services under the current statutory formula and, frankly, encouraging them to seek other representation if that is their desire.

In addition, Mr. President, if a waiver was obtained, that it was knowing and voluntary from that individual, then, in that limited circumstance, the plaintiff would be, I'm sorry, the plaintiff's attorney would be ineligible to recover any fee or any out-of-pocket costs if, ultimately, there was no recovery or judgment obtained in the case.

Essentially, Mr. President, it shifts the risk away from a plaintiff and onto the attorney if there was a fee waiver obtained.

In Section 2 of the bill, Mr. President, we have modified the good faith certificate issue. This is an issue that requires a plaintiff's attorney to, under current law, to obtain a report from a qualified medical expert in a similar practice area, and to certify that, based upon that inquiry, the attorney believes that there is a good faith basis to believe

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that the standard of care has been breached in a particular case.

Mr. President, this makes substantial improvements over the current system because it would require that that report be in writing and presented in a detailed fashion, and a copy of that report, with the name of the doctor supplying it expunged, would be attached to the complaint as an exhibit. The failure to attach such an opinion would require the court to dismiss the case.

In Section 3 of the bill, we have modified, I'm sorry, in Section 3 of the bill, for medical malpractice cases, we have required that not later than six months after the commencement of an action, in a medical malpractice case, the court would be required to review the case at its then current status to determine whether the case was sufficiently complex as to warrant a referral of the case to the complex litigation docket, where they have specialized expertise in capabilities for expeditiously moving forward such complex cases.

Section 4 of the bill modifies our, what we currently call our Offer of Judgment Statute, Mr.

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President. And what the working group has tried to do in this section of the bill is to modify the way we approach the Offer of Judgment principle.

And we have actually renamed it an Offer of Compromise, Mr. President, because the notion is that if someone makes an offer to settle a case, short of a trial, if a defendant wishes to accept that offer, that defendant shouldn't have to accept a judgment against him or her in order to settle the case.

So under this scenario, if such an Offer of Compromise was accepted, and the settlement proceeds were actually paid to the plaintiff, then the case would be withdrawn, and there would be no judgment entered against the doctor or the medical institution.

And we thought that was very important because oftentimes there is reticence in accepting such an offer because of the societal stigma of having a judgment against oneself.

In addition, Mr. President, under this section, we have modified the timeframe within which such an Offer of Compromise can be submitted. And under current law, any time after the commencement of an action, an Offer of Judgment may be filed.

Under this proposal, however, we have created a 180 day blackout period, if you will, at the beginning of the case so that the defendants have a meaningful opportunity to undertake discovery, so that they have a reasonable basis of facts and law to determine whether to accept an Offer of Compromise.

And, Mr. President, if such an Offer of Compromise is to be accepted, it would be within 30 days after the Offer had been filed.

Again, Mr. President, we also acknowledge some of the unique provisions of federal law in the disclosure of medical records under the Health Insurance Portability and Accountability Act of 1996.

And we require, under this provision of the bill, that prior to filing an Offer, at least 60 days prior to filing the Offer of Compromise, the plaintiff or his attorney would have to provide the defendant with the authorization to disclose those medical records under HIPAA.

And finally, with respect to this section of the bill, Mr. President, we have dramatically decreased the interest rate that would be available to a plaintiff if the Offer of Compromise was rejected.

Under current law, it is a 12% interest rate, and we have dropped that by 1/3 to 8%. That will provide a significant savings to defendants if they mistakenly or wrongly choose to reject an Offer of Compromise, and later, and later there is a judgment or, a judgment in excess of what the Offer of Compromise was.

Mr. President, under Section 5 of the bill, we also make similar adjustments in the defendant's opportunity to file an Offer of Compromise.

In Section 6 of the bill, that's the further section about how the plaintiff may, within 60 days, accept that Offer of Compromise.

Under Section 7 of the bill, we are making, conforming changes to the Offer of Compromise provisions.

Under Section 8 of the bill, Mr. President, we address what is normally known as the collateral source rule, which would require that a healthcare provider, in an action against such a healthcare provider, the healthcare provider could introduce at trial the amount of damages awarded to the plaintiff for any injury or death before the trier of fact, if

that plaintiff has received other compensation in other actions relating to the same injury or death.

Mr. President, at the suggestion of my good friend and colleague, Senator Roraback, we have taken a page from the Colorado Legislature, and incorporated in Section 9 of the bill, a rather unique provision, which would allow medical professionals to essentially acknowledge the potential that something had happened which resulted in an unanticipated outcome in that medical treatment.

Some have called this the ability to apologize without fear of retribution. Under this provision, Mr. President, if a medical professional or anyone who works for that medical professional makes any statements or affirmations or expresses an apology or represents a sense of remorse or guilt, if you will, or liability in the context of offering an apology, that apology would not ever be admissible as evidence, as an admission of liability, or as evidence of an admission against interest.

And that is significant because we have heard, at least anecdotally, that many people who feel that they have been the victims of malpractice think that had

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the medical professional only acknowledged what might have been the case, the lawsuit might have been averted. And we thought that that was a wise inclusion in this bill.

And finally, Mr. President, under Section 10 of this bill, we would require that if a jury rendered a verdict specifying non-economic damages, and those non-economic damages exceed \$1 million, the court would be required to undertake an analysis of the jury verdict to determine whether, as a matter of law, that verdict is excessive.

If it is excessive, and so shocks the conscience and sense of justice of the court, then the court would be required to order a remittitur of the verdict, and if the remittitur is not accepted, of course, a new trial would be ordered.

Mr. President, that is a relatively brief summary of the tort sections of this bill. And I'd like to yield to my colleague, Senator Crisco, so he can explain the sections relating to the insurance package.

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Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President. I accept the yield.

Let me again commend Senator McDonald and Senator Murphy for their outstanding work in an issue that has been before us for too long of a time.

In addition, Representative Fritz has also played a major role in constructing a vehicle, which we think is the appropriate beginning to resolve the malpractice issue.

Section 11 of the bill requires all medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner.

And this is significant, Mr. President, because like other rate filing companies in the commercial end, all the manuals, rate information, all related to provide adequate basis for rate increase will be necessary for the Insurance Commissioner to review the requests.

Also, unlike in the past, we have stipulated here that when a rate is 7.5% or more, then the Commissioner needs to give prior rate approval, notices have to be sent out to the insurers, the

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Insurance Commissioner has to be notified of the lists of who received the rate increase.

No longer will we be faced with the stealth increase of substantial rate increases and not giving advanced notice to the insurers.

In addition, subsequent to this, the Commissioner shall find out if there is not a substantial decrease or too much of an increase in malpractice rates. The Commissioner shall convene a working group to consider various factors involved, including the amount of awards in settlements, and recommend appropriate revisions to the General Statutes.

The Insurance Commissioner will appoint a working group, made up of the appropriate individuals in the Legislature, and also in the agency side to fulfill this function.

Also, Mr. President, Section 13 requires the Insurance Commissioner to develop a plan to maintain a viable medical malpractice insurance industry.

Unfortunately, we have before us what is known as a distorted oligopolistic market structure, where only one or two companies provide malpractice insurance.

In addition, Section 14 through 16 requires the Insurance Commissioner to establish an electronic database, composed of closed-claim reports. It also requires the Commissioner to provide an annual report, consisting of trend analysis of closed-claim information.

There has been a deficiency in our rate structure and in our insurance analysis of adequate information. In addition, it also, the bill also, for the first time, will require those companies that are considered captive insurers to provide specific information to the Insurance Commissioner.

Let's be cognizant of the fact, Mr. President and Members of the Circle, that so 54% of the malpractice insurance in the State of Connecticut is now underwritten by the captive insurance market.

In addition, this will give us sufficient information for the Insurance Commissioner to carry out her responsibilities in regards to this law.

Mr. President, I would like to yield now to Senator Murphy.

THE CHAIR:

Senator Murphy.

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SEN. MURPHY:

Thank you very much, Mr. President. And thank you to my colleagues, Senator McDonald and Senator Crisco, as well as our compatriots in the House, for their good work on this bill.

I rise to speak briefly about the public health sections of the bill, and I do so with the recognition that I made at the beginning of this debate last year, is that although we may throw around a lot of terms, like Offer of Judgment and Collateral Source and Prior Rate of Approval, in the end, the goal of this legislation is really simple and twofold.

It's, one, to stabilize and increase access for the consumers, the healthcare consumers of this state. But secondarily, but just as importantly, to do something in this bill to address the issue of medical malpractice, the issue of adverse events, and to go forth from today not only with the sense that we will be able to stabilize rates, but also with the sense that we will have done something to reduce the number of errors in our healthcare system.

Towards that end, there are several sections in the underlying bill that deal with the issue of

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patient safety and public health protections, and I'll go over them very briefly.

First, we've included sections in this bill to standardize our process of discipline and investigation through the Department of Public Health. We will have now firm guidelines for how we go about the process of discipline for physicians, and we will have screening guidelines for complaints that come into the department.

Too often, complaints are simply heard in the order that they arrive. We now will have a process in which we screen out those that have the most merit to them, and those will be heard first.

We also will make sure that we have real standards for how we broaden the investigation from one single complaint into a more general investigation of a particular physician or practice, along with specific protections for the information relevant to the patient, the provider, or the hospital involved, so as to maintain that confidentiality during the investigation.

Mr. President, there is also a provision here to broaden the current membership of the current pool for

medical hearing panels. These have been successful tools in trying to expedite the process of review before the medical examining board.

The problem is that because there are so many complaints, we've had some trouble in getting some people to serve on the panels. Given the scope of the work, we would now move up to 24 members who would be eligible to sit on these screening panels.

We for the first time, include in this bill continuing education for doctors. We have added that as a requirement for so many of our healthcare professionals throughout the state.

We now have on the books, for the first time, a requirement that doctors in this state have continuing education, so that they can make sure that they are up to date on the developing current standards of practice.

The vast majority of doctors already participate in this type of professional development. This just assures that they will all do that as a condition of their licensure.

There are increased data collection requirements in this bill. We need to make sure that we have

accurate and realistic data, to try to determine the nature of our access problems throughout the state.

One of our issues is that we have data concerning the number of licensed physicians, but we don't know how many of those licensed physicians are in active practice.

So for the first time, after this bill becomes law, we will have a reporting requirement so that we know not only the number of licenses held in a particular specialty, but also how many of those licenses are attached to practicing physicians.

That data collection will also bring into the state data on whether the physician has been disciplined in other states and information on their insurance carriers.

Finally, we have language here that will develop through each hospital or outpatient surgical facility, as the case may be, protocols for the practice of surgery.

We'll have those protocols filed with not only the Department of Public Health, but sent to the Committees of Cognizance here at the Legislature, to make sure that every institution in this state

practicing surgery has developed and standardized and written protocols on file before any procedures take place.

And finally, we work off of a, I think, very productive development last year in the field of patient safety, and that is the establishment of patient safety organizations.

Through legislation passed last year, the wisdom of the Legislature allowed for the creation of these patient safety organizations, which would be groups that could come into a hospital, collect data confidentially, review that data, and then make recommendations back to the hospital on systems change.

Because in the end, that is the entire and final relevance in terms of patient safety from error reporting. It's not enough just to turn that error into an investigation or an act of individual discipline. You've got to turn our information on adverse events in hospitals and healthcare institutions into systems change.

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It's not enough to discipline one physician. We've got to make sure that the system changes so that that error doesn't occur again.

We now have language in this bill, which would require every hospital in the state to contract with a patient safety organization, so as to better facilitate the improvement of institutional systems for patient safety.

Again, I'd like to thank all of my colleagues for their work on this. I think, in particular, the work that's been done on the public health portions of this bill will guarantee not only that we do something about stabilizing rates for physicians, but that we move forward on making sure that the end result guarantees a safer environment for patients that enter our healthcare system. Thank you very much, Mr. President.

THE CHAIR:

Thank you, Senator. Will you remark further on the bill, actually on the amendment? Senator Kissel.

SEN. KISSEL:

Thank you very much, Mr. President. Well, here we are, and it seems like déjà vu all over again.

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What we have before us, by way of this amendment, is reform legislation that is substantially similar to medical malpractice reform that we had just a year ago.

I remember I worked on that reform legislation. Many of us, Senator McDonald, Senator Murphy, worked on it last year as well. It was a good bill. Unfortunately, former Governor Rowland vetoed it.

At the beginning of this discussion, Senator McDonald had quite a bit of praise for his Democratic colleagues. I would note that there were Republicans that participated in this process along the way.

And the person that I think most important to acknowledge, because I was there in the Governor's Office at that very first meeting at the beginning of this legislative session, was Governor Rell herself.

And at that meeting, she made it very clear, she acknowledged that there probably was not enough support in the House and the Senate to have caps, which has been touted or has been touted by proponents of reform as the single only way that we could effectuate positive change regarding medical malpractice premiums.

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But the realities of the House and the Senate are the realities of the House and the Senate, and I think it was quite right in assessing that there was not enough support for that measure to take place this year.

Nonetheless, Governor Rell was very clear that she wanted reform legislation. She wanted something good to come out of our legislative process, and indeed, we have it here through this amendment which becomes the bill.

Would this necessarily be exactly what the Governor would want? Well I can't speak for her, but it's probably somewhat of a step or two away from what she had proposed. Nonetheless, I stand here today, as I did a year ago, supporting this legislation.

It's one thing to take this bill and bring it out to an actuary and say, you know what, at the end of the day, this is only going to save maybe 1% off of premium increases. I don't necessarily believe that.

What we have here is a sum that is greater than the totality of its individual parts. It really is somewhat of an experiment, but it's a well thought out experiment.

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We're trying to address the medical malpractice premium issue in a variety of ways, and that was borne out by the three speakers previous to me.

Senator McDonald, reflecting judicial reform, Senator Crisco, insurance reform, and Senator Murphy, public health reform. All three of these things are encompassed in this reform legislation.

The judicial reforms, in and of itself, I think are substantial, and over the long term, and hopefully the short term, will have salutary effects.

Indeed, one area that is of a particular importance to me, that I worked on last year in this, is the whole idea of appending that medical report to this good faith affidavit, and have it attached to the complaint.

That will help the defense counsel and their clients right into the ballpark, right at the inception of the medical malpractice case.

Up until this point in time, months could go by, even over a year, until defense counsel and their clients could really narrow down exactly what was the basis for the determination of the basis for the

plaintiff's claim that there was medical malpractice and why they had brought that case.

We get right out of the shoe, because part of what we're doing is reforming the process. We're trying to speed it up. We're trying to expedite it.

Indeed, I believe that Senator McDonald indicated that six months after the filing of the complaint, that the Judicial Branch would sit down with the litigants, and they would make sure that this went to the complex litigation docket.

And that's the way to go, with judges that have experienced these kinds of complex cases, that can make rulings based upon their experience, and they can track the case from the beginning almost to end.

And while the term of the judges on the complex litigation docket may not exactly parallel the suit itself, they certainly are there for long enough periods of time that there is a substantial chance that they would be able to follow much of the litigation from beginning to end.

Is this necessarily everything that the physicians want? No, clearly not. But is this a substantial first step? Absolutely. And I feel very

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badly that we missed a year of putting these kinds of reforms in place. And so now is the time to do it.

I sincerely commend Senator McDonald, Senator Crisco, Senator Murphy, Senator Roraback, and, most importantly, Governor Rell for the leadership she has shown regarding this legislation. And I urge my colleagues to support the amendment. Thank you, Mr. President.

THE CHAIR:

Will you remark further? Senator Fasano.

SEN. FASANO:

Thank you, Mr. President. Mr. President, through you, I have a question for Senator McDonald.

THE CHAIR:

Please proceed, Senator.

SEN. FASANO:

Thank you. Senator McDonald, with respect to Lines 133 through 135, it indicates that the written opinion shall not be subject to discovery by any party, except for to question the validity of the certificate.

And I'm just confused as to what's the difference between discovery and validity, in terms of the

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confines for legislative intent, through you, Mr.

President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President, and thank you, Senator Fasano, for the question. Those lines of the bill are really intended to only address the name of the physician who is signing the certificate of good faith, that the identity of the signer of the certificate is not subject to discovery, but for the limited exception of determining its validity. And I thank you for the question.

THE CHAIR:

Senator Fasano.

SEN. FASANO:

Thank you, Mr. President. Mr. President, I'd like to associate the comments that I've heard so far with respect to this bill. I believe this is not the perfect bill, but certainly, as I said last year or the year before, I can't remember now, but that this is a good attempt to deal with the issue.

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This is a complex issue. We need to get something moving. As this bill proceeds to become law, I hope, I think it will have to be tinkered with from time to time, and, therefore, I support this bill. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator. Will you remark further?
Senator Meyer.

SEN. MEYER:

Thank you, Mr. President. You know, I said a few days ago that the fun thing about being in this Legislature is the dialogue we have on important ideas of the day, and we've done that since January 5th, and we're doing that again tonight with medical malpractice insurance reform.

This is a comprehensive bill. There are parts of it that I'm going to, I've worked, I've tried to work with Senator McDonald to make a few changes, and I'll perhaps introduce some revisions next year in that regard, in particular, with respect to the screening of cases.

I think that the more effective method might be initial screening of medical malpractice cases before we actually allow them.

What we're doing here is we have a process for dealing with what could be bad cases by requiring an expert opinion. But of course, that expert opinion will be a lawyer, probably in the stable of the plaintiff's lawyer, and not as reliable and as objective as we might like.

But this bill is comprehensive. It deals with everything from fee agreements to a settlement mechanism to excessive non-economic damages. It's extremely creative with respect to how it deals with excessive non-economic damages.

And then it goes on and is comprehensive as to deal with the insurance issues, which many of us feel are at the bottom.

When I read last year that the Insurance Commissioner of our state granted an 89% increase to an insurance company, a medical malpractice insurance company, of which there are only three in this state, an 89% increase was granted, you know, we knew then

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when we saw that that we needed the kind of insurance provisions that this bill contains.

So let me really take off my hat in thanks and appreciation to the various sponsors who have put this together, and I look forward to supporting it as actively and with as great an enthusiasm as I can. Thank you.

THE CHAIR:

Will you remark further? On the amendment, will you remark further? Senator Freedman. Senator Freedman.

SEN. FREEDMAN:

Thank you, Mr. President. Through you, a question to Senator McDonald.

THE CHAIR:

Please proceed, Senator.

SEN. FREEDMAN:

I believe one of the issues we've heard a lot about is the cost of the medical malpractice insurance to particularly the OB/GYNs and the neurologists. Through you, Mr. President, can you, Senator McDonald, tell us how much money they would save in the purchase of their policies?

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THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. Through you, Mr. President, we've learned a lot in this process, and one of the things we've learned is that the art of actuarial predicting is not a precise one.

And so we have no firm numbers about what the savings would be, although we do have the representation of some actuaries who came before us to indicate that this would provide as little as at least 2% savings and perhaps much more than that. But there is no exact number. There is no guarantee in this.

And frankly, that is one of the elements of the bill that would allow for a period of two or three years to determine how well these revisions are working, so that we can make an informed decision later on if they've actually achieved their intended goal.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Thank you, Mr. President. And again, through

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you, was there a discussion in the Judiciary Committee or any of the other Committees about building in a specific savings to the insurance part of the program so that these doctors would be able to save money on the premiums, through you, Mr. President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you. Thank you, Mr. President. Through you, I'm going to ask my colleague, Senator Crisco, to help me out on this. But as I understood it, there was a very real concern that if we tried to legislate certain savings, that we would drive some of the very few companies left in the state out of the state, and that would be counterproductive. But I'd like to yield to Senator Crisco, if I might.

THE CHAIR:

Senator Crisco, do you accept the yield in response to Senator Freedman's question?

SEN. CRISCO:

Yes, Mr. President. Thank you. Through you to Senator Freedman, there was an extensive discussion, not only in the Insurance Committee, but also in the

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bipartisan working group in regards to that elusive subject of how much could we save?

My personal opinion, through you, Mr. President, to Senator Freedman, was that to start, you have to begin somewhere. And reviewing everything that was possible and practical, we decided that this particular package was the best package possible.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Yes, again, thank you, Mr. President, I guess to Senator Crisco. In your discussions in terms of taking a look at the actuarial figures, you came up with a three-year period in order to be able to set a baseline for some future action on this, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Yes, Mr. President, through you to Senator Freedman, I believe in the discussions with Governor Rell and her staff, and I could be mistaken, and my colleagues could correct me, that this three-year

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window was basically the recommendation of the
Governor.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Yes, and finally, once again through you, and I'm
not sure whether it's to Senator Crisco or I'm not
sure which one of the Chairmen, but do you anticipate
any doctors who will not be able to practice their
specified specialty because we are not acting right
now to help them save on the cost of their medical
malpractice insurance?

And if so, how many doctors do you anticipate
will be leaving the State of Connecticut and stop
their practicing?

THE CHAIR:

Senator Crisco, do you care to respond?

SEN. CRISCO:

Yes, Mr. President. Through you to Senator
Freedman, you know, Mr. President, to Senator
Freedman, there are soothsayers negative and positive.
We cannot quantify how many doctors may possibly leave

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the state or how many doctors may possibly enter specific practices that we all share a major concern.

The most important thing, Mr. President, through you to Senator Freedman, is to begin the process of trying to address the issue.

I am verbally convinced that there is a silent storm out there that no action would be more, be disastrous, that this is the proper way to go, and we would, as we discussed last year in the previous bill, like to make specific reductions available as immediate as possible to those physicians that are facing a particular crisis.

Unfortunately, last year's legislation was not finally approved by the Governor. In reviewing everything that was possible, we thought this was the best way to address the problem.

THE CHAIR:

Senator Freedman.

SEN. FREEDMAN:

Yes, thank you, Mr. President. No further questions. I'm just very concerned because we're following the same path we did a year ago. We're presenting a bill to our colleagues, and we're saying,

we're going to solve the problem. Give us three years, we'll come up with specific numbers.

And three years from now, all of our medical professionals, who may or may not still be practicing in this state, will get some break in their medical malpractice insurance.

I don't think we're following the proper path on this. I think we've heard over and over again that the medical profession itself was looking for us to do something that would help them, and help them immediately.

Even last year in the testimony given by the Insurance Commissioner, she said, a bill without any caps built into it would be a bill that's a sham.

And once again, I think that we're trying to pull the wool over everybody's eyes saying, here we are, look at us, we're doing something great. But guess what, don't expect any savings when you get your bill from your insurance company for your medical malpractice.

This is wrong, Mr. President. This is not the route we should be taking. If we want to give immediate relief, we should be looking to those states

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who have truly tried to address the problem in a reasonable manner.

I, for one, see it as an access issue. And the more we dilly-dally around by not doing anything, the more we say to our constituents, you will no longer have some of these services available to you, particularly those women who are pregnant and need to go to an OB/GYN, particularly those children who may need neurological surgery.

How many of those people are going to stay in this state, as long as we don't give them true relief? Rhetorical questions, yes, but they're questions that we as a body should have answered. Thank you, Mr. President.

THE CHAIR:

Will you remark further? Senator Gunther.

SEN. GUNTHER:

Mr. President, I rise to oppose the bill. I'll say this. It's a big disappointment to me. We've had two sessions where we worked on the malpractice in this Legislature.

Last year, it was quite extensive. We had three different Committees, all three did do some

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consideration, put things together, had special meetings of the three Committees and members of that three Committees.

But the big disappointment is this year, we get this laid on our deck by a group that sat down and took three bills that were considered by three Committees, and they compromised the whole report of the three Committees to come up with what we have here.

And I won't say it's without some good things that they have tried to do. On the other hand, there is an awful lot that doesn't, hasn't been included. In fact, I don't even know if they were ever considered in the discussions on this particular bill.

I think that when I hear the report on the Judiciary, and my good leader, Mr. McDonald, that it really sounds very, very familiar to me that this considers to be a very, very new thing.

But in listening to his report, I think they've done 99% of it is to justify what has been the practice over the years that I've been sitting up here and listening to the dialogue on malpractice.

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And that is, you know, we passed a bill that said, gave a whole formula on how much a lawyer could charge when he handled these cases. It was a pro rata thing. It was, you know, high in the lower levels of settlement, and lower as you went down the line, and that type of thing.

But lo and behold, two years ago, when we had a hearing, I brought the fact out that the judges had ruled that that was unconstitutional. You can't do that with lawyers. You can't tell a lawyer how much he can take on a case. Even though you had a state law, he says, it's unconstitutional.

What amazes me, Mr. President, I don't think that there's another profession in the State of Connecticut, in either medicine or anything else you can think of, that prohibits us from passing laws that say how much these people can get.

May not be on the percentage in that, but doctors, we have the HMOs, we have Medicare, we have Medicaid, sets out all the fees on exactly how much you can charge.

But you can't do that in the legal profession because a judge rules it's unconstitutional.

Now, in this particular bill, all they've done is recited what's been the practice over years, that I can understand. I mean, I read it. I couldn't believe it, because all they are is justifying, all right.

Now, the lawyer can say, oh, we're only supposed to take a third of the fee here. But if you want me to handle this case, you better take and sign a waiver that tells me I can charge anything I damn well please.

And the nice part about that, they're really generous with that, because if the patient at that point decides he doesn't want him to represent him, all he has to do is say, oh, fine, I'll look for another lawyer. That's really a generous thing to put into the law.

As far as I'm concerned, there were things that we had talked about over the years we've been considering this, and I know in my bag of worms, for the malpractice, I'd say that I'm amazed that lawyers take a third of the economic settlement that comes in.

This means the person's actual cost to doctors, cost for his loss of time, cost for his braces, every

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dime you can think of that affects him economically, the lawyer in estimating his fee takes a third of it.

Now, in addition to that, we have the approval on the compromise and that, that he takes a third of that. Now, I can see where he can get the non-economic expenses and that or awards, then I can see he can justifiably say, look, I worked for that. And if I take my third, I can almost justify in my mind that at least that was a decent thing.

I practiced for 47 years, Mr. President. And it used to amaze me that, out of the settlements, that the patient never had a case, mind you, that affected me.

But on all the cases, the settlement to the lawyer was a third of all the costs, whether expenses or settlements and that type of thing from the insurance company or what not. In other words, it was a pretty good deal to take and handle those particular cases.

When we get into the insurance, I will say, there are a few little gimmicks that the Insurance Committee come up, the pre-approval for rate increases and that type of thing.

That's, I think that's normal. It should have been before this. But at least that's in this particular bill.

When it comes to the Public Health, one of the things that bothered me with all these meetings we had for years, is the fact that the Public Health, the examining board, or I should say the medical examining or any other of the professional boards, are advisory to the Public Health Department.

I've asked time and time again, that we put the control of the different professionals into the examining boards themselves. The examining boards should have the right to take and select the people that are in licensure, the profession they're in. They should also have all the responsibility for the, for the discipline.

And now we're coming in with the public health side of this thing. We're going to set up guidelines. And of course, I see they've got a big committee, if they go by the bill itself, a committee that's going to develop these guidelines and tell them what they should do, how they should do it, and that type of thing.

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I also noticed that there is a couple of public members that are going to be on some of these panels. You know, if you'd like to take a look at your examining boards in this state, back about maybe eight or ten years ago, we put public members on every examining board in the State of Connecticut.

What you ought to do is go out back and revisit that, and you'll find that they can't even get public members to serve on the examining boards, and that we have vacancies all over a ten-acre lot in practically every profession that is there.

I think that the whole bill, frankly, is a disappointment to me because I think, as Senator Meyer said, he was for a strong screening committee. We should have had a pre-screening committee identified in this particular bill. Doesn't show at all.

As far as pre-screening, I think that will be one way of eliminating a lot of the frivolous cases and that. But even if you don't want to go that route, I do think that we should have even the consideration of an arbitration that would be set up to take and arbitrate all these cases before they get to the final level of being brought into court.

So all in all, Mr. President, I'd like to say that talking about the Preamble of the Constitution, for the people, by the people, I think we ought to say that this particular bill is for the lawyers, by the lawyers, and of the lawyers, because all through this whole process, the attorneys in this Circle have taken and preempted on the whole writing of this and developing this whole bill that we have before us. And I don't think that we have the input that should have been in this by the professionals themselves.

So, Mr. President, unfortunately, I will vote against this because I think we could have done a lot more, and there has been very little done, as far as I'm concerned, that's going to be a benefit to the malpractice in the State of Connecticut with this law.

THE CHAIR:

Thank you, Senator. Senator Nickerson.

SEN. NICKERSON:

Thank you, Mr. President. Mr. President, if I may, through you, some questions to the proponent with regards to the insurance industry aspects of this, if I may.

THE CHAIR:

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In that case, I assume you would like to direct your questions to Senator Crisco.

SEN. NICKERSON:

Your assumptions, as always, are dead on.

THE CHAIR:

Thank you.

SEN. NICKERSON:

If I may through you, would you agree with me that Connecticut has experienced a significant reduction in the number of insurance underwriter providers, who remain in the Connecticut market, in the business of providing medical malpractice insurance, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Yes, Mr. President. Through you to Senator Nickerson, obviously, as I stated before, that we have, in my opinion, a distorted oligopolistic market structure, which basically is defined as too few insurance carriers.

THE CHAIR:

Senator Nickerson.

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SEN. NICKERSON:

Thank you. I interpret the answer as being yes. Would I, would you further agree with me, would you further agree with me that there is one carrier that has an overwhelming bulk of the insurance, a Connecticut-based insurance, and only one other carrier, which is based out of state, that competes in this business of providing medical malpractice insurance, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Mr. President, through you to Senator Nickerson, depending upon how you define, you know, degree of business, I believe he's referring to CMIC, which is owned by physicians, and also I think Pro Select from Massachusetts, and that is correct.

SEN. NICKERSON:

Thank you--

THE CHAIR:

Senator Nickerson.

SEN. NICKERSON:

And would it not be the case that while it is a

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regrettable fact, but a fact, as you point out, there are too few insurance, that unlike other industries, such as electric utilities and others, these companies are not obligated to provide insurance, nor even obligated to remain as competitors in the Connecticut market, but are free to come and go and leave the market at will, leaving aside the issue of rate approval, which we'll get to?

They are free to come. They need not serve you and I or anyone, contrary, for example, to a utility company, which must serve its local customers who seek electric service, through you Mr. President.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Yes, Mr. President, through you to Senator Nickerson, I agree, but they are in the business to write malpractice insurance in Connecticut, and they are directing their market, you know, approach to that line of insurance.

THE CHAIR:

Senator Nickerson.

SEN. NICKERSON:

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Correct. Would it not also be a logical and, in fact, an inescapable conclusion that in an environment of rising insurance premiums, and an environment of sharply declining insurance underwriters, those two facts together bespeak a feeling in the insurance provider marketplace that Connecticut is an unprofitable place to do business?

One might expect that in an environment of rising insurance premiums, that you would find more insurers entering the market. But would you agree with me that the fact that less insurers are entering, a declining number of insurers are participating in the market with rising rates tells us something about the unprofitability of providing medical insurance in this state, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Thank you, Mr. President, through to Senator Nickerson, you know, that is correct. But again, one has to define what profit is.

THE CHAIR:

Senator Nickerson.

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SEN. NICKERSON:

Good. Now we come to the heart. We've decided that there is a declining number of insurers in an environment of rising rates, that that can only mean one thing, and that there is a declining profit-inducement profitability to participate in that market.

And now I come to a question, if I may through you, under Section 11 of the bill. Section 11 in Lines 433, 434, and 435, provide the Insurance Commissioner, as I read it, with the authority to approve or disapprove a pre-filing rate approvals application submitted by an insurer. Am I reading that correctly, through you Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Mr. President, through you to Senator Nickerson, that is correct.

THE CHAIR:

Senator Nickerson.

SEN. NICKERSON:

Thank you. And I think we're coming to the end

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of our colloquy and we'll draw some conclusions, but a last question. What standards is the Commissioner to apply in granting or disallowing such an approval under this bill, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Mr. President, through you to Senator Nickerson, all the standards that are required in regards to commercial insurers, in regards to rate filing, rate manuals, and, you know, I could go on and on and on, which has been the standard procedure for, previously for the Insurance Commissioner to approve or disapprove a rate.

THE CHAIR:

Senator Nickerson.

SEN. NICKERSON:

No, no, no, no, that doesn't tell me anything. What conceptual motivations are authorized in the hands of the Commissioner in granting approval or disapproval? What does he look to?

Not, I don't mean you to recite the whole statute, but what concepts does he look to? What

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factual evidence does he look to? What criteria is he to apply, in general terms, through you, Mr.

President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Mr. President, through you to Senator Nickerson, obviously, whether the rate increase is warranted based on the company's experience.

THE CHAIR:

Senator Nickerson.

SEN. NICKERSON:

Thank you, Mr. President. I appreciate my colleague answering those questions. Ladies and gentlemen, in a market of declining insurance competitors, in a market with rising rates, we are not going to accomplish anything in prior rate approval, but send a disincentive into the marketplace to those who participate, to exit, and certainly a disincentive to others to enter.

Why would they enter a difficult market, where profits are under great pressure, as evidenced by the fact that there are a declining number of

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participants? And then, contemplate whether they wish to continue as participants in that market, when they have to get rate approval.

Who is going to go and on their bended knee, with hat in hand, saying, oh, dear Commissioner, may I please have a rate increase?

No one is going to want to do that. No one is going to want to do that, and we have no right to ask them to do that. We do have a right, where a utility and an electric company has an obligation to provide service to every customer who wants it, to provide rate approval because they are a monopoly, and they're obligated to stay as a provider in this state.

Insurers are not. They are not obligated to provide service. They are perfectly capable of walking away.

And I submit, ladies and gentlemen, that Section 11, containing prior rate approval without any specific criteria in the hands of the Commissioner, other than it's warranted, is sending a clear signal to the insurance market that to those few of you who are left in this arena providing insurance, beware.

We are going to cut you off at the knees if we feel like it, and you have no recourse, no standards.

That is not going to help medical malpractice insurance, ladies and gentlemen. It's going to, some say that this is a, well, it's an okay bill, not a great bill, but it'll make things better.

Section 11 will make things a great deal worse because we could wake up one morning and find that some of the few providers that are in the marketplace today will read Section 11 and say, I don't need this.

I don't need to go hat in hand to the Commissioner to seek a rate increase in an unprofitable environment where I'm already losing money. I don't know what standards the Commissioner is going to apply. I don't need this. Connecticut is a small state. I can go write insurance elsewhere.

I urge rejection, Mr. President.

THE CHAIR:

On the amendment, will you remark further?

Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. I rise in support of the amendment, and particularly to remark on the

importance of Section 9. Mr. President, it is a fact of life that when people communicate with one another, they are much less likely to sue one another.

And under an existing law, Mr. President, the fear of retribution or lawsuit discourages healthcare providers when there are unanticipated outcomes from coming clean with their patients and saying that something might have gone wrong and apologizing for the outcome.

What Section 9 of the bill will do, Mr. President, is to encourage healthcare providers, when there is an unanticipated outcome, which is not always the result of negligence, and I would say, quite frankly, it is more often than not, not the cause of negligence when there is an unanticipated outcome.

Our healthcare providers should have the liberty to apologize to their patients when the outcome is not what was anticipated, and should know that by so doing they will not be opening themselves up to a lawsuit.

So, Mr. President, I think that this Section of the bill represents the beginning of a culture shift, which I hope will only grow as time goes on. I do

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want to thank Senator McDonald and Senator Kissel for including this provision in the bill.

I also have one quick question for Senator McDonald, if I may, through you, Mr. President. As I read Section 2 of the bill, we are now going to, upon the filing of a certificate of, upon the filing of a medical malpractice lawsuit, we are going to append to the complaint a certificate of good faith, which has appended to it a written opinion detailing the basis for the negligence.

And through you to Senator McDonald, is that, am I, generally speaking, do I have the procedure right, how this is going to work, through you, Mr. President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Through you, Mr. President, the, I believe the answer to Senator Roraback's question is that the detailed opinion itself would be the certificate.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

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And through you, Mr. President, okay. I thought that the certificate would be signed by the lawyer and that the opinion would be signed by a doctor.

And I direct Senator McDonald to the Line 118, which says, the complaint, initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action that such reasonable inquiry gave rise to a good faith belief.

So wouldn't a certificate be signed by a lawyer, through you, Mr. President, to Senator McDonald?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. Through you, I believe the certificate, I guess my answer is it doesn't necessarily have to be a separate document. But yes, there would have to be a signed document by the attorney that is accompanied by the written opinion of the medical professional providing the analysis.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

And through you, Mr. President, would the

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language on Lines 135 to 137, which says that claimant or the claimant's attorney shall retain the original written opinion and shall attach a copy of such written opinion to such certificate, suggests that we really contemplate two different documents, a certificate with a written attached to it, through you Mr. President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Through you, Mr. President, that would appear to be the most efficacious way of dealing with it, and not necessarily the only way.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. And really, where I'm going with all of this, Mr. President, is I'm trying to ascertain the extent to which the defendant will have an opportunity to look at both the certificate and the underlying opinion, recognizing that the provider of that opinion's identity is going to be expunged.

Through you, Mr. President, does Senator McDonald believe that the bill is going to have the certificate as a matter of public record in the file, and that the written opinion attached to the certificate will also be a matter of public record in the file, again, with the name being deleted from the provider of that opinion, through you, Mr. President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

Thank you, Mr. President. That is correct. They would be attached to the complaint.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

And through you, Mr. President, and they would be there for all the world to see, through you, Mr. President.

THE CHAIR:

Senator McDonald.

SEN. RORABACK:

Anybody, through you, Mr. President, to anybody

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who had the inclination to go to the courthouse and look.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. And finally, what really, Mr. President, it's, the reason I'm asking these questions is because there is another sentence on Lines 133 through 135 that says, such written opinions shall not be subject to discovery by any party, except for questioning the validity of the certificate.

And as I hear Senator McDonald's answers, I'm guessing that what that language is intended to do is to conceal the identity of the provider of the opinion, not the contents of the opinion.

And through you, Mr. President, to Senator McDonald, would he concur that that reading is the most logical reading in light of the scheme that we're putting together, through you, Mr. President?

THE CHAIR:

Senator McDonald.

SEN. MCDONALD:

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Thank you, Mr. President. Through you, not only would it be the most logical, it would be the intended consequence of the legislation.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. It doesn't get any better than that. I will thank Senator McDonald for his answers, for his clarification, and I urge support of the bill. Thank you.

THE CHAIR:

On the amendment, will you remark further, on the amendment? If not, we'll try your minds. Senator McDonald.

SEN. MCDONALD:

Mr. President, actually, I think we were, Senator DeLuca and I were both looking at each other to see who was going to get up first. And I want to thank him for allowing me to just acknowledge Senator Kissel, again, and apologize to him and to Senator Roraback, and, of course, to Governor Rell, if I inadvertently left them out.

Mr. President, I do think that this legislation is groundbreaking and will provide substantial relief to medical professionals, while at the same time protecting victims of malpractice. And, Mr. President, I ask that when the vote is taken, it be taken by roll call.

THE CHAIR:

The vote will be taken by roll call. Anyone else before I call on the Minority Leader? Mr. Minority Leader.

SEN. DELUCA:

Thank you, Mr. President. At the outset, when this amendment was being introduced, I heard the comment that it has been before us too long. By that, I would assume that that means we have a problem or we recognize a problem.

To the degree of the problem, we can debate. Some people say it's a crisis. We've heard this from the medical profession that it is in the crisis stage because it is affecting care of patients, especially as has been mentioned here in the OB/GYN and neurosurgeon areas where the highest increases have been, and we hear that many are either retiring,

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leaving the state, or declining to enter into these specialties.

So we can debate whether it's a crisis, but I think we recognize that it is a problem, and a problem that needs to be corrected. And in the discussions that I have had in the past couple of years, one of the prime objectives was to take the money out of the system in order to control the premiums.

I'm looking, I'm listening this evening, for where the money is coming out of this system to provide that relief in the premiums.

I heard that we have tort reform, tort reform that first addresses attorney's fees. It says we have set up a schedule of the fees, that we already have, by the way, and they can still get a waiver that we can already get, but in this waiver, this time, we're going to look at it more closely.

I don't know what that changes. I don't know how that takes money out of the system, because the system is the awards. Yes, attorney's fees are a complaint, but that doesn't take the money out of the system and affect the premiums.

I would agree with Senator Roraback on Section 9 that maybe that might have some effect, because I have read articles, and I think one of the places it started was in a Veteran's Hospital where the chief surgeon stated that, and there was a decline in cases and a decline in suits. That may, in the future, afford some. That could really happen.

And also, to address what Senator Nickerson talked about in Section 11 regarding insurance companies. We find that it's declined from a number of insurance companies offering malpractice insurance in the State of Connecticut is down to about two, down to about two.

And we want them to continue, or we would like more to come into the state, because competition helps to reduce cost.

But in Section 11, in addition to the prior rate of approval, it says that if an insurance company wants to increase their rates, they have to send by certified mail return receipt to every single insured, and provide this list to the Insurance Commissioner. And upon receipt, the insured, within 15 days, can request a hearing.

Now, I don't know if this makes it easier for the insurance company to do business. It would seem to me that this kind of adds money, adds cost, rather than take cost out of the system.

And if we're only down to two insurance companies, why are we making it more difficult? We should be making the procedures easier for more companies to come in, not to make it harder for those that are here.

I also heard that people have worked hard on this bill for the last couple of years to get it to where it is today, and I appreciate that, and I respect that. But hard work in itself doesn't say that it came out right. Hard work in itself doesn't say we solved the problem.

Doing it right says we solved the problem, not working hard. And I respect the work that was done. I just disagree with the final result because, as I continue to say, very little did I hear that this is going to address the problem.

Address the problem that the medical community, whether it be doctors, hospitals, or other medical providers are saying that the medical malpractice

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premiums are out of control, and they have to be controlled.

Now, some people will say, insurance companies make too much money. They could be right, because all you have to do is check their filings with the Commissioner.

It's assumed that if you do business, and I guess this applies not only to insurance companies, but it assumes that if you're a corporation and you do business, you automatically make a lot of money.

Profit has become a dirty word. But without profit, companies do not continue to do business in the State of Connecticut.

So I don't see this as taking the money out, addressing the problem that has been identified, and helping in the reducing the cost of malpractice insurance in the State of Connecticut, and addressing the problem that we all agree it is affecting healthcare.

And it's affecting healthcare to the people of the State of Connecticut when they cannot get those doctors or there are less of them to be available to treat patients. If a doctor has to treat more

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patients, that's less time for each one, and less time for each one leaves more time for mistakes.

We're going in the opposite direction, ladies and gentlemen. This is a very comprehensive bill. It's not much different than last year's bill where it says a lot, and, unfortunately, in my opinion, does very little. Thank you, Mr. President.

THE CHAIR:

Will you remark further? Mr. Majority Leader.

SEN. LOONEY:

Yes, thank you, Mr. President. Rising in support of the bill, this, obviously, has reflected a great deal of work by the efforts of at least three Committees.

Certainly, the Judiciary Committees, the Public Health Committee, and the Insurance Committee have all labored long over this year's incarnation of the bill, after having thought they had had a consensus bill last year, which was, unfortunately, vetoed by the Governor.

And certainly, want to commend Senator McDonald, Senator Murphy, Senator Crisco, and their

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counterparts, and also the Administration for its work on this bill.

It is, I think, it is a modest effort forward, but it does, I think, move in some important directions.

First of all, one of the things that is, that is probably of some pragmatic import is the issue of change in the Offer of Judgment, now to be called the Offer of Compromise.

I think it is unfortunate, in some ways, that that extends now to all cases, rather than just a medical malpractice case, and so be it, but it was not possible to necessarily carve out a definition of one as opposed to the other.

But I think that issue of 8% versus 12% is going to have some, some great significance. I hope it will not result in an incentive to, for additional foot-dragging in the settling of cases.

I think it is important to have the issue of malpractice insurance as part of a ratemaking structure and the possibility of some prior approval and prior review.

I think one of the problems we've seen over the years is that the Insurance Department has not been aggressive enough or vigorous enough in challenging rate increases or examining them very closely, and making sure that the requests for the huge annual increases in the rates that we're seeing are, in fact, are, in fact, justified.

So I think that this bill makes a move in that direction of perhaps strengthening the regulatory role of the Commissioner. So it is, I think, a modest step forward. I certainly hope that the, that the physicians who are struggling, as they point out, with the malpractice burden will see it as that.

I think it is important that the bill does not contain arbitrary caps on forms of damages, which I think would be highly unjust and creating a category of, in effect, privileged defendants who would be exempted from the kind of liability that other defendants have. It's fortunate that does not contain that.

It is, in some ways, very close to last year's bill. Obviously, it has a, one of the significant differences that last year's bill offered a special

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tax credit to physicians who suffered a significant increase in their malpractice insurance, and that is not in this year's bill. So to that extent, it is somewhat less ambitious.

But I think it has been a very painstaking process. I know the work that our Senate Chairs have put in on it. I know that House counterparts have done the same kind of work in a highly conscientious way to deal with what is a real problem, to, at least to make a contribution toward lessening that problem and to allow us to go forward and see how this works in the next several years.

And I, again, commend those who have labored so long on this, and so conscientiously tried to negotiate very often intractable positions on opposite sides who were essential to the debate, and so I would urge passage. Thank you, Mr. President.

THE CHAIR:

Will you remark further? If not, a roll call having been requested, the Clerk will announce the pendency of a roll call vote on the amendment. The machine is open.

THE CLERK:

An immediate roll call vote has been ordered in
the Senate. Will all Senators please return to the
Chamber.

An immediate roll call vote has been ordered in
the Senate. Will all Senators please return to the
Chamber.

THE CHAIR:

Have all Members voted? Senator Hartley. If all
Members have voted, the machine will be closed. The
Clerk will please announce the result.

THE CLERK:

Motion is on adoption of Senate Amendment
Schedule "A".

Total number voting, 36; necessary for passage,
19. Those voting "yea", 27; those voting "nay", 9.
Those absent and not voting, 0.

THE CHAIR:

The Amendment is adopted. Will you remark
further on the bill as amended? Senator Murphy.

SEN. MURPHY:

Thank you, Mr. President. The Clerk is in
possession of a second amendment, LCO 7847. I'd ask
that he call and I be allowed to summarize.

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THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 7847, which will be designated as Senate
Amendment Schedule "B". It is offered by Senator
Murphy of the 16th District.

THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Thank you, Mr. President. I move adoption.

THE CHAIR:

On adoption, Senator Murphy.

SEN. MURPHY:

Thank you, this is a fairly minor cleanup
amendment to the, drawn to now the adopted Senate "A".
It strikes one section of the bill that added a few
additional reports to the Department of Public Health.

This initially drew a fairly substantial fiscal
note, so in the spirit of financial responsibility
that we all live under today, we have eliminated this
provision and also made a few other cleanup changes to
the bill's public health sections. I would urge
adoption.

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THE CHAIR:

On the amendment, will you remark further, on the amendment? If not, I'll try your minds. Senator Gunther?

SEN. GUNTHER:

Mr. President, a very curious amendment. It's a little difficult sometimes to take and wade through this. I see that you're continuing to have the Department of Public Health being advised and assisted by the Connecticut Medical Board. There is nothing changed there, is there, through you, Mr. President?

THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Yes, thank you, Senator Gunther. And I apologize for the uncertainty that may underlie this note. The one change to that section, which was actually rewritten as the amendment stands before you, is only that there has been an addition that relevant medical professional associations should be advised or consulted when establishing the guidelines. But the Connecticut Medical Examining Board would continue to be part of that process.

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THE CHAIR:

Senator Gunther.

SEN. GUNTHER:

Well, the other question I have here, is guidelines in the, under Chapter 54 of the State of Connecticut requires the promulgation of regulations. You are now taking and defining that these guidelines do not have to come under Chapter 54.

So there is no guidelines that, you establish them as guidelines with no regulations or nothing formally even being put before the public so the people can take and respond to them.

I think Chapter 54 has been on the books, I think, 30 or 40 years at least, and we've always taken and had guidelines adopted through a day, Chapter 54, which is a process where the Department will actually draft the regulations, put them up to public hearing, and allow people to take and respond to them.

It would look to me as if you're eliminating that area, which I believe is very important, and has been a great thing in the State of Connecticut. I think we've had the longest period of regulation and review

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by the Legislature of any Executive Branch regulations.

So you really want to take and ignore the Chapter 54, and bypass them, making this a better bill, through you, Mr. President?

THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Thank you. Through you, Mr. President, this amendment makes actually no changes to the nature or scope of the guidelines. The only change to Section 17 in this bill is the inclusion of advise from the relevant medical professional associations in the establishment of those guidelines.

So in Section 17, we've made no change to the amendment just adopted regarding the development of those guidelines as they may be compared to regulations.

SEN. GUNTHER:

MR. President, I believe that--

THE CHAIR:

Senator Gunther.

SEN. GUNTHER:

I believe that this area is serious enough that it should be under Chapter 54, and should go through the process of promulgation and allowing for public hearings and the reaction of the public.

I think there's no exception here should be allowed, and I would oppose this because, well, getting back to something I said before, and I've said time and again, the medical examining boards should have the responsibility for licensure discipline and should not be just advisory to the Public Health Department, as all other examining boards in all other professions.

So I don't think this is a very good regulation or amendment, and I think we should take and vote it down. If you want to take and promulgate regulations, then go through Chapter 54. It shouldn't be excluded.

THE CHAIR:

Will you remark further? Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. Senator Gunther's line of inquiry ignites some questions in my own mind, through you to Senator Murphy. I've always been, I've always understood that guidelines have no force of

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law, Mr. President. That while many of our agencies like to have them, it's really regulations which carry force of law.

And through you to Senator Murphy, what's the current practice with the Medical Examining Board when they discipline people, do they have regulations, through you, Mr. President, if Senator Murphy knows the answer to that question?

THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Thank you. Through you, I actually don't know whether they have standing regulations currently. We certainly do acknowledge that there is a difference between guidelines and regulations, and that, in fact, one of the reasons we may look to guidelines or protocols rather than regulations is their ability to be changed as circumstances warrant.

And so therein lies the reason why the underlying amendment and still this amendment before us as Senate "B" referred to guidelines versus regulations.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

And through you, Mr. President, to Senator Murphy, I've also understood that one of the differences between guidelines and regulations is that regulations have force of law and guidelines do not. Through you, Mr. President, to Senator Murphy, does he share that understanding of the distinction, of that distinction between guidelines and regulations, through you, Mr. President?

THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Thank you. Through you, Mr. President, I will not profess to know the exact judicial interpretation of the difference, but I would certainly acknowledge that there is a significant difference in the weight accorded to regulations versus guidelines.

THE CHAIR:

Senator Roraback.

SEN. RORABACK:

Thank you, Mr. President. And I don't purport to be an expert, and I'm not expecting Senator Murphy to be an expert, but I am afraid that by looking to imbue

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guidelines with force of law, we may be setting up a system that is destined for failure, because my, what I can remember of the law suggests that if you contest agencies operating under self-created guidelines, you've got a pretty good chance you're going to win.

And if the agencies want something to have teeth, they have to go through the regulation-making process. So for whatever it's worth, I think we should be, have our eyes wide open. I appreciate Senator Murphy's answers. Thank you, Mr. President.

THE CHAIR:

Will you remark further on the amendment?

Senator Cook.

SEN. COOK:

Thank you very much. Good evening to you, Mr. President. Through you, I might ask a question of Senator Murphy. The amendment be, may I ask a question of Senator, through you?

THE CHAIR:

Absolutely, Senator Cook.

SEN. COOK:

Thank you. The amendment before us strikes Section 22 completely.

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THE CHAIR:

Senator Murphy.

SEN. COOK:

Is that correct?

SEN. MURPHY:

That is correct.

THE CHAIR:

Senator Cook.

SEN. COOK:

Okay. Section 22 has been with us since 1986, and what we are going to eliminate now, is any information going to the Governor and to the Public Health Committee regarding outcomes, petitions for investigations, whether they were appropriate or not appropriate, and any other policy questions that should be coming before the Governor and the Public Health Committee about systemic changes that we might need to make regarding the efficacy and safety of the practice of medicine in the State of Connecticut.

So through you, Mr. President, I'd be curious to know why this is an improvement to better medical practice in the State of Connecticut by eliminating this section?

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THE CHAIR:

Senator Murphy.

SEN. MURPHY:

Thank you. Through you, Mr. President, just to remind Senator Cook, when you strike a section from a bill, you don't strike the underlying existing statutory references. You only strike the changes that were referenced in that particular amendment.

So all that we have changed here, by eliminating a section of the bill, is that we are not going to add to the current reports that are required by this section, so that it is, in fact, no change from current law as it references these reports.

I think we all would have liked to have done it, except the cost, in consultation with the Department of Public Health, was prohibitive to placing these additional requirements on them. But by striking this section of the underlying amendment, we are simply reverting back to current law, not striking the underlying language relevant to these reports.

THE CHAIR:

Senator Cook.

SEN. COOK:

Thank you very much. Well, the problem is that, for several years, we've been trying to save current law to make our medical system safer, safer for patients, safer for doctors, safer for the public.

And we need to have information about not just what would remain if we do not strike, if we do strike Section 22, what would remain, you're correct, is the existing law which says, we'll get a report about the number of petitions received, the number of hearings held on the petitions, and no information about who did it, why they did it, what happened, and that is a concern to me.

I think that the difficulty of striking Section 22 and the language that's in the bill before us, strikes to the very heart of the patient's safety issues that we are trying to improve.

One of the reasons that medical malpractice is a problem for the State of Connecticut is that we don't get the information of how to improve the system.

These reports are the policy parameters upon which we can improve patient safety and make our medical system better. Apparently, you don't think that's worth the cost.

I think precisely what we need to do is invest in the safety of patients in our state so that we don't have medical malpractice cases.

So I would reject this amendment and ask that we go forward and make sure that we get the information that we as policymakers need to improve the patient safety of Connecticut's medical system.

And I believe a safer system will yield lower malpractice rates because we will have less malpractice.

THE CHAIR:

On the amendment, will you remark further?

SEN. COOK:

I would ask for a roll call vote, Mr. President.

THE CHAIR:

A roll call vote will be taken, Senator Cook. Will you remark further on the amendment? Will you remark further? If not, the Clerk will announce the pendency of a roll call vote. The machine is open.

THE CLERK:

An immediate roll call vote has been ordered in the Senate. Will all Senators please return to the Chamber.

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An immediate roll call vote has been ordered in the Senate. Will all Senators please return to the Chamber.

THE CHAIR:

Have all Members voted? Senator, all Members have vote, Senator Daily. If poor Senator Daily can just get to her chair. It's not working. If all Members have voted, the machine will be closed. The Clerk will announce the tally.

THE CLERK:

Motion is on adoption of Senate Amendment Schedule "B".

Total number voting, 36; necessary for passage, 19. Those voting "yea", 25; those voting "nay", 11. Those absent and not voting, 0.

THE CHAIR:

The amendment is adopted. Will you remark further on the bill as amended? Will you remark further on the bill as amended?

If not, I gather a roll call is in order. Mr. Clerk, Mr. Clerk, will you announce the pendency of a roll call vote. The machine is open.

THE CLERK:

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An immediate roll call vote has been ordered in
the Senate. Will all Senators please return to the
Chamber.

An immediate roll call vote has been ordered in
the Senate. Will all Senators please return to the
Chamber.

THE CHAIR:

If all Members have voted, the machine is closed.
The Clerk will announce the result.

THE CLERK:

Motion is on passage of S.B. 1052.

Total number voting, 36; necessary for passage,
19. Those voting "yea", 27; those voting "nay", 9.
Those absent and not voting, 0.

THE CHAIR:

The bill is passed. Mr. Clerk. Hang on a
second, Mr. Clerk.

[GAVEL]

Need a little quiet in here, please. Thank you.
Mr. Clerk. Mr. Majority Leader.

SEN. LOONEY:

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success in your new field. Thank you. And I would ask my colleagues to rise and wish Dana Bershefsky well.

(APPLAUSE)

SPEAKER AMANN:

Gentlemen, please rise.

(APPLAUSE)

SPEAKER AMANN:

Well, Dana, you obviously made an impression. So I hope you continue with that throughout the rest of your life. So thank you for being with us this year. Representative Donovan.

REP. DONOVAN: (84th)

Mr. Speaker, Mr. Speaker, I move for a suspense of the rules for immediate consideration of the Calendar Number 651.

SPEAKER AMANN:

Question is on suspension. Do you object? Do you object? Hearing none, so ordered. Will the Clerk please call Calendar Number 651.

CLERK:

On Page 17, Calendar Number 651, Substitute for Senate Bill Number 1052, AN ACT CONCERNING MEDICAL

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MALPRACTICE, Favorable Report of the Committee on
Appropriations.

SPEAKER AMANN:

Representative Fritz. Excuse me, Representative
Fritz.

REP. FRITZ: (90th)

Good morning, Mr. Speaker.

SPEAKER AMANN:

Good morning. Good afternoon, Madam. It seems
like morning. Who knows? I don't even know what day
it is, Madam. But you may proceed.

REP. FRITZ: (90th)

It's a very big day. It's a very important day.
And we're today going to do something for the people
of Connecticut. And it's known as medical
malpractice. And I would at this time like to yield
to Representative Lawlor please.

SPEAKER AMANN:

Thank you, Madam. Representative Lawlor.
Representative Lawlor, do you accept the yield, Sir?

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Yes, I do.

SPEAKER AMANN:

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Thank you, Sir. You may proceed.

REP. LAWLOR: (99th)

Mr. Speaker, I move acceptance of the Joint
Committee's Favorable Report and passage of the Bill.

SPEAKER AMANN:

Question is on acceptance of the Joint
Committee's Favorable Report and passage of the Bill.

Will you remark, Sir?

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I will. Mr. Speaker,
the file copy contains a wide assortment of changes to
the laws governing court procedures, insurance
procedures, and public health procedures, all of
which, we hope, will have the effect of bringing under
control the recent steady increase in rates for
medical malpractice insurance.

Mr. Speaker, the Senate adopted an Amendment,
which is a strike-all Amendment. The Clerk has LCO
Number 7695. I ask the Clerk call, previously
designated as Senate Amendment "A". I ask that the
Clerk call and I be allowed to summarize.

SPEAKER AMANN:

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Will the Clerk please call, no. Will the Clerk please call LCO 7695, which was previously designated Senate Amendment "A."

CLERK:

LCO Number 7695, Senate "A", offered by Senator Williams, et al.

SPEAKER AMANN:

The Representative seeks leave of the Chamber to summarize. Is there objection on summarization? Is there objection? Being none, Sir, would you proceed with summarization?

REP. LAWLOR: (9th)

Thank you, Mr. Speaker. This Amendment is a strike-all Amendment. And it substitutes in place of the file copy a similar wide assortment of proposed changes in the court procedures and rules governing medical malpractice cases, the rules and procedures, regulations of the Insurance Department as they relate to malpractice insurance carries, and makes a variety of changes in the rules governing the conduct of the medical profession, as it is regulated by the Department of Public Health.

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Mr. Speaker, before I begin a brief summary of the various sections of the Bill, I'd like to point out a number of things.

First of all, this work product is yet another example of why it is always a good idea to bring together the various Committees of cognizance to work together to solve complicated problems, which span or bridge the jurisdiction of two or more Committees.

In this particular case, Mr. Speaker, the House Chairs of the present and former Judiciary Committees, Public Health Committee, and Insurance Committee have worked in corroboration with the Program Review and Investigations Committee when it was under the leadership of Representative Wasserman.

And, of course, all of this was spearheaded in the House by the Deputy Speaker, the distinguished Deputy Speaker, Representative Fritz, who has been as tenacious as anyone in fighting for a fair, but meaningful reform of the medical malpractice system.

In addition, Mr. Speaker, the Governor has been an active participant in these discussions. In fact, two of the centerpiece proposals that she put on the

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table, involving prior rate approval and data collection, are incorporated in this Amendment.

She made many other proposals, but those were two of hers, which are incorporated in this Amendment. And, obviously, as always, we are grateful to her.

The nature of this problem, Mr. Speaker, is such that it came on the Legislature's radar screen just a few years ago. Many doctors in our state have seen a steady increase in our medical malpractice insurance premiums over the last four or five years. Some specialties are affected more than others.

For example, I think we've all heard from pediatricians, neurosurgeons, and other specialties explaining to us how significant the rise in premiums has been. And it is our hope that the changes we are proposing here today will affect that rapid rise.

In other words, it is our hope that when all is said and done, the insurance premiums will not continue to rise in the precipitous manner, which has been the case over the past few years.

And I should also point out, Mr. Speaker, that as far as I know, and I think I can speak for the other Members of the process, no one has actually proposed

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the solution, which would actually reduce the premiums that doctors pay beneath what they are currently paying.

All of the discussion has been how to stem the rapid increase, not so much how to drop the actual day-to-day premiums. And I think that's important to keep in mind because some have suggested that that actually is an option, which the Legislature has rejected.

To my knowledge, no one has put a solution on the table, which would actually reduce premiums. And by way of comparison, Mr. Speaker, I can recall back in 1993 when this Legislature debated another similarly complex and controversial reform, in that case of the worker's compensation system.

The goal then was to enact a series of changes, which would actually reduce the current premiums by an average of 17% for employers. And that, in fact, was the Bill that passed. And that was, in fact, what actually happened.

No one has ever put a proposal on the table here, which would, in any way, reduce current premiums, let alone dramatically, for example, 17%. Instead, our

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proposal requires sacrifices by all of the affected areas, by lawyers, by doctors, and by the insurance industry.

The goal is to get the premiums down, to make sure doctors can continue to provide quality medical services in our state. Section 1 of the Bill changes the rules governing contingency fees, which lawyers can set in medical malpractice cases.

The simplest way to explain it, Mr. Speaker, is this tightens up the rules, which govern the fee that can be imposed, and in particular, the area where the especially complex cases, in the past, it has actually been possible for a client to agree with an attorney that a fee in excess of 33 1/3% could be charged.

This changes the rules on that, makes the fee in excess of one-third impossible or illegal and provides much stricter scrutiny of fee agreements, which exceed the existing tort reform limits, which apply to all negligence cases.

The second Section involves good faith certificates. This Section makes it much more difficult to bring a medical malpractice action in court. Under this requirement, another medical

provider would have to state, in explicit detail, his or her opinion that this is a meritorious claim.

There are some protections involved in the Bill, which would protect the identity of that doctor. But the full extent of the opinion would have to be attached to the actual complaint when it's filed.

Section 3 makes sure that your typical medical malpractice case, which tends to be extremely complicated, has an opportunity within six months to be shifted over to the complex litigation docket.

It is our hope, by doing this, judges and staff who are specially trained to deal with these types of extraordinarily complicated matters can get the case resolved quickly and at a savings to all parties involved.

Section 4 relates to what's now called the offer of judgment. We've changed the terminology to refer to it instead to an offer of compromise. The goal here is to have medical malpractice cases settled as soon as possible, when there is a legitimate claim being made by an injured plaintiff.

Under this procedure, it would make it fairer for the defendant, usually the doctor or hospital to fully

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investigate the case before having to make a decision on whether or not to settle the case.

It would also build in penalties, would lower the penalty, the interest penalty for not reaching an agreement in a timely fashion, but still would retain the incentives to resolve these cases when they are meritorious.

And I think the change in terminology, Mr. Speaker, from the current law, which talked about offers of judgment, to what we're proposing here, offers of compromise, makes it more likely that a doctor or defendant would agree to settle a case without necessarily admitting specific areas of fault.

And it's our sense that this will help resolve cases more quickly when they would otherwise be fully litigated. Sections 5, 6, and 7 govern, in essence, the mechanics of that offer of compromise procedure.

Section 8 provides some new definitions or some tighter definitions and includes a reference to the fact that if there are so-called collateral sources of money, if there has been a previous claim against another defendant, which has been settled, that would

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be brought to the attention of the jury in the newer or second case.

Section 9 provides additional definitions and most importantly, provides reference to what was suggested by Senator Roraback, which I think everyone feels is an extremely good idea.

And that is, because so many cases seem to be filed, because initially after the apparent mistake, the healthcare provider or doctor could not and would not apologize for the injury that occurred. Many malpractice cases seemed to flow from that initial reluctance to apologize.

This language makes it clear that if there is such an apology, the fact of that apology could not become evidence in a subsequent trial.

And it's our hope that, perhaps, doctors, as soon as they realize a mistake has been made, can begin to work with the injured patient, in some cases, their family, to smooth over not just the financial impact of the injury, but also the emotional impact.

And evidence seems to indicate that this would help avoid medical malpractice cases and certainly make them easier to resolve in the future.

And the final Section, which relates to sort of the legal rules governing this, there's a provision that would put a special emphasis, so when there is a verdict in excess of \$1 million, a judge would have special guidelines to look at to determine whether or not the jury in this case was influenced more by emotion or other factors, rather than the actual evidence of the case.

And we'll give the judge a special authority and certain guidelines, which would allow the judge to actually reduce the verdict, based on what the judge may conclude is inappropriate consideration, which had been taken into consideration by the jury.

Mr. Speaker, those are the Sections that relate to the rules governing what lawyers and what courts do in medical malpractice cases.

At this time, I'd like to yield to Representative O'Connor to explain the insurance portions of the proposed Amendment.

SPEAKER AMANN:

Thank you, Sir. Will you accept the yield, Sir?

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. I do accept the yield.

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SPEAKER AMANN:

You may proceed, Sir.

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. The Sections that pertain to insurance and medical malpractice insurance are Sections 11 through 16.

Section 11 requires prior rate approval when an insurer wants to increase medical malpractice insurance rates by 7.5% or more for physicians, surgeons, hospitals, advanced practice, registered nurses, and physician assistants.

It also requires an insurer to notify the insured of the proposed rate increase and the right to request a hearing on the matter before the Insurance Commissioner.

Section 12 requires the Insurance Commissioner, by October 1st, 2008, to review medical malpractice insurance rates to determine if the amount or frequency of insured awards and settlements against these providers have decreased since October 1st, 2005.

Do the rates reflect a decrease? And, three, the rates bear a reasonable relationship to the cost of writing medical malpractice insurance in Connecticut.

Also, Section 12 requires the Commissioner to convene a working group to recommend appropriate changes to the law to decrease rates or establish reasonable rates, if, after her review, she determines that rates have not decreased and are reasonably related to the cost of writing such insurance.

Section 13 requires the Commissioner to develop a plan to maintain a viable medical malpractice insurance industry in Connecticut and is supposed to submit it to the Governor.

I think this is probably the most important part of the insurance section because one of the things that we're trying to do is maintain a competitive marketplace, so we can get more carriers involved. And I think that will ultimately reduce premiums, if we have more competition.

Section 14 requires insurers to report information about each malpractice claim they close to the Commissioner, including details on the insured and the insurer, the injury or loss, the claims process, and the amount paid on the claim.

Also, Section 14 requires the Commissioner to compile and analyze the reported claim data and report

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on it to the Insurance and Real Estate Committee and the public. And finally, Sections 15 and 16 require captive insurers to provide copies of financial statements at large to the Commissioner.

I just want to point out that captive insurers represent approximately 50% of the market. And the two admitted carriers represent the other 50%. And one of the things that we're trying to do is bring the captives in line, so we can get a better handle on what they're doing as well.

But ultimately, I think we have to be leery of any kind of overly burdensome administrative costs. So as Insurance Chairman, we're going to look at this Section as it moves forward.

There was also some concern that the public hearing process might become too political and represent a hostile environment for carriers to look at our state as a viable marketplace. So, again, these are some of the areas that we're looking at.

I think the other point I just want to make is that the 7.5% level for prior rate approval is, again, something that we're going to monitor. We want to

make sure that it is realistic that insurance carriers can come in without the public hearing process.

And 7.5% may be a level that may be too low, based on some of the trends, but it's something that the group came to a consensus on. And it's easier to go up, if it proves that it is not intensive enough.

So at this point in time, I would like to yield the floor to Representative Peggy Sayers, the Chair of Public Health. Through you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Sir. Representative Sayers, do you accept the yield, Madam?

REP. SAYERS: (60th)

Yes, Mr. Speaker. Thank you. The Public Health Sections of this start with Section 17 and go to the end.

And it requires the Department of Public Health to adopt guidelines for use when conducting disciplinary actions concerning physicians, expands the list of persons who may serve on medical hearing panels from 18 to 24, and establishes membership rules for each of the medical hearing panels.

One of the problems that we were able to identify was that Department of Public Health sometimes has difficulties getting enough people to serve on hearing panels, simply because they may be serving on as many as six at one time.

And by expanding the number of members of the panels, it lessens that burden somewhat. It also requires the Department of Public Health members to establish guidelines concerning the screening and investigation of complaints about physicians to determine which complaints shall be investigated.

They need to set priorities for those complaints and determine when a complaint needs to be investigated beyond the scope of the initial complaint.

It also requires that they list when a board is authorized to restrict, suspend or revoke the license or limit the right of practice of a physician or to take any other action as needed.

It requires the Department of Public Health to file a report, which includes information on the number of petitions received, the number of petitions not investigated, and the reasons why, the number of

hearings held, and the outcomes of such hearings, plus an additional action to be taken.

It makes failure to comply with continuing education requirements a cause for disciplinary action by the Connecticut Medical Examining Board.

Sections 23 to 24 make changes to the information that must be reported by a physician within their physician profiles, including information as to whether or not the physician is actively involved in patient care, and require the physician to report any changes in the profile.

Sections 25 through 26 establish continuing education requirements. The Department of Public Health will be required to make available forms for use by the physician when attesting to his or her satisfactory completion of the continuing education requirements or for physicians renewing a license that was voided because of military duty, that they may be reinstated not later than one year after discharge.

Section 27 requires each hospital or outpatient surgical facility to establish protocols for screening patients, prior to any surgery. It also requires licensed hospitals to contact with a patient safety

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organization to collect data and make recommendations on ways to improve patient care and safety.

Most of the hospitals currently already have a contract with a patient safety organization to improve patient safety and care. Section 28 eliminates the voluntary medical malpractice screening panels because these panels were not utilized. I move adoption.

SPEAKER AMANN:

Question is on adoption? Will you remark?
Question is on adoption. Will you remark? Will you remark? Representative Fritz.

REP. FRITZ: (90th)

Thank you, Mr. Speaker. I also want to thank Representative Lawlor, Representative O'Connor, and Representative Sayers for their hard work, and also the Members of the Trial Working Group, the working group that came together, which was staffed from the Governor's Office this year.

In addition to those people, as you all well-know it is very, very important to thank the people in LCO and OLR for all their due diligence in making sure that what we put before you today is done in the proper manner.

As you know, this is not an easy issue. There are three very major money players involved in it. We talk about the trial lawyers, the doctors, the insurance industry.

However, to all of that, our concern was truly to try and help the people of Connecticut who, in some way, have become victims because, you know, there wouldn't be a need for medical malpractice insurance, if there were not victims. We truly tried to do no harm to any of the groups. And I believe that we have succeeded.

But this is only a blueprint. We still need to do a great deal more in the area of patient safety. This is a foundation, a base upon which we can build in the future.

I think we have made a good first step and the tomorrows that will come will greatly aid and help the people of Connecticut. And I ask for your support.

SPEAKER AMANN:

Will you remark further? Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Just for a second time, several colleagues asked me about Section 10. I just

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wanted to clarify. This governs the remitter language. The Section doesn't change the longstanding test for what's an excessive verdict.

It makes it mandatory in every medical malpractice case where the non-economic damages exceed \$1 million. And I think that's our special emphasis on where there is a large verdict to make doubly sure, under the longstanding test, that the verdict is not in excess. I just wanted to clarify that. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Winkler.

REP. WINKLER: (41st)

Thank you. Thank you, Mr. Speaker. I rise reluctantly in support of the Bill as amended before us. And I appreciate Representative Fritz's comments about this is a blueprint and there is more that still needs to be done.

What we have before us, I believe, is a start and will provide some relief, but only on a minimal basis. There are parts that the Medical Society were looking to have included that are not part of the legislation

before us. One being premium reduction reform, I know they were looking for caps.

Caps have been an issue in this Chamber and the Chamber upstairs for quite some time, since it has been proposed. I do believe caps of some form need to be part of the equation. However, what we have before us, at least, as I said, it is a start. We can see where we go from here.

I know the medical society was also looking for whistleblower protection for physicians who report deviations from standards of care. They were looking for increased authority and autonomy of the Board of Medical Examiners. Those things are not included.

I will support the Bill today. I think we need to get something on the books to show the physicians that we are in support of them and that we're willing to do something to help them with the high malpractice costs that are putting many of them into retirement at an early age. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?

Representative Wasserman. Representative Wasserman.

REP. WASSERMAN: (106th)

Good morning, Mr. Speaker. Very briefly, I would like to make a few comments to you, Mr. Speaker, because Program Review and Investigations, that wonderful Committee, did do a review a couple of years ago.

And I would like to say that the Amendment before us is better even than that review that was done. The Amendment addresses areas that Program Review and Investigations did either differently or not at all. And I would just like to mention a few of the issues that this Amendment addresses and makes it so much better.

For instance, it addresses the lawyer contingency fee issue in that it allows the claimants to waive the percentage increases in statute, if the claim is so substantially complex, unique or different from other types of civil actions to warrant such a deviation.

It also addresses the certificate of good faith. It requires party conference to determine if the case should be designated as a complex litigation case and transferred to that docket. It addresses the pretrial offer of compromise where formerly the offer of

judgment, where the claimant or the defendant offered to settle the case.

I'm mentioning these things only because we had talked about them, but they were never really finalized to the degree that they are in this Amendment.

And just to summarize, the Amendment offers, mandates court review, non-economic damages over \$1 million to determine if the award is excessive, as a matter of law, and order remittance upon that finding.

And then, of course, the Insurance Commissioner is required to develop a plan to maintain a viable medical malpractice insurance industry.

And that has to be submitted to the Governor. I could go on with a list of issues that are addressed in this Amendment, Mr. Speaker, realizing that the document is far from perfect.

But I think it's a very good beginning. I think it's very necessary. And I hope that Members of the House support it. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?
Representative Powers.

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REP. POWERS: (151st)

Good afternoon, Mr. Speaker.

SPEAKER AMANN:

Good afternoon, Madam. Good to see you.

REP. POWERS: (151st)

Thank you, Mr. Speaker. I rise in opposition to this Amendment. Representative Hetherington and I were the House Republican Members of the, quote, unquote, bipartisan Working Group. And as always, I enjoy working with Mary.

But I want to be very clear that what is before you is 98% partisan. Basically, the Bill was heard in Judiciary. When we voted on it in Judiciary, there was a strike-everything Amendment. This is a strike-everything Amendment. We're basically not accomplishing, unfortunately, a whole heck of a lot.

My ob-gyn who delivered two of my four sons has dropped the ob part. And that's fine for me because I'm old, but he's not around for all those other ladies. And he's a really good doctor. And it's really, really unfortunate he can't deliver babies anymore.

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You have a situation where you have a lot of things in this Bill. Unfortunately, when you have an actuary look at it, it does not affect premiums. It only will, at maximum, affect possibly up to 1% of the next increase.

So we are not decreasing premiums, and we're not really assessing the next increase. I wish that we had been able to have a full and frank discussion, and fair discussion, on caps. That was not part of our discussions.

And, unfortunately, what this Bill does is it puts many, many more requirements and mandates on the insurance companies, Department of Public Health, and on the doctors. And I don't think we're really getting anywhere, unfortunately.

So there is a cost to the doctors. There is a cost to the insurance companies. The Department of Public Health, there is a change here in Senate "B" that will help with some of the costs for Public Health, Department of Public Health.

But what we have here is a Bill, excuse me, I'm tired. I drove home to let the dog out. He was extremely happy to see me, but I'm very tired.

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Oh, the dog's name is Baron. Baron was very happy to see me. He was rather cross-legged by the time I got home. Yes. He's in the record. At any rate, Baron is much more comfortable.

Our doctors are not more comfortable. The insurance companies are not more comfortable with this Bill. And I, unfortunately, think we spent a lot of time, Representative Hetherington and I were either singly or together in all the meetings until we got close to the end here.

And actually, a Senator passed me in the hall about a week ago and said, oh, you're going the wrong way. The meeting is back this way. And I looked at him, and he said, oh, that's right. You all aren't included in the meeting anymore. And that was kind of how bipartisan we were.

So I would love to have stood here, and I started out hoping to be able to stand here to tell you this is a great Bill. It does a great job. Unfortunately, I cannot.

And I will be opposing the Amendment. I will probably support Senate "B" because it takes some of

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the cost out. But I will not be supporting this Bill as amended either. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?
Representative Truglia. Representative Truglia.
Representative Truglia.

REP. TRUGLIA: (145th)

Good afternoon, Mr. Speaker.

SPEAKER AMANN:

Good afternoon, Madam.

REP. TRUGLIA: (145th)

Thank you, Mr. Speaker. This Session, we, again, had the opportunity to make a difference in the healthcare crisis that Connecticut is facing. But we have failed again. Access to healthcare is being impacted today by the current liability insurance crisis.

Five years ago, there were 15 companies writing malpractice coverage policies in Connecticut. Today, there are three. The reason is simple. Our medical liability system is broken. Connecticut physicians need immediate premium relief and long-term market stability to ensure insurance availability.

Without serious and comprehensive actions, the access to care crisis in Connecticut will continue to worsen every day. Connecticut physicians and hospitals have documented irrefutably that our healthcare system is in trouble.

Physicians, and not just senior physicians, are leaving practice. High-risk procedures are being eliminated or reduced. And you have heard testimony on several occasions from the Connecticut Hospital Association that hospitals have difficulty recruiting new physicians.

Patients are being referred to emergency departments sooner, creating a strain on hospital resources. Here is how medical liability insurance rates are impacting physicians in my area.

According to a survey by the Fairfield County Medical Association, 38% of the physicians who responded indicated that they no longer perform high-risk procedures or surgery. Thirty-six percent have dropped Medicaid. Fifty-one percent have reduced or eliminated pro bono care.

Twenty-seven percent have reduced the number of sicker, more complex, high-risk patients they see.

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Fifty-two percent of respondents indicated they have raised fees to patients when possible. Sixty-three percent have increased the number of tests they perform in order to avoid being sued.

Mr. Speaker, quite simply, it was time to act. We needed to provide immediate meaningful premium relief and long-term stability of insurance premiums.

I've listened to physicians who are looking to leave Connecticut to practice elsewhere. I've heard from female ob-gyn's who will no longer be delivering babies because they cannot afford their insurance premiums.

Two years ago, we had 13 physicians practicing general and thoracic surgery in Stamford. Today, we have only seven. The one primary care physician in Stamford, who cared for those no one else would, closed his practice this year because he could no longer afford his insurance premiums.

These low-income patients are now forced out of the private practice environment and into clinics or the emergency department. Of last year, 25 graduating residents from Saint Vincent's Medical Center, only 1 chose to stay in Connecticut.

Reports have started to come in that radiologists are seriously considering whether they continue reading mammograms because the liability exposure is too great. And these physicians can receive premiums up to 30% lower by not reading them.

Physicians are forced to see more patients every day to meet their overhead expenses, leading to a decline in the quality of medical care and compromising patient safety. These impacts are real.

And we need to enact meaningful reform that would provide immediate relief and long-term care for our physicians, long-term stability for our physicians. However, the current liability crisis is left unchecked. Our medical care delivery system may be changed forever. It has already changed.

Remember, without a physician, there is no healthcare. I may be naïve, Mr. Speaker, but I thought with the passage of the 1986 Tort Reform, Tort Reform Act, the cost of medical liability insurance would be lowered while also permitting increased compensation for victims of medical negligence.

This legislation required attorneys to carry out a scrupulous review before filing a case. This was to

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ensure that nuisance suits were eliminated, saving judges, insurance companies, and physicians' unnecessary time and expense.

This good faith requirement has done little to address the escalating cost of medical liability insurance because this has not been enforced.

I repeat, this tort reform has been unforced. This 1986 tort reform legislation should have lowered the cost of medical liability insurance while permitting increased compensation for victims of medical negligence.

I am very disappointed, Mr. Speaker, that we, again, have failed to legislate meaningful medical liability reform. I cannot support this Bill. Thank you.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?
Representative Ward.

REP. WARD: (86th)

Thank you, Mr. Speaker, and good afternoon.

SPEAKER AMANN:

Good afternoon, Sir.

REP. WARD: (86th)

I rise to join in the remarks from Representative Truglia. One of the challenges of this Session was to address what is a real crisis in Connecticut. Medical malpractice premiums are rising to the level, doctors are being driven from the state or driven from their practices.

A reporter asked me a day or two ago, who were the winners and losers in this Legislative Session? And I first said, and I misspoke, I said, it looks like doctors are the losers this Session because the only Bill I see on medical malpractice, left to the last minute, does nothing. But I was wrong.

It's patients that are the losers, and most particularly in this state, women that are the losers because as doctors, particularly in specialties related to the delivery of babies, will be leaving the State of Connecticut.

This Bill, at best, and probably doesn't even do that, could affect a 1% reduction in the anticipated increase in medical malpractice premiums. This Amendment before us, which would become the Bill, tinkers. It's neither bold, nor creative, nor substantive, nor real.

The bipartisan effort to do something, and the Governor started out saying she'd give up on caps, if we could do something else that was real and bold. This is not that product. I generally, a practicing lawyer, believe in the tort system. It is failing us when it comes to medical malpractice.

The tort system is failing the people of Connecticut. We need to address this crisis, and we are not. When it comes to medical malpractice in Connecticut, I liken it to Rome.

Rome is burning, and the General Assembly is fiddling. This is wrong. Vote this Amendment down. We are better with nothing than with this.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. If I may, I would like to address several questions to the proponent.

SPEAKER AMANN:

Please frame your question, Sir.

REP. HETHERINGTON: (125th)

Thank you. On this Amendment, I notice there is no provision for a mediation panel. That is correct, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. That's correct.

REP. HETHERINGTON: (125th)

I see. I was privileged to be a Member of the Working Group on this. The last draft that I had seen contained such a provision. I guess that turned out to be unacceptable to somebody.

The second question, through you, Mr. Speaker, to the proponent, do we have any analyses or projections, which indicate how much or what percentage, either in reduction in increase or in reduction of existing premiums, this legislation is expected to produce? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Through you, there's no specific estimate of the exact savings. In fact, it's one of the most frustrating parts of this process.

Unlike the situation I described 12 years ago where we had actuaries able to tell us precisely what different changes would amount to in terms of reduction in premiums, that has not been the case for anything here, including caps of any limit, anything like that.

The best people have been able to say that different proposals would have different impacts on the rate of increase. Nothing that I'm aware of that has been proposed, including caps, would result in an actual reduction of current premiums. But notwithstanding that, no one can precisely estimate the reduction.

I think the Minority Leader mentioned a moment ago he thought this might have a 1% or 2% impact. So that's one guess.

But we think the other, I'm not the expert on the insurance regulations, but I think we're also adding to this not just a hope that premiums would go down,

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but an ability to control premiums through the prior rate approval process.

There has been some speculation that potentially, since the insurance companies themselves set the premiums, they might actually be responsible for the amount of the premiums, maybe in part due to verdicts, but also in part due to business decisions on the part of the insurance company, which not everybody would agree are in the best interest of the doctors they insure.

So we'll certainly be able to find out, if this passes. And that is one of the advantages of this Bill, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you. Through you, Mr. Speaker, as the proponent has indicated, I have seen the projection of 1% to 2% reduction in the rate of increase, and that was with the mitigation, pardon me, the mediation panel.

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Would a reduction in increase of 1% to 2%, would that, would that be considered a reasonable projection by you, through you, Mr. Speaker?

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Through you, I am certainly not an actuary, even though I did stay in a Holiday Inn Express last night. I can't answer that question. But I think there's a certain amount of guesswork here.

And in part, that's because of the way the Insurance Department regulates this particular type of business.

In contrast with worker's compensation, I was amazed 12 years ago when we did the Bill, you could precisely estimate the impact on premiums of different specific changes in the formula, which governed worker's compensation cases because of the nature of these claims.

It's, worker's compensation is a very precise injury-by-injury percentage, disability, disability by

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percentage. You can really estimate the impact on premiums.

What we don't have today, and perhaps, Representative O'Connor is the better person to answer this, but what we don't have today, I think, is as good a system for regulating the setting for premiums as we could have, if this Bill passes.

And, you know, unfortunately, last year, the former Governor vetoed an attempt like this to begin the process of getting these premiums under control. Had that Bill not been vetoed, today, we'd know a lot more than we currently know about what, if anything, we can do to affect premiums.

All the experts seem to agree, even caps will not reduce premiums. We're only talking about what changes we can make that might impact the future rates of increase.

I think everyone agrees, this would affect, in a good way, the future rates of increase, in other words, have lower rates in the future than they might otherwise be.

And I think, given where we are in the Session, given what happened last year, it might be better to

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try this. And next year, when we're in this discussion, we'll know a lot more than we do today. I think that's the hope here.

But, no, there are no exact estimates of what this will do, nor are there exact estimates of what caps will do, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. Through you, I would ask the proponent direct his attention to Lines 284 to 290. This language deals with an offer of compromise on behalf of the defendant and a failure by the plaintiff to accept the compromise.

The sanction, if you will, if the compromise appears by the experience, as the litigation goes forward, to have been a reasonable one, the sanction is that the plaintiff shall recover no costs. Those words, no costs, appear in Line 286.

Through you, Mr. Speaker, would the proponent expand on those words somewhat and give us an idea of what those costs may amount to? Through you, Mr. Speaker.

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SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I think that refers to the interest, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Through you, Mr. Speaker, that would refer to the 8% interest that, under this language, under this legislation, would accrue to the point of claim. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Yes, the current rate of interest in these offers of judgment is 12%. This Bill would reduce the rate of interest to 8%, what we would now be characterizing as an offer of compromise rather than offer of judgment. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

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SPEAKER AMANN:

Representative Hetherington.

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REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. Then if we might proceed to Line 290, which refers to the costs, including attorneys' fees, not to exceed \$350. Through you, Mr. Speaker, would the proponent say that \$350 is not an unusual hourly rate for an attorney? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Well, not in East Haven, Mr. Speaker, but perhaps in some places, somewhere, they bill \$350 an hour. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Through you, Mr. Speaker, what would you estimate, what would the proponent estimate to be the hourly rate for an attorney, an experienced trial attorney who might be handling a complex malpractice claim? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

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REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I, well, first of all, these claims are handled on a contingency-fee basis, almost without exception. What those lawyers might otherwise charge in other cases on an hourly basis is a matter of pure speculation on my part.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. Through you, but I would just suggest to the proponent that the language in 290, those attorney fees are the attorney fees of the defendant's counsel. So those would be hourly rates.

And I would just, having clarified that, I would ask the proponent if he might have an estimate of an experienced trial counsel's hourly rate in handling a complex medical malpractice claim on behalf of the defendant. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I really don't know the answer to that question. It would be in the several

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hundreds of dollars an hour range. I guess that would depend on the situation, through you, Mr. Speaker.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. And if I may, through you, once again, so is it fair to say that what the plaintiff, the sanction upon the plaintiff for refusing what turns out to be a reasonable offer of settlement would involve attorneys fees involving approximately one hour of work by the defendant's counsel. Is that accurate, through you, Mr. Speaker?

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you. Thank you, Mr. Speaker. I think the real penalty is if you guess, if you refuse to accept a reasonable offer, you are missing out on the potential of, obviously, getting the immediate money and the possibility that if things had been different, you could have recovered. I guess I can't answer your question, through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. And I thank, I thank the proponent for his answers. I would simply comment that I think this Bill does not address effectively the problem we have.

That is not to say that I do not appreciate, and fully respect, and applaud the dedication and the skill that the proponent and others have brought to this legislation.

And I believe that everyone who has participated in this, certainly those that I had the privilege to work with in the Working Group, certainly worked on this in good faith. And I believe, without any reservation, that the proponent and others approached this as a genuine effort to remedy the situation that we have.

Nevertheless, this Bill does not remedy that situation. It does not remedy the situation because it assumes that the escalating premiums are a regulatory failure rather than a product of the marketplace.

If the amount of money flows out of the system unrestrained, that we see in the escalating jury verdicts in medical malpractice cases and the

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escalating settlements, there is no alternative, but for the premiums to increase.

You can have all the complicated regulations, regulatory supervision that we might imagine, but none of those are going to beat the market forces, which are going to continue to drive premiums higher and higher.

I associate with, my comments with those of Representative Truglia who has worked long and hard, and with remarkable dedication on this subject. We are losing doctors rapidly in this state. We are particularly losing the critical skills. We are losing doctors in the critical specialties.

We are losing, I know personally, the services of women who wanted to practice and at the same time, raise a family. But they cannot do that because there is no way of part-time medical malpractice coverage.

We are also risking the loss, the catastrophic loss of those organizations, that without profit, provide services to particularly our inner-city needy through clinics, whose medical malpractice premiums to increase. They receive no income.

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What they do is operate with retired physicians, and they provide a first line of care. Mr. Speaker, I would suggest that just as we went through the offer of compromise by the defendant, there is nothing in this Bill that encourages a reasonable settlement.

The sanctions upon rejecting a reasonable settlement are virtually nil, one hour of a lawyer's time plus, in fees.

And I'm glad to see this established, but for legislative history, it appears that the cost on failure to accept a reasonable compromise will be the loss of interest by the plaintiff.

I do not mean to suggest that the victims of medical malpractice are not suffering. I do not, for a moment, suggest that they should be reasonably compromised, compensated. Excuse me. That was an unfortunate choice of words. I got up too, went to bed too early, too late rather.

But the fact remains, we are losing an opportunity for affordable and accessible healthcare. We are losing the doctors. We are losing those who are our first line in the cause of healing.

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And I would suggest, and I don't mean to be flip, but I'll just conclude my comments by saying that if we continue on the path we are going, the best advice we can give our constituents is, the next time you get sick, call your lawyer. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Boucher.

REP. BOUCHER: (143rd)

Thank you, Mr. Speaker. Mr. Speaker, I wish I could rise in support of this Bill, but, unfortunately, I don't think I can do it at this time. Although, we've just recovered recently from a pretty difficult financial time, we had a budget crisis. We've also had a situation where our medical community has been in crisis as well.

And I have testified on this issue every time this Bill has been discussed in Committee because access to quality medical care is something that is becoming increasingly an issue to the people in my community.

The doctors are struggling to maintain their medical practices because the financial burden of the

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excessive premiums for liability insurance have jumped quite substantially, up to \$100,000, in some professions, even as high as \$400,000 in very high-risk specialties.

You know, even the wonderful doctors in the medical community, groups that I belong to, a number of them have left the profession prematurely and have even encouraged their own children, who have gotten medical degrees, to not practice in this state.

And we have talked about quite a bit of the specialty of pediatrics and ob-gyn, an area that is at great risk because an individual can bring a suit up to the age of 21 for a birth that may not have been perceived as problematic early on. So they might not even know what kind of exposure they have for quite a long period of time.

But for me, this issue has become and became personal within my own family because a couple of years ago, on the very last day of Session, I got a phone call from our local hospital that my husband was admitted in excruciating pain.

It became not a simple matter, not a vast problem, but it ended up becoming a diagnosis that

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there was a tumor intertwined in the base of his spine. And it was one of the rarest, most difficult operations to perform and has since been documented in the medical journals in this state.

Nationally, it's very rare as well. I think there are only four or five operations like this conducted. That very doctor, that neurosurgeon that performed that operation, if you asked him today, he would have turned down this operation.

And my husband would have had to go elsewhere because he could not assure, and it was true, that there was not going to be some damage in this process. And even though you might say at the beginning, well, we'll take that risk.

We have to do it. We have to save the person's life. Afterwards, after the person has difficulty walking or has numbness in his body, they could bring a lawsuit and probably get quite a big award.

In fact, I was called for jury duty just in the last year a couple of times. And sitting there, awaiting to be called, it was one lawsuit after another that was on the docket. It was a medical

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malpractice lawsuit right here in Fairfield County and Stamford.

But that very doctor that saved my husband's life, today, is at risk for losing his own practice because he cannot afford a nearly \$400,000 premium, so much so that the hospital has to consider underwriting this, and not because he's had a lot of cases where there have been problems.

So it is not just the ob-gyn that is reluctant now to perform birth, but it's also other high-specialty areas that have become problematic. There are areas of law in this state that are different from other states.

That 12% penalty, that doesn't exist in a lot of places. It's another burden placed on the insurance carriers. And, in fact, if it were the insurance carriers that were at fault here, then why have we lost so many? Because they do where there is a profit to be made.

In fact, they're not a nonprofit. They're in the business of making a profit. So Connecticut has become a difficult place for insurers. We seem to have an aversion in addressing the issue of caps when,

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in fact, other states, the largest state in the country, and the fifth largest economy in the world, California, has had a cap since the '70s.

They also have oversight on insurance premiums through their Insurance Department. So there are a lot of ways to look at this, many different perspectives.

I wish this Bill addressed a lot of those because there's been a lot of work on this, and I commend the individuals that work very hard on this, particularly Representative Fritz.

I understand that they're trying hard to make improvements in the system. But from what I can see, the improvements did not go far enough, enough for me to be able to support it because I am really concerned.

I am concerned for other individuals that have to face the very problems that we have had to face in our family. And their doctor looks at them and says, I can't take that case, or they might not even say it, but they're thinking it.

Because right now, our doctor says that every time a patient walks in his office, he has to assess

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whether that one case will put him out of business.

That's a terrible position to be put in.

So I'm afraid that I will not be able to support this Bill, although I would really want to and again, I commend all the efforts being put into it. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Representative Fritz.

REP. FRITZ: (90th)

Thank you, Mr. Speaker. I'm speaking for the second time. I believe it's important for me to go on the record and to correct some of the statements that have been made.

What I have before me is a chart from the Connecticut Department of Public Health License and Renewal Master Analysis.

I'd like to share with you the numbers, with regard to the number of doctors in the State of Connecticut. And contrary to what has been portrayed here today, that the number of doctors is dropping, let me read to you the numbers, if I may.

On January 8, 2004 in the State of Connecticut, there was 11,460 doctors. On April 10, 2005, there

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were 12,318 doctors. I would submit to you this is a significant increase.

We hear over and over again about the OB-GYNs, our favorite primary doctors for the women. Thank God. We hear how they're only practicing GYN now as opposed to obstetrics.

But Dr. Galvin, the Commissioner of the Department of Public Health made a very telling statement when he testified before the Insurance Commission, or Committee, on this very issue, when he talked about the OB-GYNs who were moving into just the gynecology, because after 20, 25 years, they were tired of getting up in the middle of the night and it was time for the younger people in the practice to do that routine.

Also, he talked about how people assume that the OB-GYNs or other doctors are leaving the State of Connecticut because of malpractice insurance, etc. But he said, let's realize it folks, they're leaving for warmer climates. They are getting older.

As many of our citizens in Connecticut do, they move to Arizona, they move to Florida, they move to the Carolinas. It's a comfort thing.

And yet, you know what? They still keep their Connecticut licenses. And that's another whole group of numbers that we have from the Department of Public Health.

Also, you should know, in that same time frame from 1/8/2004, OB-GYNs, there were 653 in 2004. Excuse me, there were 665 and in April 10, 2005, there were 671. So in this area, again, we are increasing.

Somewhere out there, there's a message being given, but it's not accurate, and I want the record to show what the Department of Public Health has given us for statistics. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you. Representative Alberts.

REP. ALBERTS: (50th)

Thank you, Mr. Speaker. Like many of my colleagues from both sides of the aisle, I share the concerns with the language in this Amendment. I understand the statistics that have just been provided to us by our Deputy Speaker and I believe them to be accurate.

My concern, however, with the number of doctors practicing, is actually the distribution of those

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physicians throughout Connecticut. In Windham County, we have two regional hospitals, Windham Hospital of Willimantic, Day Kimball Hospital of Putnam.

What I'm hearing from the administrators, the staff of those hospitals, is that they are having a hard time recruiting physicians to come in and practice. Retention is down. Perhaps the desire to leave for a warmer climate is part of that process.

I surely don't know the answer to this very complicated question, but I feel that this Amendment is somewhat like the proverbial thumb in the dike. It provides us some time.

Hopefully, it will last for us to make some resolving change in the way we deal with medical malpractice insurance rates in the state and can go forward. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Sir. Will you remark further?

Representative Fahrbach.

REP. FAHRBACH: (61st)

Thank you, Mr. Speaker. I've been having a difficult time deciding whether I'm going to support this legislation or not.

I guess, as one of the Members of our Caucus said, doing something is better than doing nothing. But this is almost nothing.

We really need to address the concerns of the Medical Society and the doctors in the state regarding caps on non-economic damages.

And I say that because, 19 years ago when I was campaigning, that was an issue that I had discussed with doctors in this state.

And 19 years ago, I put in legislation to address malpractice concerns and to put a \$250,000 cap on non-economic damages. Here we are 19 years later and we really haven't addressed the problem.

As far as OB-GYNs are concerned, the major problem that they have is new technology that has brought about births of children, babies that previously could not have been born.

They are born low birth rate. They are born with birth defects and the families of those infants want money to sustain those children for the rest of their lives. That's understandable.

But in the meantime, what we're doing is, we're putting doctors out of business and it's important for

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us to be concerned about those doctors and make sure that we have them available to us in the future.

Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I just wanted to request that when the vote is taken, it be taken by Roll.

SPEAKER AMANN:

The question before the Chamber is on a Roll Call Vote. All those in favor of a Roll Call Vote please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER AMANN:

The requisite 20% has been met. When the vote is taken, it will be taken by Roll. Will you remark further? Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Madam Speaker. I apologize, Mr. Speaker. Thank you, Mr. Speaker. I rise to pose a couple of questions to the proponent of the Amendment.

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SPEAKER AMANN:

Please frame your question, Sir.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. Mr. Speaker, in Section 1 with regard to the contingent fee agreements, starting in Line 30, it reads, or it elicits some of the reasons why the standard contingent fee agreement may be waived.

Through you, Mr. Speaker, it would appear to me, and I'm not a plaintiff's attorney who does med mal, but that med mal cases by their nature are complex and unique.

And through you, Mr. Speaker, if the proponent of the Amendment could just explain how a court would arrive at a decision to waive the standard contingency fee agreement. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Well, the importance is that the change from the current rules governing such an agreement between an attorney and a client.

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Under this proposal, for the first time we are writing into the law, very clear and actually very strict standards, which would govern such an agreement.

We made it clear that for one thing, under no circumstances shall the fee ever be in excess of 33-1/3% although theoretically that's possible now. And we've also indicated that if it's going to exceed the established statutory guidelines, which I could go over if it were necessary, but for different increments of the recovery, there's different percentages allowed.

This would make it clear that in the aftermath of the settling of such a claim or the winning of a case in an actual trial, that the fee could not actually be paid unless these criteria had been met and that would be the obligation of the court to sort of oversee it.

So there are no standards written into law at the moment governing these types of agreements. For the first time we'd be writing in these relatively strict standards and it would have to be demonstrated that this was an unusually complex case compared to other medical malpractice cases.

So as the Representative stated, generally speaking, all medical malpractice cases are complicated, but this would require a showing that this is more complicated than the typical medical malpractice case according to the standards outlined in the Bill.

So I think it's a rather strict rule, which would govern such agreements, and I think it's fair to say judges would take these very seriously. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, do we have a procedure that is similar to this in other areas of the law? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Depending on the exact situation, obviously we have different rules governing different types of agreements between lawyers and clients.

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These are governed in general by the tort reform rules and some of the ethical rules imposed on attorneys with regard to the fee agreements they can have with their clients.

Depending on the situation there are different rules, but I think it's fair to say that these, if adopted, these would be the strictest rules governing exceeding the guidelines established for fee agreements. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

Through you, Mr. Speaker, and currently, we have a sliding scale that governs the contingency fees that are allowed in our current law.

Through you, Mr. Speaker, is there a cap on the fee agreement, even with these, even with these considerations that the court would have to go through to waive the standard contingency fee?

Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

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Thank you, Mr. Speaker. Through you, yes, the cap would be one-third or 33-1/3% in total. Through you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. Through you, Mr. Speaker, in Section 2 it goes through the expert statement that is required in order to bring a medical case.

Through you, Mr. Speaker, is this statement required to be provided by a provider in the same field as the field that the defendant practices? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Yes.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

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And through you, Mr. Speaker, there's also an explicit prohibition that this statement is not subject to discovery. Through you, Mr. Speaker, why was that provision included in this?

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. Well, let's just explain precisely what the procedure is that this Bill would establish. I mean, already, there's a procedure for a good faith certificate.

This is making it a considerably more significant a hurdle to overcome in order to file a medical malpractice case.

The entirety of the decision would be attached to the complaint with the name and address of the physician providing the decision would be expunged for the purpose of the claim. But the entire decision would be there, or the entire opinion would be there attached to the complaint.

Typically, once a medical malpractice case is filed, there are disclosures which are made subsequently and obviously, one of those disclosures

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is, who will be the expert testifying on behalf of the plaintiff indicating that in fact there was medical malpractice involved.

That, the identity of that person would be discoverable and would be certainly, I mean the person would be known if it ever came to a trial and that person testified. So we're talking about this sort of threshold opinion that in fact this is medical malpractice.

Then if this were the expert whom the plaintiff intended to call as the expert in the actual case in the trial, then that would be disclosed.

But this is for this initial benchmark of actually filing the claim and I think it's fair to say that physicians would be reluctant to render an opinion that another physician had in fact engaged in malpractice, for reasons I guess would be understandable.

That would be the likelihood that there would be some backlash against that physician from other physicians when it comes to referrals, etc.

So we're not saying that the physician who will ultimately testify at the trial as the expert would

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remain a secret, just this initial showing this good faith certificate. It's the identity of the particular physician who writes that which would be withheld from public disclosure, at least. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

And through you, Mr. Speaker, is it usually the case that the expert who provides the initial opinion will be the expert that's used at trial? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. First of all, through you, I am not personally an expert on medical malpractice cases and their procedures, but I do believe it's fair to say that more often than not, if it comes to trial, that the expert who gave the initial opinion would probably end up being the expert who would testify at trial.

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Sometimes there's more than one expert retained by the plaintiffs. That is all fully discoverable once the case has been initiated. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. In Section 10, there's a provision in here that allows for judicial review of a judgment, and it gives certain reasons why a judgment could be set aside or remitted.

Through you, Mr. Speaker, do we have a provision in our statutes currently that is similar to this? Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. The standards themselves, as far as I know, are not written into the statutes. However, these particular standards are the standards which judges do apply when they consider whether or not to reduce a verdict rendered by a jury with regard to damages.

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These, of course, evolve over time as a matter of common law or case law, reviewed subsequently by Appellate Courts. So these are the existing standards.

What's different about this language is, there will be a requirement that judges conduct such a, a review of this nature is discretionary on the part of a judge.

However, this will make it mandatory if the amount of the non-economic damages exceeds \$1 million in a particular case. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. And, Mr. Speaker, I'm not sure if Representative Lawlor would be the appropriate person to direct this question to, but in Sections 11 and 14, there are provisions to order the Department of Insurance to do certain things.

Through you, Mr. Speaker, is the money in the budget that was adopted in order to fund these things that the Insurance Department is going to be required to do? Through you, Mr. Speaker.

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SPEAKER AMANN:

Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I would defer to the Chairman of the Insurance Committee, Representative O'Connor.

SPEAKER AMANN:

Representative Hamzy, would you like to redirect the question, Sir to Representative O'Connor? Representative O'Connor, please prepare yourself, Sir. You may proceed, Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. Mr. Speaker, through you to the distinguished Chairman of the Insurance Committee. In Sections 11 and 14, the Bill, or the Amendment, directs the Insurance Department to perform certain tasks.

And I was wondering if the money is in the budget that was adopted, to allow the Insurance Department to complete these tasks?

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

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Through you, Mr. Speaker, it's my understanding it is not, but that the carriers, there could be an assessment charge to the insurance carriers to make up that difference, but it is not in the budget as we passed the other day. Through you, Mr. Speaker.

SPEAKER AMANN:

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. And through you, how many insurance carriers do we have that write malpractice, medical malpractice insurance in our state?

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Through you, Mr. Speaker, there are two that are active in the market, and there's also another company that was just bought by an outside company that may practice.

We'll have to wait until July 1st to find out if they're going to continue to operate in the State of Connecticut. Through you, Mr. Speaker.

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Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. And I thank the Chairman of the Insurance Committee and the Chairman of the Judiciary Committee for the answers that have been provided.

Mr. Speaker and Members of the Assembly, there are a couple of things in here that I think serve the purpose of reforming our medical malpractice laws. But for the most part, what this Bill requires us to do in the Insurance Department and the Public Health Department, is collect data.

And the collection of data, I don't, while I think it would be helpful, I don't think serves the ultimate purpose of reducing professional liability insurance rates, which is what the assumed goal was of this General Assembly.

I believe that this is a good start, but I don't believe it achieves the ultimate goal. It does not have the support of the group of people that this is intended to help and for those reasons, and others, I would urge rejection of the Amendment.

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Will you remark further? Will you remark further? Representative Hamzy, would you remark further, Sir? Thank you, Sir. Representative Lawlor? I'm sorry. The Chamber will stand at ease.

(CHAMBER AT EASE)

Will you remark further? Would you care to remark further on the Amendment before us? Would you care to remark further on the Amendment before us?

If not, let me try your minds. Oh, excuse me, it's a Roll Call. You're right. I'm a little tired. Thank you, everybody. Keep the Speaker awake.

CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber. The House is voting Senate Amendment Schedule "A" by Roll Call. Members to the Chamber.

SPEAKER AMANN:

Have all the Members voted? Have all the Members voted? If all the Members have voted, please check the board to make sure that your vote has been properly cast.

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If all the Members have voted, the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

CLERK:

Senate Amendment Schedule "A" for Senate Bill

Number 1052.

Total Number Voting	148
Necessary for Adoption	75
Those voting Yea	103
Those voting Nay	45
Those absent and not voting	3

SPEAKER AMANN:

The Amendment is adopted. Will you remark further on the Bill as amended? Will you remark further on the Bill as amended? Representative Sayers.

REP. SAYERS: (60th)

Thank you, Mr. Speaker. Mr. Speaker, the Clerk has on his desk an Amendment, LCO Number 7847. I ask that he call it and I receive permission to summarize.

SPEAKER AMANN:

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Will the Clerk please call LCO Number 7847, which will be designated House Amendment, excuse me, previously designated Senate Amendment "B".

CLERK:

LCO Number 7847, Senate "B", offered by Senator Murphy and Representative Sayers.

SPEAKER AMANN:

The Representative seeks leave of the Chamber to summarize the Amendment. Is there objection on summarization? Is there objection? Can you hear me? Can you hear me now? Still can't hear me. Will you adjust my mike, Sir? Thank you.

Hear me now, Representative? Thank you, Madam. You may proceed with summarization, Madam.

REP. SAYERS: (60th)

Thank you, Mr. Speaker. This Amendment clarifies the language for the guidelines the Department of Public Health must set.

It changes the information that can be collected when conducting an investigation or expanding an investigation to include such things as patients' records.

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It removes Section 22, which is the filing and tracking of petitions, including their outcomes and eliminates the fiscal note.

It removes the requirement that the physician's insurance never be included with the information that is included on the web site. I move adoption.

SPEAKER AMANN:

The question is on adoption. Will you remark? Will you remark? If not, let me try your minds. All in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER AMANN:

All opposed, Nay. The Ayes have it and the Amendment is adopted. Will you remark further on the Bill as amended? Will you remark further on the Bill as amended? Representative Ward.

REP. WARD: (86th)

Yes, Mr. Speaker. Mr. Speaker, one of my disappointments in this Bill is that it does nothing to address the maximum award that can be received when a tort claim is brought for medical malpractice, although the Governor in proposing a bill, indicated

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she was prepared to support a bill that didn't contain medical malpractice caps, she did so saying she was looking for a bill that was substantial and would significantly affect premium increases without caps.

Unfortunately, in my opinion, the Bill before us doesn't accomplish that without caps, and therefore, I would ask the Clerk to please call LCO Number 7932 and I be permitted to summarize.

SPEAKER AMANN:

Will the Clerk please call LCO Number 7932, which will be designated House Amendment Schedule "A".

CLERK:

LCO Number 7932, House "A" offered by
Representative Ward.

SPEAKER AMANN:

The Representative seeks leave of the Chamber to summarize. Is there objection to summarization? Is there objection? If not, Sir, you may proceed with summarization.

REP. WARD: (86th)

Thank you, Mr. Speaker. Members of the Chamber, what this Amendment does is what's commonly known as a caps amendment. It limits the amount of non-economic

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damages that will be allowed a claimant in a medical malpractice case to the following limits.

If an action is brought against a medical provider, a physician, if you will, there is a limit of \$500,000 per claimant.

If a claim is made against a healthcare institution, for example a hospital, there is a limit of \$1 million. And I move adoption of the Amendment, Mr. Speaker.

SPEAKER AMANN:

The question is on adoption. Will you remark, Sir?

REP. WARD: (86th)

Yes, Mr. Speaker. Mr. Speaker, as I indicated, speaking on House "A", I do not believe that the Bill before us does enough to deal with what is a serious crisis in the State of Connecticut.

There's not only a serious crisis in Connecticut, but across the country. Many states have been willing to put a limit on non-economic damages as a result of medical malpractice.

I believe the most recent may be the State of Illinois where it had been opposed for a long time by

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members of the General Assembly and their crisis got bad enough that they worked together and came up with a cap amendment.

I believe this Amendment before us will help alleviate substantial rate increases and I believe it is fair and just.

I say that because I think the pure tort system that we use that is unlimited, is not serving us well with regard to medical malpractice, is resulting in extremely high premiums that will, in fact, and is, in fact, driving, particularly in some specialty areas, physicians to leave certain specialty practices.

It also adds substantially to all of the costs of healthcare. The cost of healthcare is something we've all said we should do something about as a General Assembly but then often throw up our hands and say, well, how do we do that? How can we possibly address the cost of healthcare.

This is one Amendment that does address, in I believe a not insignificant way, the cost of healthcare.

I would urge the Members to support this Amendment, limit non-economic damages awards to

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\$500,000 in a suit brought against a physician and \$1 million in a suit brought against a hospital.

Put some predictability into the system. It will be much easier to control costs. It will help keep doctors in the State of Connecticut providing needed medical care to our citizens. Mr. Speaker, I would request when the vote is taken on this Amendment, that it be by Roll Call.

SPEAKER AMANN:

The question before the Chamber is on a Roll Call Vote. Those in favor of a Roll Call Vote please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER AMANN:

The requisite 20% has been met. When the vote is taken, it will be taken by Roll. Will you remark? Will you remark? Representative Lawlor.

REP. LAWLOR: (99th)

Thank you, Mr. Speaker. I rise in opposition to the Amendment, and I want to basically make two brief arguments in opposition.

First, process. It's twenty of three on the final day of the Legislative Session. We've got just more than, just over nine hours to go.

If this Amendment were to be adopted, for anything to actually become law, it would have to be taken up and approved in the Senate. And I think, we're all politicians here. We understand how this would work, and the odds that anything would happen this year would be very long indeed.

So, last year's attempt to reach a compromise and get things moving in the right direction was scuttled by a gubernatorial veto.

In effect, I think adoption of this Amendment right now would be a type of legislative veto, although it's certainly within our prerogative to do it, just as it was in the former Governor's prerogative to veto last year's attempt.

And you know, I think I've become something of an expert this year on this, the wisdom of all or nothing strategies.

And you know, sometimes we can't get everything we want, and sometimes it's important to take one step at a time, and I think all that the Bill attempts to

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do this year is to require everybody to make some sacrifice, the lawyers, the doctors and the insurance industry, and see if we can make some additional progress on the topic of bringing the increase in rates for medical malpractice under control.

Now to the substance. On the substance of this, it's a very interesting dilemma because not once, and I've certainly been a party to plenty of public hearings over the last few years and plenty of private meetings discussing this topic, but not once has any insurance company ever said that if any cap is adopted, regardless of the amount. First it was \$250,000, now apparently \$500,000.

No one's ever said that if we adopt a cap they will cut premiums for doctors. And if you're like me and you've spoken to many doctors throughout the state, that's what they're asking for. Do something that will cut our premiums.

And I say, well, I don't agree for reasons of justice, with arbitrary caps. But I want you to know, even if we do them, your rates are not coming down. In fact, no one can tell you how it will even impact future rates.

There are predictions that you'd be better off with caps than without them, but no one has quantified that and not a single person has ever said that with a cap, premiums will actually go down to where they were six months ago or a year ago, let alone five or ten years ago.

So that's not happening with or without caps, and that's the nature of the current crisis, right? The premiums are too high. So our goal is to bring premiums down.

But that's not our only goal here, Mr. Speaker. Our other goal here is to insure that justice can be accomplished. If the only thing we needed to do was bring doctors' premiums down, then it might be relatively simple.

For example, the state could directly subsidize premiums and that was in a complicated sort of way, that was one of our goals last year in the bill that was vetoed.

We could do that if that was our only goal. We could get premiums right down over night. In fact, we could pass single payer, single provider, single payer

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insurance system and that would knock it right down immediately.

I don't think they have a medical malpractice crisis in Canada, Mr. Speaker, and I know people disagree about the advisability of that type of medical care system.

But if that was our only goal, we could accomplish it without a lot of complexity. But the one thing we know for sure is, this won't accomplish that. This will not reduce the current premiums. You don't get that.

But what you definitely do get, are arbitrary limits on the amounts that can be recovered by patients who are the victims of what it turns out in some cases is outrageous, outrageous malpractice.

Now, it's important to emphasize that these are few and far between. But when they occur, they certainly lead juries to feel that the amount of non-economic damages needs to be more than, whether it's \$250,000 or \$500,000 or whatever it happens to be.

Sometimes the victims are work at home mothers with young children who have never been employed and are not employable in the future.

In fact, there was one case like this I recall, I may not have all the facts straight, but there was a woman who went in for sort of a routine treatment and her family care provider just stopping in, I think, for some type of an injection or something like that, once in the office had an adverse reaction and died very quickly in front of her children, in front of a number of physicians who happened to be in the practice.

And the cause of her death, apparently, was the absence of emergency medications that are required to be in every single doctor's office in the state.

Clearly, clearly, malpractice. So what are the non-economic damages there? She didn't have a job. She was a stay-at-home mom. The family lost their mother. The husband who could count on his wife to provide day care for the children and do all the other things a mother would do, is suddenly without that.

I don't know what the costs of that really are. I don't think any one of us here wants to be in the position of trying to quantify those. But I think we all agree that there's certainly more than \$500,000 over a lifetime, and that's just one example.

And it is important to emphasize these cases are very few and far between. When they occur, once in a while, they sometimes result in large verdicts. But those are large verdicts determined by juries, so our jury process, that's what justice requires.

And in the Bill we've got without caps, we have the ability for a judge to step in and say, if it's not warranted by the evidence, to ratchet the verdict down. So that's what justice is all about, Mr. Speaker, making decisions on a case-by-case basis.

So the only thing passage of this Amendment would accomplish is to set an arbitrary limit and clearly, there will be cases where everyone in this Chamber would agree that the victim deserved more than the arbitrary \$500,000, but it will be illegal for a jury to award that verdict, and that is a fundamental violation of those words inscribed under, on top of the entrance to the United States Supreme Court, equal justice under law.

All of us have the right to go to court to make our claims. And once in a while, when there's outrageous negligence, outrageous malpractice by a

healthcare provider, just the same way as it would be if it were an engineer or a lawyer or anybody else.

If a professional screws up in an outrageous way, then the compensatory damages ought to be appropriate under the circumstances. So for that reason, Mr. Speaker, I urge rejection of this Amendment.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. I rise in strong support of the Amendment that's being offered, and I just want to address a couple of points.

A couple of the points being that I also realize it's ten of three on the last day of session, and that this Bill was brought up about two and a half hours ago. But we don't make those decisions as to when these bills are brought up.

This obviously is an important Bill to a lot of people in our state, and the fact that it was brought up today is not of our doing.

But we have an opportunity to improve the underlying Bill as amended. We have an opportunity to

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actually solve a crisis that we have in our state with the adoption of this Amendment.

The other thing I want to mention, or reiterate, which our Minority Leader brought up, is the fact that the State of Illinois adopted a cap on non-economic damages. And why is that significant?

It's significant for two reasons. Illinois is the home of Madison County and Madison County is famous for two reasons, the book that was written and the fact that it is the single, best jurisdiction to bring lawsuits by plaintiffs' attorneys.

The other reason why it's significant that Illinois adopt the caps is because it has a Democratic Legislature and a Democratic Governor, who also recognized that part of the solution to medical malpractice premium increases is a reasonable cap on non-economic damages.

It was also mentioned that no insurance company has guaranteed a decrease in professional liability rates if caps were adopted. CEMIC, which is a mutual insurance company for physicians in the state, has made that guarantee.

They have put a proposal before us and said, if adopted, they would immediately reduce their professional liability rates. So that guarantee has been made.

No one has made a guarantee that if the underlying Bill as amended is adopted, would result in significant premium relief.

And just the last two things I'd like to add is that the provision in the Bill as amended that allows a judge to overrule a jury, I don't believe will ever be enforced. Because to ask a judge of this state to overturn a jury verdict, I think is completely unreasonable.

And the last thing I'd like to state, if a physician or other healthcare provider makes a willful mistake or engages in willful misconduct, that provider should be stripped of his or her license to practice in this state. That's the penalty that I believe should be applied to that type of conduct.

And, Mr. Speaker, I would strongly urge the Members of this Legislature to achieve real reform and adopt this Amendment.

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Will you remark further? Will you remark further? Representative Thompson.

REP. THOMPSON: (13th)

Thank you, Mr. Speaker. Mr. Speaker, I had supported caps in the past and I believe in many different ways I support them now.

However, I watched a 60 Minutes show one evening and it was the story of a woman who underwent radical breast surgery and the surgery was based on a review of her files and records and images and so on by a key physician in the process, a woman physician, as a matter of fact.

And she gave the green light for the surgery. There was nothing wrong with her reading of the records and files and so on, except that they weren't those of the patient who was to undergo the radical surgery and she had that surgery, had both breasts removed and changed her life, I guess, forever.

They interviewed the woman and her husband as part of the program. But after the showing of the error, they interviewed a couple of other people and one of them was the Congressman from the Midwest who had introduced in Congress a cap of \$250,000 and they

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asked him for his reaction to the cap and the effect it had on this family and so on.

And he said, it just doesn't make sense to him, it didn't make sense to him, and that he would, you know, couldn't put a price on it, \$12 million, \$25 million, or whatever. He said nothing will ever compensate that woman and her family for this error.

They also interviewed the director of the hospital and she said that they had taken no formal disciplinary action against the physician who made the wrong call based on that information.

She had an exemplary record for 15 years or so in that work, but however, what they were doing was to change the protocol for decisions of that magnitude.

And I think she mentioned this was a couple of years ago, but I think she mentioned that there would be a committee of 23 that would interview, that would review all the facts before that type of surgery or other surgery of that magnitude was taken in the future.

And they interviewed the doctor who made the wrong call and she was just heartbroken. I mean, it was a mistake. It wasn't her mistake in one sense.

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I'm not sure what you do in a case like that, you go back and check each step along the way. Apparently, that's what they decided to do.

But what I'm getting at is that I'm frustrated by our progress in this area and I think having caps or passing the Amendment would run into the problem we have of last day high jinks on getting legislation through.

But nevertheless, I do think there was some refreshing movement in the way of piking up some of the practices within our system so that lawyers are giving somewhat under the underlying Bill as amended, so I'm going to support the Bill as amended.

I will not support the Amendment, but my heart is tortured by this decision because in my own family life I know of a doctor and gynecologist who probably is in her fifties who notified us recently that she was leaving her practice and I think that's repeated.

But somewhere along the line, we all have to sit down and go with what we have and I think the underlying Bill as amended makes some sense and some movement in that direction.

So I hope that the non-economic damages and the caps and that whole milieu is out there and will be continued to be studied and will make some further progress.

But I think the caps at this time probably will not go and I don't think it should discourage us that we will not be making progress in the future on this. It's a very serious problem and I've seen it firsthand and I hope that we can make some progress. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Powers.

REP. POWERS: (151st)

Thank you, Mr. Speaker. I rise in strong support of the Amendment before us. We all know that to tackle this particular issue of medical malpractice premiums and the cost and the docs checking out of the state, it's not a one solution pie. You've got to have a lot of different pieces in the pie.

This is a very, very important piece that is not in the underlying Bill or pie. Other states have done

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this. They have seen good, positive results in terms of future increases.

We really need to get a handle on this. There's nothing in the underlying Bill as amended that does that. This is the one Amendment that makes that kind of difference.

We have to remember that we all represent patients, because they're our constituents, and our constituents, the patients, are dealing with the cost of the docs, the cost of insurance, the availability of the docs, and the availability of clinics.

And this is the single Amendment that will fix the underlying Bill as amended that will make that change. So I urge everyone to support this Amendment. This will really make the difference in the Bill. Thank you, Mr. Speaker.

SPEAKER AMANN:

Thank you, Madam. Will you remark further? Will you remark further on the Bill before us?

Representative Spallone.

REP. SPALLONE: (36th)

Thank you, Mr. Speaker. Mr. Speaker, I rise briefly in opposition to this Amendment, as I did last

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year. I think Representative Thompson's remarks emphasized and provided an example of how each case that comes before the courts of the state is different.

Creating or obtaining substantial justice in each case varies by the facts of that case, and that arbitrary caps on damages do not recognize the uniqueness of each person's case and injuries.

We put a great faith in juries in our system of justice. We have been doing so for centuries. We enshrine a jury trial in civil matters in our State and Federal Constitution and we need to maintain that faith in order to reach justice in these cases.

Finally, Mr. Speaker, the underlying issue is about rate setting and trying to get premium relief to physicians who need it and I do not think that enough emphasis has been placed on that. There are ways to provide relief and this is not the most effective or fair means to do it. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further on the Amendment before us? Representative Noujaim.

REP. NOUJAIM: (74th)

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Thank you, Mr. Speaker. Mr. Speaker, I would love to have a solution for this problem in my back pocket. As a matter of fact, Mr. Speaker, I would love to have some genie come up from a bottle and give us a solution for this problem.

I've been here four years, Mr. Speaker, and there is 151 of us here and 36 upstairs and it seems to me that this problem never goes away. Every year we discuss it and the same thing happens and we never come with a solution that will be satisfactory to everybody.

Mr. Speaker, the proponent of the Amendment said that it was 2:45 o'clock p.m. in the afternoon and we only have about nine hours to go. Well, we've been here since January 8th, and it's about six months to the day and we have not really come up with a solution for this problem.

Last year, I remember there was a bill that was important at 11:30 o'clock p.m., 30 minutes before we adjourned. It was amended here. It was sent upstairs and it came back down. It was voted upon and voted upon before midnight.

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We still have time. It is now five minutes after three. We still have eight hours and 55 minutes to act upon this issue and act upon this issue to be of a satisfactory nature.

Mr. Speaker, I have a friend of mine in Waterbury who is an OB-GYN. He is 56 years old, 56 years old and still in the prime of his life and in the prime of his practice.

He is abandoning his practice because the rate of his insurance is \$186,000 a year, the rate of his premium. How many of us can pay a premium that is \$186,000? Limiting the caps will be a reason to reduce premiums. It has already been proven.

I am looking at this Bill, Mr. Speaker, and there are 13 Amendments to the Bill and the Bill itself and I don't think any of those Amendments, neither the Bill, would give us any reduction or relief in premium, will not make the doctors happy, will not make them continue to be here and remain in Connecticut and practice in Connecticut.

We are losing them and we are losing them fast because they can no longer afford the premium of the practice that they pay.

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What else do we do? We need to do something, and this Amendment will afford us the opportunity to negotiate with insurance companies to reduce premiums on doctors so that they can stay in Connecticut.

I read a report about two weeks ago that said in about 15 years we lose the fact that there will be no OB-GYNs remaining here in Connecticut and that will be a problem.

That will be a problem for ladies who are going to be delivered, for hospitals that will have shortages and for young people who want to join this practice and cannot afford it.

Therefore, Mr. Speaker, it is time for us to put our money where our mouth is and vote for this Amendment and get to conclusion on this Bill and make sure that we get relief to doctors so that they will remain active in their practice.

I strongly, strongly, urge my colleagues to put, to put their differences aside and vote in support of this Amendment. It is not time for partisan politics. It is time for reason. We only have about nine hours to go and we need to start thinking about reason.

Thank you, Mr. Speaker.

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SPEAKER AMANN:

Thank you, Sir. Would you care to remark further? Representative Fritz.

REP. FRITZ: (90th)

Mr. Speaker, I stand in strong opposition to this Amendment, not only for the reasons that Representative Lawlor stated with regard to what happens to the women who don't have a career, don't have a huge job, who cannot be compensated for economic damages. Their only area of relief will be in non-economic damages.

And also, I am quite concerned about what's being promoted today with regard to what caps being the end all and the be all of reducing, or at least stabilizing premiums.

Before me I have an OLR report from 2003, which states about some of the states that have caps and what their premium increases were. The State of Virginia went up 101% with regard to their increase in premiums.

The State of Mississippi went up 43%. New Mexico went up 42%. Texas, 22%. Ohio, 34%. Florida, 43%. Indiana, 29%, and Montana, 19%, just to name a few.

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So if you think caps are going to do it, I think you're sorely mistaken. Even California, which instituted the caps in 1979 has had significant increases in their premiums over the years.

The only thing they were able to do for a very short period of time was to stabilize rates because they have an elected insurance commissioner, number one.

And number two, they have given their commissioner the power. That's what I had suggested early on and it was turned aside and dismissed out of hand. So, Mr. Speaker, I suggest that all of the Members of the Chamber defeat this Amendment.

SPEAKER AMANN:

Thank you, Madam. Will you remark further?
Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker, and good afternoon to you. Mr. Speaker, I rise in strong support of this Amendment.

Being on the Insurance and Real Estate Committee for the past few years, this issue has been before us over and over again. And when you sit on that

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Committee, you're dealing with the doctors, you see their faces, you hear their stories.

And ladies and gentlemen, we are in a crisis here in the State of Connecticut and I do believe that this Amendment will help address that crisis.

We had doctors, Mr. Speaker, that came before our Committee that were working part-time. They no longer will do that because they can't afford to because of their insurance rates.

We've had young doctors come before the Insurance Committee that announced that they were leaving the State of Connecticut because they couldn't afford to live here and do business in this state. These are real stories. We met these people, Mr. Speaker.

We also had doctors in the prime of their life that came before the Committee that announced that they were retiring because they just couldn't put up with it any more, trying to meet and have their ends meet, running their office and trying to pay these high premiums. It just didn't make sense for them any more.

And we have doctors that are coming out of medical school that will not look at the State of

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Connecticut because they know that their future wouldn't be bright in the State of Connecticut, and that's an awful loss for all of us in here.

Each and every one of us in here has a doctor. We thank God that we do have these doctors, because when a family member is ill or when we're ill, the first thing that we turn to is our doctors.

But we're not doing anything to help these doctors and I can't understand why we're not doing that.

Ladies and gentlemen, how would you like to have two companies only that provide auto insurance. Or only two companies that provide homeowners insurance and they tell you, this is the rate. Pay it. What would you do then? That's what these doctors and physicians are faced with. It's a real dilemma.

The underlying Bill, I know it's been worked on over and over again. It was before the General Assembly last year. It has not provided any relief. Doctors need immediate relief, and unfortunately, caps are the only thing that could provide that immediate relief.

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So I urge you please, to really to search within yourself. I'm sure you have physicians that have called you on this issue. Let's do something this year that could provide some immediate relief for them.

I don't think it's fair that they only have two insurance carriers that they can turn to. We certainly wouldn't like that if that was in our case.

And the only way to help these doctors is to make the state more attractive for insurance carriers, and I believe by passing this Amendment, we will open up the gate and finally have more insurance companies coming into the state. We'll have more competition. More competition means better rates. It's a no-brainer, in my judgment.

So I urge my colleagues to please look at this Amendment and to adopt it. Thank you.

SPEAKER AMANN:

Thank you, Sir. Will you remark further on the Amendment before us? Representative Cafero.

REP. CAFERO: (142nd)

Thank you, Mr. Speaker. Mr. Speaker, every day there are thousands, literally thousands of people, unfortunately, that get hurt at work.

And they get hurt at work sometimes due to the negligence of their employer. They are not allowed to bring their case against their employer to the court system. They are not allowed to seek non-economic damages.

The reason we deprive them of that right is because we have created a system known as Workers' Compensation. It was a system created, quite frankly, because we were facing a crisis many, many years ago where employees were suing their employers and the cost of such lawsuits was spiraling out of control and in many cases closing businesses and costing jobs.

So our predecessors in their wisdom, created the Workers' Compensation system, whereby it is no fault, if you will, that if you get hurt on the job, there is a certain way you get compensated after a hearing, etc.

So I rise to take some issue with what Representative Lawlor has indicated, which is that if we were to caps in this particular case, it would be

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somewhat unprecedented is that we do not deny a jury trial to anyone else. We do it every day.

Ladies and gentlemen, I would submit to you that we are facing the same kind of crisis with regard to the cost of medical malpractice insurance, and the victims, the victims are the general populous, especially women and the elderly, who are being deprived of healthcare access, deprived because their doctors are leaving the State of Connecticut because they can no longer do business here.

The measure before us, this Amendment, attempts to solve that problem, or at least address that problem, by putting the only known meaningful actuarially proven method by which we could control the cost of malpractice premiums and therefore provide healthcare access to our citizenry.

We've done it before. We could do it again. We owe our citizens that. Please support this Amendment.

SPEAKER AMANN:

Thank you, Sir. Will you remark further?
Representative Miller.

REP. MILLER: (122nd)

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Good afternoon, Mr. Speaker. Thank you very much for recognizing me.

SPEAKER AMANN:

Good afternoon, Sir.

REP. MILLER: (122nd)

I rise to speak in favor of the Amendment. This reminds me of Rich Roy's telephone bill. The majority of the people in the State of Connecticut want caps, and here we are, the General Assembly digging in and saying no, they're not going to help.

I think as Representatives of the people, we ought to pass this Amendment, put caps in, and let's see how they work out.

The physicians want this. The insurance companies want this. The majority of people want it. I think we ought to pass this thing, get it on the books, check it out for a year or so. If it doesn't work out, there's always opportunities to change it.

But again, this is not a problem strictly for Connecticut. I know many southern states are going through the same type of discussions regarding caps, but I guess I would like to see this thing pass and

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maybe give some relief to some of the physicians so that they'll continue to work in Connecticut.

So with that, I hope the Chamber decides to pass the cap Amendment. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. I will not strain your patience and impose on the patience of my colleagues in this Chamber by going over and over the same arguments.

But I would like to briefly remark in support of this Amendment. The colloquy we've had is very useful because the proponent is a good, careful draftsman and lawyer and advocate, and so I think it's enlightening that we have these debates.

But I think that there is an awful lot that can be concluded on this subject if we just think about it for a moment, just use our own intuitive skills to understand what this is about.

What it's not about is doctors versus lawyers. We need both doctors and lawyers. What this is about

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is, in our society, forming a better way to deal with the suffering of people who are injured in the course of medical procedures, and that's really what we're doing.

We cannot say with mathematical certainty that caps will help or won't help bring down the cost of premiums. In fact, we can't say with mathematical certainty that anything will bring down the cost of premiums.

Well, just consider the fact that if you have millions of dollars draining out of the healthcare system in an unpredictable way, don't we intuitively conclude that that has got to have a significant impact on premiums?

If that doesn't have the most significant impact, what does? We tend to look at this as a regulatory problem, as though all we need to have is a tough elected insurance commissioner who would tell the insurance companies to bring their premiums down.

Well, as a matter of fact, insurance, like so many other things is simply a product of market forces.

If you cannot make a profit as a private insurer, insuring the risk because it's excessive and unpredictable, you're not going to offer that insurance, at least not at a reasonable price. So caps, just our intuition tells us, are the only way that we're going to see any relief.

It is true, we cannot put a price tag on someone's suffering. We want to because we want to make things right for people. But when someone has suffered the loss of use of some body part, or even the loss of a loved one, you can't put a price tag on that. That is certainly true.

But don't you see? Under the present system that's exactly what we're asking the jury to do. We're saying, we don't know what it's worth, but you put a price tag on it.

You just sit down and feel how it is, think about this and then put a number on it and the jury is doing their job as best they can, feel the pain, and so they put a price tag on it.

The problem is not that we're trying to put a price tag on suffering. We're trying to avoid a system that does put a price tag on suffering.

Finally, as Representative Cafero ably stated, there are many curbs that already exist in the jury system. If we, if any one of us walked out of here today and fell down the stairs because they were slippery, we wouldn't get a jury trial against the State of Connecticut.

By the way, I find that hard to believe that that would happen because it was pointed out at the beginning of this session, how wonderful a job the cleaning people do here. I mean, it's one of the labors of Hercules. I don't know how they get this place clean after we leave it at night.

But in any event, if we did, we would not get a jury trial because we are employees and we would be covered by Workers' Compensation, and it was long ago decided that in the thousands and thousands of cases where employees are injured on the job or in the course of their employment, they do not get a jury trial and a claim against their employer. As a trade off, they have the certainty of recovery.

So let's not be distracted by these clichés about the justice system. The justice system is one of the finest, is the finest in my judgment, and the finest

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in the world, and one of our great contributions to civilization.

But it is not as simple as it is often described. Let's try to do something about this problem. Let's stop a system that doesn't reward consistently the injured, and that in fact is causing us to lose affordable and accessible healthcare. Mr. Speaker, I urge adoption of this Amendment. Thank you, Sir.

SPEAKER AMANN:

Will you remark further? Will you remark further on the Amendment before us? If not, staff and guests please come to the Well of the House. Members please take a seat and the machine will be opened.

CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber. The House is voting House Amendment Schedule "A" by Roll Call. Members to the Chamber.

SPEAKER AMANN:

Have all the Members voted? Have all the Members voted? If all the Members have voted, please check the board to make sure that your vote has been properly cast.

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If all of the Members have voted, the machine will be locked and the Clerk will take a tally. The Clerk please announce the tally.

CLERK:

House Amendment Schedule "A" for Senate Bill

Number 1052.

Total Number Voting	148
Necessary for Adoption	75
Those voting Yea	61
Those voting Nay	87
Those absent and not voting	3

SPEAKER AMANN:

The Amendment fails. Would you care to remark further on the Bill as amended? Would you care to remark further? Representative D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. Mr. Speaker, in looking through the Bill, it came to my attention that there's a couple of sections in the Bill that would really put a strain on the Insurance Department.

Section 11 would subject medical malpractice rates to prior approval by the Insurance Department. That Section requires the Insurance Department to hold

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a public hearing on the rate filing if the increase is over 7.5%, and an insurer requests the hearing.

The Section also requires the Commissioner to approve the filing within 45 days after its receipt. And Section 14 requires the Department to collect information on closed medical malpractice claims.

It requires insurers to send these closed claims to the Insurance Department, and this Section requires the Department to establish an electronic database and provide an annual report, which includes trend analysts on the closed claims.

Mr. Speaker, the Clerk has an Amendment, LCO Number 8056. May he call and I be allowed to summarize.

SPEAKER AMANN:

Will the Clerk please call LCO Number 8056 which will be designated House Amendment Schedule "B".

CLERK:

LCO Number 8056. House "B" offered by
Representatives D'Amelio and Miner.

SPEAKER AMANN:

The Representative seeks leave of the Chamber to summarization. Is there objection to summarization?

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Is there objection? Sir, you may proceed with your summarization.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker. Mr. Speaker, all this Amendment will do is state that the Insurance Commissioner shall, within available appropriations, provide the proper information to the Public Health Department.

There's a lack of funding in the budget for this. We just passed our budget last night. The Insurance Department was not adequately funded to perform this function and all we're saying is that the Insurance Department needs to be adequately funded to provide these duties. I urge adoption. Thank you, Mr. Speaker.

SPEAKER AMANN:

The question is on adoption. Will you remark?
Will you remark? Representative O'Connor.

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. I rise in opposition to this Amendment. As was stated by the Ranking Member of the Insurance Committee, that we did not

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appropriate this directly in the budget that we passed the other day.

But it's my understanding that there will be pass through dollars paid for by the assessment of insurance carriers that will make up the difference and will allow the Insurance Department to adequately process the data that's being collected.

So again, I ask my colleagues to oppose the Amendment. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark further? Will you remark further? Representative Feltman.

REP. FELTMAN: (6th)

Thank you, Mr. Speaker. Briefly. I voted in favor of the Amendment, the first Amendment, because I feel like it does something in the direction of helping people to practice medicine better.

But I plan to vote against the Bill, and I voted against the caps Amendment because I feel it's too blunt an instrument.

I feel like there's problems on both sides on the [inaudible] of people, largely on my side of the aisle. I don't think there's yet a full appreciation

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for the dimension of the problem that we're facing and the patients that we're facing for failure to take bold action.

I feel with regard to people who are supportive of caps that given the nature of the problem, they only have one instrument to deal with it, which is a hammer, and there may be other instruments that might be more suited to the situation at hand.

I feel we should be more creative. I feel we should be more flexible. I feel we should be looking at some other states that have done some, made some progress on this issue, and some other countries that have as well.

And for that reason, and because I don't think that having another commission that would start in 2008 and having another working group thereafter where the same people have been working on this for the last two years is really going to solve the problem.

I do not intend to support this legislation as well intentioned as I believe it to be. Thank you, Mr. Speaker.

SPEAKER AMANN:

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Thank you, Sir. Will you remark further?

Representative Hamzy.

REP. HAMZY: (78th)

Thank you, Mr. Speaker. I rise in support of the Amendment, and just would offer this for the Members of the Assembly to consider.

Ten years ago we had 15 companies writing professional liability insurance for healthcare providers. Five years ago, we had six carriers. Today we have two carriers.

And in order to fund the report that the Insurance Department's going to be required to make, we're going to assess the two remaining carriers a fee to fund the Insurance Department to collect this data and forward it to the Department of Public Health.

I'm not sure how much sense that makes when in ten years we have reduced the number of carriers by 13. To put an added burden on the two remaining carriers I think is shortsighted, and I urge support of the Amendment.

SPEAKER AMANN:

Do you care to remark further? Representative Powers.

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REP. POWERS: (151st)

Thank you, Mr. Speaker. Very quickly. I have a fiscal note from the Connecticut Insurance Department and they have costed out Section 11 and Section 14 and in 06 for an examiner, an actuary and an attorney and their computers and that kind of stuff, it's 06 is \$475,864, 07 is \$422,264.

This is not in the budget we passed. This is almost a million dollars for the Insurance Department that is not in the budget that was passed.

I don't understand what we're doing here. This is an Amendment to take the cost out, because the Insurance Department is going to have a shortfall of a million dollars that they're going to have to make up somehow.

I don't think that helps your, the folks in your district or the folks in my district because we know insurance companies only pass those costs on.

So understand, this is almost a million dollars that is not in the budget that you passed. Please support the Amendment. Thank you, Mr. Speaker.

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Thank you, Madam. Do you care to remark further?
Do you care to remark further? Representative
D'Amelio.

REP. D'AMELIO: (71st)

Thank you, Mr. Speaker, for the second time, and
I thank you. I just want to bring to the Chamber's
attention that the Insurance Department is funded
through an insurance fund that is financed through an
assessment on the insurance companies, but the
Department's budget undergoes the same process as
other state agencies.

The amount appropriated to the Department by the
Legislature is the amount that is assessed from the
insurance companies. We did not appropriate the money
that Sections 11 and 14 will cause for the Insurance
Department.

So all this Amendment is doing is saying that the
Commissioner within available funds, could proceed
with these two Sections, so I urge adoption. Thank
you.

SPEAKER AMANN:

Will you remark further? Will you remark
further? Will you remark further? If not, let me try

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your minds. All in favor please signify by saying

Aye.

REPRESENTATIVES:

Aye.

SPEAKER AMANN:

All opposed, Nay.

REPRESENTATIVES:

Nay.

SPEAKER AMANN:

The Nays have it, and the Amendment is defeated.

Will you remark further? Will you remark further on
the Bill as amended? Representative Hetherington.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. The Clerk has in his
possession LCO Number 8171. I ask that it be called
and I be permitted to summarize.

SPEAKER AMANN:

Will the Clerk please call LCO Number 8171, which
will be designated House Amendment Schedule "C".

CLERK:

LCO Number 8171, House "C" offered by
Representative Hetherington.

SPEAKER AMANN:

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You may proceed, Sir.

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. This Amendment offers some relatively simple relief. It says that when an attorney's fee is permitted to exceed that set forth in Section 1b of the Bill, that is when the attorney's fee is allowed to exceed what is stated to be the public policy of this state in terms of attorneys' fees, then that excess when the attorney recovers that fee, that excess between what's permitted in 1b and what the attorney actually recovers, that excess is subject to a 10% charge, which goes into a fund to pay the medical malpractice coverage of those clinics that offer free healthcare to people in our large cities over 50,000 in population.

If I may comment further? And I move adoption.

If I may comment?

SPEAKER AMANN:

The question is on adoption. Will you remark?
Will you remark further?

REP. HETHERINGTON: (125th)

Thank you, Mr. Speaker. We have several private nonprofit organizations that offer free clinics in our

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large cities. They offer primary healthcare to the poor people at no charge.

They are staffed largely by retired physicians and other medical professionals, but they are under a great deal of strain because they must carry medical malpractice coverage, and of course, we would want them to.

What this Bill, what this Amendment does is simply take a small part of the excess attorneys' fees over the limit provided in the statute and says, that goes into a fund to pay for the malpractice insurance.

This approach has a couple of particular advantages, I think. One, of course, it gives relief to the charitable providers.

Two, it makes sure that the people who are cared for at these clinics do have the protection of medical malpractice insurance. It makes sure that the recipients of this free care have exactly the same right to be compensated for malpractice as anyone else in the state.

The cost of this is small. Ten percent of the excess over limitation of the attorney's fee. It

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costs the victim nothing. Nothing. No amount is taken from the plaintiff's recovery.

Mr. Speaker, I believe that this is a very careful targeted way of assuring the sustainability of these clinics in our cities of over 50,000.

I would add that I do not represent a city. I do not have that privilege of representing a large city. I have the privilege of representing a small town, two small towns. So this, this is not a Bill that benefits any organization in my constituency.

But I think that it is time, and I know many of us do, and I would like to join in that, that we look at what is good for our entire state. Let's use our creativity.

Let's use our power, if you will, to try to make life better for everybody whether or not it's in our own district or affects our immediate interests.

So for the sake of these clinics and those who use them in our larger cities, I urge adoption, Mr. Speaker. Thank you.

SPEAKER AMANN:

Will you remark further? Will you remark further on the Amendment before us? Representative O'Connor.

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REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. I rise in opposition to this Amendment. I have a couple of concerns in particular. The previous Amendment there was some concerns about how the Department would reallocate its resources in order to administer the data that they collected.

And I'm concerned again here that we don't have any kind of determination of how they're going to be able to administer this fund, how many employees they may need to hire or multi task in this fashion, and what that may do to the resources of the Department.

So I ask for my colleagues to oppose this Amendment since this was not part of the budget and I think would limit the resources of the Department in carrying out its duties. Thank you, Mr. Speaker.

SPEAKER AMANN:

Will you remark? Will you remark? Will you remark? Will you remark further on the Amendment before us? If not, let me try your minds. All in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

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SPEAKER AMANN:

All those opposed, Nay.

REPRESENTATIVES:

Nay.

SPEAKER AMANN:

Nays have it and the Amendment is defeated.

Will you remark further? Will you remark further?

Will you remark further on the Bill as amended?

If not, staff and guests please come to the Well of the House. Members please take your seats and the machine will be opened.

CLERK:

The House of Representatives is voting by Roll
Call. Members to the Chamber. The House is voting by
Roll Call. Members to the Chamber, please.

SPEAKER AMANN:

Are there any announcements or introductions?

Oh, I'm sorry.

Have all the Members voted? Have all the Members voted? Have all the Members voted? Please check the board.

There are a couple of Members that are sitting that I'm looking at who have not voted. Please check

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the board. Have all the Members voted? Have all the Members voted?

If all the Members have voted, the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

CLERK:

Senate Bill Number 1052, as amended by Senate Amendment Schedules "A" and "B", in concurrence with the Senate.

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	105
Those voting Nay	43
Those absent and not voting	3

SPEAKER AMANN:

The Bill passes in concurrence with the Senate.

Will the Clerk please call Calendar Number 634.

CLERK:

On Page 14, Calendar Number 634, Substitute for Senate Bill Number 94, AN ACT CONCERNING REFORM OF THE STATE CONTRACTING PROCESS, Favorable Report of the Committee on Commerce.

SPEAKER AMANN:

JOINT
STANDING
COMMITTEE
HEARINGS

JUDICIARY
PART 18
5382-5674

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There are a number of bills that are pending before the Judiciary Committee on the issue of medical malpractice. If you have had an opportunity to look at them, you will clearly see that many of them are incompatible with each other.

While you can feel free to testify about any particular bill that is before the Committee, please be aware that, at some point in the next week, the Committee is going to be synthesizing many of the ideas that are incorporated in the legislation that is before us.

Depending on the information provided by this public hearing, that could be incorporated as well. You can obviously address the issues that are in the bills, but realize that the larger picture of the issue of medical malpractice is probably more important than the specific language in any bill.

However, if there is specific language in the bill that you think is good or bad that we need to know about, please make sure you apprise us of that as well. Welcome, Commissioner.

COMM. SUSAN COGSWELL: Thank you, Senator McDonald. Good afternoon, Representative Lawlor, Members of the Committee. My name is Susan Cogswell. I'm the Commissioner of the Connecticut Insurance Department.

I'm here to speak in support of Senate Bill 1052, AN ACT CONCERNING MEDICAL MALPRACTICE. Currently, there are three traditional

insurance companies writing physicians' and surgeons' medical malpractice liability coverage in Connecticut.

I would like to clarify that there are companies writing medical malpractice liability insurance for other medical specialties in Connecticut, for example dentists and nurses. It is the physician and surgeon specialties which are in crisis.

Last year, the Department explored reasons why medical malpractice insurance companies were not offering policies in Connecticut. As part of the effort, the Department surveyed a number of companies writing medical malpractice insurance in other states.

We found that insurance companies were withdrawing from the medical malpractice market nationwide. The trend is towards smaller, regional carriers and provider-owned medical malpractice insurers such as Connecticut Medical Insurance Company.

Some of the insurance carriers indicated that this trend is based upon overall insurance and legal environments in the states, as well as the insurance companies' ability to control exposures.

Companies indicated to us that they were not interested in writing medical malpractice insurance in Connecticut unless there was significant tort reform. Alternative markets have also been increasing in Connecticut in the

form of risk-retention groups, captives, and self-insurers.

For example, one of the leading writers of medical malpractice insurers in Connecticut for 2004 was MCIC Vermont Inc., a risk-retention group which covers hospitals in the state.

This group brought about \$47 million in premium as compared to our local mutual, CMIC, which wrote about \$52 million in premium. The cost drivers that originally created the need for alternative markets have not been addressed.

Therefore, if the market is allowed to continue in its present state with no meaningful reform, some of these alternatives offering medical malpractice insurance when faced with a few large claims could potentially become insolvent.

Governor Jody Rell's medical malpractice reform plan as contained in Senate Bill 1052 would put stricter requirements on insurance companies to make sure rates don't rise any higher than absolutely necessary.

The Department supports the prior rate approval provision which is contained within the Governor's bill.

Prior rate approval requires any company offering professional liability insurance for physicians and surgeons, hospital advanced practice registered nurses, or physician assistants to be subject to prior approval.

The proposal requires that companies seeking a rate increase of 10% or greater notify the Department and policyholders 60 days in advance of those rates.

This proposal enables insurers to request a public hearing. Currently, medical malpractice companies operating in Connecticut submit their rates to the Insurance Department prior to their effective date.

This allows the Department time for actuarial review and analysis in advance of the rates going into effect. Putting prior approval rates into statute would therefore codify current practices.

Governor Rell's legislation also provides for periodic payment of medical malpractice judgments of \$200,000 and over.

This provision can be expected to result in cost savings to insurers because of the investment income earned over the time period when the payments are made.

The Governor's bill also provides for reducing the offer of judgment penalty assessed on defendants for failing to settle certain lawsuits from 12% to prime. We believe this will also have an impact on reducing costs.

These initiatives will aid in stabilizing the medical malpractice marketplace in Connecticut and hopefully make it an attractive place for companies currently doing business in other states.

More importantly, it will attract new companies into our marketplace. I ask the Committee to act favorably on Senate Bill 1052, AN ACT CONCERNING MEDICAL MARKET MALPRACTICE. Thank you for your time, and I'd be happy to answer any questions.

SEN. MCDONALD: Thank you, Commissioner. Let me just ask you a couple of questions because we had the pleasure of having your testimony before us when we last addressed this issue. At that time, your testimony was remarkably different than your testimony here today.

In fact, I have a very clear recollection that you were adamantly opposed to having prior rate approval come before the Insurance Department. What's changed?

COMM. SUSAN COGSWELL: No, we were never opposed to prior rate approval, Senator. We have no problem with having prior rate approval.

SEN. MCDONALD: My recollection was that you didn't want to do that because there was, your testimony as I recall, if I'm wrong, please correct me, was that you didn't want to be involved in that process because if you were doing it, you'd actually be recommending higher increases than what are coming through.

COMM. SUSAN COGSWELL: We never opposed prior rate approval because of the practice that's already in place in the Department where we're seeing the rates prior to them going into effect and having the time to have our actuaries review

them. I think what you're referring to, Senator, is past history.

I think we were talking about there were years in which the rates were inadequate. If we had had prior rate approval, we would have found them inadequate and would have been raising rates higher than they were rising at the time. That would have had its own set of special difficulties.

SEN. MCDONALD: So you've always been in favor of prior rate approval?

COMM. SUSAN COGSWELL: We have no problem with it. Yes, Senator.

SEN. MCDONALD: Okay. In your testimony, you talked about how various insurance companies might be more encouraged to come into Connecticut with tort reform. You've outlined some of the suggestions that were included in the Governor's proposal.

Did these same companies talk to you at all about the advisability of reducing risk and exposure through other means, such as improvements in the provision of medical care?

COMM. SUSAN COGSWELL: I don't think we got into specifics of what they would have to see in the marketplace. It was just strictly that they need to be able to have a more stable marketplace for them to come in.

They have to better understand their risks before they'd be willing to come into the

marketplace. I don't think any of them suggested specific changes to us.

SEN. MCDONALD: Okay. I can't seem to find your testimony right now, but I thought I heard you say that they told you it would be advantageous for the state if we focused on tort reform. I didn't hear any other type of reform as being advantageous to that goal.

COMM. SUSAN COGSWELL: That's what they specifically referred to, without getting into what they would like to see.

SEN. MCDONALD: What's your opinion? Would reforms other than tort reform be helpful in attracting more insurance companies into the state?

COMM. SUSAN COGSWELL: I think that any reforms that bring stability to the marketplace and allow the insurers to better gauge and understand their risk will be helpful in attracting companies.

SEN. MCDONALD: Okay. You mentioned periodic payments as something that would be helpful in that regard. I think you testified that it would allow for the insurance companies to invest the reserve amounts over a period of time and reap the benefits of that investment income, is that correct?

How, in your estimation, does that work for somebody who is the victim of malpractice and is an 85-year-old victim? What type of periodic payment schedule are we talking about?

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COMM. SUSAN COGSWELL: I guess we'd have to look at that situation individually, if you're talking about an 85-year-old individual.

SEN. MCDONALD: I understand. I'm just sort of following on with your suggestion, or the Governor's suggestion, that periodic payments are advisable. I'm trying to figure out how the Department and how the Administration thinks it will work for somebody who is 85 years old.

COMM. SUSAN COGSWELL: Obviously, we were thinking about long-term payments over a long period of time. There would have to be an option in a situation with an 85-year-old. We wouldn't be looking at long-term payments over time.

SEN. MCDONALD: Okay. You don't have any suggestions at this point?

COMM. SUSAN COGSWELL: Not at this point.

SEN. MCDONALD: Thank you. Representative Fritz?

REP. FRITZ: Thank you, Mr. Chairman. Good afternoon, Commissioner. I have two brief questions for you. You talked about the number of insurance companies that are here in the State of Connecticut that are covering our physicians.

Could you make a comment about the Doctors Group, which covers many, many OB-GYNs and it's a captive? My question to you on that area would be how would you feel about registering captives so we would really know who is doing

business in Connecticut and who they are covering?

COMM. SUSAN COGSWELL: We've talked about that in the past, Representative. We would have no problem with registering captives. However, some of these captives are offshore. I don't think we would be able to force them to give us the information or register with us.

Certainly, the captives that are formed in states such as Vermont we can readily get information on. We can get a lot of information about them.

The problem is going to be with offshore captives. They're probably not going to be willing to share information with us, and we probably can't force them.

REP. FRITZ: Don't you think getting a handle on some who are doing business in Connecticut is better than not knowing anything about any of them?

COMM. SUSAN COGSWELL: We can get information from Vermont, which is the largest captive state, at any time we wish. Yes, we can get that information readily from them. That would not be a problem.

REP. FRITZ: Okay. My second question deals with, in the Governor's Senate Bill 1052, the reduction, as you've stated, goes 12% to prime. My question to you is don't you believe this would actually destroy the incentive, which is

the reason for the 12%, to force people to come to a settlement?

Actually, the way the language is written in the bill, don't you think that what it is saying is actually going to bring an end to settlements? If that is true, according to the language, the costs would be exorbitant.

Everything would have to go to a trial. It would end up being awards as opposed to settlements, which are much lower. I guess I would like your opinion on that.

COMM. SUSAN COGSWELL: I don't see that reducing the amount would put an end to the settlement process or deter the settlement process.

REP. FRITZ: I said the language of how it is written.

COMM. SUSAN COGSWELL: I'd have to look at that. It's not meant to end settlements.

REP. FRITZ: The way it is written it almost sounds the death knell for settlements.

COMM. SUSAN COGSWELL: I'd be happy to look at that and get back to you.

REP. FRITZ: Thank you.

SEN. MCDONALD: Senator Kissel.

SEN. KISSEL: Commissioner Cogswell, delighted to see you again. Actually, as much as I believe your testimony is that many of the positions

you're articulating this afternoon are consistent with what we've heard in the past, I do think there's more flexibility being expressed by the current Administration as opposed to the previous Administration.

It would be remiss of me if I did not both congratulate and thank Governor Rell for taking such a hands-on approach to the issue before us.

Indeed, I think it would be fair to state that the current Administration led by Governor Rell understands that there are probably not enough votes in the Legislature this year to support medical malpractice reform legislation that has, as a part of it, caps.

In the past several years, proponents of reform legislation have really utilized that as the centerpiece of their efforts. That's off the table this year, and I think justifiably.

My first question to you is, because I get asked this quite often by my constituents and those in the medical community, do you feel that we can craft legislation, albeit with the changes expressed by my colleagues, Senator McDonald, Representative Fritz, and others, that absent caps can still be considered meaningful reform regarding medical malpractice, that will at least create a construct to afford some relief to those physicians that have seen astronomical increases in their premium costs?

COMM. SUSAN COGSWELL: I think absolutely. I think that's what the goal is this year. We really do need reform. For all the affected parties to sit down and construct a bill that will bring stability to the market and hopefully attract other companies, allow companies that are here to reduce their rates, that's the goal that needs to be achieved.

It needs to be achieved this year because the situation and access to doctors by patients is continuing to get worse. That's really what we all should be focusing on. This is an issue of access to care.

SEN. KISSEL: In a nutshell, we can have meaningful reform and afford relief to physicians in Connecticut without having reform legislation necessarily having any caps component?

COMM. SUSAN COGSWELL: I would hope so. Part of the Governor's bill is to take a look at that over time and see if what comes about from this Legislature is making a difference in the rates before starting the discussion again about caps.

SEN. KISSEL: That concerns me. We're not going to start the discussion again about caps unless there's a failure in the reform legislation that hopefully passes our Legislature this year.

That almost sounds, in the way you articulate it, that we're going to be coming back to caps no matter what. I don't want it built into the reform legislation.

Assuming that we bring in some of the concerns put into language that the Governor feels strongly about, but I don't want it to be a foregone conclusion that this is going to fail and we're going to be revisiting caps.

What I'd prefer is that what we put in place actually gets proven to be effective in addressing that issue and that we don't have to revisit caps.

COMM. SUSAN COGSWELL: That's absolutely our goal and our desire. We don't want to have to start that discussion either. We want to see the reform make meaningful changes in the rates for doctors here.

SEN. KISSEL: I think that's a very important message for the Administration to keep sending out.

Secondly, and this is in reference to the line of questioning that my friend and colleague, Senator McDonald, had touched upon, what would you do with the structured settlement or the payments over time?

Senator McDonald said an 85-year-old plaintiff that was found to be successful in litigation, but I think it goes even beyond that.

If one looks at the tables of mortality and morbidity, you can track back, and essentially I think nowadays a man's life expectancy is about 77, a woman's is up around 79, maybe

higher, I haven't looked at the tables in a few years.

If one cycles back and looks at those tables of mortality and morbidity, I think that any system that we create, if it has that as a component, and I'm very skeptical regarding that as a necessary component, and I'll get to that in a minute, but if one shortened that.

In other words, if one lengthened the payment period beyond one's life expectancy, as expressed in the current tables of mortality and morbidity, I think that by its very terms it would work an injustice on someone who has clearly gone to court and proven that they've been wronged. Wouldn't you agree with that?

COMM. SUSAN COGSWELL: You see structured settlements used in other awards than medical malpractice liability awards. The structured settlements are structured based on the expectations of the individual that they're being put in place for.

SEN. KISSEL: Right. But I think there's an important distinction to be drawn regarding the whole proposition from the Executive Branch regarding structured settlements.

First of all, I think that the concern that I expressed, that if it was to be implemented at all, one would have to build in a connection to the tables of mortality and morbidity.

If one sent out a structure that went beyond one's normal life expectancy, that has to be unjust by its terms.

Secondly, and you articulated this, it's used often, but it's in terms of structured settlements, two parties coming together and working together and working it out themselves. In the proposal before us right now, by a mechanical mechanism, it will trip into effect.

Now we're imposing that on a party that has gone to court, proven their case, some injustice has been visited upon them that has caused some harm to their physical well-being.

Now we're going to impose on them that you're right, you availed yourself of our revered rights to a trial, and as much as you and your body have been harmed, you can only get your compensation for that over a period of time.

A couple of things about that I have concerns with. If the parties want to do that themselves, that's okay. Both sides are probably giving something up.

The defense counsel is saying there's some element of risk to my client, the physician, so we're going to barter away. The plaintiff might say there's some element of risk on our side. Rather than rolling the dice, we'll agree to this.

Quite often, structures are utilized for young people. You can then plan it out so that perhaps there's a bubble, a lump sum when they

reach the majority that can be utilized for college or things like that so there's no real reason.

Also, secondly, they can be used for individuals that have recurring medical problems, such as if you're paralyzed, have a urinary tract infection, or something like that. I think those things need to be touched.

I'm being passed a note, and I just have to glance down. I have, indeed, glanced down. That's very kind of you, Senator. I think we have a lot of concerns.

I think what you're saying is that by having structured settlements we're going to afford a greater profit margin for insurance companies. I'm not so sure that's the root of the problem.

My other question is much more pointed. There's a discussion as to what we want to use for the prior rate approval. What's the trip mechanism?

I know there are individuals we've spoken with that feel very strongly that it should be the Consumer Price Index.

You have come out here on the Governor's proposal of 10%. I don't know where the 10% came from. Is that a magic figure that the Governor's Office and you yourself feel strongly about?

Is that something that's on the table for negotiation? Would you see any benefit to

having something tied into something like the Consumer Price Index?

COMM. SUSAN COGSWELL: The number is something you commonly see in other prior rate approval laws across the country. That's why we chose to adopt that number.

It's basically a benchmark when people start looking at prior rate approvals. That's why it was put into the legislation.

SEN. KISSEL: So I'm hearing that there is some flexibility regarding that?

COMM. SUSAN COGSWELL: As Senator McDonald says, there are a lot of bills out there. There's a lot of discussion to be had. That's our benchmark.

SEN. KISSEL: Thank you very much, Commissioner, and thank you for the indulgence of the Chair.

SEN. MCDONALD: Thank you. Just as a reminder, if you have a cell phone, please either turn it off or set it on silent mode. Are there other questions from Members of the Committee? Let me just ask one then myself, Commissioner.

The time value of money that's associated with the periodic payments and, as you expressed it, the purpose of a periodic payment would be to make life better for insurance companies.

A jury, when it awards a verdict, does so based on evidence before it about both economic and non-economic damages incurred.

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I guess sort of a fundamental philosophical question to you would be why is it better as a policy matter to ask the victims of malpractice to forego the time value of money in favor of an insurance company?

COMM. SUSAN COGSWELL: The provision is not meant to make life better for insurance companies, Senator. There are costs in the system that are driving up rates.

We have to find ways to take some of those costs out of the system before we can lower rates. This is one way to reduce some of the costs to the insurance companies, which would be reflected in lowering rates to doctors or at least stemming the increases.

SEN. MCDONALD: That sort of leads to the follow-up question. Why is there, admittedly, the conversations I've had with physicians have been anecdotal on this issue, but there seems to be extraordinary swings in premium increases between doctors even within the same specialty.

OB-GYNs are not consistently seeing the same rates of increase as their colleagues are in other parts of the state. I wonder, do you have an explanation for that?

COMM. SUSAN COGSWELL: The base rate for OB-GYNs is dependent on what company--

SEN. MCDONALD: I'm talking between companies.

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COMM. SUSAN COGSWELL: Oh, between companies, no they're fairly consistent. They're not that far apart after last year's rate increases. They're pretty close across the board.

SEN. MCDONALD: Do you have that information? If you could get that to me, that would be very helpful. My evidence is only anecdotal. I've been told that the rate increases, particularly with OB-GYNs, has varied dramatically.

COMM. SUSAN COGSWELL: The rate of increases has, yes. It's going to depend on the company and their underwriting of that particular risk and their expenses. The rates themselves are not that far apart for OB-GYNs among the three companies that are writing.

SEN. MCDONALD: I'll save those questions until I get some additional information.

COMM. SUSAN COGSWELL: We'll send you a chart saying various specialties and what they look like right now.

SEN. MCDONALD: We talked about the offer of judgment. The Governor is proposing that it be at prime. Clearly, we all know that the purpose of an offer of judgment is to encourage settlement.

There are inherent risks with the negotiation and consideration of an offer of judgment, whether you are a plaintiff or defendant. There are upsides and downsides to that process. It's an intricate balance.

It's really quite a fascinating dynamic that takes place on both sides. We've actually had judges who are coming back here for reconfirmation who specialize in trying to mediate and resolve medical malpractice cases.

They've told us that the Offer of Judgment Statute, as it currently exists, with all of its inherent risks, is a very persuasive tool that they use to drive cases to settlement.

If the proposal is to modify that Offer of Judgment interest rate, clearly there's going to be a shift in the dynamic, a thumb on the scale in favor of the defendants under this proposal.

I'm trying to find out from you, based on your experience with these companies, what is the rate right now that these companies are receiving on the investment of their reserves in the market, is it above prime?

COMM. SUSAN COGSWELL: May I ask our Chief Actuary to come up and answer this?

SEN. MCDONALD: Feel free. I don't expect one person to have all the answers.

JOHN PURPLE: Yes, John Purple. I'm the Chief Actuary for the Insurance Department. I would say something in the neighborhood of 4% to 4-1/2% would probably be about the rate of return that they're seeing on their investment portfolios at this time. Prime as of today is about 5-3/4.

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SEN. MCDONALD: Okay. That answers it. We had a debate. We thought it was more along the lines of 3. Thank you for that clarification. So their investment income is below prime right now by a relatively small amount. I'm sorry. I didn't hear your last name?

JOHN PURPLE: John Purple, like the color.

SEN. MCDONALD: Mr. Purple, what are the parameters for investments for insurance companies of their reserves? I assume they're not trading in equities out there. Could you just clarify some of that for me?

JOHN PURPLE: Sure. There are statutory restrictions on insurance companies as to the time of investments they can invest in. There are limitations on types of bonds and those kinds of things.

For most insurance companies, they're primarily, and I'm going to say 80% to 85%, maybe even higher, in bonds of various types.

These would be highly rated bonds, some treasuries, corporate bonds, those kinds of things. Probably a very, very small portion, such as 5% might be in equities.

SEN. MCDONALD: Thank you very much. I appreciate that. Are there any further questions? Thank you very much for your testimony. Next is Commissioner Christine Vogel. Good afternoon, Commissioner.

COMM. CHRISTINE VOGEL: Good afternoon, Senator McDonald, Members of the Judiciary Committee. I'm Christine Vogel, the Commissioner of the Office of Healthcare Access. I'm here today to testify in support of Senate Bill 1052, AN ACT CONCERNING MEDICAL MALPRACTICE.

My testimony and concerns about medical malpractice insurance relate specifically to the issue of access to care for our citizens.

The mission of the Office of Healthcare Access is to ensure that every citizen in Connecticut has access to a quality healthcare delivery system.

To that end, there exist some areas of weakness in our current delivery system if the issues of medical malpractice insurance remain unchanged.

Most notable are the concerns that physicians will be leaving the Connecticut market and recruiting will become even more difficult than it is at present.

Some of my thoughts regarding access relate not only to the private physician practicing in the community, but to our hospitals. Some of our hospitals are experiencing difficulties and significant cost in recruiting medical staff.

The reasons vary, but even without taking into consideration the medical malpractice expense, the on-call schedule of specialists, the decreasing number of available physicians looking to relocate, and the quality of life

issues facing younger physicians all play a role in recruitment.

We have all heard the concerns with the obstetricians retiring or limiting their scope of practice. If this continues, there will be an impact on access for office obstetrical care and also once arriving at the hospital for labor and delivery services.

Our hospitals are the healthcare safety net. They may need to rethink how they continue delivering services to meet patient demand and maximize their resources in order to preserve care.

Reducing the medical errors and improving patient safety will reduce the number of malpractice claims. All hospitals should have protocols and performance measures to address patient safety.

Some hospitals are beginning to computerize more of their medical records, pharmacy programs, and operating room information. This will have a positive impact on reduction of errors.

Reducing errors and improving safety will improve patient satisfaction and improve the quality of care provided to our citizens.

I thank you for the opportunity to express my concerns regarding access. I'm here for any of your questions.

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SEN. MCDONALD: Thank you, Commissioner. Just one from me, actually, no, maybe a couple of questions. How many hospitals self-insure or do they?

COMM. CHRISTINE VOGEL: Hospitals do self-insure. I don't have the exact number. I believe the Department of Insurance does. A large portion of our hospitals do self-insure.

SEN. MCDONALD: You may or may not know the answer to this. Do you know whether those who do self-insure, what the history of premiums has been over the last couple of years?

COMM. CHRISTINE VOGEL: The Office of Healthcare Access does have access to those direct numbers. I believe in this past year, from fiscal year '02 to '03, hospitals, medical malpractice insurance increased 65%.

Overall, hospitals' medical malpractice insurance is about 2% of their overall expense statewide.

SEN. MCDONALD: Thank you. Anything further? If not, thank you very much. Next is Chief State's Attorney Chris Morano. Good afternoon.

CHIEF STATE'S ATTY. CHRIS MORANO: Good afternoon, nice to be here again. I'll be brief. I'm here to testify on House Bill 6975, AN ACT CONCERNING FORFEITED BAIL BONDS, THE COLLECTION OF UNPAID FEES, PRIVATE PRISONER TRANSPORTATION AND FUNERAL SERVICE CONTRACTS. I'm also in support of Senate Bill 516, AN ACT CONCERNING THE PENALTY FOR CRUELTY TO PERSONS.

COMM. GALVIN: Thank you, Senator McDonald. I will be very brief. I have two subject experts with me. If there are specific questions, either Ms. Furniss or Mr. Garcia can address those. Basically, we're in support of the Governor's medical malpractice bill.

SB1052

There are two things I'd like to emphasize in that particular bill. One is the provision that individuals licensed in Connecticut should be required to report any infractions which were incurred in states other than Connecticut.

The second issue has to do with post-graduate or post-doctoral or continuing education. We think this is a very reasonable requirement. I endorse it very strongly.

There is a provision that we track and keep reports on these hours. We do not currently have the staff that could track and report on the hours provided, nor do we have the type of info system set up so that we could do that without a cost expenditure.

We recommend, along with the Governor's recommendation, that we require the individuals to keep records of their post-doctoral educational activities and be required to produce them on demand from the Department or should there be an inquiry as to the state of their practice.

The other bill we're prepared to talk about has to do with an act concerning liability for use of an automatic external defibrillator.

HB6964

They don't necessarily have trained people. It seems to me that if we're going to do something, that would be a better way to do it.

LEONARD GARCIA: Yes, Sir. The airlines probably about eight or ten years ago now learned that lesson through litigation that I've read about. Now it's the standard on every airline here in the United States, I can't speak for abroad.

I think the answer is probably somewhere in the middle of what Senator Roraback pointed out and some of the protections.

There are lots of companies that would like to put these things out there for the good of their employees or their visitors but are apprehensive. My staff gets probably four or five calls a week asking about the nuances of protection. Thank you.

SEN. MCDONALD: Thank you. Thank you for your testimony. I want to thank the public for their indulgence as we finished up with Commissioner Galvin. The first person on the public list is Neil Vidmar, followed by Margaret Andrews. Good afternoon.

NEIL VIDMAR: Good afternoon. I'm Neil Vidmar. I'm SB1052
a law professor holding a Ph.D. in social psychology from Duke Law School in Durham, North Carolina.

I'm here today because of the work that I have done on medical malpractice over a number of years.

I was invited up here to talk to give my perspective in particular on a study that we've conducted in Florida which has gained nationwide interest in the last month or six weeks, although it was completed sometime before that.

I want to be clear to you that I do realize that doctors have had serious problems is getting liability insurance.

The problem has been blamed on the tort system, increases in claims, increases in jury awards, increases in settlements driven by the awards and increases in defense costs.

There are several states that have raised these kinds of issues. Many of them have, as you know. Three that I'm particularly familiar with are Mississippi, Florida and Texas. In Mississippi, claims were made that there were 52 awards over \$1 million between 1995 and 2001.

I investigated those claims and found that, in fact, there were only six. The claims that were being made were mixing apples and oranges, including torts that had nothing to do even with personal injury.

That gives an idea of the kind of atmosphere where I think the public and Legislators become misled.

It turns out that our study that is now going to be published, in fact may be published as I speak in *DePaul Law Review*, we managed to get

the closed claims data from the State of Florida, which has been collecting information on medical malpractice since 1975.

It requires every insurer to report considerable details, seriousness and other things like that, as well as the outcome for both paid claims and unpaid claims, as well as explain the litigation costs that they incur.

I'll summarize, because I have the written testimony that I've submitted to this Committee, the findings from our study, just some central ones.

There have been no increases in the frequency of closed claims between 1990 and 2003 when you adjust for population and number of doctors in Florida. There have been increases in the mean and median awards to prevailing claimants.

In fact, this is due in part to more serious injuries in the claims. Fewer than 8% of the awards are made following a jury verdict and even for \$1 million cases this is true. Most of them are settled.

Only about 8% are decided by juries, 15% were settled without a lawsuit. In fact, of 34 claims, over \$1 million in our sample, only 2 were decided by a jury.

In short, and I'm summarizing an awful lot of data in a short period of time because I know my time is short, our findings are consistent with the fact that it's the tort system that's at fault for the problems that have arisen in

Florida. Our data is supported by research in Texas and some other research we have.

SEN. MCDONALD: Thank you. And let me ask you a question. First of all, you're a professor at Duke Law School? Okay. It's interesting that you have related your experience in Florida and perhaps your examination of materials in Texas with little Connecticut.

One of the difficulties I've had around this whole issue is extrapolating from a very small sample group of cases and drawing broad public policy conclusions from a very small number of cases with a very limited amount of data to understand the nature of those cases.

I don't have it in front of me now, but my recollection is that of the big insurance companies that have come in and talked to us, the number of cases that actually go to trial and result in a jury verdict is extraordinarily small if you think about the entirety of the legal system in Connecticut.

It's an extraordinarily small number. Maybe this is a statistical question, I don't know. In your experience, what level or quantum of information or sample size do you need to have any kind of integrity in the numbers that you're analyzing?

NEIL VIDMAN: It really depends on a lot of factors, Sir. Are you referring specifically here to the State of Connecticut or in general?

SEN. MCDONALD: Well, and I really don't have the materials in front of me, my recollection is that we have something like 8 to 12 large cases a year. By large I mean not over \$1 million. I'm talking about several hundreds of thousands of dollars.

Some would have us draw huge public policy implications from a very small number of cases, especially when we don't understand the facts of the cases and have not seen evidence about economic and non-economic damages that were supported.

One time I had an opportunity to dig behind some of the numbers and found out that actually, that was the jury verdict but they settled for about 20% of that in order to avoid going up on appeal.

That was never appealed to us. Even the integrity of the numbers is sometimes suspect. Is it appropriate for us at all to draw broad policy conclusions from a sample size of maybe ten cases a year?

NEIL VIDMAN: In fact, I looked up on the verdict reporters how few you have in the state every year going back about three years worth. In this short period of time, you're absolutely correct, you have a small sample.

What we do know is that the majority of the cases are settled. In fact, in Florida, about 15%, including million-dollar awards, are settled without a lawsuit even being filed.

One of the things that I would recommend to this state to follow a pattern that Florida has, that Maryland is now developing, that Illinois has of requiring insurers.

In fact, when issues like this arise, you can answer that question by going back and looking at this.

The bulk of these cases may never see the light of day because they're settled privately, which is your point. I wouldn't worry about statistical evidence. I would worry about simply trying to find out what those actual cases are.

I could speculate from what I know, if I counted up the number of, like if you have ten verdicts here per year, you have quite a few defense verdicts as well. If you multiply that by about nine, that would tell you about how many claims that you have.

Again, I'm really going out on a limb in saying this to you, but I'm extrapolating from Texas, Florida, and even North Carolina. Those are the kinds of things I would look at.

I really mean it. So much of this could have been settled without all of the controversy going on or at least focused on what the real causes are if that data had been available. Fortunately, in Florida, they were.

That's why the work that we've done in Florida and the work my colleagues have done in Texas

have raised so much attention. It begins to answer those questions.

SEN. MCDONALD: We understand the need for that data as well. We're looking into that as well. Thank you. Are there any other questions? Representative Farr.

REP. FARR: Doesn't the data, though, I think Senator McDonald talked about the very small samples we're dealing with. Then in Connecticut, I think medical malpractice is also skewed because we have a disproportionate amount, as I understand it, paid to a couple of specialties.

Obstetricians are a big factor, and I guess neurologists are as well. Then when you take a small state and narrow it down to obstetricians and neurologists, one case distorts the whole system. Isn't that a major problem?

NEIL VIDMAN: The really major problem in the sense that, yes, it will distort this overall distribution. The real question that I think has been ignored in much of the debate is, and I've looked at these cases and actually sat at jury trials as part of my research to get behind the scenes, what you really have to stop and think about is the fact that the people who are injured badly at birth, the enormous cost of keeping those people alive and comfortable, which we must do as a moral society, the medical costs are phenomenal.

There's a judge-decided verdict in Illinois of \$20 million for a brain damaged baby. It was

decided by a judge, not by a jury, carefully investigating the things. Those costs are incredibly high.

There was something else, and I discuss this in my paper. It really comes down to a public policy decision. Should the negligent party pay or should the taxpayer pay? In fact, we pay as taxpayers for Medicare, Medicaid, welfare payments.

In the cases I've investigated, many of the people injured must fall back on welfare, Medicare, Medicaid, and so forth. That's something else that's not discussed in this area, but is something that's very important.

Those amounts actually end up going, if they're recovered from the negligent party, go back into the public coffers. There are liens from Medicare and Medicaid against any award that is recovered and the costs that have been incurred by Medicaid and Medicare and so forth.

It becomes a very complex problem. I tried to discuss this in my written remarks, and I make reference to an article that I have coming out in the *Loyola Law Review*, which I can make available to you, that discusses these kinds of public policy issues.

They're very important ones. This is a complex area, and we shouldn't seek simplistic solutions. It isn't that simple.

REP. FARR: One of the problems, particularly with the baby syndrome, is that when you have a baby

born with cerebral palsy, as you say, the cost is unbelievable.

It becomes sort of a crapshoot for everybody in terms of is an insurance company really going to pay nothing when they have a chance that they're going to pay \$20 million.

You have this system that, in those types of cases, maybe they offer \$100,000 even if there's no liability. My God, getting rid of a case with \$20 million worth of exposure for \$100,000 is pretty good.

NEIL VIDMAN: I guess. I think that in many instances \$100,000 would be pretty cheap if you had a \$20 million injury on a person. Yes, there's no question.

Really, the issue is that we could get rid of all this by abolishing our tort system, I don't think anybody's in favor of that, and having some form of socialized medicine which is not practical in the costs that are involved with this.

Once again, I come back to the fact that the only thing I can tell you that often comes up is the insurers end up saying that they are sort of held with their feet to the fire.

When I've talked with insurance adjusters and insurance executives privately, they've simply said that they do not settle cases on the basis of the threat.

The reason is that they believe that if they start doing that it's going to increase frivolous litigation.

There is research, not research that I've conducted, but several other people have conducted, showing that insurers tend to settle these cases based upon their own medical experts' judgments over whether they have liability.

The disputes arise sometimes, and I think maybe you were getting at this, we've got to consider liability. And then the other issue is how much are the damages?

Sometimes disputes end up around damages and not liability. In fact, I found one that happened in the past couple of years here in Connecticut.

Once again, this is a really complicated problem. I don't think that the kind of simple solution, just saying the tort system's at fault, the evidence doesn't necessarily support that.

There have been major changes in the tort system in the preceding years that predict or would support this notion that all of a sudden we have this major crisis.

REP. FARR: It's kind of ironic when someone comes in and says we have a problem and doesn't lend itself to simple solutions and you tell that to the Legislators. We're kind of the masters of

simple solutions. That's what we're looking for here in everything, so thank you.

NEIL VIDAM: One of the advantages of being a professor, of course, is I can point out where the problems are without pointing out solutions. I apologize for that.

I frequently am criticized for that. I do think it's important that we are now gathering data that addresses some of these questions.

SEN. MCDONALD: Thank you. Are there other questions? Senator Cappiello.

SEN. CAPPIELLO: Thank you, Mr. Chairman. Thank you very much for your testimony. Just two very brief questions. I may have missed it during your testimony. You said you were invited to come up here. May I ask who invited you?

NEIL VIDAM: Yes, the Connecticut Trial Lawyers Association. I have that and have mentioned that. I want to emphasize that the research I undertook was supported in part by Duke University and in part supported by other things.

It was done for academic purposes. This has taken away 12 to 14 hours of my time, and I said to do this if they offered to pay for that, that I would accept an honorary for the time it's taken away. In fact, it's taking away from my time working on some other research.

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SEN. CAPPIELLO: Thank you. So to be clear then, just to make sure I understood your answer because that was my second question, you were paid to come up or you were not paid?

NEIL VIDAM: I was paid to come up.

SEN. CAPPIELLO: Thank you very much.

SEN. MCDONALD: Just so we're clear, you were paid to come up to compensate you for your time today, but the research that you undertook was not paid for by the Connecticut Trial Lawyers Association.

NEIL VIDAM: Absolutely not. In fact, I should indicate that my co-investigator on the project, who is actually a Duke medical doctor who has worked very hard with me on this and has kept me honest throughout all of this, wouldn't have even touched this if it had been paid by anything.

It is totally neutral research, and that's what the purpose was in the first place, to tell it like it is.

SEN. MCDONALD: Thank you very much. Next speaker is Margaret Andrews. Margaret Andrews followed by Paul Jacobs and Susan Giacalone.

MARGARET ANDREWS: Good afternoon, Chairman, distinguished Members of the Judiciary Committee. My name is Margaret Andrews, and I'm the Program Director of the Western Connecticut Chapter of the National Multiple Sclerosis Society based in Norwalk,

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they can to secure the bond. Once again, we're dealing with poor people.

If you write a \$50,000 bond, the chances of getting a mortgage on their house for \$50,000 of equity are slim to none.

REP. FARR: Thank you very much.

REP. LAWLOR: Are there other questions? If not, thank you very much. Next is Susan Giacalone.

SUSAN GIACALONE: Good afternoon, Representative Lawlor, Members of the Judiciary Committee. For the record, my name is Susan Giacalone and I'm here on behalf of the Insurance Association of Connecticut.

There are many bills on your agenda today that we've submitted testimony in. I'm going to keep my comments very brief. I'm going to try to focus on just a couple of them. SB1364

To draw your attention to the bills that we have submitted testimony to are House Bill 6811, Senate Bill 1197, Senate Bills 3814 and 3817, Senate Bills 1222 and 1362, 692, 696 and 1052. (1106817) (1106817)

I'd first like to address Senate Bill 1222, which requires a shift in the burden of proof in uninsured motorists' claims. It actually looks to change the very nature of insurance.

Currently, right now for any insurance product or insurance claim an insured has to prove they have a viable claim. In an uninsured motorist,

If anything can help bring these people into line and have them basically do what they're required by law and maintain the insurance then I think we would willingly work on something like that.

SEN. CAPPIELLO: It just seems like we have somewhat of a hollow law if now the insurance company is required to chase that person down. They may have had false information to begin with.

I don't even know if their license was in Connecticut, I think it may have been that they lived here but their license was from another state.

I don't know if they were a citizen in this country because we have nothing on them, nothing whatsoever. We have to pay for that in the end. It's your company spending the time and money to chase them down, for what, because we have no teeth to our laws.

SUSAN GIACALONE: What we can do and in those cases we'll probably put something in like that and try to sue them through the court system. If you can't find them, you can't find them.

SEN. CAPPIELLO: Okay, thank you very much.

SEN. MCDONALD: Any further questions? Thank you very much. Next is Denise Funk followed by Patrick Moynihan.

DENISE FUNK: Good afternoon, Senator McDonald, Members of the Judiciary Committee. My name is Denise Funk. I'm the CEO of Connecticut

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Medical Insurance Company or CMIC as we refer to it.

I have submitted written testimony and would like to make comments on a couple of the bills focusing on some consistency and themes here.

At the outset I would just like to say that over the last two years significant time and effort has been expended by the Legislature, the State's physicians and hospitals, CMIC and other interested parties in an attempt to effectively bring the medical malpractice crisis in our State under control.

Unfortunately, such resolution has not been achieved. The most effective tool in such a resolution is not contained in any of the bills before the Committee today.

Specifically, I'm referring to reasonable restraints on non-economic damages, which have proven to be the most effective method to stabilize and potentially lower medical malpractice premiums.

This is resoundingly supported by the recent rate rollbacks taken by malpractice insurers in Texas and the entrance of many new insurers in that State since the passage of reasonable restraints on non-economic damages two years ago.

Regarding the specific bills before the Judiciary Committee today I would like to comment on Senate Bill 518, which deals with

limiting expert testimony in medical malpractice cases.

As the Judge in his prior testimony stated, we are confused as to the purpose of this bill. We strongly oppose it because it arbitrarily denies a physician or other healthcare professional a full and complete defense by limiting expert testimony to one healthcare provider on their behalf.

Regarding Senate Bill 514, which deals with periodic payments, we do support the requirement that future damages in excess of \$200,000 be paid periodically.

In order to be effective this must be mandatory in all cases and should apply equally to out of court settlements, which represent a much higher percentage of dollars paid for medical malpractice cases than those awarded as a result of a jury trial.

Regarding collateral source offsets, just to introduce this topic, a collateral source offset is essentially a reduction to a verdict by amounts that have been paid against the amount owed that have been priorly paid, most times by a health insurer so that the plaintiff is not double-paid for the same expenses.

In section two of Senate Bill 1052 there is a provision to increase the offsets if plaintiffs are allowed to put into evidence for their health insurance from the date of injury to the date of trial and then into the future.

These payments will effectively wipe out collateral source offsets. If a patient has a medical condition that will require some medical care over his or her entire life, this provision would allow the plaintiff to reduce the collateral source offset for the cost of health insurance over his or her entire life. We strongly oppose this provision.

Sections three and four of Senate Bill 1052 deal again with periodic payments.

There is some ambiguity in this statute but the language which states that the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such damages could be interpreted to mean that the court would determine how much interest should be added to the judgment to reflect that they payments will be paid periodically.

This would eliminate any benefit derived from the periodic payments. We strongly oppose this language as well.

As the prior speaker indicated, we also strongly oppose Senate Bill 1362, which is the ACT REQUIRING DISCLOSURE OF LIABILITY INSURANCE POLICY LIMITS PRIOR TO THE FILING OF A CLAIM.

This provision essentially would allow potential plaintiffs who have not filed a lawsuit yet to identify those defendants that have the highest coverage limits and shop for the highest limits that might be available to determine the amount of insurance coverage.

Currently, this information is available after the lawsuit is filed and during discovery. Regarding Senate Bill 1364, Sections 3 and 4 which deal with the Offer of Judgment Statute which has been addressed prior as well.

While this amendment provides a reduction in the rate of interest from 12% to 8%, the provisions contained in House Bill 6811 are far superior.

They do deal with the other element of the Offer of Judgment Statute, which is the need for the information to make a judgment as to whether to accept the offer.

House Bill 6811 contains language requiring the plaintiff to provide information necessary to determine whether to accept the offer. In addition, the House Bill provides a more reasonable reduction in interest rates from 12% to 6%.

We strongly support House Bill 6811. Finally, under Senate Bill 1364, Sections 19 and 20, which deal with insurance rate approval, the procedure outlined for insurance rate approval would be onerous to any insurer currently doing business in the State or companies that we would like to see in the State.

We would strongly recommend that a reasonable threshold be established such that only rate increases exceeding a certain percentage, such as 10%, which is contained in Senate Bill 1052, would be subject to the process described.

It would be certainly a tremendous amount of effort to undergo a 2% rate increase request. I'll conclude my comments there and be happy to respond to any questions.

SEN. MMCDONALD: Thank you. You began your testimony by speaking about reasonable restraints on non-economic damages. Is that the new phrase we're using for caps?

DENISE FUNK: Well, I've been using it for the past year and a half, yes.

SEN. MCDONALD: As far as I know, none of the bills that are out here are contemplating reasonable restraints on non-economic damages.

DENISE FUNK: That's my understanding as well.

SEN. MCDONALD: Is it just CMIC's position that you are asking us to entertain that?

DENISE FUNK: I don't believe we're proposing that, but as of this moment we're the only ones I'm aware of.

SEN. MCDONALD: Now, with respect to the periodic payments, you may have been in the room when I was asking Commissioner Cogswell about that. SB1052

Now that we've had some time to set here and listen to people testify, do you have an answer to what we would do if somebody was 85 years old and the victim of malpractice?

DENISE FUNK: Each of these cases would be treated individually. An 85-year-old person probably would not have future damages. Future damages are the key words here.

Anything that has occurred including non-economic damages prior to the judgment would be payable upon the judgment being entered. You're not taking the full amount of the judgment and structuring it over time.

It's usually used in cases where you have a child or someone who would require a lot of medical care in the future and you have some anticipated timeframe over which that will need to be covered.

You can therefore put into place a structure that will pay that over time. There will also potentially be a provision for a lump sum payout to the State if and when the person expired. The attorney's fees would in all likelihood be paid up front as well.

The other good benefit of this is that particularly for younger people there would be a guarantee that there would be a funding mechanism in case to take care of that person over time and not be wasted away early on after the money's received and then there's no money to take care of the child. That's another [Gap in testimony. Changing from Tape 2A to Tape 2B.]

SEN. MCDONALD: Assume for a moment that we're not going to have reasonable restraints on non-

economic damages, as you've cast it, just for argument's sake.

Are you suggesting that juries should bifurcate their award for pain and suffering that is retrospective versus what they're awarding for future pain and suffering?

DENISE FUNK: I believe the way Senate Bill 1052 lays it out that this would be after the judgment was entered. The judge would meet with both parties.

What often happens in these cases is that the insurance company, to answer the Judge's question, is responsible for investigating structures.

They would go to a structured settlements company or usually two or three of them and obtain different types of structure arrangements. The plaintiff's attorney oftentimes will hire their actuary to make sure that they agree or disagree with a proposed element being made.

At that point in time the judge would sit down with the two parties and make the determination as to how the structure would be done. I do not believe the jury would be in a position to make that decision.

SEN. MCDONALD: Would you have an opinion on whether or not a jury should be made aware that any verdict that they might enter in favor of a plaintiff would be subject to periodic payments?

DENISE FUNK: I think if the law were in place that when the economics of a particular case are laid out in front of a jury they would have a good sense of how much would be future payments.

SEN. MCDONALD: That's what I'm asking you. Wouldn't they be entitled to know it?

DENISE FUNK: I would think so. It would be the law. There would be no reason not to let them know.

SEN. MCDONALD: If that were included, they could contemplate and incorporate the potential for future payments over time into their award of damages.

DENISE FUNK: I think I understand your point. They shouldn't, in my opinion, be allowed to inflate the future payments based on the fact that they're paid periodically.

SEN. MCDONALD: Why not?

DENISE FUNK: These payments would be made to provide care or whatever need is there at the time it is needed. This is recognizing that this is in the future, so--

SEN. MCDONALD: I guess I'm still fixated on the elderly victim and--

DENISE FUNK: --Let me answer that directly. In all likelihood there would be no structure for

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elderly victims. It wouldn't make much sense, probably, for an 85-year-old woman.

SEN. MCDONALD: I agree with you. So where's the cut-off in your estimation?

DENISE FUNK: Again, that's why the judge, plaintiff and defendant would be involved in the ultimate decision.

SEN. MCDONALD: Okay. Now, if we're going to be talking about the elements of how, because you've contemplated this periodic payments issue to involve private settlements as well.

I have to tell you that that's the first time I've heard the suggestion that we're going to mandate the conditions that are going to be incorporated into a privately arranged settlement contract. I've never heard of that.

It's not to say we couldn't do it, but it's a unique perspective. If we're going to inject ourselves into that process, would you think that there would be any value to making sure that those settlement agreements are always made available to the Department of Public Health or Department of Insurance?

DENISE FUNK: I suppose that would be fine. I think the purpose for that is twofold. First of all, as I think everyone is aware, most of the money that is paid out for med-mal cases is in the form of settlements.

If we're trying to make some impact on the problem, we're going to have to deal with the

bigger dollars as well. Certainly, I would expect that there would be a similar arrangement where a judge would be involved in the final.

This is true with a minor, of course. It goes to probate. A judge is involved to make sure everything is taken care of properly.

If the Department of Health were interested in that information I see no reason why it couldn't be given to them. I don't think the Department of Insurance would have a role there though necessarily.

SEN. MCDONALD: Let me commend you for at least being consistent on the issue. I guess I am trying to figure out what the public policy reason is for the State to essentially inject itself and interfere with the privately arranged settlement of litigation in what admittedly is the largest bulk of the cases that are out there.

DENISE FUNK: I guess I don't understand why you'd want to draw distinction between a jury verdict and a settlement. The same elements are at play there.

SEN. MCDONALD: Well, one of the underlying assumptions in our legal system is that to the greatest extent possible we encourage people to settle their differences on a voluntary and amicable basis.

The jury system is in place to deal with those situations where the primary goal cannot be

achieved. For the State to interfere in that undermines the voluntariness of it and undermines the arms-length transaction.

You're really putting the force of the State into that private contractual arrangement and substantially altering the relative bargaining power of one party over another. Isn't that true?

DENISE FUNK: I don't believe that to be true, Senator McDonald. I think the vantage point I'm coming from is to try and find a way to deal with the rising medical malpractice costs. That's why I'm taking that focus.

SEN. MCDONALD: I don't do medical malpractice cases and never have. If I'm very fortunate going forward I never will. I do do litigation, and I understand the dynamic that goes into settling cases. It's not terribly unlike legislation.

You don't always want to see how it's done, it just sort of happens sometimes. I'm trying to figure out in the context of a settlement agreement where, for whatever reason, whatever the motivation is, we derive a number between two private litigants.

In your estimation would you then have to break out that settlement amount in economic damages versus non-economic damages?

DENISE FUNK: Well, no. What we're really talking about are future damages versus incurred damages.

SEN. MCDONALD: But hold on, I agree, that's a fair point. You're talking about future damages versus historical, but you're also talking about economic damages both retrospectively and prospectively and non-economic damages retrospectively and prospectively.

You've really got sort of four quadrants, if you will, of analysis to go through. If we're going to have these settlements provided to the Department of Public Health or the Department of Insurance or wherever so that we can derive statistical data from which to draw public policy conclusions, wouldn't you be requiring parties to actually break that out in the form of a settlement?

DENISE FUNK: I don't believe the non-economic/economic issue is important. When you go to a settlement conference you use much the same approach that you would before a jury.

These are the expenses I've incurred, these are the expenses I foresee for the future, and this is the value of non-economic damages. The process is not that different from a jury making the same kind of decision.

SEN. MCDONALD: It's the bottom-line figure you care about, not so much whether it's economic or non-economic damages.

DENISE FUNK: Correct. Up to the point of the settlement and the future, past and future is where we're drawing the line here.

SEN. MCDONALD: From your perspective then, it's past damages versus future damages, not economic damages versus non-economic damages.

DENISE FUNK: It's not non-economic/economic, just past and future.

SEN. MCDONALD: Okay. Frankly, we've all probably heard about the case that transpired down in my neck of the woods.

I live in Stanford, but there was a case out of Greenwich which wasn't a medical malpractice case, it was a sledding accident case where a doctor was involved in a very unfortunate accident that caused him substantial damages and limited his ability to practice medicine for I believe five or six months.

He ultimately recovered from the Town of Greenwich in a voluntary settlement \$9 million. In that case I suspect you're probably right that the taxpayers of Greenwich didn't really care whether it was economic damages for somebody who was making hundreds and hundreds of thousands of dollars a year in a salary versus the pain and suffering that he is going to experience going forward.

From that perspective I think we might have an agreement that there's an overriding concern in the value of the settlement and not necessarily the components of the settlement. The next thing I wanted to ask you about was the Offer of Judgment.

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operation that A.M. Best deems to be worthy of a rating. They actually visit one site to make that determination.

SEN. MCDONALD: Is CMIC profitable? Last year, was CMIC profitable?

DENISE FUNK: I believe we did make a slight profit for the first time in five years.

SEN. MCDONALD: What was the profit? Was it \$100,000, \$10 million?

DENISE FUNK: I don't know, to be exact. It wasn't \$10 million. Because we're a mutual company, whatever profit we make goes into our surplus or our capital unless we issue a dividend. I would say \$3 million to \$4 million perhaps.

SEN. MCDONALD: Did you put that \$3 million to \$4 million into your capital reserve account? You didn't issue a dividend?

DENISE FUNK: We did not.

SEN. MCDONALD: Thank you. Senator Kissel.

SEN. KISSEL: Thank you very much, Mr. Chairman. It's nice to see you. I'm going to go back to the issue regarding the State's intervention in settlement conferences as well as this notion that seems to be out there in the Governor's underlying proposal and one you seem to espouse even to a greater extent regarding periodic payments.

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I'm very skeptical of periodic payments. I understand that they have value when litigants come together and wish to work out a settlement. I think that Chairman McDonald raised a very good example when he said that you have the four quadrants.

His articulation of that I think leads me to believe that before I even get into the difficulties to impose that after a verdict there are the greater difficulties to impose that on individual parties coming up with a settlement. Let me explain why.

You said you don't really care about the breakup between the non-economic and the economic. Specifically when we talk about non-economic it's pain and suffering primarily.

DENISE FUNK: Loss of consortium, there are other elements. That's basically the one.

SEN. KISSEL: Right. When I look at the example that Chairman McDonald said about the four quadrants, we'll say that today's the horizontal line and you and I working on a settlement. We have the pain and suffering, the non-economic component passed.

We have the fixed dollar amount passed. We have an actuary come in and say based on this person's injury we can with a fair amount of certainty figure out project out hard economic, whether it's projected medical services, lost wages going forward and we can predict other things going forward.

There will be a component for pain and suffering going forward. I represent a client that has been horrendously injured, and you want to now superimpose on the settlement discussions that we're having this structure.

Aside from the fact that the structure is being thrown out there, the periodic payment notion is essentially you give more money to your company.

That's the only reason I'm hearing. More money will go into the insurance companies and somehow that's going to help them reduce premiums for physicians.

DENISE FUNK: In point of fact, a structure oftentimes will pay out because of the time value of money a significantly higher amount to the plaintiff than a lump-sum payment would.

It has the added benefit of being tax-free whereas any investment income earned on a settlement is taxable.

SEN. KISSEL: I agree with that to some extent. I think that will lead us down the path to Senator McDonald's other questioning regarding if I'm a plaintiff's attorney, let's say beyond the settlement stage and I'm before a jury.

I'm going to want to ask for specific jury instruction that goes to what's the heart of the time-value of money so that they can figure all that out.

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If my client who has been injured has to get their money over a period of time, I want the jury to know in their head what the right number is given the fact that the plaintiff is going to get it spread over time. I'll leave that aside.

Back to the other issue though, regarding the settlement. It strikes me that if I'm the plaintiff's attorney and I'm sitting down with you, we haven't gone to court, first of all how would we intervene in this?

Do I have to file a lawsuit for the law to take effect where there'd be some sort of periodic payment?

DENISE FUNK: Yes. There would have to be a lawsuit in place.

SEN. KISSEL: If I just sent a letter out notifying the physician and the physician then passes it on to the insurance company, we exchange documents, at that point we could settle it and we couldn't have this periodic payment service superimposed on it.

DENISE FUNK: No, we could. That happens so seldom that realistically it wouldn't have an impact. For purposes of our discussion yes, we could do that.

SEN. KISSEL: Would you agree that if we did sort of go down the path and have this law, and I as a plaintiff's attorney really see a lot of disincentive to have periodic payments that that might actually mean that there are more

heartfelt discussions prior to the filing of a lawsuit? Maybe to some degree, maybe not a lot, but a little bit.

DENISE FUNK: I'm sorry, could I ask you a question? As a plaintiff's attorney, why would you have a disincentive to move forward with a lawsuit as a result of that?

SEN. KISSEL: If there's a law that says now I have to have periodic payments if I filed a lawsuit.

DENISE FUNK: What I said is that the attorneys' fees are also paid upfront before any consideration of the periodic payments.

SEN. KISSEL: I don't care about attorneys' fees. In my example, I simply care about my client. I think that it's in the best interest of my client, the injured party, to get the money up front. I don't care about attorneys' fees.

You're assuming the motive of the plaintiff is simply the attorneys' fees. I think they also have this overriding concern, ethically as well as this is what they do, that if I can get you all your money today that's better off for you than something less than that and a promise into the future.

We're going off track from where I really want to bring us. You're saying that you really want to look to the past and the future. What I'm saying is that in the example that Senator McDonald gave there are quadrants.

The problem that I see, whether it's before the trial or after the trial, is that there's a very amorphous part that's both before and after today. That's the non-economic. There's non-economic behind and non-economic going forward.

If my impetus is to try to build that initial amount as big as possible, I can see the arguments going down the road whether we're working in settlement or it's after the trial that when the initial malpractice occurred and the trauma was vested upon my client that was the peak period of pain, the acknowledgement of when you lost the use of your legs or whatever occurred.

The immediate amount of treatment that had to occur at that time typically in these cases is all frontloaded. Even though, let's say it was paralysis, you can extrapolate out urinary tract infections and things like that so you have some element of economics going forward.

As much as you want to build in this periodic payment, it's easy to do with the economic side going forward.

If your concern is the non-economic part of this equation, I see a tremendous push by the plaintiffs bar to make this non-economic portion as much on the front side going forward as possible.

I think there are going to be built-in problems regarding what you want to do. I don't think it's practical. I think there are deep-seated

jurisprudential reasons why I don't want the State to get involved in private negotiations.

I don't think that's fair. I think as a practical matter, if we were going to superimpose that, I see real mechanical problems with it as well.

DENISE FUNK: Senator Kissel, the reason that we are even suggesting this, we're coming together, I think all the parties are interested in achieving some solution to this overall problem.

This is one component of trying to solve that problem. If we don't deal with any of these issues we're not going to make any progress.

SEN. KISSEL: I heard you made a profit last year of at least a couple million dollars at the same time physicians were canceling their policies and leaving the State. It strikes me that there's a disconnect there.

DENISE FUNK: The reason that we actually were able to make any profit at all is because the years in which we lost an incredible amount of money, when they were reevaluated this year we hadn't lost quite as much money as we thought we had.

It doesn't have to do with making a profit. It has to do with a reevaluation of our losses and the determination that they weren't quite as bad as we thought they were.

SEN. KISSEL: The last point, and again I haven't really heard a good answer. Judge Pellegrino

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said who's going to pay for the actuaries? The courts are ill equipped to do a super analysis as far as these periodic payments.

Again, Senator McDonald's example has an 85-year-old individual. Indeed, if you look at the tables of mortality and morbidity, you can be 65 and we know what your life expectancy is.

In your construct that's thrown out there, are you suggesting that we should have payments going forward past someone's life expectancy? Would you at least agree that you would have to build it up until that point?

DENISE FUNK: I think when I was describing it before I indicated that there can be all kinds of variations on how these things are structured.

You could have a lump sump payment at the death of an individual if they died prior to the anticipated timeframe in the structure. The estate could receive this money.

The children could receive this money. It could be structured in any number of ways so that at the end of the day there's not a loss of money to the plaintiff.

SEN. KISSEL: Thank you very much. I thank the Chair. I think that we can pass, as the Commissioner of Insurance indicated, meaningful reform this year that will have a dramatic and positive impact on physicians and the premiums they pay.

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I would say that I have great concerns regarding this notion of periodic payments being any kind of solution. Thank you, Mr. Chairman.

SEN. MCDONALD: Thank you. Senator Meyer.

SEN. MEYER: Thank you, Mr. Chairman. Good afternoon. Obviously, the Judiciary Committee's got to look at damages in all cases. Do you favor putting a cap on damages in all court cases or just in respect to medical malpractice?

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DENISE FUNK: Well, I'm here representing only the medical malpractice side of the business. That would be by my proposal. I wouldn't extend it beyond that.

SEN. MEYER: Our job, obviously, is to look as policymakers at the whole field of people who are injured and it's difficult for me as one State Legislator to say we should take one field of injured people and limit their damages. I gather that's what you're saying.

DENISE FUNK: I'm certainly not suggesting that you don't extend it broader. I'm just not in a position to really make that statement or make that judgment.

SEN. MEYER: Let me ask you as a citizen, and give you an example. It's dangerous, I suppose. Let's assume you left the car garage here, the legislative building garage, and you went out and were crossing Capitol Street.

You get on Capitol Street and the light was in your favor and some car came through at 50mph after you leave the building today and this you and you got pretty badly hurt but were out of the hospital in the weak.

You have a painful back for the rest of your life. Would you expect your Legislators to have capped the damages you could recover from having that back in pain the rest of your life?

DENISE FUNK: As a practical matter I think, Senator, that the auto policy limits that almost everyone carries are significantly lower than what physicians are required to carry.

Unless there was some reasons to take that individual to court, I would have to settle for the policy limits they were carrying.

SEN. MEYER: That would be someone who didn't have funds beyond the policy limits. Let's assume you got hit by a corporate car or by someone who was wealthy.

Are you saying that in this State, in this country your right to recover from the pain you're going to feel for the rest of your life from your back is something we should curtail and restrict? Are you just saying it applies only to medical malpractice?

DENISE FUNK: The proposal that we put forward last year regarding restraints on non-economic damages provided up to \$1 million in non-economic damages for any individual claimant in addition to all the economic damages that would

be incurred. I find that to be reasonable, yes, I do.

SEN. MEYER: One of the things that has been a high standard for our country has been our jury system.

What your proposal is doing is suggesting that we Legislators sitting in the ivory tower of this building without benefit of the facts of a particular case have a better sense of judgment than a jury of peers of someone who's been hurt, as for example you in an automobile accident outside of the legislative office building.

Have you thought that through in terms of how you'd be interfering with a very traditional jury system in this country?

DENISE FUNK: I think there has to be a balance drawn here. I think over 30 states in our country have put such restraints on non-economic damages into law. This is not something that is wild and crazy and untested.

I think the balance again has to be drawn between making sure that patients are taken care of properly and the balance as to the cost of providing healthcare in this State, which includes the cost of malpractice premiums.

SEN. MEYER: Let me ask you about the Insurance Department. We were told that last year the Connecticut Department of Insurance in a situation where there are three insurance companies that give med-mal policies to

doctors, that the Insurance Department granted a 90% premium increase against doctors to one carrier.

Are you familiar? I had a chance to talk to the Commissioner of Insurance about that and did not get what I found to be any satisfactory explanation.

Does your company or do you personally talk with the Insurance Department and be sure that there's some regulation on what could become outrageous rate increases?

DENISE FUNK: I will tell you that we submitted our rate filing for a January 1st date on September 29th. The Insurance Department attained outside actuarial review for that and I believe we had at least five meetings with the Department before our filing was approved. Our filing was for 14%.

SEN. MEYER: Are you aware of the 90%? It's well known, isn't it? Do you know any basis for that kind of an increase?

DENISE FUNK: That's what that company and their actuaries felt they needed in premium increases.

SEN. MEYER: They felt they needed that? Let me ask you one final question. As we seek to find some solutions here, would you favor confidentiality of settlement agreement in the med-mal field?

DENISE FUNK: That is currently the status quo. I don't think it's a necessity, no.

SEN. MEYER: Do you feel that confidentiality of settlement agreements might lead to faster settlements or do you feel that this is not a factor?

DENISE FUNK: I don't believe it's a factor. Even if a confidentiality agreement is in place, any moneys that are paid on behalf of that physician are reported to the Department of Health as well as to the National Practitioner Databank.

The fact that there is that agreement in place does not affect our reporting to the appropriate authorities.

SEN. MEYER: Wouldn't your company be more likely to settle a case if you knew that you weren't going to set a public precedent by having that settlement advertised and promoted all over the State of Connecticut?

DENISE FUNK: Again, I would have to get back to the reason that we settle cases. The reason we settle cases is because we've identified that there's liability there and we need to evaluate that and settle the case. That really has nothing to do with it.

SEN. MCDONALD: Thank you. Just one quick follow-up to that. That was an interesting question by Senator Meyer. Is it CMIC's position that you don't care whether settlement agreements are

confidential or that we prohibit confidentiality of settlements?

DENISE FUNK: I think in some cases it may facilitate a settlement, but it's not an important issue to us as a company.

SEN. MCDONALD: Great. Thank you. Senator Cappiello.

SEN. CAPPIELLO: Thank you, Mr. Chairman. Thank you very much for your testimony. I was struck by some of the parallels that Senator Meyer was making. I have a few comments and a few questions for you.

When Senator Meyer was talking about the jury system and that they know better than Legislators that we shouldn't set caps, I think to myself in the criminal justice system we set caps on how people are punished.

We could eliminate all of those guidelines and statutes and let them determine exactly how many years someone should go to jail for armed robbery, for stealing a car, for stealing a computer. We should eliminate those statutes according to that parallel that was given before.

The idea that we would be setting different precedents throughout the Statutes, we already right now have passed vicarious liability reform for leased vehicles in the State but we have not yet and maybe never will pass that for rented vehicles.

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We do make these decisions on our own as a Legislature when we think those decisions are necessary to be made.

With regards to the insurance companies, can I just ask you to restate, are there only three medical malpractice insurance companies left in the State of Connecticut?

DENISE FUNK: Yes, there are three commercial companies. I'm not sure. I did include our company in that, because we are owned by the physicians we insure. Pro Mutual, a company from Massachusetts and GE Medical Protective are the only other two companies, yes.

SEN. CAPPIELLO: Did you say there was a great decline over the last decade or so about how many companies we used to have?

DENISE FUNK: Oh yes, a significant decline.

SEN. CAPPIELLO: A parallel was made to auto insurance companies. I'm not sure that we have a shortage of auto insurance carriers in Connecticut. I even heard there's a problem attracting various carriers to cover auto insurance. I see commercials all the time.

They're all competing with one another. Sometimes because there are so many the numbers go down, the rates go down due to competition. There seems to be no shortage of drivers to purchase that insurance.

Correct me if I'm wrong, but because we've been losing these medical malpractice insurance

companies, obviously they're leaving the State or closing down because I would assume they're not making the money, they can't afford to do business here. Would that be a correct assumption?

DENISE FUNK: That is a correct assumption. Major companies in the country have withdrawn from the business. A couple of companies, two or three that I can think of that were doing business in the State are actually in bankruptcy.

SEN. CAPPIELLO: I would also assume that if there are certain doctors in certain fields where numbers are diminishing, you have fewer positions to even buy that type of insurance. I would assume that having a smaller risk pool could raise rates as well. Okay, thank you very much.

SEN. MCDONALD: Anything further? Representative Farr.

REP. FARR: To clarify one thing, CMIC is a mutual company, is that correct?

DENISE FUNK: That's correct.

REP. FARR: Somebody talked about you making a profit. I know I got an auto insurance policy with a mutual company and all that happens is that at the end of the year I get a refund of part of my rate.

Is that what happens if you have a "profit"? Do you refund it? Do you roll it over to the

next year to hold rates down? How do you handle that?

DENISE FUNK: We review it and make a determination as to whether we can make a dividend or sometimes credit to our physicians for the following year. That's correct.

REP. FARR: So it's a dividend or a credit. What did you do with this year's dividend or credit?

DENISE FUNK: Well, we make that decision in the year following. We look at the results each year and we would make the determination probably in the summer or the fall as to what, if anything, we wanted to do with that money.

We've been losing money for five or six years now. It hasn't been a decision up until this point.

REP. FARR: What is the average rate for obstetricians now? What are you charging obstetricians?

DENISE FUNK: Depending upon the limits of liability it runs from about \$125,000 to about \$150,000.

REP. FARR: If you paid out the million dollars as dividends, do you have any idea what that would do to the rates?

DENISE FUNK: It would probably range. It could provide a 10% to 15% credit.

REP. FARR: The other thing is on structured settlements. I've been involved in some

structured settlements that we negotiated on. I haven't done any serious medical malpractice stuff.

When we've had structured settlements it usually results in the defendant and insurance company simply acquiring annuities. The annuities can be for the life of the individual, they can be fixed term.

I've got one now where one annuity was for the life of the individual and the other part of the settlement was an annuity for a fixed term with children named as the beneficiaries.

That plaintiff was probably in her late 70s at the time we agreed to that, and we understood that at the time. In my experience the annuities are not a difficult thing.

An annuity is something desirable for both sides. I don't see why legislation is needed to talk about having a structured settlement.

Usually it's desirable from the company's point of view and the plaintiff's point of view. With the annuity, as you point out, you avoid some taxes.

DENISE FUNK: To be honest, in the past ten years or so we've had very little interest from the plaintiff's side in entering structured settlements. They don't want to do it, which is why we haven't been able to do it.

REP. FARR: Do you have any idea what would motivate them to? I've seen structured settlements

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where you structure part of the settlement. It's not a question of fees or anything. You can get that out of part of the settlement.

DENISE FUNK: I'm not sure what the understanding is. Perhaps it could represent what Senator Kissel said, that they would prefer for their clients to have the money up front. There has not been interest on the plaintiff's side to enter into the se agreements.

REP. FARR: Okay. Thank you very much.

SEN. MCDONALD: Thank you. Is there anything further? If not, thank you very much. We will pause for a public service announcement. Somebody apparently lost a wallet. Yes, in fact there is cash in it.

You'll have to properly identify it to retrieve it, however. There's not that much in it. The next speaker is Patrick Moynihan, as opposed to Pat Monahan.

Apparently we have a plethora of Irishmen in the room. This is Patrick Moynihan, from the bail bondsmen.

PATRICK MOYNIHAN: I'm the only Pat Moynihan that's a bail bondsman, I'm sure about that. Mr. Chairman, Members of the Committee, my name is Patrick Moynihan, not the other one.

I'm here today on behalf of MaryAnn Casey, president of the Connecticut State Surety Association, who is out of state. Our

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DOUG DAVENPORT: In the past we didn't have payment plans, at least not to the enthusiasm that they have at the moment. It didn't lead to any overcrowding.

Again, you're going to have some limits on this. It's not just going to be the front-rebating which it very often is now. There may be something that could be worked out on that matter.

REP. LAWLOR: Any further questions? Thank you. Next speaker is Mike Neubert.

MIKE NEUBERT: Good afternoon, Representative SB1052 SB513
Lawlor, Members of the Committee. My name is HB6817
Mike Neubert. SB1362

I'm with the firm of Neubert, Pepe & Monteith and I'm here to testify on behalf of the Connecticut State Medical Society in connection with five proposed bills that will potentially impact medical malpractice litigation.

For background purposes you should know that I've been representing healthcare providers and hospitals in medical malpractice cases since the early 1980s.

I know this Committee is aware of the intense debate surrounding the dramatic rise in malpractice premiums in recent years.

Regardless of the disagreements regarding the cause for the steep rise in malpractice insurance rates I think everybody's in

agreement for the need of legislative reform in this area.

The first bill I'd like to address is Proposed Senate Bill 1052, AN ACT CONCERNING MEDICAL MALPRACTICE. I would like to start with section one, which requires a written opinion of similar healthcare providers to be provided or submitted along with the complaint.

Presently in medical malpractice cases, they can be filed with a simple good faith certificate which is signed only by the attorney.

This merely states that a reasonable inquiry has been made as permitted by the circumstances and that there are grounds for a good faith belief that there has been negligence in the care and treatment of the plaintiff by the defendants.

The plaintiff's counsel is required to file a written report signed by a physician providing a basis for the conclusion that malpractice has been committed. As a result, malpractice cases are presently instituted without such a written opinion.

It's my experience in the past 20 years that the present statutory scheme does not adequately ensure that an attorney filing a medical malpractice action has a reasonable basis to believe that the defendants have violated the standard of care in causing a plaintiff's injury.

I can tell you that it's virtually impossible, despite the statutory provision for it, to get your hands on the basis for that information. Under the present statute you can only do so at the conclusion of the case.

The Proposed Bill before you would require counsel to obtain a written opinion signed by a similar healthcare provider that there are grounds for a good faith belief that there has been negligence in the care and treatment of the plaintiff.

Keep in mind that in a medical malpractice case the plaintiff has the burden anyway of providing expert testimony to prove his case. This clearly can't be viewed as an added burden. It's just a matter of when this opinion is provided.

The Bill would also provide that failure to obtain and file the written opinion would be grounds for an immediate dismissal of the action.

In our view, the Society's view and my own personal view, this requirement would help ensure that there's a reasonable basis for filing a medical malpractice action under the circumstances.

It would help eliminate some of the more questionable and meritless claims filed under the present statutory scheme. The next section of Senate Bill 1052 I'd like to address is the Offer of Judgment in Section 3.

I know there's already been testimony here today, and there seems to be some interest in this Committee for reforming the present situation and the present status of the Bill. I think everyone is familiar with it presently.

A plaintiff can file an Offer of Judgment at any time, regardless of the state of discovery. Defendants are required within a mere 60 days to respond.

In my experience, since that Statute's been adopted, I don't know of one defense attorney, including the one sitting before you, that has ever accepted an Offer of Judgment.

I would suspect that if you commissioned a study you might find one in the whole State that has been accepted since this statute has been passed. I presume that the Statute was adopted originally to promote settlements.

It has hardly achieved that at all. It's only used for a purpose to drive up damages potentially in the event of a verdict in excess or equal to the Offer of Judgment or to provide unfair leverage in negotiations. Certainly, the 12% contributes to that.

That's constantly thrown in our faces as to the potential damages you might face. While I don't necessarily think the 12% is what's a factor in deciding whether defendants settle cases, I do agree with Ms. Funk that it's ultimately the merits of the case, I do think that the Statute is inherently unfair.

If indeed you want plaintiffs to have the ability to file Offer of Judgment, you should also want defendants to have a clear and fair opportunity to review sufficient information to know what the case is about so they can fairly respond.

That sufficient information would clearly involve all the medical records. Under the Statute that's proposed they would have to provide HIPAA authorization 60 days prior to the Offer of Judgment, allowing defendants to obtain all those records.

They would also have to provide a clear statement of damages. Most importantly, they would have to disclose experts. The only part of this bill I have some disagreement with is the amount of time which defendants would have to respond.

Presently, in the Bill I reviewed, it was 30 days. I think that under the circumstances this is not sufficient. These tend to be extremely complex cases, and I think that 90 days would be more appropriate.

Committee Bill 513 is AN ACT LIMITING EXPERT TESTIMONY IN MEDICAL MALPRACTICE CASES. We share Judge Pellegrino's concern and skepticism regarding this legislation.

I personally think it proposes a radical if not reckless alteration of the status quo, which honestly I don't think is the source of the problem that we face. Obviously, both sides get to disclose experts.

services and injuries the plaintiff did indeed not suffer and award damages they're not entitled to.

Finally, the last bill I'm here to speak to you about is Raised Senate Bill 1362, AN ACT REQUIRING DISCLOSURE OF LIABILITY LIMITS PRIOR TO FILING THE CLAIM.

I know you heard testimony earlier from a woman associated with the insurance industry who is opposing it. We, too, oppose this bill.

To me, this bill would only serve to allow plaintiff's attorneys to learn limits of liability prior to filing suit and then tailor their lawsuit towards the individual who has the most insurance.

It shouldn't be that process when somebody is seeking compensation as the result of an alleged tort. We vehemently oppose the Bill. There does not seem to be any valid public policy or purpose that would support it.

It would just tend to result in lawsuits that were aimed at individuals with the most insurance. I have also submitted written testimony on those bills. I'd obviously be happy to answer any questions.

REP. LAWLOR: Thank you. Senator Kissel?

SEN. KISSEL: Thank you very much, Mr. Chairman. I know there are a lot of people. I'll be very brief.

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Now that caps are sort of off the table, whether your folks are happy with that or not, it strikes me that the compromised legislation that's being worked on regarding medical malpractice, we're in close agreement on a lot of things you're concerned about.

Again, the question is absent caps can we come up with meaningful medical malpractice reform that will have a positive impact on physicians within our State?

Do you feel that if we can incorporate a lot of these other ideas into a bill that that will have a positive impact upon the folks that you represent?

MIKE NEUBERT: The best answer I can give is hopefully. I have read and reviewed all of it. As a whole, I think that there is some sincere hope that it will make a difference, also hopefully with the understanding that if it fails to do so that other considerations will be reviewed.

I think it's clearly a step in the right direction. As a trial attorney I haven't done all the fiscal analysis some of the other people that have testified before you on this issue have. I think any reform is certainly a step in the right direction.

SEN. KISSEL: I think that it's not widely debated, it's probably not even well-known, but you touched upon it at the beginning of your testimony.

It strikes me that one of the things I've always firmly believed in, in any kind of medical malpractice legislation, is getting that physician's report appended to the complaint.

Granted, we're going to strike the physician's name for a variety of reasons. That's part of the compromise.

Have the substance of the report appended to the complaint so that you as the defense counsel can review the nuts and bolts of what's in there and make a reasonable determination.

I think that's a great reform, as opposed to the current attorney just sort of signing off in good faith. How do you generalize that without going right to the integrity of the plaintiff?

If you're coupling that with something such that plaintiffs could not file an Offer of Judgment for six months post that date and then perhaps you'd have six months to review that, we'd build that in and then also during that six-month window you're going to have the report appended to the complaint.

Then you can go about the standard requests for disclosure and production. Hopefully within that timeframe you can get most, if not everything, that you're looking for.

Granted, they have a duty all the way up until the end of the trial to provide information, but it strikes me that if we have a six-month

window in there, and again I'm thinking of things that have been discussed, sort of a variation of what's before us today.

If we had the request for production and discovery and they didn't comply, you could at least have one trip to court or maybe even two for a request to the court to say we've requested this, let's assume they're going to ask for an extension right of the bat.

You're still going to get into the courthouse at least once to start creating a record that you're either having a very difficult time attaining the information or that it's going to come together.

I'd like to believe, and maybe you can share with me that when you couple at least those components together that you have a much better ability to assess any offers that are made.

MIKE NEUBERT: It's clearly an improvement. I would respectfully disagree with the six-month assessment.

My experience, and I don't think it matters whether you're on the plaintiff's or the defendant's side of the bar, is that because of the complexity and the way these cases proceed, they last for four to five years in many jurisdictions.

Meaningful discovery really isn't obtained in six months. That's just reality. I'm not sure I would say that they can be filed within six months.

I like the provision that they have to provide HIPAA authorizations in advance. We're only talking 60 days in advance of filing the Offer of Judgment. I also think that the disclosure of experts is important too.

I still think that if we had a meaningful Offer of Judgment Statute like that, we might actually find that cases were resolved as a result of the Offer of Judgment based on the information provided, provided that the Offer of Judgment was reasonable.

Call me a cynic, but right now the present status is that no plaintiff wants an Offer of Judgment accepted. If you called them and said it was accepted, they'd probably be shocked and figure it was way too low.

I think that you're going in the right direction, but I would strongly recommend something a little closer to what Senate Bill 1052 envisions, which is that you cannot file an offer of judgment until you meet those three requirements.

If you do in six months, that's fine. I have no problem. If the plaintiff wants to disclose his experts within six months, wants to give me all the HIPAA authorizations and wants to give me a clear statement of his damages within six months, which I think he ideally should be able to do since presumably they investigate the case for a number of months before they're ever filing it if they're doing their job, they should be in a position to do that.

To just say well, after six months you can file an Offer of Judgment, I don't know I agree with that. I still think the three requirements for filing an Offer of Judgment are critical.

With respect to the doctor's written statement, to me that just makes good sense. Clearly that's going to help defendants accept cases earlier, as you pointed out. I think that will perhaps lead to a quicker resolution in many cases.

SEN. KISSEL: One last question, Ms. Funk had testified earlier, or stated in her opinion that she didn't feel that confidentiality of settlement agreements helped move matters along.

As someone who's represented physicians, my question is that I've always thought that one of their concerns was that their reputation would be damaged.

I'm willing to accept the fact that plaintiffs might be able to make a case. But if I was a physician involved in a case, I wouldn't want my reputation damaged.

Therefore, confidentiality is a pre-requisite to entering into any kind of settlement. Do you feel that confidentiality has importance?

MIKE NEUBERT: It is very important to the physicians and healthcare providers that I've represented. I think it will continue to be, there's no doubt about it. I think that the

confidentiality agreements that we enter into don't harm the plaintiffs.

Typically, frankly, I think a lot of the reasons they don't want confidentiality is because plaintiff's lawyers want to tout their own successes.

I think the fear that doctors have is opening the newspaper the next morning and seeing that Dr. Smith settled a case for \$2 million or whatever, or even \$750,000.

It doesn't matter. Just the fact that it would be trumpeted in the newspaper is something that could impact on them. This information is available anyway now through the DPH website, in other words settlements and verdicts. The patients aren't hurt.

They go to the website to find out what their doctor's medical malpractice history is. I'm in favor of maintaining some ability to enter into confidentiality agreements.

Whether some limitation needs to be put on that I don't know, but I certainly would be against it being prohibited.

SEN. KISSEL: Okay, thank you very much. Thank you, Mr. Chairman.

REP. LAWLOR: Senator Handley?

SEN. HANDLEY: Thank you. I'm a little concerned about this issue of this confidentiality area. It seems to me that we in this arena have the

public health and safety as one of our major concerns.

It does trouble me that we often don't have complete information as we as ignorant consumers shop for a doctor. I do understand, and I did check the Connecticut Medical Society's Public Health listing.

I saw this. Certainly, that's a wonderful help. How soon does that information get posted? [Gap in testimony. Changing from Tape 3A to Tape 3B.]

MIKE NEUBERT: As you know, all settlements and verdicts are reported to DPH. I think the first question is what's the requirement on insurance companies or people who are making settlements to report it, how soon?

I assume it's a 30-day requirement. Presumably within 30 to 60 days it will get posted. I don't know that.

SEN. HANDLEY: I think that's an important issue in terms of as I said our function, which is the public health and safety involved in whatever work we do here.

MIKE NEUBERT: If I might say something very briefly on the confidentiality issue, again keeping in mind that the information is going to be available in the proper context on DPH's website, because they really explain what the impact of a settlement of a case means.

I think the doctor's concern, thus my concern or the hospital's concern is that when you have what might be an inflammatory article in the newspaper, is that something that really serves the benefit of the public, or does it serve to scare them away from a doctor who maybe is a very good doctor?

We have no control over the process of what a reporter writes. Very often, obviously, it's the plaintiff's lawyer who's going to talk to the lawyer and is going to set the tone of the article.

I'm not sure the type of information you're looking to get to the patient is really going to be a benefit to the patient population.

SEN. HANDLEY: I'm not going to continue this discussion. I do think it's an important issue that we at this side of the table have to think about.

REP. LAWLOR: Representative Currey.

REP. CURREY: Thank you. Good evening. As I look at your testimony, I'm looking at sections one and three of Senate Bill 1052. Are you saying that those would be the most beneficial pieces before us to solve the healthcare crisis?

MIKE NEUBERT: With respect to the medical malpractice issues as they impact litigation, there are other parts of that bill which I think deal with the issues about the Connecticut Medical Examining Board and the Department of Public Health, which another

representative or individual from the Connecticut State Medical Society is going to testify about.

I don't want to undercut the importance of that aspect. As far as the impact on medical malpractice litigation, yes.

REP. LAWLOR: Senator Meyer.

SEN. MEYER: Thank you, Mr. Chairman. Mr. Neubert, I compliment you on the constructive quality of your positions and your testimony.

I want to ask you, in connection with Senate Bill 1052, which as you pointed out provides that if the plaintiff's lawyers would file the written expert opinion the case could be dismissed.

Do you understand that would be a dismissal with prejudice? Or could the plaintiff come back with a new complaint?

MIKE NEUBERT: I think the latter. Obviously, the Statute doesn't say with prejudice. Of course, the Statute of Limitations is always an issue. Let's say you were to file a case. The letter doesn't state what he says it says and the court agrees with me and dismisses it.

I guess clearly he could have another bite at the apple and submit another complaint with another letter or possibly respond by attaching the letter that met the requirements of the Statute.

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I guess my answer is that it doesn't say with prejudice so I assume it is not drafted with prejudice in mind.

SEN. MEYER: Then it doesn't have a lot of teeth.

MIKE NEUBERT: It might or might not. Obviously this isn't going to impact the majority of cases. We're talking about the cases on the margins.

Those cases where attorneys, based on their own judgment and maybe in good faith have misread what an expert's told them, we don't know now what an expert's told them.

Very often you hear what you want to hear as an attorney, or interpret what's been told to you as you want to interpret it. The fact of the matter is that if a letter's been provided or he/she can't get a letter.

In other words, if the doctor's not willing to sign on the dotted line, maybe that's a good indication that this isn't a good case to bring. We don't have that hammer, so to speak, over the plaintiff's counsel's head at this point.

If part of what we're trying to do here is eliminate those cases which should not be in the system then I think this serves to do it.

SEN. MEYER: I introduced a bill that would have required the screening of cases. I set up a screening mechanism. The Chairs of this Committee did not think that that bill

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obviously had a great deal of wisdom, as it has not seen the light of day.

Do you feel that this bill, Senate Bill 1052, is probably a better way to handle it than the screening process? They're both trying to get at the same kind of goal.

MIKE NEUBERT: I think it's cheaper. The screening process, one of the concerns is that I suspect it adds another layer in the judicial system which has to be funded in some respect.

It actually may increase the costs in other respects. I know the screening mechanism has been adopted in many states, I think I read something like over 30 states at one time or another, although I also think I read that it's only actively used in about five.

I haven't studied the statistical impact, so I can't speak to that issue. I think the aim is noble. This may be an easier way to try to achieve the same thing with less expense.

I can't speak to the exact legislation, but I certainly know the type of legislation you're talking about.

SEN. MEYER: I'm hesitant to call on your help, but if you're able to give me a reference to the screening legislation of the states, I would be appreciative of that.

MIKE NEUBERT: I can send that to you.

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SEN. MEYER: The last question I have is on the experts, the Bill that would limit the experts to one court-appointed expert. You've come out against that. You know, when I first read that--

MIKE NEUBERT: Strongly. Completely, and on behalf of the Society, as a trial attorney, I think probably even plaintiff counsels would agree with me on that.

SEN. MEYER: --Well, I've been a litigator during my life and I think I understood your point of view. I also saw it as a way to reduce the costs of med-mal litigation, the cost of time and the cost of experts.

You've considered that and on balance you feel that not being able to have your own expert takes away some due process.

MIKE NEUBERT: I do think it takes away some due process. With all due respect, I think again the aim is noble, but I think the process is fraught with problems and puts the judge in an untenable position of trying to select one expert. I'm not in favor of it.

SEN. MEYER: Thank you, Mr. Neubert. Thank you, Mr. Chairman.

SEN. MCDONALD: Thank you. Senator Roraback.

SEN. RORABACK: Thank you, Mr. Chairman. Good afternoon. I have two questions. The first one, I think you said that in your experience you can't ever remember a defendant having

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accepted a plaintiff's Offer of Judgment? Do defendants also have an opportunity to file Offers of Judgment?

MIKE NEUBERT: Although meaningless, but yes, they do.

SEN. RORABACK: Okay, because they're meaningless, do you ever file them? I guess that's not very good phrasing.

MIKE NEUBERT: I'll tell you what. I have filed them, but only at the insistence of a client.

SEN. RORABACK: And they probably want you to put zero on it, right?

MIKE NEUBERT: No, they might not. I don't recall the numbers. Literally, if I've done it, it's one or two times. The problem is that the best you can get are costs if you win. It's not the same clout. It's not 12% on top of a nice number.

SEN. RORABACK: We've just spent hours and hours gnashing our teeth over interest rates and Offers of Judgment. It's helpful to learn that at the end of the day they may have some leverage in settlement negotiations, but they're not often accepted.

MIKE NEUBERT: They're never accepted. Their leverage in negotiations is a question that I think is a good one. Is it fair leverage? I'll admit it's leverage in some respects.

We're constantly beaten over the head by judges saying well, you realize they have an Offer of Judgment in here. If you get hit for \$4 million, that's going to translate to \$8 million.

In other words, is it's going to translate to a windfall for the plaintiff, is what you're telling me, Judge. And because of that and because we don't want the upside risk we should pay something we don't want to pay.

We all know that's what insurance is about, but I think it's part of the problem with the system. I think there's overpayment on settlements as a result.

SEN. RORABACK: The second question that I have, Colorado recently passed a law which enabled healthcare providers, physicians in particular, in case of an unanticipated outcome to actually apologize to the patient and say you know, patient, you didn't get the outcome you were hoping for.

I'm sorry for that. The law in Colorado says that if the physician comes clean with the patient, it's not going to be later used against them in a court of law.

Right now, doctors run the risk of opening themselves up to a lawsuit if they come clean with a patient.

I'm just wondering, in your experience, how many of the cases you've had have maybe been the result of physicians concealing their

mistakes and the rage that that can instill in the injured patient resulting in a lawsuit? Do you think this law would help in Connecticut?

MIKE NEUBERT: I think it could very well. I'm familiar with the Colorado law. I recently reviewed it. I also read a publication from the Joint Commission on this whole issue, that we're approaching the whole issue of malpractice in the wrong way because the system is not set up to protect the patient.

It's designed for physicians and healthcare providers to hide their mistakes. If, indeed, in Connecticut or most states a physician were to come in and say I'm sorry about the outcome, not even knowing whether it was his fault, guaranteed plaintiff's counsel would try to turn that into an admission.

The plaintiffs would claim that that was a sign of guilt or admission of guilt. The other issue is, and I think in that regard the legislation is beneficial.

I think there is some statistical truth, certainly there are studies that have shown that if physicians own up early on to a mistake being made and discuss it openly with a patient and also efforts are made to figure out how to best deal with it, that that can help in eliminating the filing of a lawsuit.

There's a psychological aspect to this whole process that if allowed to be addressed earlier and honestly, potential plaintiffs may not be motivated to pursue.

I think you're right, because the system encourages covering up or not saying anything, there's resentment that's built up. That resentment and anger fuels the whole litigation process. It can't help in the resolution of these matters.

The Colorado legislation won't resolve things, but maybe it would help. Certainly, in the present state I think doctors, and I think they're probably instructed quite often to not say anything. If you do, it's going to be interpreted as an admission.

SEN. RORABACK: I thank you for your testimony. Thank you, Mr. Chairman. Thank you for your answers.

SEN. MCDONALD: Representative Farr?

REP. FARR: I have a couple of questions. One relates to the issue of Offer of Judgments. In your experience, how long does it typically take for a case to get to either go to a trial or get settled, a major malpractice case?

MIKE NEUBERT: Major malpractice cases, in my experience, in your major jurisdictions which would be Bridgeport, Stamford, New Haven and formerly Hartford when I used to practice up here, three to five years would be the range. Obviously, it could settle earlier.

Very often these cases don't settle until a time very close to the end of discovery and within months of trial. Whether it's

settlement or trial, we're talking about major cases lasting for a significant period of time, a number of years.

REP. FARR: When are Offers of Judgment made?

MIKE NEUBERT: They come in at various times. I think that frankly, the way the present Statute is set up, the more astute firms file them earlier knowing they're not going to be accepted.

As you know, I think in the present scheme if you file them within 18 months of when the case is filed, the interest relates back to when the case was filed.

Again, the attorneys who are on top of their cases I think file them early. That, of course, promotes that they're not to be accepted because you don't have all the information.

REP. FARR: The current interest is 12%, is that correct? If it took four years and related back to the time to settle this, it would be 48% plus some compounding on the interest?

MIKE NEUBERT: I think it's simple interest, as I recall. In any case, that's correct, but only on verdict. Obviously, while it could be a factor in motivating settlement, we never sit there and calculate interest.

Maybe the plaintiffs do in their mind. It would only be on a verdict. You're right. It

would go back four years and be 12% per year. It adds up, believe me.

I've been told that if you've been hit for \$10 million, you realize that with the Offer of Judgment you're going to pay \$16 million. It can jumpstart the number incredibly at the higher ends.

REP. FARR: One would assume that if it's four or five years out there that any settlement is going to reflect that value. Nobody's going to ignore the fact that if you go to trial you're going to be potentially hitting extra interest.

MIKE NEUBERT: I don't agree with that necessarily. The argument's thrown in our face, but I think as the president of CMIC pointed out, I do agree with her on this.

I think that ultimately the people who pay the money really look at the merits of the case, the liability of the case and the damages of the case.

They're not necessarily intimidated by 12%, at least not to the extent that they're going to increase the offer significantly.

I think it may play a part in terms of ultimately deciding do we take this case or trial or not, but I don't think it necessarily impacts the amount they pay.

REP. FARR: Why wouldn't it?

MIKE NEUBERT: Because that's how they approach it. Their approach is such that they're willing to pay out what the merits of the case demand. They're not going to pay you a percentage of what you could get if you got a certain verdict and you got the 12%.

They just don't do it that way. I know I'm repeating myself, but it may be a factor in terms of them saying do we want to run the risk of going to trial and expose ourselves to the additional \$3 million, \$4 million, \$5 million or whatever it would be in interest?

My sense is that it does not impact in that regard, but it would impact the decision of whether they choose to go to trial or not.

REP. FARR: Another question is, do you know the largest verdict against an obstetrician in Connecticut?

MIKE NEUBERT: Fortunately, it isn't one that I represented. No, I don't. I know of some large verdicts in Connecticut, down in New Haven. They didn't involve obstetricians.

I can think of two involving the hospital in New Haven, which will remain nameless. They did not involve an obstetrician.

REP. FARR: Do you know how many obstetricians there are in Connecticut?

MIKE NEUBERT: No. I'm sure there are less than there were four years. I think that's probably fair to say, but I don't know.

REP. FARR: Okay, thank you very much.

SEN. MCDONALD: Anything further from the Committee? Let me apologize first for not being here for the initial part of your testimony, although I've read what you submitted and heard many of the questions by other Members of the Committee.

I just wanted to dig a little deeper on the Offer of Judgment testimony that you had. I don't know if it was modified when you testified orally, but you said in your testimony that while the Offer of Judgment Statute was originally intended to promote settlement of cases before trial, it has never achieved this goal. You don't think it has any utility in helping settle cases in its current configuration?

MIKE NEUBERT: What I was referring to specifically was that it doesn't settle cases by virtue of it being accepted. I know the argument by some Members of this Committee is that it's a useful tool to beat defendants into settlements they otherwise wouldn't accept down the road.

I recognize that that's the reason plaintiffs file them. I would too, if I was on their side. It is potentially an intimidating tool.

Again, we're looking into the hospital's mind, the insurance company's mind, the payor's mind. Are they paying more money or settling cases only because of this Offer of Judgment or in

large part because of the Offer of Judgment? I can't say that.

In my mind, I think the Statute is a failure in achieving what I thought it was designed to achieve, and that is to provide the plaintiff to make a fair demand within a period of time, a completely unreasonable period of time in my judgment, for the defendant to make an assessment of whether to accept it.

If that was the goal and that's what's written, it didn't achieve that. If, as a leveraging tool, a negotiation tool it's been effective in resolving some cases, I'm not going to disagree with you. Do I think the Statute should be preserved just because of that? I don't.

SEN. MCDONALD: I appreciate that answer. One of the things that we've been struggling with on that question is whether or not we wanted to have some kind of bifurcated Offer of Judgment Statute, one for medical malpractice cases and one for the rest of the litigation system.

I clearly am opposed to the notion. We have one civil litigation in the State. Setting up separate systems really would create a very bizarre result in the end.

When I look at this whole issue, I don't just look at it from the perspective of medical malpractice. Perhaps you look at it that way, I don't know if you have other practice areas as well.

In contexts other than medical malpractice, I do know that the Offer of Judgment Statute has a lot of merit to it.

I will agree with you that it's probably not often the case where somebody would accept an Offer of Judgment during the 60-day window that they have to do so. It does happen in some commercial litigation, it's not unknown.

It may be unknown in the medical malpractice area. Really, at it's core it has a lingering effect. It has a lingering impetus, if you will, to try to propel litigants to settlement.

It may have more value or eventual club effect, if you will, on a defendant in that lingering tail. It still has a role to play.

What I'm trying to figure out from you is whether your concern as a defense attorney is focused primarily on the rate of interest or the timing continuum that we've set up in this Statute.

MIKE NEUBERT: It's the latter, not the former. I think 12% is excessive. I think the bill I looked at set it at 7%. That certainly seems more reasonable.

I think the potential for a windfall for a plaintiff exists at 12%, and I just think that's wrong. I just wanted to very quickly speak to an issue which I would respectfully ask you to at least reconsider, and that is whether malpractice cases may need a separate piece of legislation in this regard.

I agree, you hate to start doing carve-outs in civil litigation because you'd like to think your statutes should apply broadly.

On the same token, there are specialized interests in this country and Legislators have never hesitated to pass laws in particular industries in which the public interest is very high.

I think health, malpractice and the issues we're talking about here today, the reason you have all these speakers is that these are enormously important issues. They aren't the same in the smaller tort cases.

The Offer of Judgment Statute that's on the books may be an effective tool in auto accident cases and other non-medical-malpractice cases. I would actually probably disagree with you.

In most cases I would agree with you, but in this particular case I don't think a carve-out for medical malpractice cases would be inappropriate.

I just think it's one of those things that the Legislature needs to decide what's the best public policy for an issue that's clearly one that you guys have had to deal with for how many years now? Every two years you're going to come back and revisit this issue.

SEN. MCDONALD: You know, to my knowledge I've never had the privilege of meeting you before, but you have a tremendous reputation in this area.

I deeply appreciate your viewpoint. I profoundly disagree with it, but it doesn't mean I don't appreciate it.

Frankly, this sort of really gets to what I consider to be one of the main causes of this crisis, that is that in the context of what you're describing which is that malpractice premiums are going up, the practice of medicine is under extraordinary pressure, I think everybody agrees that that's the case.

The difference is that in the context of a personal injury action, for instance the injury action that I spoke of earlier in the Town of Greenwich, if that was a business, there were personal injuries of that magnitude and their premiums are going up in property and casualty, liability for all of their insurance requirements.

The difference is that almost every other business, every other profession, every other individual that carries on a business activity has the ability to modify their business model and adjust for increased costs.

Nobody likes it, it's not good, it's probably not even good for business, but if you're a product manufacturer and you suffer a huge loss, you can adjust the rate structure for your products.

The problem in large measure is that in the medical community doctors are constrained by forces outside their control. It's not the rate of increase. It's extraordinary.

It's that they have no way to pass on that cost because of a failed economic model for the practice of medicine.

When you say that we should carve out something for the medical profession in the Offer of Judgment Statute I understand the motivation. We're looking for a release valve to let some of the pressure out of the practice of medicine.

To me, that's making victims of malpractice bear the cost of a failed national medical strategy. The Medicare and Medicaid reimbursement rates haven't been adjusted for 30 years. There are HMO factors that are just stifling to the practice of medicine.

When I look at the Offer of Judgment issue I don't consider it necessarily to be the fact that we're trying to create two separate systems. I think that's papering over the real problem.

I'm trying to figure out what the right balance is between an interest rate that is sufficiently high to prove helpful in driving all litigants towards settlements and the necessary timeframe within which to offer such an Offer of Judgment, and to evaluate an offer and accept it.

If I heard your testimony correctly, it's the time structure that's more critical rather than the rate--

MIKE NEUBERT: And information, that's critical.

SEN. MCDONALD: Right. If we said that we were going to allow a different timeframe within which to craft an Offer of Judgment, it may very well be that you have a more meaningful opportunity to evaluate it as a defense attorney.

You might be motivated to accept an Offer of Judgment because you want to have full information or maybe not full information.

We can still wind up doing discovery in the middle of a trial sometimes, but a better quality of information and therefore an opportunity to evaluate it and evaluate the risks of a higher interest rate if you didn't accept it.

MIKE NEUBERT: That's true. Again, I think 12%'s a little high, but I understand that you would want a rate that would motivate defendants.

I think that the more information and the time issue that we're talking about, even though I might end up picking up the phone and saying to the plaintiff's attorney I'm not going to accept your Offer of Judgment for \$5 million, but you've convinced me that we have something to talk about so let's get together.

What I'm trying to say is there is a carry-over effect by virtue even if the Offer of Judgment in itself isn't accepted.

The additional information may also help people push towards a quicker resolution and a fairer resolution. One other thing about the Offer of Judgment, you said that it's a release valve. I think that's a good way of putting it. I realize that there are other problems.

The one you're referring to is that doctors get squeezed on both ends and can't push back on the other end, the payor end, because they just don't have the negotiating leverage. Maybe you're going to take care of that as well, but--

SEN. MCDONALD: I think that's the national problem that the entire country is struggling with.

MIKE NEUBERT: --having said that, I don't think that we're asking on the Offer of Judgment Statute that the plaintiffs take less. We're not asking them to take the brunt, so to speak.

We're just merely saying that in the process if we're going to try and promote fair settlements based on fair information, then let's design a statute that does that.

We're not saying that plaintiffs should get less than what they're entitled to based on arms-length negotiations. That's all I'm saying.

SEN. MCDONALD: Let me ask one final question. I assume from your testimony that you predominantly, if not exclusively, represent hospitals in medical malpractice cases?

MIKE NEUBERT: Primarily, but I have represented and continue to represent a fair number of physicians as well. Our practice has transitioned a little bit more towards hospitals in recent years.

SEN. MCDONALD: Your clients are the physicians involved. You're working with the insurance companies as well in crafting settlements?

MIKE NEUBERT: Less so. To be honest with you, most hospitals are self-insured and--

SEN. MCDONALD: I'm talking about when you're representing physicians.

MIKE NEUBERT: --Oh yes. Although, in many cases a lot of physicians we're representing are covered by captives that have been started by hospitals, which takes the insurance company out of the equation.

I have worked with a lot of insurance companies who have insured doctors over the years, METNA in the 80s, CAN in the 90s, CMIC in the 90s--

SEN. MCDONALD: Are you currently working with any of them?

MIKE NEUBERT: --No.

SEN. MCDONALD: Good. Let me ask you this question. One of the things I've heard consistently is that there's a motivation on the part of insurance companies to not realistically evaluate cases early on in the case.

They will benefit from prolonging the litigation and, as you indicated a little earlier in your testimony, really get down to the brass tacks of negotiating settlements in the couple of months right prior to a trial. Why is that?

MIKE NEUBERT: Okay, well the issue about what I said about in reality cases not settling until a few months before trial, I'm not sure I would lay it at the footsteps of insurance companies.

Again, I think it's part of the process in medical malpractice cases, the way the litigation proceeds. Frankly, in the bigger cases and most of my cases, the plaintiff's counsel does not disclose their experts until three years into the case and sometimes kicking and screaming.

There are then depositions because a lot of these doctors are out of state. The deposition process can get dragged out. Of course, they then want to take your experts. All of that process really contributes to that delay.

With respect to whether it's in insurance companies' interest or seems to be in their interest to delay settlement, I think that really goes by the individual insurance company. I think it even goes in cycles.

I think there are probably times where with insurance companies senior management takes a stance where we're going to defend more cases, we're going to aggressively defend, we want to send a message out to plaintiff's lawyers.

Then there will be a change in the management, that philosophy, because it changes at the top and they'll try to identify cases earlier on that they want to settle. I don't think that one size fits all in the insurance industry. I think it's subject to change over time.

I don't think, regardless of whatever philosophy an insurance company has, that that's necessarily the reason or even a significantly contributing reason as to why these cases take three to four years to not only litigate but to settle.

I think that's the process. I'm not necessarily being critical. I know people wish these cases moved more quickly. In some cases it would be great if they did.

On the other hand, it would be costly to appoint the number of judges and everything else that would be required to move these cases within one or two years.

SEN. MCDONALD: Actually, the leadership of this Committee had the occasion to speak recently with some of the judges of the Superior Court and were told that any litigant who has got a case ready to try in the State of Connecticut can have that trial post-haste. Is that not your experience?

MIKE NEUBERT: It's not mine. That's not because I'm saying they couldn't but because the cases I handle aren't ready. Maybe that's just the way they've always gone through the system.

The process of the collecting of the medical records and the number of depositions, the disclosure of expert witnesses, the taking of those, that process has always just proven to be a slow one. It's hard to say.

Could it be sped up? Obviously it could. The answer is maybe, in theory that's true. If a medical malpractice plaintiff's lawyer and defense attorney walked in after eight months and said we're ready to try this case, they could give us a courtroom.

SEN. MCDONALD: In your experience when you were working with many of these insurance companies did you ever have problems getting a case manager to focus on settlement negotiations until just prior to trial?

MIKE NEUBERT: I suppose I did. As a pattern of behavior I can't say I have. Certainly, there have been cases where I haven't gotten the attention on it that I would have liked it to have gotten as it approached that stage.

I would also hasten to add, Senator McDonald, that I don't know if that's the result of an intentional philosophy or anything else, manpower or other issues within the companies.

For the most part though, I have not viewed that as a major problem or even a significant problem.

SEN. MCDONALD: At least anecdotally I've heard that if you think about it logically it's not in the

interest of plaintiffs or their attorneys who are working on contingency fees to prolong the litigation, is it?

MIKE NEUBERT: One wouldn't think so, but then by the same token my experience is that they aren't trying to hustle the case either. Maybe it's because business is good and they have so many cases.

I don't get a lot of intense pressure from my brethren on the other side of the aisle saying come on, come on, hurry up. Again, my experience is that disclosures come very late in the ballgame.

If they were truly invested in trying to get these cases to settlement or trial early on it would be easy enough to do. They could disclose their experts in the first year, go to a court, ask for a status conference, and say, Judge, I want them to disclose their exports.

I'm making mine available for deposition and I want them to disclose. I never get requests for status conferences like that. I never get requests for scheduling orders from claimant's counsel requesting an expedited schedule.

I'm not sure why and I'm not asking them to run off and do that, but I can tell you that that's not my experience. I don't know if there's blame to be laid.

I don't know where it lays. It's just the way it's been and continues to be, that these cases

take a long time to work their way through the system.

SEN. MCDONALD: Thank you. If I asked any questions that were duplicative of your earlier testimony I do apologize. I appreciate your coming and sharing your experience with us. It has been very helpful. Thank you. Steven O'Brien followed by Elizabeth Reed and then John Fleming. Good evening.

STEVEN O'BRIEN: Good evening, Senator McDonald, Representative Lawlor is not here at the moment, but the rest of the Committee. I appreciate you taking the time to listen to our testimony today. My name is Dr. Steven O'Brien, and I'm a family physician.

I've been practicing in Enfield, Connecticut for about 25 or more years. I'm currently the president of the Connecticut Academy of Family Physicians.

I'm here today to speak to you on my own behalf and that of our 400 active physician members and 200 student members.

While we like many of the provisions in Senate Bill 1052, we strongly urge this Committee to make that any reforms that are in serious consideration for passage pass independent actuarial scrutiny.

Doing so will ensure that any reform that is passed is meaningful. Today I canceled a full schedule of patients, some of whom have been

booked for approximately three months or more, to come here and testify.

I'm hopeful that those patients will understand that my need to reschedule for another day is based on my feeling that coming here today is critically necessary. It is for their sakes and the sakes of all of Connecticut's families that I am here.

For the reasons that I am about to discuss, passage of meaningful reform is more important now than ever. Many people believe that the medical malpractice crisis is only a crisis affecting neurosurgeons and OB-GYNs. Let me assure you that that is not the case.

First, like OB-GYNs, many of my family physician colleagues deliver babies, not as many as a few years ago. For example, 27 years ago in Putnam, all nine family physicians in town provided obstetrical care.

Three years ago there were only six family physicians still doing OB, and today there are only three. All three are seriously considering whether or not this will be their last year.

A year and a half ago my grandson was lovingly guided into this world by an extraordinary family physician. That physician ceased delivering babies on December 31st, 2004.

My next grandchild, due in August, will be delivered by one of the few obstetricians left to accept new patients. Those changes in

practice are directly tied to the escalating cost of professional liability insurance.

Like all other specialties, some family physicians have moved to other states. Some of us are considering early retirement. The average age of the family doctors in this State is in the mid-50s.

Retirement may be an attractive option. I couldn't do it while remaining in Connecticut. The time-honored tradition of cutting back while ramping up a colleague who will take over the practice can no longer be considered.

This dilemma facing a lot of my contemporaries is making us need to consider whether the devotion to our patients remains a viable choice. Serious physician shortage is around the corner.

Our specialty has been blessed with many female family physicians. Nearly half the graduates in family practice residency programs are women.

Many of them desire to practice part-time while establishing their own families. Because of the incredible jump in malpractice premiums over the past few years, most cannot cover their expenses in part-time practice.

With 50% of our medical school classes comprised of women, whether they seek careers that would provide them with a reasonable living during their early practice years, where will they practice?

It won't be in family medicine and won't be in obstetrics, that's for sure. Now the threat of litigation hangs over every encounter with our patients, the days of fearing a malpractice suit because of surgical procedure gone wrong have been replaced with the fear of failure to diagnose cancer, heart disease or stroke.

Now we're facing the very real threat that no level of care and concern in diagnosis and treatment of our patients will satisfy the expectations of the population that early detection of all ailments is achievable.

In this litigious climate when physicians refuse to perform high-risk procedures or care for high-risk patients can you wonder why? When physicians who deliver babies stop and women can no longer find obstetrical care, do you wonder why?

When radiologists refuse to read mammograms, neurosurgeons stop operating on serious brain tumors, surgeons refuse to take care of serious trauma cases because they're too risky, can you wonder why?

When primary-care physicians dismiss from their practices people who refuse to stop abusing their bodies with food, drink, drugs and other substances, can you wonder why?

The people of Connecticut will not look kindly on those who sit by while the medical care that they cherish is crumbling around them. I'm afraid the time is running out.

You might not feel it, but changes are taking place. Those changes are threatening the very health of our State. Consider this a very personal issue for you and your family.

I'm sure you have a caring and competent physician who's doing his or her best to keep you and those you love healthy. Support the ability of that physician to continue in your care and that of your constituents.

I urge you, now is the time to pass meaningful medical malpractice reform. There's just too much at stake. I'd be happy to entertain any questions.

SEN. MCDONALD: Thank you, Sir. Any questions?
Senator Kissel.

SEN. KISSEL: Dr. O'Brien, I just want to thank you for taking the time to come and testify before us here today and all the good work you do for the people up in Enfield and north-central Connecticut. Do you live in Enfield?

STEVEN O'BRIEN: I live in East Windsor.

SEN. KISSEL: Senator LeBeau is your lucky Senator. As much as it may have been torturous at some times sitting here this afternoon, I think that you can see that we here on the Judiciary Committee are very much concerned.

It's a difficult issue. Many of us worked very hard in passing reform legislation last year.

Ultimately, it was vetoed by former Governor Roland.

I will say that Governor Rell is committed to getting meaningful reform through the Legislature this year. There was a working group formed, and indeed Governor Rell sat in on that initial meeting.

She's very serious about this issue, as well as all of us are on this Committee. As much as we've heard from folks on the insurance industry and from the plaintiff's bar and from the defense bar I think that it's always extremely important to have representatives like yourself from the medical community to bring right home to us what pressures you're facing.

I think that Senator McDonald aptly put it that for whatever reasons, whether it's an inability to negotiate better payment plans with HMOs, whether it's the inability of the federal government to compensate through Medicare and Medicaid proper payments to physicians.

I think that what we're seeing is that unlike other professions where you can raise revenues in other areas, you're being undermined by the payments that you're able to obtain from your services and at the same time the pressures from higher overhead costs, not the least of which and probably one of the primary ones is medical malpractice premium costs.

I think that yourself, other family practitioners and other physicians are just being squeezed from both ends.

We're committed to trying to do something to try to resolve that issue for you. Thank you so much for your patience this afternoon.

SEN. MCDONALD: Thank you. Representative Farr followed by Representative Walker.

REP. FARR: Just a quick question for you. What're the premiums that family practitioners are paying today?

STEVEN O'BRIEN: It's somewhat variable depending on the scope of practice, years of practice etcetera. For me personally, this year it was \$35,000.

REP. FARR: And you don't deliver babies. There was testimony earlier that obstetricians are paying as much as \$125,000. Do you know what it would cost if you were to deliver babies?

STEVEN O'BRIEN: It would depend on which carrier and would depend a little bit on circumstances. If, indeed, through CMIC [Gap in testimony. Changing from Tape 3B to Tape 4A.]

Neither is a family physician limited to, if my memory serves me correctly, 30 in a calendar year. The premium would be somewhere in the range of \$46,000 to \$48,000.

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REP. FARR: That limit on the deliveries is imposed by the carrier or by some regulation in statute?

STEVEN O'BRIEN: It's imposed by the carrier.

REP. FARR: So that's \$40,000 for 30 babies, is that what you've testified?

STEVEN O'BRIEN: You can't deliver enough babies to pay the premium.

REP. FARR: It'd be about \$1,500 a baby and probably you'd get paid about that.

STEVEN O'BRIEN: Again, it depends which insurer you're talking about but basically that's correct.

REP. FARR: Thank you.

SEN. MCDONALD: Representative Walker.

REP. WALKER: Good evening. Thank you for coming here today. I was going to ask pretty much what Representative Farr was questioning. Can you tell me, has your insurance gone up, let's say over the last five years?

STEVEN O'BRIEN: Yes, insurance has gone up considerably over the last five years.

REP. WALKER: Can you tell me incrementally how much?

STEVEN O'BRIEN: I can tell you that between 2001 and 2004 the premium for the group which I

represent, which is somewhere between 12 and 15 physicians depending on what year, went up 200%.

REP. WALKER: The reasoning for that from the carrier was what?

STEVEN O'BRIEN: The reasoning is that it's more expensive to ensure primary-care physicians because of failure to diagnose cases.

REP. WALKER: Can I ask if you've had any suits against your organizations?

STEVEN O'BRIEN: Yes, I have.

REP. WALKER: Have any of them been substantiated? Have any of them been settled?

STEVEN O'BRIEN: Yes.

REP. WALKER: And you're talking about 12 people in your practice?

STEVEN O'BRIEN: That's correct.

REP. WALKER: Thank you.

SEN. MCDONALD: Senator Roraback.

SEN. RORABACK: Thank you, Mr. Chairman. It wouldn't be fair for me to ask whether you've ever made mistakes. I'm not going to ask that question.

The question I would ask is were you to make a mistake in the future, would you feel inhibited

from telling your patient that you made a mistake out of fear that disclosing that would expose you to a lawsuit?

STEVEN O'BRIEN: Clearly I think that's the case. We all live in trepidation of the fact that we say the wrong word to the wrong individual.

I've had long and wonderful relationships with my patients over the years that I've practiced and I think it's a trusting relationship in which I feel that I can discuss anything and they can discuss anything with me.

We have been counseled over and over and over again that if there is something that you feel has been an error in judgment, probably a medication error, you clearly do not go to the patient and say you've made an error until you've had some sort of counsel discuss with you what you're getting yourself into.

We can't even really discuss it with our colleagues, as you can well imagine, because that would be discoverable.

SEN. RORABACK: Would it come as a surprise to you that recent science suggests that a physician who admits an error and talks with their patient about it can be less likely to be sued than a physician that conceals an error out of fear of being made the subject of a lawsuit?

STEVEN O'BRIEN: Like yourself, the Colorado experience would be very interesting to see how it goes. I would relish the idea that something would give us a similar level of

discussion as we discussed in terms of Good Samaritan laws for defibrillators.

The capacity to at least openly discuss the fact with your patient that there's been something that's gone wrong doesn't open you up to a career-threatening situation.

SEN. RORABACK: The Colorado law only says that if you have that conversation with your patient, that conversation can't be used against you. That doesn't mean they can't sue you.

It just allows you to admit that you're human. We're all human. Thank you for your answer. Thank you, Mr. Chairman.

SEN. MCDONALD: Are there other questions? I just have one. You said your practice group is 12 to 15 doctors?

STEVEN O'BRIEN: Yes. We've had some new people coming in and some other people who have left over the past few years.

SEN. MCDONALD: Over the last two or three years, what efforts if any have members of your practice group taken to minimize risk losses?

STEVEN O'BRIEN: The members of our group are all certified, number one, in a family practice specialty and have continued to go through the process of recertification our specialty started in 1969 with mandatory recertification every seven years.

This requires lifelong learning. All of the members of our group, all family physicians, all Board-certified have continued that process.

In addition, there are courses in continuing medical education funded or provided through our malpractice carrier which help us to try to anticipate where there are problems in terms of our practice styles or ways of documentation that would hopefully lessen our capacity to enter into that situation.

Similarly through our hospital settings and through our medical meetings statewide and nationally, these are topics which are constantly coming up as we attempt to find methods for risk reduction.

Now we look forward to the possibility at some point in the near future, if anybody can ever figure out how to fund it, of using electronic medical records systems which hopefully may also reduce that risk of failing to pick up on a piece of information that's six years old that you just don't have your finger on a paper copy of.

SEN. MCDONALD: Do you think it would?

STEVEN O'BRIEN: I have my doubts. I think there are some really major things that can come about from electronic medical records to streamline it. Frankly, I think it opens up another branch of litigation.

We're deriving from an electronic record sometimes more information than we'd get from a paper. That one I haven't heard a good answer for yet.

SEN. MCDONALD: Thank you. Thank you for your testimony. Elizabeth Reed followed by John Fleming and Fitzhugh Pannill.

ELIZBAETH REED: Good evening, Members of the Committee. My name is Elizabeth Reed. I'm honored to be here to speak on behalf of those who have died as a result of avoidable medical error. I'll briefly tell a person's story. (SB1052)

My husband died tragically 12 years ago at the age of 47, leaving behind myself and two young sons. His death was due to medical malpractice. When a patient dies due to medical error, the consequences of the death are devastating to the entire family.

Child psychologists agree that children who lose a parent grieve repeatedly as they revisit the loss at different stages of development. I have seen that happen to our children, who are now 19 and 21.

The loss is life-defining and hugely traumatic. The medical community and healthcare industry do not want to talk about these consequences, rather they collectively refer to what happened to my husband as an adverse event.

This insensitive terminology is an indication of the refusal of healthcare leaders to accept

responsibility and accountability for these tragic and avoidable deaths.

The medical malpractice bills before you today do not deal with the malpractice itself but what happens after that malpractice when there's a lawsuit against the practitioner, hospital or both.

These bills do not choose to address vitally important changes that need to occur in order to avoid more such unnecessary tragedies. In our case a shocking lack of communication directly contributed to my husband's death.

In addition, various specialists felt no moral obligation to speak to my husband or me when a serious disagreement occurred regarding his treatment.

My husband and I were misled and also made to feel foolish when questioning doctors and decisions. I have learned that communication among doctors and family is vital when the patient is hospitalized, and I tried my best to communicate.

Ironically, we as a family had the most extensive insurance coverage available. The doctors involved and the hospital did not need to be concerned as to whether they or the hospital itself would be fully paid for running extensive tests, tests that were appropriate.

The tests were not run and my husband died. Our hospitals and medical societies have had years to deal with problems with preventable

deaths, such as this one which occurred 12 years ago, and they have failed.

The United Kingdom has moved to a system of computerized patient entry. If our Connecticut hospitals had made use of that kind of technology 12 years ago my husband would have had a better chance of being alive today.

It's appalling to find that we don't have consistent computerized prescription entry. I find myself wondering why it is that so little accountability is asked of our hospitals and doctors when there's so much at stake.

Article after article in medical journals, international press and on television have documented the simple steps that have to be taken to avoid most obvious of preventable deaths that occur in our hospitals.

They have also documented the system changes that must happen to decrease the numbers of these deaths.

It is too late for my husband, myself, and our children, yet I ask you to make these significant changes happen so that others do not have to die so tragically and unnecessarily. I thank you for your time.

SEN. MCDONALD: Thank you for your testimony, Ms. Reed. Thank you for reminding us why we're here. You do have to stick around to let me see if anybody has any questions for you. Do any Members of the Committee have any questions? Representative Walker.

REP. WALKER: Thank you for your testimony. I know that was hard. It's important to be an advocate in these situations. You talked about some steps and measures you thought needed to happen. One was doing a database on prescription drugs that are being dispensed and I didn't get the others.

ELIZABETH REED: We would have benefited had medical records been part of the entry into the hospital.

I ended up getting them the medical records, but because of the lack of communication among specialists, it was critical medical information but I honestly do not know how many of them actually sat down together and worked on that.

What happens in very complicated cases is that it becomes very specialized. We can all appreciate that doctors are incredibly talented, intelligent and caring, but when you get a number of specialists and a lack of communication, avoidable errors occur.

No one wanted this to happen. I know that. I know that there was no malice and forethought. As someone said to me at the hospital, he fell through the cracks.

I would just like to see when we hear so much, especially in the last couple of years, about how doctors do absolutely everything and we're never satisfied, that is so absolutely not true

in this case. I don't think it's true in other cases.

Our medical insurance was so far-reaching and they did not avail themselves of it. It was also particularly confusing when I had questions, as complicated as it was, because they made a big to-do about well they certainly wouldn't want to get sued so don't worry, we're doing everything appropriate.

It was a very painful realization to find out as a studied it for the two years after his death and found out exactly what had happened.

REP. WALKER: Thank you so much for sharing that. Thank you for having the courage for coming in to testify.

ELIZABETH REED: There are two sides to this.

SEN. MCDONALD: Senator Roraback.

SEN. RORABACK: Good afternoon. Thank you for your testimony. I was just wondering, how long did it take for someone to apologize to you for the mistakes that were made?

ELIZABETH REED: There has never been an apology.

SEN. RORABACK: There's never been an apology? Would you have appreciated an apology?

ELIZABETH REED: In the two years that I tried to find out what had happened for the sake of my two sons, because it involved cardiology, of course I would have.

SEN. RORABACK: And to this day presumably you would still welcome an apology if one were to be forthcoming.

ELIZABETH REED: That would never happen, but yes I would appreciate it, absolutely.

SEN. RORABACK: Thank you. I appreciate you being here. Thank you, Mr. Chairman.

SEN. MCDONALD: Anything further? Representative O'Neill.

REP. O'NEILL: I'm sorry if I missed it in the course of your testimony, but did you go to court over this? Did you litigate?

ELIZABETH REED: I'm only allowed to say that the case has been resolved.

REP. O'NEILL: Okay, so it sounds like you must have done something. It sounds like what you've described is a failure to properly diagnose your husband's case, is that what we're talking about here?

ELIZABETH REED: That's correct.

REP. O'NEILL: Okay. Thank you.

SEN. MCDONALD: Anything further? Thank you very much. John Fleming followed by Fitzhugh Pannill. Mr. Fleming? Fitzhugh Pannill followed by Joram Hirsch. Good evening, Sir.

FITZHUGH PANNILL: Good evening, Senator McDonald, (SB1052)
Members of the Committee. I'm Dr. Fitzhugh
Pannill, a fellow of the American College of
Physicians and a member of the Connecticut
State Medical Society.

I greatly appreciate the opportunity to speak
to you and I thank you. I graduated from Johns
Hopkins and trained in internal medicine and
geriatrics. I have been in practice with the
Southbury Medical Associates since I left the
Yale faculty in 1997.

Our practice has served the Southbury community
since 1978. It takes care of patients with the
ages of anywhere from the ages of 18 to
currently 103 in the office, hospitals, nursing
homes and at home.

I'm here representing myself and my partners,
but most importantly I'm representing my
patients who tell me daily that they'd be lost
if I left practice.

They turn to me for advice in all aspects of
their medical lives, from what to do about a
child who drinks too much, how to handle their
aging parents in New Jersey and whether they
should buy medicines from Canada.

After seeing a specialist they come to see me
because they didn't have enough time to get all
their questions answered and what they did get
they didn't quite understand.

I'm usually the only physician who sees them in
the hospital every day, calls them when they're

hospitalized at the Waterbury area, at UConn or Yale, follows them from nursing home to assisted-living facility and sees them at home if they can't get into the office.

I used to think the hardest part of medicine was knowing the right test, drug and diagnosis. I've found recently that the hardest part of medical practice in 20th century Connecticut is our daily struggle to pay the staff, collect the bills from the insurances and Medicare and to pay our rapidly increasing malpractice bills.

When I left Yale, malpractice insurance cost me about \$3,400 a year. Our rates rose to \$20,000 for each of the practitioners for our office in 2002. We switched carriers to one of the only two other available carriers in the State.

Last year with this new carrier we paid less, at \$15,000 a year apiece despite having had no claims or suits against the office. Our rates have doubled in the last two years.

Overhead and staff salaries consume 65% of our revenues, malpractice insurance last year amounted to over 6% of the overhead and comes to close to 15% of my take-home pay.

If our insurance costs continue to double as they have every year, we'll soon pay, like the other physicians you've heard from, over \$40,000 a year.

That would be 20% alone of our overhead. While we pay rates similar to many specialists,

specialists benefit from having far more revenues from procedures, surgeries and tests. Unfortunately, the only procedures we do in our office are throat cultures and EKGs.

Medicare and the HMOs have fixed our rates and haven't increased them as fast as our insurance costs have risen. The only way we can increase our revenues in our office is to see more patients. My partners and I refuse to shorten our appointment times.

We have a harder time working more hours. The revenues for our practice have been stagnant for the last five to ten years. It's no surprise that more and more students and residents are becoming ophthalmologists and orthopedists.

Many of those who do treat primary care are moving to other states with similar reimbursements but far lower malpractice costs. It's really a shame.

I can say without any hyperbole that the practice of primary-care internal medicine with patients you know and befriend for years is the most satisfying career that I could imagine or recommend to you, your children, mine or anyone else.

I've been privileged as few other professionals could have been to be a part of patients' lives and make a difference. If there's no control over the increases in malpractice insurance costs, I and many other general practitioners

will be forced to quit practice or to work for a general institution.

I hope that you can find a fair and equitable solution to this crisis that will allow primary-care physicians like myself to continue caring for their patients and to stay in practice. I thank you for your time and my patients will thank you for finding a solution.

SEN. MCDONALD: Thank you, Sir. Let me ask you, I assume you heard my prior interchange with Attorney Neubert. I guess I know the answer to the question, but have you received any adjustments in the last ten years or more in Medicaid or Medicare reimbursement?

FITZHUGH PANNILL: Medicaid patients I see, basically we send the bills but I have no idea what they are because the reimbursement's so low that it doesn't even matter to count. Medicare goes up slightly.

It's my general impression that I can't quote you figures, but the Title 19 patients that we see in the office I really basically have no idea what we charge for them because the reimbursement rates are so low that they don't count.

Most practitioners in our area don't take Title 19. I've tried to get specialists to take the patients of mine that do and you can't find specialists who will see them, for the most part.

Medicare does tend to go up a little bit, but as you know from reading recent reports, every year there's been an automatic 5% reduction proposed based on some budgetary mechanism that has to do with the rate of physician reimbursements and stuff and the system as a whole.

So far, most of the proposed reductions have been stopped. I've heard recently that it's going to occur at a 5% rate for the next six years. We're facing a 5% reduction in Medicare fees. Our practice is about 30% to 40% Medicare.

SEN. MCDONALD: Even if the reductions are stopped, in real dollars they're down because of inflation.

FITZHUGH PANNILL: Of course they are. I actually did a back-of-the-envelope calculation and looked at Medicare's reimbursement for a proposed visit time which they have.

If you calculate the number of hours I'm in the office and assumed I just saw Medicare patients during that time, I wouldn't even cover my overhead for the office.

The one thing you can say about Medicare is at least they pay a little more quickly than private insurers. That's also becoming a bit of a problem.

The rates on our insurance have gone up over 300% and certainly our Medicare rates or any of

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our commercial insurances haven't risen by anywhere near that amount.

SEN. MCDONALD: Thank you. Other questions?
Representative O'Neill.

REP. O'NEILL: Not really a question, I just wanted to say hi and hopefully you can have a nice trip back to Southbury for your long day here.

SEN. MCDONALD: Tell them back in Southbury that Representative O'Neill will be back there by midnight.

FITZHUGH PANNILL: I can't say that I share Dr. O'Brien's economic disadvantage for being here because this was my day off. I've enjoyed it.

SEN. MCDONALD: We appreciate you spending that day with us. Joram Hirsch followed by Greg Pepe.

JORAM HIRSCH: Good evening, Senator McDonald, SB1222 SB1354
Representative Lawlor, Members of the SB1362 SB1197
Committee. My name is Joram Hirsch. I'm a partner in the law firm Adelman Hirsch & Newman in Bridgeport, Connecticut.

We've been practicing law since 1980. I'm a member of the Board of Governors at Connecticut Trial Lawyers Association and since 1993 have been Chairman of that organization's Amicus Committee.

I'm here to give testimony on four bills, none of which include the medical malpractice bill which will be the subject of other members from CTLA.

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JORAM HIRSCH: In that particular case they were uninsured. The registration for that vehicle was suspended at the time of collision for failure to pay insurance.

Although there was an insurance card presented to the police officer through Allstate in that case, Allstate said we don't insure this vehicle, he didn't pay premiums.

What else could we do? We contacted the insurance company that they claimed they had and they denied there was any coverage. Now we had someone who was not cooperating with us and we could not otherwise prove it.

SEN. MCDONALD: Any other questions? Thank you very much. Greg Pepe followed by Dick Pugh.

GREG PEPE: Good evening. My name is Greg Pepe. I'm here today on behalf of the Connecticut State Medical Society as well, following up my partner, Mike Neubert.

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I want to discuss with you an aspect of the medical malpractice problem which you have not heard about yet today but which has arisen several times during testimony.

It's before you as an amendment to Senate Bill 1062 which came to you from the Public Health Committee. What we've heard about today is the astronomical increases in the cost of malpractice insurance.

It has come at a time when doctors have almost no ability to negotiate fair and adequate

reimbursement from managed-care companies to cover all the costs of their offices. Managed-care companies are getting bigger, that's undeniable.

Their market power and their ability to dictate terms to doctors in the market is today virtually unrestrained, to the point where most independent doctors and small groups are presented with take it or leave it contract terms with no negotiation possible.

This perfect storm of market conditions has put doctors in an untenable position. I think we've all heard testimony that the effect on patient care and patient access to care are undeniable.

Obstetricians are leaving the practice in record numbers or being constrained by the numbers of babies they can deliver by insurance companies. Radiologists willing to read mammograms are hard to find.

Physicians' willingness to undertake procedures which carry any significant risk profile is an issue that patients are being forced to deal with and doctors are being forced to deal with over and over.

All these issues are recurring so that the increases in medical malpractice rates can be tempered. The cost we all pay for this is reduced access to care. Ultimately it will make us all have to deal with the reduced quality of care.

This bill seeks to provide relief to doctors on the reimbursement side by permitting doctors to collectively negotiate with managed-care companies upon a finding by the State Attorney General of a compelling need for doctors to do so in Connecticut.

As you know, federal law allows states to develop their own regulatory schemes in areas where the federal government has already developed a regulatory scheme under a doctrine that's referred to as State action.

This bill applies that doctrine for the purpose of enabling collective negotiations by nominally competing physicians of certain terms and conditions of a physician's provider contract with a health benefit plan.

Under the Proposed Bill the joint negotiation of the type being proposed will be permitted in instances where the State, acting through the office of the Attorney General, either finds that a health plan has significant power which enables it virtually to dictate the terms of provider agreements to physicians or finds that negotiations on these issues have been one-sided in favor of the health benefit plan.

Because the evening is getting late and my time is short I'm not going to go into specifics. They're in front of you off in my testimony as well as the draft bill which has been provided to you.

I would like to point out two things. First, some of the most poignant moments today have

been those which relate to real stories that people have told you where they've been affected by horrible healthcare events.

This bill would empower doctors to adopt the technology and information systems that might prevent such events from occurring in the first place.

Suffice to say, the liability insurance crisis is multifaceted and requires policy change in a number of areas if Connecticut is to preserve access to care and to preserve the quality of care for its residents.

The Connecticut State Medical Society believes that this bill provides a policy focus in an area which complements other reforms that the Legislature is considering. Thank you and I'll entertain your questions.

SEN. MCDONALD: Senator Kissel.

SEN. KISSEL: Thank you very much for coming to testify. Previously Senator McDonald had indicated, and I think very correctly so, that physicians are being squeezed in two directions.

On the one hand they really just can't get a handle on the compensation that is being delivered to them because of Medicare and Medicaid restraints on funding and also to a great extent what you had just articulated, that the HMO industry has grown very powerful.

As far as bargaining positions, physicians are not in the same boat. Is it your testimony here today that, and I also agree with Senator McDonald, or at least as I understand his testimony.

I think it's an unwise course to try to relieve physicians by looking towards the victims of medical malpractice, or at least at the first instance. There have got to be other ways to try to address this.

Is your proposal such that if, for example, the Attorney General made a determination that physicians could unite and that somehow we could construct a statute that would allow them to not be in violation of anti-trust limitations, that that would allow them to almost unionize to some extent for limited purposes, to form a greater bargaining unit such that they could get better compensation or better contractual relations with HMOs?

Thereby, they would be able to have more funds available to try to help as a safety valve as they try to address paying their medical malpractice costs.

GREG PEPE: I think I'd like to expand a little bit on what you just said. Actually, I think Senator McDonald put it quite well when he said the system is out of balance.

Certainly, if as a businessperson you knew the particular costs in your business were to go up 300% in a two-year period, you would seek to try to address that issue.

You would try to cut costs, increase hours or services etc. You would also try to get a higher price for the commodity you deliver.

One of the things this bill would seek to do would be to try to identify those issues where physicians have no voice, have no bargaining power with managed-care companies and authorize them upon a finding by the Attorney General to negotiate collectively through their IPAs, through their PHOs with managed-care companies.

That negotiation today simply does not happen. That authorization would lift the fear of anti-trust prosecution that many physician organizations today operate under.

The position of the State Medical Society is that this is a necessary bill if you want to address the other side of the malpractice crisis as Senator McDonald pointed out.

SEN. KISSEL: One last point, it's your suggestion that we should perhaps consider making this part and parcel of our singular medical malpractice reform bill rather than having this isolated possibility out there subject to the vicissitudes of this legislative process.

Really, if we're going to address this in its totality and capture off the table as it appears to be this year, this is something that would afford some real, direct relief for physicians as part of our reform efforts.

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GREG PEPE: I think actually, again, if the question is one of balance, that is trying to achieve some equilibrium in the managed-care market so that physicians could address these malpractice crises from a number of perspectives so that the State could adopt policies that allow that to happen from a number of perspectives, this bill is certainly a necessary component in that balance.

SEN. MCDONALD: Anything further? Representative Farr.

REP. FARR: I'm a little confused here with the testimony and certainly the history of medical payments in Connecticut has been that Medicaid pays a small portion of the actual cost, Medicare doesn't keep up with inflation.

Certainly, all of the institutions and doctors have testified that this has resulted in shifting the cost of medicine to where it has to be borne by the private sector.

In other words, the HMOs have to pick up the cost of carrying the system because the government-sponsored operations aren't doing that.

Now I'm being told that gee, if we just had better control over HMOs, it seems to me that the real problem with not being able to be compensated comes in the fact that it's government that's not paying their share, not the HMOs.

If we shift of more costs to HMOs, aren't we just going to drive the costs of medical coverage up dramatically, have fewer people covered and then ask government to cover more people and pay a lower rate?

GREG PEPE: In fact, that very argument was raised in Texas in 1999, when this bill was first proposed. When it went into effect in Texas three and a half years ago, the Texas State Legislature specifically wanted to review that on an annual basis.

That has not been the case in Texas. In fact, the Attorney General of Texas has reported that this has been a success as a trial in Texas. I think it's a success that Connecticut can easily replicate.

REP. FARR: What percentage of uninsured individuals is there in Texas as compared to Connecticut?

GREG PEPE: I don't know the answer to that.

REP. FARR: I think that's one of the measures.

SEN. MCDONALD: Anything further? Thank you very much. Dick Pugh.

DICK PUGH: Senator McDonald, Members of the SB1052 SB1364
Judiciary Committee, thank you for the privilege of appearing before you today to let you hear from me my concerns about the medical liability insurance reform.

The insurance crisis is not just a problem for physicians, it's a critical problem for

hospitals and the entire healthcare delivery system.

Since 2001, in Milford Hospital's medical liability insurances have increased by 480%. We are considered a good risk hospital. These increases take away resources that could have been used to enhance patient care.

In addition, the premium experienced by doctors who serve our hospital has had a direct and detrimental effect on the Milford Hospital. These escalating insurance premiums threaten and compromise our ability to deliver patient care in the following ways.

We've lost 20% of our OB staff this past year because annual premiums often were in excess of \$100,000. We have a group of five orthopedic surgeons who had to scramble to find insurance because their insurance company went out of business.

They're not paying \$425,000 in annual premiums for their group. Our primary-care physicians are finding that their premium experience is doubling.

One of our pediatric groups reduced their coverage from \$2 million, \$5 million to \$1 million, \$4 million because the premium increases were too expensive. Now they're worried that they may be having too much exposure.

These are just a few of the instances that have occurred in our area. While we appreciate that

there are a number of facets to liability reform, it's clear that the most important thing that we can do to adequately reform the system is to adopt a reasonable cap on non-economic damages.

The unpredictability of litigation outcomes in the State of Connecticut is the major driver or at least a significant contributing factor to these outrageous premiums.

We want patients compensated appropriately for malpractice cases and done so fairly under the economic damages. They deserve nothing less.

We can't let the process be driven beyond reasonableness and destroy a medical system that is the best in the world that does so much good for so many people everyday.

Hospitals and healthcare are losing physicians weekly. If we wait for physicians to leave in larger numbers it will be too late to undo the irreparable damage that will harm access to quality physicians because they will have walked away from medicine.

They will have done so at a time when there's already a shortage of physicians. It will soon be too late to put the system back on its feet if we don't recognize and address the root issue of meaningful medical liability reform.

We look to you not just for action. We look to you for vision with your actions. I hope someday that the vision and action includes caps on non-economic damages.

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I appreciate the substantial work that you've all done on this complex and very important issue. We hospitals and the Connecticut Hospital Association stand ready to try to work with you in any way we can. Thank you very much.

SEN. MCDONALD: Thank you. Are there any questions?
Senator Roraback.

SEN. RORABACK: Thank you, Mr. Chair. I just want to share a piece of information with my colleagues on the Committee. I think that Mr. Pugh has the distinction of having served as CEO of his hospital now for 26 or 27 years, the longest reign.

He's the Doc Gunther of CHA. For that, I know my district is very grateful. Se serves our community very well. I'm grateful he's spent his time here today and shared his views. Thank you, Mr. Chairman.

SEN. MCDONALD: Thank you. Anything further?
Thanks very much. Penny Seaman followed by
Howard Allison.

PENNY SEAMAN: Little did I think, when I got here this afternoon, that I'd say good evening. Thank you, Senator McDonald, the rest of the Committee, for allowing me the opportunity to come here. My name is Penny Seaman.

I'm an attorney with Wiggin & Dana in New Haven, Connecticut. For the last 20 years I

HB 6814
SB 1052
SB 515
SB 514

have represented healthcare providers in medical negligence cases.

I'm here at the request of the Connecticut Medical Society to talk to you about three specific topics that are contained in the legislation before you.

I have submitted written testimony and I won't duplicate what I've written. My first topic is collateral sources. Collateral sources in Connecticut are not introduced at the time of a trial to a jury.

The current Statute provides that we don't produce evidence of collateral sources. HB 6814
There's a proposal in Senate Bill 1052 that would modify that to allow the introduction of evidence of a prior award received by a plaintiff in a different case against a different healthcare provider.

That kind of circumstance is unusual. First, because our law provides that you can recover a single time for a single injury, it is unlikely you can another award against a different tortfeasor would have been made and paid in Connecticut.

Under the current tort system it is also more common that you would have all of the potential defendants in a case at one time so that the responsibility could be apportioned.

It would be far more helpful if the law was changed to allow evidence of prior settlements as opposed to awards.

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wouldn't even say minorities. It would be the people that don't have the money.

REP. GONZALEZ: Thank you for being here the whole day. I know that it's been a long day.

HOWARD ALLISON: I don't mind. I'm here for a cause. There's a reason why I'm here. I want to say it again, before you guys kick me out. The system is not broken. It just needs to be fine-tuned.

SEN. MCDONALD: Thank you. We appreciate your testimony. Oh, I'm sorry, Senator Roraback.

SEN. RORABACK: Mr. Chairman, I just want to say that for a guy who said he was nervous he did pretty well.

HOWARD ALLISON: No, believe me, I'm shaking. Have a good weekend, guys.

SEN. MCDONALD: MaryAnn McDonnell followed by Maureen Dinnan. People thought I was lying when I said at one o'clock that we'd be here until seven or eight. We'll probably be here until after eight. Welcome.

MARYANN MCDONNELL: Thank you, Senator McDonald, SB1052
Representative Lawlor, Members of the Judiciary Committee. My name is MaryAnn McDonnell. I'm the current chair of the Connecticut section of the American College of Obstetrics and Gynecology.

I'm also in private OB-GYN practice in Manchester, Connecticut. I would like to bring

you up to date on how the ongoing medical liability insurance crisis continues to impact OB-GYNs and their ability to provide complete women's healthcare services throughout the State.

I continue to hear of additional OB-GYNs who have left or who are planning on leaving the State to practice elsewhere. One example is Dr. Brad Walk, who gave up his practice in Tolland after 12 years to move to another state.

There also continue to be more doctors who give up obstetrics for a GYN-only practice in order to save on insurance rates. I would like to give you a few examples of how OB-GYNs are struggling to keep their doors open.

First, in Greenwich two OB practices merged so that three of the physicians could drop OB. This was done as a cost-saving measure which allowed for continued OB services. There are now fewer OB doctors to take care of the same number of patients.

Second, many of you are familiar with the OB group from Windham, Connecticut that almost had to close their doors last January. This past year, in order to avoid a repeat of the situation the group has been forced to sell their practice.

They were also forced to close an office, lay off employees, freeze remaining staff salaries and decrease pension contributions. All this

was done to ensure that they could continue to have insurance coverage.

Third is the experience of my own group. Last year, GE Medical Protective insured us. As many of you are aware, the company proposed a 90% increase in the rates for 2005.

For our group this would have meant that insurance would have cost approximately \$180,000 per MD for the year. At the time, we had to give serious consideration to having three of our six doctors give up OB.

If this had happen we would have had to arrange cross-coverage with other OBs in the community in order to continue to provide obstetrical service to our patients.

Fortunately we were able to secure a policy with another company that allowed us to go through a risk-management evaluation and set our rate based on a favorable evaluation at approximately \$100,000 per MD per year.

This allowed us to afford coverage for the group with only one of the doctors going to GYN-only.

As these examples illustrate, aside from the increase in the size of the premiums there is also the uncertainty of not knowing if your current insurance plan will even be available from one year to the next.

As OBs in practice continue to face these issues, there is also strain placed in the

field for new OB-GYNs. My colleagues in academic medicine continue to report that they see fewer medical students choosing OB-GYN as a specialty.

They have a more difficult time filling OB-GYN residency slots with top candidates. Fewer OB-GYN residents choose to stay in Connecticut upon completion of their training.

In the long run this could be the most devastating impact of the current crisis. As you evaluate the legislation that is before you I ask that you consider each item for its ability to control costs and stabilize the available insurance market.

To pass legislation that neither provides true reform nor is proven to have an impact on the problem would be a disservice to our community. Senate Bill 1052 does contain many necessary changes to our current tort system.

I am not sure that they would be sufficient to have any significant impact on the current crisis.

In addition to the changes contained in the current bill, consideration should also be given to a pre-trial screening panel that is both mandatory and discoverable and would allow for the disclosure at a trial of any other settlements the plaintiff may have accepted from other sources to a particular injury.

Consideration of a separate medical court system to adjudicate medical malpractice cases should also be given.

If effective reform measures are passed, then it would allow OB-GYNs to again have patient care as their only focus compared to having so much time wondering if they'll be able to provide women's healthcare services from one year to the next. Thank you for your time.

SEN. MCDONALD: Thank you. Representative Farr?

REP. FARR: Thank you for coming here. You indicated that right now you've worked a deal that each doctor's paying \$100,000. I think only four of the five are delivering babies, is that right?

Five out of six. That's sort of a blended rate, everyone's paying \$100,000, is that what's happening?

MARYANN MCDONNELL: Yeah, it's sort of averaged out. The physician who's doing the GYN-only is not paying that much. That's a blended rate, correct.

REP. FARR: There was testimony earlier that some doctors are paying \$123,000. It sounds like this is the going rate now, somewhere between \$100,000 and \$120,000.

MARYANN MCDONNELL: Originally the company that we're currently with, when they gave us an original quote it was around the \$120,000 mark. We then went through that risk-management

evaluation and they were able to lower the rate based on the information we provided them.

REP. FARR: How many babies can you deliver, or do you deliver a year?

MARYANN MCDONNELL: I probably personally average around 100 a year.

REP. FARR: Is that true amongst most of the others in the group?

MARYANN MCDONNELL: Yeah, with slight variation. I might deliver slightly more than some of the others. It's just a luck-of-the-draw kind of thing.

REP. FARR: About how much would an HMO typically pay for you to deliver a baby?

MARYANN MCDONNELL: Anywhere from \$1,500 to \$2,300 for total pregnancy care including the delivery.

REP. FARR: That's usually what, eight visits or something?

MARYANN MCDONNELL: Eight would be on the small side. I'd say they range anywhere from 11 to 13 for pre-natal visits. Usually it includes an ultrasound and then the delivery and the post-partum visit.

REP. FARR: So on average an HMO might give you \$2,000. How much would you get if it's a Medicaid patient?

MARYANN MCDONNELL: I don't know that answer.

REP. FARR: Even if you got \$2,000, your total per patient, and it was all private pay, your total income would be about \$200,000. The cost of your medical insurance alone would be \$100,000.

Then there would be some staffing that you would have to pay as well for this. How do you financially survive? Do you do it through billings for other types of services?

MARYANN MCDONNELL: We're a full OB-GYN practice, so we have gynecology services as well, including office visits and surgery. We offer mammogram services. We offer [inaudible] services.

We do try to offer multiple services, not necessarily all as income services. Some of them we just break even on, but as a resource for the patients, that's available.

REP. LAWLOR: Thank you. Are there other questions? If not, thank you very much for your testimony. Next is Maureen Dinnan. Is Marc Storch still here? Okay. Jean Rexford? Okay. You guys are next. Please go ahead.

MAUREEN DINNAN: Thank you. Good evening, SB1052 SB1354
Representative Lawlor, Members of the Judiciary Committee. I'm Maureen Dinnan, an attorney at Neubert, Pepe & Monteith.

I provide counsel to the Connecticut State Medical Society regarding regulatory matters and issues involving the Department of Public

Health. I'm here to give testimony on portions of Senate Bills 1052 and 1354.

The Connecticut State Medical Society is supportive of the goals contained within sections nine and ten of Senate Bill 1052, as each of those sections acknowledges the importance of the Medical Examining Board in a process that's informed and consistent.

Sections nine and ten require the establishment of guidelines for disciplinary matters against physicians that go from the time of the filing of the petition to the dismissal or imposition of sanction.

The Connecticut State Medical Society considers this an important step in improving access to and the operation of physician review in Connecticut for both the physicians and the public.

At the present time, physicians feel that they have very little understanding of what is factored into the Department's decision-making as to when, how and to what extent to investigate petitions that are made against physicians or how terms of consent orders are determined.

That is in contradistinction to if the matter goes to a hearing before the Medical Examining Board, there is a memorandum of decision. There is more understanding as to why the Board has come to its decision.

Section nine, subsection four of this bill does present concern regarding when a DPH investigation should be brought to include sampling of patient records and conducting additional interviews of other patients.

This may have patient privacy implications and create additional negative impact on a physicians practice in situations where there has yet to be any determination of wrongdoing on the part of the physician.

If the necessary precautions and restrictions are not addressed, this may foster the appearance of a hunt to find problems and create an unnecessary burden and stress on the physician and his or her practice.

Section nine, subsection four also provides for review of performance and discharge data from hospitals and managed-care organizations. The Medical Society seeks to strengthen the ability of peer-review processes and fears this section will thwart that goal.

Currently, the Medical Society has asked that whistleblower protections for healthcare providers who come forward to raise concerns or report suspected deviations from the standard of care or suspected grounds for a sanction be added to any medical liability solution.

The Connecticut Medical Society has serious concerns regarding any measure which may erode peer-review protected documents pursuant to General Statute 19A-17B.

Currently, if a DPH investigation exceeds 18 months or goes to a hearing, the documents will not be protected by confidentiality provisions. As you've heard from one physician tonight, he's said he's afraid to talk to his colleagues.

That's a very poor indicator for our ability to help make systemic improvements to help prevent malpractice from occurring.

We have further concerns as to how managed-care organizations will respond to such a request and whether physicians will be dropped or scrutinized simply because the Department requests the information.

Section none, subsection five also presents concerns as it will be very difficult to protect and ensure confidentiality of provider-identifiable information when the Department may be seeking performance data regarding a specific physician or interviewing a patient regarding care rendered by a specific physician.

We ask that section ten include a guideline as to when a respondent may access the Board during negotiations of a consent order and before a hearing. Currently, the Department has a compliance conference.

It is limited to an attorney for the Department. The respondent deserves access to the Medical Examining Board without the threat of a statement of charges being filed.

The Board needs to have a presence and give advice regarding the stages in the investigation, so we appreciate sections nine and ten, involving both the Department and the Medical Examining Board.

The Medical Society wants to work collaboratively in cooperation with the Department and the Board to evaluate and develop these guidelines which we believe will generate positive change in our system.

Our physician members would be profoundly impacted by any guidelines, and we ask our Legislature for a role in developing the same.

Section 16 of Senate Bill 1052, the Medical Society supports providing additional details to the Department including the name of the physician's liability carrier.

The medical Society has great concerns with the Department entering policy numbers and carrier names to the publicly-accessed physician profiles. The profile is to give patients information regarding qualifications and backgrounds of physicians.

Our concern for the potential identity theft is widespread. In addition, acknowledgement of coverage is important but identification of specific identifiable information is not prudent. Section 18 we support, which goes to the continuing education for rescissions.

We have previously testified for other committees to be asked to be involved in the

establishment of appropriate CMA requirements. In fact, the Public Health last week approved two proposals which we support with modifications.

We have worked with the Department over the last year in the development of an appropriate program of continuing medical education. Finally, Senate Bill 1354, section one.

This provides for a copy of a summons and complaint to be filed [Gap in testimony. Changing from Tape 4B to Tape 5A.]

Language is unclear as to the impact of this change. If filing a complaint initiates an investigation by the Department, then this provision will have far-reaching implications for medical liability actions.

It will, in fact, exacerbate the current medical liability situation in Connecticut. As we all know, the filing of a suit does not indicate that a deviation from the standard of care has occurred.

Based on this proposed change we may see settlement amounts in jury verdicts decrease, along with a weakening of a Department of Public Health process we are all attempting to help strength. I appreciate your attention. If you have any questions at this late hour, I'm here.

SEN. MCDONALD: Thank you. Are there any questions? Thank you very much. Next is Marc Storch, followed by Jean Rexford.

MARC STORCH: My name is Marc Storch. I live in SB1052 Westport. I've been practicing OB-GYN for 32 years and have delivered about 8,000 babies. I stopped delivering last year. I would have kept going for another few years.

I miss delivering my patients, and I suspect some of them probably would hope I was there. I think if one OB stops or moves out of the State it is one too many.

This is an issue that has little effect on myself presently. My premium would have been \$150,000 this year, but I'm now paying \$17,000. I'm not sure it's beneficial to your health to keep all the doctors in the State unhappy.

Why would a young medical student, who can be sued for \$100 million, have the risk of being stuck during surgery by an AIDS needle, wake up in the middle of the night and go see a full day's worth of patients, and not start making any real money until you're 30 and then make an average salary, go into this profession?

The answer is that most of the bright students are not going to obstetrics now. The system is obviously broken. You've touched the problem on many of the points here today. There's the malpractice aspect.

It takes too long for a case to make it through the system. It takes cases near us six to seven years. I haven't heard anything about medical courts today.

I think there might be many benefits about medical courts. Malpractice lawyers are collecting outrageous fees, part of which could go to the injured and lower malpractice premiums. Malpractice companies are increasing premiums up to 90%, as you've heard.

Even the company that is owned by the doctors, which I gave seed money to 20 or so years ago, has made it quite clear that they don't want obstetricians.

That might be one of the reasons that they made a few bucks this year. There's no way they could have made bucks up until now. It's quite clear that the awards are too big. What is someone worth? I don't know the answer to that. Some type of cap would be helpful.

It would hopefully decrease some of the outrageous awards. Half the states have them or something like that. I'm sorry to hear they're off the table. As I said, my buddy got sued for \$100 million in New York. It's unacceptable.

We do have the HMO problem which we have no power to change. Do you think it's fair that some of the CEOs of HMO companies are billionaires now? I don't think so.

Let them give back \$800 million, \$900 million to some of the 30 million to 40 million Americans who don't have insurance. That will cover a nice number of them.

Oversight, but I know that's been brought up, my feeling about that is that most doctors have no problem with increased oversight or any plan to decrease medical errors. That should be part of the plan.

Senator Meyer before she left said if someone is hit and injured on the way out, what do you think about that? I say I want to collect a reasonable amount. I don't want my lawyer to get 50%.

This is too important an issue to be bipartisan. It's having a disastrous effect on my profession. All the care is decreasing. We need to take action now. I think Senate Bill 1052 is a start, but it doesn't do enough.

SEN. MCDONALD: Thank you, Sir. Let me ask you, you said you practiced in Westport, how long have you practiced in Westport?

MARC STORCH: Twenty-eight years.

SEN. MCDONALD: Twenty-eight years. And you stopped delivering babies last year, right?

MARC STORCH: April 1st of last year.

SEN. MCDONALD: All 28 years in Westport? And you spoke about some of the financial constraints about medical students after they come out of medical school.

After seven years of training, you talked about the average salaries of OB-GYNs. What's the average salary of an OB-GYN in Westport?

MARC STORCH: It's decreasing because it's \$150,000 when you put the key in the door. Obviously, the staff salaries increase every year, the rent in Westport is as well. The building with J.Crew just sold for \$9 million. Rents are expensive.

On the income side of it, for myself, being older my patients were getting older so I wasn't doing many deliveries. The delivery fee was capped and I was a dinosaur. I was the last of the solo OBs. It just didn't make sense for me anymore.

SEN. MCDONALD: The question is, what is the average salary of an OB-GYN in Westport?

MARC STORCH: Years ago it would have been several hundred thousand dollars. Are you personally asking me? I don't know how the other group is. All I know is that there are five of them in Westport and myself.

The five of them, all of them should be here testifying here today. It's not an issue here for me anymore. I'm here today because I think that medicine has a huge problem in this State.

For this Committee and the government in Connecticut, as Governor Rell said, we have Yale here and we're reasonably intelligent in the State. Not to make a huge impact on a huge problem is a disaster.

I can't speak for them. I know they're paying several hundred thousand dollars in premiums,

those being malpractice premiums for one group. Myself, it's seriously become a hobby for me.

I sort of pay my expenses, and I decided not to retire completely. Fortunately I don't have to get up at three in the morning. Some of my patients still like me and I keep doing it.

In other words, from a financial standpoint what do I take as a salary? I guess I could probably substantiate this on my tax return. I make very little.

SEN. MCDONALD: Okay. I'm not asking you to disclose what your salary is. I'm asking you, based on more than two decades of experience, you must have some understanding of what the range of compensation is for OB-GYNs in Fairfield County. I'm asking you to share that with me.

MARC STORCH: Part of that answer is that a lot of them are leaving, so they can't be making much. I don't know the exact answers.

For being up several nights a week and working at a very hard profession where you can get sued at any moment, I would guess they make \$100,000 to \$200,000, maybe more depending on their volume.

I don't think it's a huge number any more. In the old days, yes, it was a bigger number. I think it's way down. Don't quote me.

SEN. MCDONALD: I won't. Representative Farr.

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MARC STORCH: We'll keep it secret on the TV here.

REP. FARR: It strikes me that the problem isn't OB-GYN. It's obstetricians. If you don't do deliveries you can survive, you can have a practice.

If you're doing deliveries, because the previous testimony was OB-GYNs are maybe paying \$20,000 in malpractice. If you're going to be doing deliveries you're going to be paying \$100,000.

MARC STORCH: Any high-risk specialty. We're about to lose our neurosurgeons. We've lost eight OBs at Norwalk Hospital.

REP. FARR: Right. But neurosurgeons also have the ability to charge more than you do for deliveries. They aren't capped as you are--

MARC STORCH: They're capped.

REP. FARR: --Let me ask you this, how much were you getting paid per delivery? Previous testimony was \$1,500 to \$2,300 per delivery. Were you doing any Medicaid cases?

MARC STORCH: For the first 25 years of my practice we would take rotation at the hospital and deliver the indigent. In which case, we frequently received no money. Those cases were covered under our malpractice.

The answer is yes, I did thousands of Medicaid deliveries, frequently not being reimbursed at

all, all the patients that didn't have insurance, and that continues today.

The reimbursement for covering indigent patients at the hospital could be zero. I was up one night. I saved a gal's life who was incredibly ill. She actually had insurance and it did not end up paying.

She kept the money. I saved her life. That's the way it can go. That's what we signed up for. We didn't sign up to lose money on our practices.

REP. FARR: If the State pays you for someone receiving State assistance under Medicaid, you don't know how much?

MARC STORCH: It's miniscule, I would say. It could be \$1,000, \$1,500 maybe.

SEN. MCDONALD: Anything further? Thank you very much. Jean Rexford followed by Jonathan Greenwald.

JEAN REXFORD: Good evening. I'm Jean Rexford. I'm executive director of Connecticut Patients' Rights and the Connecticut Center for Patient Safety. My testimony tonight is this book that I have provided for all of you.

It's something that I've put together over the last year. It's called A Cause for Action: Connecticut Families Search for Justice.

We deeply appreciate the courageous individuals, like Elizabeth Reed, who was here

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earlier, and families who have shared their stories and relived the painful experience that changed their world forever.

This book is dedicated for them and for those whose stories remain untold. Our hope is that it gives voice to the suffering that these people have sustained.

Our wish is that we had done justice to their sorrow, and our purpose is to break the silence that confronted these victims of medical malpractice and to expose the manner in which they were treated by the healthcare industry.

I've been listening for as many hours as all of you have. I really have to congratulate Connecticut, the Governor, and Commissioner Galvin understanding the complexity of this issue, understanding that there are not simple solutions.

I think the thing that continues to bother me, as an advocate for these victims of medical malpractice, is that all the legislation that you're really looking at tonight is talking about what happens after the injury occurs.

I hope that as we go forward as a State that we start looking at meaningful prevention of the injury and also the ways in which the healthcare consumer is treated when the injury happens.

I think that we have a long way to go to humanize the entire process. I look forward to

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working going forward as we hopefully resolve the issue this year.

SEN. MCDONALD: Thank you. Are there any questions?
Senator Roraback.

SEN. RORABACK: Thank you, Mr. Chairman. Good evening, Jean. In the context of humanizing the process, you may have heard my questions earlier today to the lawyer for the doctors and physicians about whether it would be desirable for us to have a policy which encouraged healthcare providers to apologize when someone makes mistakes.

As someone who represents individuals who have suffered injuries, and you probably have more exposure to victims of malpractice than any of us, how often do they tell you that they have been apologized to?

JEAN REXFORD: Virtually never. The few people, the president of my organization whose wife died in front of her children in an allergy practice, the physician came outside and said more or less, I feel awful, I will talk to my insurance company.

That was the last he ever heard from anybody until they were all in court. Apologies seem to be unacceptable. I often feel very badly for the physician that can't do that.

There's been a dramatic turnaround in southern California with Catholic hospitals on the use of apology. The people I talk to want

acknowledgement that the error happened. They might be missing two legs.

It's obvious to them that the error happened, but to have some knowledge. Also, a lot of these people, what is mind boggling to them is that the physician that did the malpractice will be paid.

Everybody else gets paid, but they are left with some horrendous bills, unable to pay them. I believe almost 15% of bankruptcies now are from healthcare causes.

SEN. RORABACK: I guess my question was more to the question, do you think it would be a wise change in our public policy to allow physicians and other healthcare providers, if there has been a mistake, to admit that to their patients and not later have that used against them in court?

JEAN REXFORD: If you can legislate that kind of humanity I think it would be a wonderful thing.

SEN. RORABACK: Thank you. Colorado has just done that. I appreciate your perspective. Thank you, Mr. Chairman. Thank you, Jean.

SEN. MCDONALD: Anything else? Thank you very much. Jonathan Greenwald. Good evening, Sir.

DR. JONATHAN GREENWALD: Good evening. I certainly knew I was going to say good evening to you fellows when I draw my lottery number.

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SEN. MCDONALD: The sad part, Doctor, is that you're number 45 and our last one is 96.

DR. JONATHAN GREENWALD: There are 40-something more after me?

SEN. MCDONALD: Well, we don't think so. Please proceed.

DR. JONATHAN GREENWALD: I knew it was going to be a long night. Anyway, I'm Jonathan Greenwald. I'm an internist and a cardiologist practicing in Norwalk since 1966. I'm a member of the CSMS, the Connecticut State Medical Society, and I'm not a lawyer.

SB 1333

The Connecticut State Medical Society puts establishment of mandatory pre-trial screening panels at the top of its list of legislative initiatives, something that I think I heard, was it Senator Meyer that said he was thinking of?

At least it's nice to know I'm on a somewhat similar page to one of you. That's listed in the latest issue of *Action* as the top priority, establishment of a mandatory pre-trial screening panel.

I want to talk about Senate Bill 1052. In section one, paragraph a, it still hearkens back to a good faith certificate. Yes, it amends it so that the physician who files the opinion of the case with the court must be from the same discipline as the defendant.

I have more to say on maybe tweaking this a little bit, if you want to hear it later. Nevertheless, the way it's written now it's not effective reform.

With a relatively minimal effort, a plaintiff's attorney can still find a single voice out there in the void who will back the case. That's a fact that can't in good faith be denied by any of you.

For the last 11 months I have studied this segment of the malpractice process, that is the pre-litigation phase, and have reworked it many times along the way.

I was very appreciative of the professional guidance given by my ex-State Rep Ken Bernard. I also received input from then-Representative and now-Senator Robert Duff of Norwalk. Naturally, I wrote it in non-legalese.

I presented it in detail before the Insurance, Real Estate and Public Health Committees earlier this session, during their public hearings.

At the close of testimony on Senate Bill 1333, which is not before you tonight, which has its own version of pre-litigation screening which I find unsatisfactory, and that should read appendix two and not appendix one if you want to take a look at it.

Richard Newman, who testified that day, president of the Connecticut Trial Lawyers Association, had a chance to read my proposal

and was glad to see that it's characterized by an even playing field.

Each of you on the Committee should be getting a copy of my full proposal, which is appendix one, which has been endorsed by the CSMS.

I will only speak to its main points now, which are mandatory pre-litigation of all Connecticut malpractice cases, regional panels which consist of two attorneys and two physicians plus a non-voting moderator.

That's my own concept of what it should be. I know there's talk about whether that's too many, but I don't think so.

The panel's finding, whether in favor of the plaintiff or the defendant or neither, that is deadlocked at two-to-two, must be reported to the court or to the settlement hearing.

Regardless of whether the case settles or goes to the court, the panel's finding must be introduced as evidenced.

I urge you to weigh my proposal very seriously, flesh out the details, translate it into the minimum legal degree of legalese and incorporate it into Senate Bill 1052 as replacement for the current section one, paragraph a.

By so doing, for the first time real teeth will reside in the pre-litigation phase of medical malpractice in Connecticut, not to mention the country.

Thanks for hearing me. Any time I can help or answer your questions, don't hesitate to get in touch with me.

SEN. MCDONALD: Thank you, Doctor. Thank you for traveling all the way from Norwalk. Though Senator Meyer is not here, I will send along to him your commendation of his recommendation.

DR. JONATHAN GREENWALD: To give you an idea of how important this is to me, I've got to go to Syracuse tonight.

SEN. MCDONALD: Okay. Well, we'll see if we can get you on your way. Are there any questions from Members of the Committee? Very well--

DR. JONATHAN GREENWALD: Can I just say one thing? If this is a realistic thing, what I've proposed, that's great.

If it's not two and two attorneys and physicians but one and one or something like that, that's also something I could live with. I think it's important to have one of each.

I would just want to comment on Governor Rell's Bill where it talks about getting the good faith backed by a physician. The way it is now, the plaintiff pays that physician and automatically that's suspect.

If there was any way that that has to be the way it is and not my proposal, it's got to be done somehow so it's totally independent of

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either side of the case that the physician takes a look at the case.

SEN. MCDONALD: We wish you well on your travels. Phil Sherwood. Rick Newman followed by Eric George. Good evening, Sir.

RICK NEWMAN: I am Rick Newman, president of the Connecticut Trial Lawyers Association. I think I have two and a half comments I would like to make. I had three and a half.

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I was going to talk about how much I hate the periodic payments, but I don't want to go into a tirade. I do want to thank the Members of the Committee for taking the time to hold these hearings and to consider these bills seriously.

I want to thank Governor Rell for the work that she and her staff have done. The two points that I want to talk about to begin with are collateral source hearings and procedures and secondly, offers of judgment.

The half-point I want to talk about is apologies. I've listened to Senator Roraback. Collateral source procedure has evolved as the common law has evolved and as the statutes have evolved.

The way it works under current statutes 52-225A and 225B is that the plaintiff in any given case offers evidence of medical expenses. The jury may make a finding compensating the plaintiff for those medical expenses.

After that the court, not the jury, has a hearing at which point the court assesses the amounts of collateral sources paid either by health insurance or those automobile insurance policies that still have some med pay.

That's a very small number. Typically the amounts under auto policies are very small. The hearing done is to adjust the amount of the verdict for any collateral sources that the plaintiff has received. That, in turn, has some ins and outs to it.

The ins are how much was paid on behalf of the plaintiff by the health insurer. An adjustment is made for the cost of obtaining the health insurance. There are cases that vary on how you calculate that cost. Is it for the entire period that the policy was purchased for?

Is it only during the time that the treatment was active? How do you calculate it? There is a split among the various courts about it. It's not clearly addressed.

The trend in the case law seems to be that whatever it costs to obtain the health insurance is offset against the amount of the collateral source.

By way of example, if a health insurer paid \$100, the verdict would conceivably thereafter be reduced by that \$100 by the judge. However, if it cost \$20 to acquire that health insurance, that would be deducted before the collateral source reduction was taken.

If it's \$20 to obtain health insurance, the health insurer pays \$100, the judge nets out the cost of the premium and deducts the remaining eighty. That is done outside the presence of the jury.

There are no procedures for deduction of other types of insurance by statute. Disability insurance is not defined as a collateral source. One speaker earlier was talking about putting this in front of the jury.

I think that that would be a mistake for a couple of reasons. First, it can and is being taken care of by the courts. Secondly, it starts getting into issues of insurance which traditionally have not been before the jury.

They are not told anything about who has insurance or how much the insurance is. They're not told about insurance fees. They're not told about costs.

The jury is simply asked to determine if there was negligence, did it cause harm and how much money is fair compensation? The judge afterwards adjusts the verdict to offset any collateral source payments.

In fact, this creates a windfall for the defendant in the sense that it's the plaintiff's health insurer that ends up paying an expense that was really caused by the tortfeasor.

That is an issue that was debated when collateral source payments went into effect.

It's been revisited periodically over the years. I'm not sure it's before this Committee right now.

What I am suggesting is that the collateral source process, as it works, works well. It has an adequate an accurate reduction of the verdict for the amounts that someone else has paid on behalf of the plaintiff.

At the end I'll be happy to answer any questions, if I'm able to, about collateral sources. I'd like to shift gears briefly to talk about offers of judgment.

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There has been a lot of talk about whether the 12% per annum rate is too high or too low. I think that there was one speaker today that said that 20% wouldn't bother her terribly much.

I think that, as the Committee has alluded to, there should be enough of a financial incentive to ensure that defendants take Offers of Judgment seriously.

My experience has been that defendants do take Offers of Judgment seriously. I think they're an effective tool at resolving cases. They do not necessarily resolve the cases within the 30 or 60 days given for acceptance of Offers of Judgment, but they sometimes do.

They also tend to foster some prompt negotiations, and as you've heard from other speakers they do form a useful piece of leverage that a mediator or judge can use to say you have some exposure

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immunity for private contractors working for the State.

SEN. MCDONALD: In the case that you referenced that was actually before the Supreme Court, had the plaintiff filed suit against the State perhaps it could have survived, but not against HNS Management?

MICHAEL STRATTON: They filed against HNS Management and the Supreme Court held that--

SEN. MCDONALD: You missed my point. The question is, if the plaintiff had filed a lawsuit against the State under 52-556, immunity is waived and that suit could be maintained.

MICHAEL STRATTON: --It would not be waived. Statute 52-556 only waives the State's immunity if it's a State employee or State employee who's operating the vehicle. If we added private contractors to that language, it would-

SEN. MCDONALD: I see. Yeah, thank you, got it. Thank you very much. Pat Charmel followed by Robert Shepherd. Good evening.

PATRICK CHARMEL: Good evening. Senator McDonald, Members of the Committee, thank you for the opportunity to testify on the subject of medical liability insurance reform. My name is Patrick Charmel.

I'm president and CEO of Griffin Hospital, which is located in Derby, Connecticut. The medical liability insurance crisis has had an

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adverse impact on Griffin Hospital's ability to fulfill its mission.

It has consumed financial resources that otherwise could have been used to deliver direct patient care, to develop new programs and services, to acquire technology to improve patient safety, to enhance our ability to diagnose and treat disease and to maintain or replace aging facilities.

Despite an exemplary claims record, Griffin Hospital has seen its liability insurance premium double from \$1.08 million in 2001, when the crisis began, to \$2.15 million this year.

To put this \$1 million premium increase in perspective, it's equivalent to half of the hospital's annual drug budget. It would pay for the entire cost of a hospital-wide picture archive and computer system to digitize, display, store and retrieve diagnostic radiology images.

Such systems have been shown to improve diagnostic accuracy and to improve physician access to important clinical information. It would cover the investment required to convert to an electronic medical record from our error-prone medical record-keeping system.

It could equip three operating rooms with state-of-the-art laparoscopic video surgery and patient-monitoring equipment.

Most importantly, the \$1 million could have been used to hire 15 additional registered

nurses to provide a higher level of patient care and to provide a better working environment for our nurses, who shoulder an ever-increasing burden.

The Hospital has been forced to make tradeoffs to fund its rapidly increasing malpractice premiums, tradeoffs that have adversely impacted our ability to fulfill our mission.

If given the choice, I believe the public would be willing to limit its rights to recover damages in cases of medical negligence if it meant that the dollars saved on malpractice premiums would be invested in improved patient care and safety.

Resources are expected to become more scarce due to a rapidly deteriorating operating environment.

Increased medical liability insurance costs, along with dramatic increases in the cost of drugs, blood products, fuel oil and employee pensions have resulted in hospital operating-cost inflation that has exceeded general inflation by a factor of three.

To cover higher operating costs, hospitals have demanded higher fees from managed-care organizations that have in turn raised the premiums they charge employers for health insurance coverage.

Those premiums have risen more than 10% per year over the last four years. Employers facing relentless competition in their

businesses have not been able to pass their premium increases onto their customers in the form of higher prices for the goods and services they sell.

In response, employers have begun to drop employee health insurance coverage or impose large co-pays and/or deductibles on their employees.

Increasing patient responsibility for the cost of care has resulted in the dramatic increase in uncollectible accounts and bad debt. Griffin Hospital's bad debt expense doubled from \$4 million in 2003 to \$8 million last year, 2004.

As more employers move to high-deductible plans, the problem will only get worse. Employers are demanding an end to rising employee health insurance premiums.

Medicare hospital payment cuts are inevitable due to record setting federal budget deficits. The State's Medicaid payments to hospitals, which cover only 70% of the cost of providing care, are likely to remain inadequate for the foreseeable future.

Given the growing scarcity of resources to fund the delivery of needed health services, it is time to adopt a more rational medical liability system to balance the needs of society at large with the needs of the few that are harmed by the care they receive.

To reform Connecticut's medical liability system I believe that a series of measures that promote predictability, efficiency and fairness for all parties involved need to be adopted.

Furthermore, measures adopted must have a proven record of effectiveness in reducing healthcare liability insurance premiums. Unfortunately, many of the measures included in Senate Bill 1052 and Senate Bill 1364 have no record of effectiveness.

I encourage you and fellow Legislators to consider adding a reasonable limit on non-economic damages to the reform measures. My prepared testimony said cap, but after six hours I know that caps are off the table. I hope that you'll consider limits.

I appreciate the substantial time and thought that Legislators have devoted to this problem. We will continue to work with you in any way we can to address this important issue in the best interest of patient care. I'm available to answer any questions you might have.

SEN. MCDONALD: Thank you. Are there any questions? I don't have any questions, but I want to thank you for your testimony. We've had an opportunity to meet in the past. I've always found your comments to be very thoughtful and helpful. We may not always agree, but it's wonderful to have your input into the process.

PATRICK CHARMEL: I appreciate that, Senator.

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SEN. MCDONALD: Thank you. There's another bill percolating through the process here somewhere about the use of external defibrillators, are you aware of it?

JOHN JACKMAN: No, I'm not.

SEN. MCDONALD: Okay. I think it came out of the Public Safety Committee. I'm just trying to figure out how we're going to reconcile them. Thank you very much. Any other questions? Have a good evening, Sir. I believe Vincent Pepe is next.

DR. VINCENT PEPE: Thank you, Senator. Good evening. Thank you, Members. I am actually an OB-GYN from Meriden, Connecticut. As an OB-GYN for the last 12 years and being a Connecticut small business, you should know that I and other OB-GYNs are under siege from our overhead, the simple costs of doing business.

Overall, as a profession we have been forced to take on more risk and liability, however our ability to absorb the costs for accepting the risks has been incredibly burdensome.

The care and access to patients are being compromised and threatened, despite the efforts of the average OB-GYN to do the best to take care of pregnant and female patients.

However, our cost to doing business, our overhead, mostly due to our persistent and substantial increases in our professional liability premium component is forcing doctors, those small business people, to make tough and

difficult decisions about their practices and how and why they practice.

What we need is a way to pass the cost on. We are and will soon be further unable to absorb these costs. We are essentially subsidizing different insurance companies on both sides of the equation to provide healthcare. We have an incredibly over-achieving judicial system.

I do not think it is reasonable to indite all doctors or all OB-GYNs trying to do harm to their patients. Negligence, medical malpractice must indeed exist but it is not rampant. Nor is it to be belittled.

Please understand that all mal-occurrences or mal-results are not purposeful, deliberate or negligent. We need your help now. We need people in political power to know there's a crisis.

We need to be allowed to pass on our cost just like any other small business. We need a mechanism to pass these ever-rising costs on. We are caught in the middle.

Doctors are subsidizing those costs of medical care without being able to pass the costs of doing business on.

You can work on your caps or your lower-limited premiums, regulations, special judicial systems, rate-stabilization super-funds, but as politicians what you will do is find a compromise. The OB-GYNs of Connecticut need your help now.

You need to know that there is a crisis. Do the hard work now. Do not postpone the work for another year. We need real relief now. There is a crisis of supply and demand in access.

Less people look to medicine as a career. U.S. medical students are avoiding specialties like OB-GYN due to increased risks and liabilities as well as the demanding lifestyle of being able to be up all hours, days and nights.

Currently-trained resident doctors, who are loaded with educational debt, are having difficulty entering into the marketplace and obtaining liability insurance as well as avoiding Connecticut as a place to practice.

Usually, University of Connecticut School of Medicine graduates about 75 to 79 doctors. Historically, seven to nine of them go to OB-GYN. In 2004, only two went into OB-GYN. And in 2005, only two are going into OB-GYN.

There is a furthering of the crisis in OB-GYN when some OB-GYNs are dropping obstetrics just to do GYN. Deeply frustrated doctors are retiring, quitting, moving out of state.

The number of warm bodies in the profession will reduce due to attrition, thus a lower supply. Approximately 15% to 20% of OB-GYNs have left obstetric or have stopped their practice in the last two years.

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The redundancy in the present system has compensated for the attrition so far, but I doubt the system will be able to absorb the loss of another 10% to 30% of OB-GYNs in the State.

This additional attrition will occur when we see our next renewals of liability premiums. This deepening crisis, however, will only manifest itself six months to one year after those premium anniversaries.

As there is attrition there will be less doctors doing the same amount or more of work. This is a recipe for increased burnout, limited services, decreased access, increased risk and liability and more attrition.

It has been remarked that doctors are not very well organized and that we are not directed. You cannot hear us. We are not clear. We do not put up a great defense against this crisis.

My only explanation is that our primary focus is our patients and delivering patient care, usually around the clock. We usually do not involve ourselves with the politics of the medical delivery system.

We have a weak voice, and other political entities are counting on that. We need your help now. Again, you can do the work on your compromises and reforms. Different entities can bicker about statistics. People can say that this solution is better or not.

What is crystal clear is that if there is no solution for the OB-GYN doctor in Connecticut, if there is no solution to pass on the cost of doing business, there will be less OB-GYNs in Connecticut.

The real and further rise expected in medical liability premiums will not allow OB-GYNs to stay in practice. You will reap inherent the crisis of patient access and limitation of services provided.

Also, many of those small OB-GYN businesses will be out of business and those valuable, well-trained employees will be also out of a job. The problem is that we have no method to pass these costs of doing business on. Please remedy this.

SEN. MCDONALD: Thank you. Thank you for your testimony and your forthrightness in acknowledging what I think most doctors would acknowledge.

They don't really care where the relief comes from. They need to pass on the costs of doing business in some form, whether it's in lowered malpractice premiums or increased reimbursement rates. It's not necessarily where the relief is coming from, it's just a need for relief, is that fair?

DR. VINCENT PEPE: That's fair.

SEN. MCDONALD: Thank you. Representative Farr.

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REP. FARR: Two quick questions. You do deliveries, how many per year?

DR. VINCENT PEPE: Probably in the range of 60 to 100 per year.

REP. FARR: Do you know what the State pays?

DR. VINCENT PEPE: You've been asking that all night. You have to distinguish two things when you ask that question. One, a global care or delivery only, that's one.

Two is that Medicaid actually gives an incentive for obstetric care. Actually, the obstetric care delivered to a Medicaid patient pays slightly less than a private payer.

However, if you look at the GYN side, the family practice side, the cardiology side of Medicaid, they pay far, far, far less.

REP. FARR: Is it about \$2,000 for Medicare for delivery? What would you get for delivery?

DR. VINCENT PEPE: For Medicaid? About \$2,000, a little less.

REP. FARR: And that includes multiple visits, the whole package.

DR. VINCENT PEPE: Yes. And you asked for how many visits. Classically, in routine OB-GYN care there's a minimum of 13 usually and some are up to 20. That's over a 40-week period.

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REP. FARR: What percent of your practice is Medicare, Medicaid?

DR. VINCENT PEPE: A small amount.

REP. FARR: Okay, in your case. If it were all, you'd be making \$120,000 a year off of deliveries?

DR. VINCENT PEPE: Let's say this. I will tell you that approximately, if you look at the professional liability premium component of my practice and it's a line item in a spreadsheet, it accounts to about 30% to 40% of my gross.

You asked what an average OB-GYN is making that has to pay for these premiums. Well, I pay about \$125,000. That's in a range of people paying probably somewhere between \$120,000 and \$140,000, up to \$160,000 in Connecticut I've heard.

You asked how many OB-GYNs are here in the State. Probably in 2001 there were about 500. Two years later there were about 450. Probably right now, the numbers are going to be re-assessed, somewhere between 390 and 430.

That's the real number of practicing OB-GYNs, not the people who have just given up GYNs, but OB-GYNs.

REP. FARR: [inaudible - microphone not turned on.]

DR. VINCENT PEPE: Not necessarily all of the people are delivering. There are probably less people delivering.

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SEN. MCDONALD: Doctor, that's fascinating. You've been more successful than we have in getting numbers about the number of OB-GYNs who have been--

DR. VINCENT PEPE: You ask the wrong people.

SEN. MCDONALD: --Well, I'm not even going to name names here.

DR. VINCENT PEPE: In *Connecticut Medicine* about a year ago, two years ago, Len Ferucci produced a, he's a doctor in Stamford I believe, produced documents documenting how many people are delivering babies in Connecticut.

What he did was call every director of OB-GYN in the State of Connecticut, i.e. the heads of the hospitals' OB-GYN units saying how many doctors do you have in the hospital?

SEN. MCDONALD: This was an internally generated number. We've been trying to get a number from the Department of Public Health.

DR. VINCENT PEPE: The Department of Public Health, it's just what someone else made. A lot of people who have license for OB-GYNs and are MDs are not practicing.

They're not necessarily delivering babies. What Len Ferucci is in the process of doing right now, again, is doing a follow-up study from 2001 to 2003 and now from 2003 to 2005.

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SEN. MCDONALD: You've indicated that in your sort of rough experience, or I shouldn't say rough experience, but your guess is that most OB-GYNs are paying about \$125,000 to \$160,000 for premiums?

DR. VINCENT PEPE: Approximately. The majority.

SEN. MCDONALD: The other doctor from Westport that was here that I asked didn't have answer for the question of what's the range of salary that an OB-GYN would take home in the State of Connecticut.

DR. VINCENT PEPE: Probably the real answer is what's left at the end. I thought about that. I would guess that probably five, six, seven years ago the range was between below \$130,000 to above \$200,000.

Now, where people have to actually tighten their belts, probably they make somewhere between \$20,000 and \$150,000.

I'm sure there are some people that make more, and I'm sure there are some people who are doing it as a hobby because they don't need the money but they're paying their staff. That's not good business.

SEN. MCDONALD: Thank you very much. Any other questions? Have a good evening.

DR. VINCENT PEPE: Thank you. Thank you for your attention.

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SEN. MCDONALD: Next is Pat Monahan, followed by Dan Ricard. Good evening.

PAT MONAHAN: Good evening. My name is Pat Monahan, not Moynihan, although I have been called that too. I am vice-president and general counsel to the Connecticut Hospital Association.

I appreciate the opportunity to speak before you in connection with Senate Bill 1052 and Senate Bill 1364 and really all of the other bills regarding medical insurance issues.

Through the testimony you've heard earlier today from Mr. Pugh from the Milford Hospital, Mr. Charmel from the Griffin Hospital, you've had at least some firsthand testimony about the impact of this insurance premium crisis and situation on our hospitals.

In addition, you have written testimony submitted today and written testimony and submitted testimony given before other committees detailing the impact that hospitals feel as a result of this.

They can be summarized in addition to what you heard earlier as affecting the hospital's ability to utilize moneys for patient-care improvement, patient safety programs, reducing the number and availability of physicians in special-service areas and hampering the ability to recruit physicians in nearly all specialties.

Another growing problem is the compromised position hospitals are in most recently in

ensuring adequate on-call and emergency department coverage, particularly in specialty areas.

Connecticut Hospital Association's position, which probably comes as no surprise, we all have been here before this Committee and others, we believe that this is really premised on the need to preserve access to care.

We continue to believe that based on what we have learned, read and studied that a reasonable limit on non-economic damages is an integral part and should be an integral part of a comprehensive reform package.

Although we have said at the outset that we view it as an integral part, we do support other measures. We recognize that a cap on non-economic damages is not part of the bills before you that you're considering.

We actually do recognize and appreciate the inclusion in the Governor's proposal regarding the recognition that if no other measures succeed, then there's an indication that caps should be revisited at some time in the future.

You've heard a lot of testimony about the nuances and pros and cons of many measures. We are supportive of strengthening the good faith certificate requirements.

We do support facilitating greater use of periodic payments or annuities as Ms. Penny Seaman testified to earlier and to improvement in the Offer of Judgment provisions.

We would, recognizing that a lot has been said about each of those measures, like to have the opportunity in working on those measures with language which actually makes them effective, balanced and fair.

We hope to do that with you and everyone on your Committee. I'd like to also take this opportunity to re-affirm Connecticut Hospital's commitment to patient safety, to quality improvement and to accountability.

Either now or in questions or some other time I can detail for you many of the initiatives that the hospitals themselves and through their Association have undertaken, not only in Connecticut but in the United States in general.

We are a leader in patient safety initiatives. That is something that is not often recognized. I think it's worth suggesting to you that perhaps that would be information that I'd be happy to share.

SEN. MCDONALD: Thank you. The hour is a little bit late, so let me just ask you to do me a favor. I would like to see that.

If you have any kind of compilation of things you have done to improve on patient safety, I'm sorry it's so broad, but if you could provide us with a laundry list of initiatives undertaken and initiatives planned, both perhaps short- and long-term planning and you

could get that to the Committee, I'd appreciate seeing that.

PAT MONAHAN: Certainly we'll do that. One quick point I'll mention, one of those initiatives is a bill that is in the Legislature to consider right now, which is basically freeing up impediments to the development of electronic medical-worker systems.

That's certainly something you'd see on this list. I'll give you an idea of that.

SEN. MCDONALD: That's the one I'm particularly interesting in. Great. Are there other questions? Thank you very much. Dan Ricard. Good evening.

DAN RICARD: Good evening. Senator McDonald, Members of the Committee, my name is Dan Ricard. I'm a bondsman from the Manchester area speaking about Raised House Bill 6966. I support the Bill.

Oversight of the bail bonds industry in Connecticut needs to be transferred to the Department of Public Safety. The Insurance Department cannot or will not enforce their own regulations.

I go to the Manchester Superior Court on a daily basis, and recently complained to the Insurance Department about one particular group of bondsmen from the same company who routinely operate there in a gang capacity reminiscent of organized thugs.

I personally know of several bondsmen who have left the business because of these abuses that have been allowed to continue. Please help us and pass regulatory reform.

SEN. MCDONALD: Thank you very much, Sir. Are there questions from Members of the Committee? If not, thanks very much for waiting tonight. I think next is Dr. Lazor.

DR. LARRY LAZOR: Thanks for taking the time to listen to us. I think the discussion has been good today. I'm an OB-GYN at Hartford Hospital. (SB1052)

I've already heard a lot of comments that kind of sum up what my feelings are as well. It comes down to business to a big extent. The overhead is high. My malpractice is \$120,000.

When I started in private practice 10 years ago it was at \$40,000. I had coverage of \$7 million per case, \$10 million per year. Now at \$120,000 I have coverage of \$2 million per case, \$5 million per year.

What happens is there has been a decrease in OB-GYNs doing deliveries, but more so there's a decrease in options. A lot of the females in OB-GYN work part time and there's no break for them. They pay \$120,000 if they work three days a week.

It's simply a business model that's tough to do with those numbers. What we're looking for is some relief. Obviously, most of the OBs are

frustrated. We have a great respect for what you do and understand the difficulties.

We've heard a lot of different issues. We need something that addresses that problem. That's what we're looking for. I can speak at Hartford Hospital, one of the best OB-GYNs when I was a resident was Tracy Brendon.

She was on the cover of *Connecticut Magazine*. She stopped doing OB. She has kids. It's just difficult to do it. One of my other mentors, Linda Taylor, picked as ConnectiCare's best OB-GYN in the State based on patient's recommendations, stops doing OB.

It's a problem. What we need are solutions. I think a couple of things. One is that if you just increase premiums, you still have that overhead.

It's going to still be tough for them to do it, and you're decreasing options for patients and who they can see. I also think what Senator McDonald said, you have to be careful.

If you say that malpractice only represents one to 2% of the medical budget it doesn't sound that significant. It hits us. It hits people. It affects patients. You see more patients in a day.

You have less time to spend with patients. People call you up. You think about the time. You spend less time talking to patients. I think all of us really try to take the time to take good care of patients.

The other side of this is that if I wanted to leave OB-GYN I would have to pay \$200,000 to buy tail. Even if you wanted to move to another state, the way our malpractice is written is you would have to come up with money to cover any suits that came up after you left your practice.

It really makes it tough. If you want to leave or do other things, you're kind of tied in. I get a little bit concerned when I hear trial lawyers talking. The sense is that we're the bad guys oftentimes.

I can tell you that obviously time-wise, in terms of going to school, I went to UConn Med School, going to residency, that's our passion. We've worked hard. No one cares about the health more than we do.

My concern sometimes when I hear people talk, and I've had many roommates in college who are lawyers, but I use the term smoke and mirrors.

Sometimes it's good that everyone talks about it, it's good that these lawyers, these businesspeople, everyone's talking about it, but I get upset if there are smoke and mirrors. There are a lot of articles in the paper saying well, caps don't work.

Does that make any kind of sense to anybody? If you cap some kind of insurance, your premiums won't go down? It doesn't make any sense. Insurance companies are making too much

money. We had six companies doing malpractice when I started, now we have two.

If they're making so much money, why are there less? Insurance companies are poor investments. Most of them do bond investments. They're very conservative investments.

I think what we're asking you to do and what we're frustrated with [Gap in testimony. Changing from Tape 5B to Tape 6A.]

Easier for us to practice healthcare in the State of Connecticut. I was at a meeting where Senator Harp said she has two daughters in medical school and they don't know if they can come back to Connecticut.

I think that's too bad. Any change you make, that's the area that we want you to try to address. I'll answer any questions that you have.

SEN. MCDONALD: Any questions? Representative Farr.

REP. FARR: Thank you for coming in. Just to get some statistics, how many deliveries do you do in a year?

DR. LARRY LAZOR: I'd say I do about 120.

REP. FARR: Do you pay for your own medical insurance? Did you say you were at Hartford Hospital?

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DR. LARRY LAZOR: I'm at Hartford Hospital but I'm a private practitioner. I'm not an employee of Hartford Hospital.

REP. FARR: So you don't have their insurance coverage?

DR. LARRY LAZOR: No, we get our own insurance coverage through ConnectiCare Insurance.

REP. FARR: How much are you paying?

DR. LARRY LAZOR: I don't know exactly. It would be whatever our group rate is. My guess is roughly \$10,000 a year, I think, for health insurance.

REP. FARR: How much are you paying for your malpractice insurance?

DR. LARRY LAZOR: I'm paying \$120,000 a year for malpractice.

REP. FARR: And you're doing 120 deliveries a year. What percentage of your practice is private-pay versus Medicare?

DR. LARRY LAZOR: A small percentage is patients with HUSKY plans or some State plans. We rotate and cover the residents who cover patients without insurance. Pregnant women, there's a pretty high percentage that have insurance.

REP. FARR: Do you know what the HUSKY plan pays now?

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DR. LARRY LAZOR: I don't, but I think they're pretty competitive with other HMOs. I don't know exactly, but I think in that area of healthcare they're pretty competitive.

REP. FARR: There was testimony before that it's about \$2,000 per delivery.

DR. LARRY LAZOR: I think it's higher than that. The reimbursement rates have gone up the last couple of years. I would say the lowest we have is about \$2,300 and next year some of them are going up over \$3,000.

REP. FARR: But if you do the math, it's \$2,300 to \$3,000 per delivery. From what your rates are and the number of deliveries, it costs you \$1,000 for malpractice insurance.

DR. LARRY LAZOR: It's expensive to do obstetrics.

REP. FARR: Okay, thank you very much.

SEN. MCDONALD: Thank you. Are there any other questions? Sorry, I was out of the room for the first part of your testimony. You pay \$120,000 a year of malpractice insurance and you deliver 120 babies. Okay, thank you.

DR. LARRY LAZOR: Like I said earlier, when you weren't here, that coverage of \$120,000 gives us \$2 million per case, \$5 million per year. When we started in practice we had \$7 million per case and \$10 million per year. That was \$40,000.

SEN. MCDONALD: Thank you.

DR. LARRY LAZOR: I just wanted to say one other thing, Senator. You're exactly right. It's best if a doctor admits that they were wrong. That definitely decreases lawsuits.

A lot of lawsuits come from poor communication. I can just see these guys, and I empathize with them, what a tough bind doctors are on. You have to understand. But you're exactly right, that's the thing to do.

SEN. MCDONALD: Next is Malcolm Brown. Good evening.

DR. MALCOLM BROWN: Good evening. Thank you very much for listening and giving me the opportunity to speak. I didn't necessarily think I'd obtain that. I drove down from Sharon this morning and there was a huge traffic jam. I got here right at the very end of the time that you could sign up.

(SB 1052)

I've been in practice for 32 years in Sharon, Connecticut as a pediatrician and 12 years as a family practitioner at the beginning of that. I'm in a four-doctor group that serves 8,000 to 10,000 patients in New York and Connecticut.

I've been a Chief of Staff at Sharon Hospital in the past, and I've been on the Executive Committee of the hospital since 1996, a committee which is combined of doctors and administrators and makes administrative policies or suggestions.

I'm now reading some hastily scribbled notes. The primary practice of medicine is not necessarily a high-end income way to make your living. That's not primarily why I went to medical school, to be a high-earner.

To place my own life in perspective, practicing in the country I've never made more money or should I say I've made less money than the Superintendent of the schools throughout my professional time while always feeling that I worked at least as many hours and went to school as least as much time.

In the past four years, the malpractice insurance for our practice has risen for four doctors. It's interesting how the figures may vary. I suppose it's with regard to company and locale in the State.

For four of us four years ago it was \$17,000. It's now up to \$55,000 and will be up to \$62,000 next year. Likewise, the limits of coverage have dropped from \$2.4 million to \$1.3 million. An internist in Sharon, Connecticut paid \$75 a year for malpractice insurance in 1948.

I've had some health problems within this past year and I've decided that beginning in July 1st I'm going to get out of the private practice of medicine and try to do something else for a living which is a little less stressful.

The image that's coming to my mind is that I think of practicing medicine the way I have as sort of being one of those childhood merry-go-

rounds where you have to push the merry-go-round yourself.

You're on it, you're crouched on it, you have to push it around in a circle and provide the power. After a while it gets to be more and more difficult. Malpractice occurs. We all know that.

To me the question is not whether or not malpractice occurs but how society goes about compensating for it.

I think there's a disconnect here, in the sense that I meant to say at the very beginning that I've been very impressed by the level of the dialogue and the very high intentions of all people speaking and listening, but the disconnect to me is that we've come to the fact that we're dealing with it essentially as a public health problem.

We're trying to compensate victims, and we're driving doctors out of business. That's a massive public health problem. This massive public health problem is now trying to be solved by the judicial system.

I don't think it's really the appropriate problem in the appropriate place. The thought process that has been occurring to me is that if one is accused of a crime, you are afforded a trial by jury and the State becomes a plaintiff.

If a doctor is accused of malpractice, the doctor is not afforded a trial by jury of

peers, I meant to say peers with regard to the criminal.

The doctor is not afforded a trial by his own peers, and the patient becomes the plaintiff. This is another part, if you follow me, of what I see as a disconnect of the current system.

The doctor and his attorney are placed in the position of having to educate the jury to provide them with a medical education so that they can make a judgment on medical matters, another disconnect.

I'm not a big fan of caps because I don't think that caps necessarily have the potential to compensate those who have been severely injured adequately. I think something has to be done, caps, limits or a switch to a compensation system.

A year ago in the *Times*, I hoped to bring this today but I forgot, a very little article, a letter to the editor was published by an attorney in New York.

It was published on the bad effects of lawsuits in America. He and an internist in Boston have written together on the concept of compensation for malpractice events as opposed to litigation. That's the end of my remarks.

SEN. MCDONALD: Thank you. Senator Roraback.

SEN. RORABACK: Thank you, Mr. Chairman. I have a long way to go home tonight, but Dr. Brown has an even longer way. All of us as Legislators

have gotten lots of phone calls over the years from physicians who care about this malpractice crisis.

I take my hat off not just to Dr. Brown, but to all the physicians who have made their way over here today to influence our process and to contribute to you, Doctor, and your colleagues that you're investing your time in our rather tedious process. Thank you.

SEN. MCDONALD: Let me just ask you, and I apologize, but apparently you're the last medical doctor who's testifying. I really don't know if you are qualified to answer this.

In our last time around, when we were having these public hearings we saw not only a number of family practitioners and OB-GYNs come out and tell about the problems that they were facing in the practice of medicine, we also had a number of neurosurgeons who talked about it.

It just strikes me that we are now eight and a half hours into this. We haven't heard from one neurosurgeon. Do you have any reason to believe that the situation is any different from previous years for a neurosurgeon?

DR. MALCOLM BROWN: No, Sir, I don't. I would say with regard to neurosurgeons, colleagues and people I've known over the years in neurosurgery as a specialty, they're characterized by being usually highly intelligent and not terribly good communicators.

I think those two characteristics might just make them reluctant to come to public hearings. That's my own assessment.

SEN. MCDONALD: Fair enough. Thank you very much. Thank you for your testimony. Andrew Bloom.

ANDREW BLOOM: Good evening, Senator, Representative. It's been a long night. I'm not used to this. You guys are, and I really appreciate you guys sticking around and listening to all of us.

HB 6966

The bail bonds industry thanks you as well. I've been in the bail bonds industry for nine years. I'm a voting member of the Professional Bail Agency of the United States and owner of 3-D Bail Bonds, Inc. I'm the owner of Dad's Bail Bonds, LSC.

I've been involved with the apprehension, surrender or otherwise locating of over 3,000 principles on bonds that failed to appear under my surety. My companies employ about 30 bondsmen, another 10 to 12 clerical and four bail enforcement agents.

We write somewhere between \$50 million and \$60 million a year in bail bond liability. One of the people who spoke earlier who was tossing around numbers of 150 agents included my agents. We do write under him.

We don't agree with his opinions. I would prefer not to be quoted as part of his agenda here. His agenda has been, like the movie Kill Bill, or actually that was last year, this year

BANITA TOUSSANT: Good evening to the good Senators. (SB 1052)
I appreciate your public service on this particular forum that will hear an act on the plight and disuse that the citizenry faces. My name is Banita Toussant.

I am a mother of four. I had some very awful experiences back in the '90s and it has left me unable to hold a job.

I was robbed of my health and my quality of life that the good Lord blessed me with when I was submitted into the hospital at five months pregnant and they allowed an unlicensed doctor to perform a botched abortion on me, after which I became very ill with my belly.

The second doctor I went to in the same instant community, I have no idea what he knew or did not know. The cover-up continued. I got pregnant twice after that, both of which resulted in losses.

The third instance it was caught and they left my left ovary and left fallopian tube in my belly. That remained there from 1991 to 2004, when I had to go to a hospital all the way in Boston because of the care that I did not receive in this instant community.

I'm not trying to put down doctors or anything, because I have four children. They're adults and they did well in the community. I have nothing against doctors. It's what happened to me in this community. The legal situation also created a lot of grief for me as well.

When I was unable to hold a job I had to seek help by taking my case to the court system. The corruption is unbelievable in there. I did not get a jury of my peers and I got nothing for my injuries.

This happened before it actually was diagnosed that my ovaries were sewn up in my belly. I went to the court system, the case was heard in 2000, and they said the Statute had passed. I continued to get medical attention. I continue to suffer today.

I have to rely on my children and a small Social Security check. There are a lot of things that went on behind the scene. It was a nightmare. They tried to find ways to shortcut their way out of it so that I don't get my day in court.

The Department of Public Health, I also went to them in the initial stages. I gave them documentation that an unlicensed doctor attended to me and that could have caused some of the problems I live with today. They did nothing about it.

It's a whole nightmare that I don't think just me as an individual might have experienced where they were unable to bring the case to fruition. I do have injuries.

They performed all kinds of unnecessary tests on me, two colonoscopies, one sinuscopy that further caused injuries, you just name it. It

was a total nightmare. There was a lot of corruption behind it. They know.

I wasn't born in this country but I've made my contribution to this country. My first child is a captain in the United States Air Force. This is a melting pot. We all belong here. It has nothing to do with here you came from or whatever.

Everybody should be able to make a contribution to their community, and this is why I'm here as well. I would like to see a change come about.

I would like things like this to be investigated so that we could have better checks and balances and so the community could be a more orderly community. This is what the Founding Fathers wanted. This is not what we're getting.

It's 14, 15 years into what happened. I became a member of Patient Rights. Myself and some others were put in a book form here that I'm sure you'll get a copy of so that you can read it. I would like to be called upon.

There are things that go on that I would like to see uprooted. We've had a lot of things that have gone on, and you're sitting there. It's only when it blows up in your faces in the newspaper, that's when you take action.

I want to tell you, this is one of the things that you can take action about and ring about changes so that people, when they go to the doctors, when they go to the legal system,

whatever, they're going to be treated as human beings and they're going to get due process and their rights.

SEN. MCDONALD: Thank you very much. I want to thank you for spending so much time waiting for this--

BANITA TOUSSANT: I know. I have to go home and get my medication and come back. I would like to hear from you all. I am an advocate for decency. I have raised my children to be decent human beings. Eric knows that one of my daughters was Ms. Connecticut, 2000.

SEN. MCDONALD: Congratulations on that. Thank you very much for coming.

BANITA TOUSSANT: I would like to hear from you all. There are things that must change. Also, I must be reimbursed for everything my family spent.

It wasn't supposed to happen. It has taken away a lot of my youth from me, and that was something that was given to me by God. Thank you very much.

SEN. MCDONALD: Have a good evening, Ma'am. Sir, welcome. Please, I don't have your name on the signup list so please just identify yourself for the record.

GENBE TEWKSURY: Good evening, Senator. My name is Gene Tewksbury. I'm here to testify on House Bill 6975, specifically the private prisoner

TESTIMONY OF SARAH COHN, EXECUTIVE DIRECTOR, LEGAL SERVICES
YALE NEW HAVEN HEALTH SYSTEM
BEFORE THE JUDICIARY COMMITTEE
April 8, 2005

SB 513, An Act Limiting Expert Testimony in Medical Malpractices Cases,
SB 514, An Act Concerning Periodic Payment of Medical Malpractice Awards,
SB 515, An Act Concerning the Bifurcation of Medical Malpractice Actions,
SB 1052, An Act Concerning Medical Malpractice,
SB 1354, An Act Requiring Notice of Medical Malpractice Actions and Notice to Patients of
Diagnostic and Laboratory Test Results,
SB 1362, An Act Requiring Disclosure of Liability Insurance Policy Limits Prior to the Filing of
a Claim,
SB 1364, An Act Concerning Reforms Related to Medical Malpractice Insurance,
HB 6811, An Act Concerning Offers of Judgment,
HB 6814, An Act Concerning Collateral Source Benefits in Civil Actions, and
HB 6817, An Act Requiring Specific Findings of Damages in Jury Verdicts

Yale New Haven Health System, comprised of Bridgeport Hospital, Greenwich Hospital, and Yale-New Haven Hospital, appreciates the opportunity to submit testimony on the subject of medical liability insurance reform.

The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire healthcare delivery system in this state. Starting in 2001, each of our System hospitals experienced a dramatic increase in medical liability insurance premiums.

Yale-New Haven Health maintains primary and excess professional liability insurance. It is important to note that commercial excess carriers view the Connecticut trial and verdict environment as extremely unfavorable. Some excess carriers have refused to write our business, while others have required substantial increases in attachment points (in essence requiring much larger primary coverage) before they will provide the coverage – while at the same time increasing the price of the coverage.

In addition, the premium increases experienced by the doctors who serve the hospital have a direct, detrimental effect on the hospitals themselves. These escalating insurance premiums threaten and compromise our ability to deliver patient care in the following ways:

- Medical students are less apt to pursue training in specialties with disproportionately high insurance premiums, resulting in a smaller pool of qualified physicians in certain practice areas.
- Many physicians are leaving high risk specialties like obstetrics and neurosurgery, or are reducing their hours due to the high cost of insurance. Some practices, which render some of the more technically specialized care in the state, predict bankruptcy within two years if premiums do not ease. If these practices close, these kinds of highly specialized care simply will not be available in Connecticut.
- Some physicians have left the state to practice in what are perceived as less risky litigation and premium environments.

- As private physicians are closing their practices or reducing services, thereby decreasing access, our hospitals are seeing more critically ill patients in our emergency rooms and at a higher cost of care to the state, insurers, providers and patients.
- These same practice closures and restrictions are causing patients without a source of routine or urgent care who do NOT require emergency services to seek care in our emergency rooms, contributing to overcrowding in the ED.
- Some physicians who formerly volunteered their services to the Hospital to teach and to care for patients in specialty areas are declining further participation due to liability fears.

Yale New Haven Health believes that our medical liability system requires a measure, or combination of measures, that will promote predictability, efficiency, and fairness for all parties in medical malpractice litigation. While some of the proposed bills contain measures that could possibly improve Connecticut's litigation process, YNHHS continues to believe that a reasonable cap on non-economic damage awards is a necessary component of an effective reform package.

However, even without passage of legislation implementing reasonable caps on non-economic damages, there are actions that Connecticut can take that would improve the environment in which cases are handled. These actions will be helpful even if they cannot be shown to have a direct impact on professional liability premiums.

- The legislature should prohibit waiver of the attorney contingency fee statute.
- Expert witnesses for both plaintiff and defense should not only be in the same physician specialty, but should have had actual experience in caring for same or similar illnesses as that claimed by the plaintiff.
- Bifurcation of the liability adjudication from the damages adjudication should be granted as of right on the motion of either party. Some proposals indicate that parties may make a motion and the judge may but is not required to grant the motion; this is current practice.
- Offer of judgment interest should be substantially decreased. We support the prime interest rate proposals contained in legislation under consideration.
- We support mandatory periodic payments for verdicts in excess of \$250,000. However, current proposals do not address a main concern of the plaintiff's bar: that is, the amount upon which the contingent fee will be calculated. If there is agreement that the fee can be calculated on the verdict amount, not what the annuity costs, there may be less opposition to the concept.
- We support proposals to permit introduction by the defense of collateral source payments during the trial. Analysis by the PIAA insurance group supports the contention that this is the second most effective method of tort reform, after effective caps on non-economic damages.

We do not support proposals that would require disclosure of liability insurance policy limits prior to the filing of a claim. We are already required to disclose limits after suit has been filed (in response to interrogatory questions). Disclosure of limits prior to the filing of suit (which requires a certificate of good faith) appears to encourage claims to be made based on available coverage rather than potential liability. This is particular true when claims are made in writing before suit is filed – which is a common and sensible practice.

YNHHS appreciates the substantial work and thought that legislators have devoted to this problem and will continue to work with you in any way we can to address this important issue in the best interests of patient care.

Testimony of Michael D. Neubert, Esq.

SB 1052, An Act concerning Medical Malpractice
SB 513, An Act Limiting Expert Testimony in Medical Malpractice Cases
HB 6811, An Act Concerning Offers of Judgment
HB 6817, An Act Requiring Specific Findings of Damages in Jury Verdicts
SB 1362, An Act Requiring Disclosure of Liability Insurance Policy Limits to Filing a Claim

Submitted to the Judiciary Committee
April 8, 2005

I am Attorney Michael D. Neubert of Neubert, Pepe & Monteith and I am here to testify on behalf of the Connecticut State Medical Society regarding a number of proposed Bills which deal with Medical Malpractice litigation. I have been representing healthcare providers and hospitals in medical malpractice actions for over twenty years. I know this committee is very aware of the intense debate surrounding the dramatic rise in malpractice premiums in recent years. Regardless of the disagreements regarding the cause for the steep rise in malpractice insurance rates, I think everyone is in agreement that legislative reform is required. In addressing the numerous bills pending before this committee which propose to reform medical malpractice law, I will analyze their practical impact on the litigation process, both good and bad and the likelihood that the proposed legislation would help reduce medical malpractice premiums.

Proposed Substitute Bill No. 1052, An Act Concerning Medical Malpractice
Section 1 – Written Opinion of Similar Healthcare Providers to be included with the Complaint

Presently a medical malpractice case can be filed with a simple Certificate of Reasonable Inquiry signed only by the attorney and merely stating that a reasonable inquiry has been made, as permitted by the circumstances and that there are grounds for a good faith belief that there has been negligence in the care or treatment of the plaintiff by the defendants. Plaintiff's counsel is not required to produce a written report signed by a physician providing the basis for the conclusion that malpractice had been committed. As a result, malpractice cases are presently instituted without an opinion by a similar healthcare provider as the defendant was negligent. As an attorney who has been representing physicians and hospitals in medical malpractice actions for over 20 years, it is my experience that the present statutory scheme does not adequately insure that an attorney filing a medical malpractice action has a reasonable basis to believe that the defendants have violated the standard of care in causing the plaintiff injury. In addition, under the present practice, it is virtually impossible to challenge plaintiff's Certificate of Reasonable Inquiry and in my experience plaintiff's counsel has never been required to furnish what the actual basis for his assertion that grounds exist for an action against the defendants. The proposed bill before you requires that plaintiff's counsel obtain a written opinion signed from a similar healthcare provider that there are grounds for a good faith belief that there has been negligence in the care and treatment of the claimant. The bill also provides that failure to obtain and file the written opinion required by this bill would be grounds for immediate

dismissal of the action. This requirement would help insure that there is a reasonable basis for filing a medical malpractice case under the circumstances and would eliminate some of the more questionable or meritless cases filed under the present statutory scheme. The Connecticut State Medical Society strongly endorses Section 1 of Bill No. 1052.

Section 3 – Offer of Judgment

(AVS 6811)

In addition, Section 3 of Proposed Substitute Bill No. 1052 adds significant new requirements before an Offer of Judgment can be filed in a medical malpractice case. Presently an Offer of Judgment can be filed by plaintiffs counsel at anytime after commencing a lawsuit regardless whether the defendants have received any medical records, statement of damages, or expert witness disclosures and defendants are required to decide within sixty days whether to accept the Offer of Judgment. In the event that they do not accept the Offer of Judgment, defendants are subject to interest of 12% on top of the verdict if the verdict equals or exceeds the Offer of Judgment. While the statute was originally intended to promote settlement of cases before trial, it has never achieved this goal. Indeed, in all my years of experience as a medical malpractice defense attorney, I have never heard of an Offer of Judgment being accepted by a defendant. The reason for this is because defendants are required to make a decision within a short period of time with very little information about the lawsuit, its merit or potential value. As a result, defendants have no choice but to decline the Offer of Judgment. As you know, medical malpractice cases are very complex and in order for defendant's attorney to properly evaluate an Offer of Judgment, he or she must have sufficient information including all relevant medical records, a statement of damage claims and plaintiff's expert witness disclosures in order to properly advise his client about whether to accept or decline the Offer of Judgment. Presently, plaintiff's counsel's only goal in filing an Offer of Judgment in a case is to take advantage of the provisions for post-verdict interest, which in larger cases can significantly increase the amount of the award. In addition, plaintiff's counsel presently uses the Offer of Judgment as leverage to extract higher settlements from defendants out of fear that they may have to pay Offer of Judgment interest.

Proposed Substitute Bill No. 1052 requires that sixty days prior to filing an Offer of Judgment, plaintiffs provide defendants with authorizations to obtain medical records. In addition, at the time plaintiffs file their Offer of Judgment, they are also required to disclose all experts who will testify as to the prevailing professional standard of care and provide a Statement of Damages. Under the proposed bill, the defendant would then have thirty days to accept the Offer of Judgment. Thirty days is clearly inadequate and should be expanded to at least ninety days in order to provide sufficient time to analyze the complex information and take plaintiff's expert's depositions. However, the Connecticut State Medical Society strongly supports Section 3 of Bill No. 1052 and the requirements that plaintiffs provide defendants with sufficient meaningful information regarding the claims on which to base a decision whether to accept an Offer of Judgment. This proposed legislation will help eliminate the Offer of Judgment strictly as a tool for increasing damages and as leverage in negotiations with defendants and will help reduce the amounts paid in settlement and on verdict. The Connecticut State Medical Society strongly supports the provisions of Section 3 of Bill No. 1052.



April 7, 2005

Senator Andrew McDonald
Representative Michael Lawlor
Members of the Judiciary Committee

SB1052 SB1362 SB1364
HB 6811 HB 6814

Re: **Testimony regarding Senate Bill No. 513 and other Medical Malpractice Bills Before the Judiciary Committee**

Over the last two years, significant time and effort has been expended by the Legislature, the state's physicians and hospitals, CMIC and other interested parties in an attempt to effectively bring the medical malpractice crisis in our state under control. Unfortunately, such a resolution has not been achieved, and the most effective tool in such a resolution is not contained in any of the bills before the Committee today.

Specifically, I am referring to reasonable restraints on non-economic damages which have proven to be the most effective method to stabilize and potentially lower malpractice premiums. This is resoundingly supported by the recent rate rollback actions by malpractice insurers in Texas and the entrance of many new insurers in that state since the passage of reasonable restraints on non-economic damages two years ago.

Regarding specific bills coming before the Judiciary Committee on April 8, 2005, CMIC's testimony is as follows:

S.B. No. 518 An Act Limiting Expert Testimony in Medical Malpractice Cases.

CMIC strongly opposes this bill because it arbitrarily denies a physician or other health care professional a full and complete defense by limiting expert testimony to one health care provider on their behalf.

S.B. No. 514 An Act Concerning Periodic Payments of Medical Malpractice Awards.

CMIC supports the requirement that future damages in excess of \$200,000 be paid periodically. However, in order to be effective this must be mandatory for all cases and should apply equally to out-of-court settlements which represent a much higher percentage of the dollars paid for medical malpractice cases.

S.B. No. 1052 An Act Concerning Medical Malpractice.

Section 2 Collateral Source Offsets—There is a fundamental unfairness to defendants in this reduction of the collateral source offset. If plaintiffs are allowed to put on evidence of what they paid for health insurance from the date of injury, to the date of trial and then on into the future, these payments will effectively wipe out collateral source offsets. What if a plaintiff has a permanent condition that will require some medical care for his or her entire life? This provision would allow the plaintiff to reduce the collateral source offset for the cost of health insurance over his or her entire life. CMIC strongly opposes this provision.

Section 3 and 4 Periodic Payments—There is ambiguity in the statute but the language *“the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such damages”* could be interpreted to mean that the court would determine how much interest should be added to the judgment to reflect that the payments will be paid periodically. This would eliminate any benefit derived from periodic payments. CMIC strongly opposes this language.

S.B. No. 1362 An Act Requiring Disclosure of Liability Insurance Policy Limits Prior to the Filing of a Claim.

CMIC strongly opposes this bill. This provision would allow potential plaintiffs to identify the most lucrative defendants prior to filing a lawsuit by determining the amount of insurance coverage available. Currently this information is available during discovery.

S.B. No. 1364 An Act Concerning Reforms Related to Medical Malpractice Insurance.

Sections 3 and 4— Amendments to Offer of Judgment Statute—While this amendment provides a reduction in the rate of interest from 12% to 8%, the provisions contained in H.B. No 6811 are far superior. H.B. 6811 contains language requiring the plaintiff to provide the information necessary to determine whether to accept the Offer of Judgment. In addition, the House bill provides a more reasonable reduction in interest rates from 12% to 6%. CMIC supports H.B. 6811.

Sections 19 and 20—Rates and Rate Review—The procedure outlined for insurance rate approval will prove onerous to any insurer currently writing in the state or for other companies wishing to do so. CMIC strongly recommends that a reasonable threshold be established such that only rate increases exceeding a certain percentage such as 10% be subject to the process described.

H.B. No. 6814 An Act Concerning Collateral Source Benefits in Civil Actions.
CMIC strongly opposes this bill for the same reasons outlined for Senate Bill 1052.



April 7, 2005

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INSURANCE COMPANY80 Glastonbury Boulevard
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Senator Andrew McDonald
Representative Michael Lawlor
Member of the Judiciary Committee

Re: **Medical Malpractice Reform Legislation**

Over the last two years, significant time and effort has been expended by the Legislature, the state's physicians and hospitals, CMIC and other interested parties in attempting to effectively bring the medical malpractice crisis in our state under control. Unfortunately, such a resolution has not been achieved.

The Connecticut **Legislative Program Review & Investigation Committee Report** dated September 16, 2003, page 31, stated:

"Insurance carrier losses for medical malpractice in Connecticut, when measured on both a paid and an incurred basis, have increased more than the national experience. Nationally, over the last 12 years, incurred losses increased on an inflation-adjusted basis 97 percent, but the increase was over 340 percent in Connecticut. Nationally, paid losses have increased 68 percent over the last 12 years, while in Connecticut the increase was 112 percent."

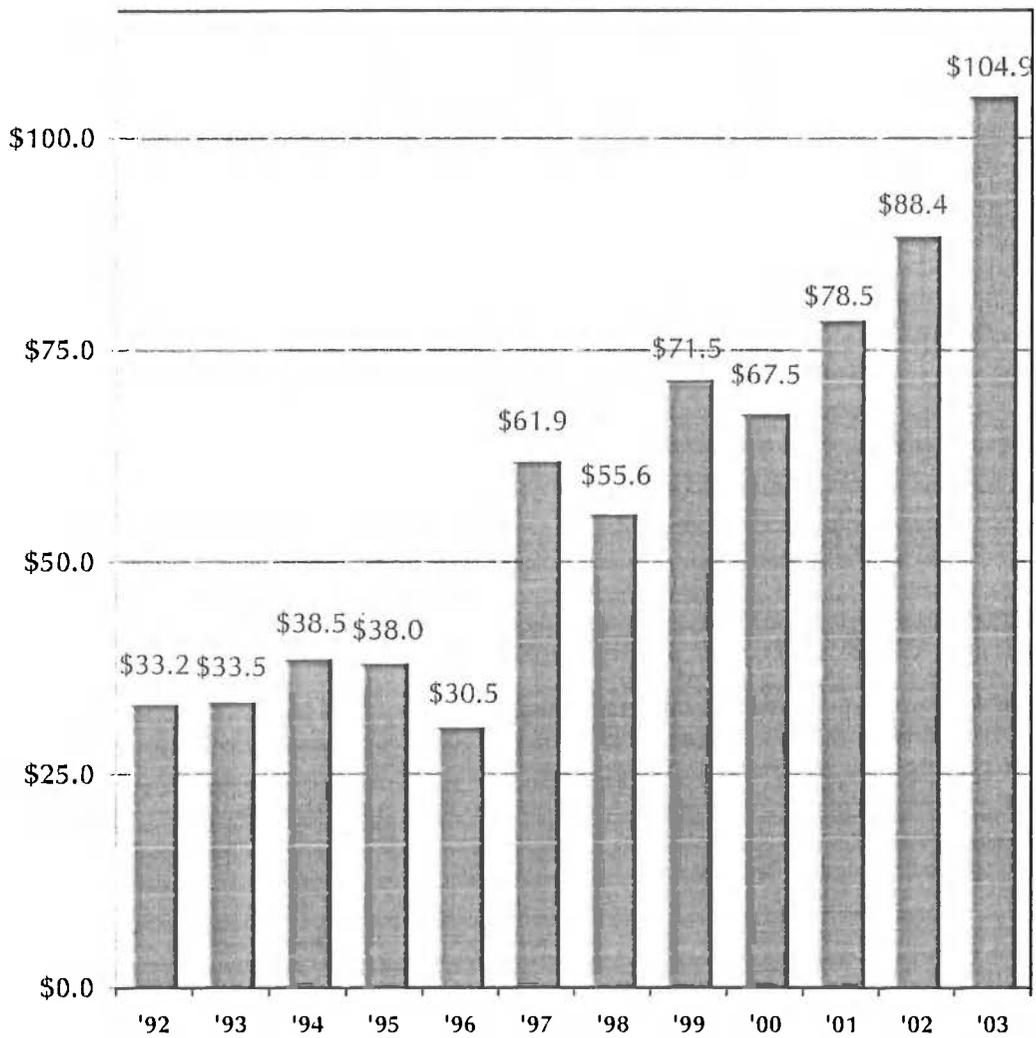
From 1996 through 2003, total loss payments increased for Connecticut physicians from \$30.5 million to \$105 million as reported to the National Practitioner Data Bank based on their most recent data. The chart on the following page displays these numbers, showing the staggering increase in the amount of loss payments made on behalf of physicians. It should also be noted that the number of claims made during this same time period remained the same. Therefore it is the "severity" or cost per claim that has produced these significant increases.

These statistics present compelling evidence that effective action needs to be taken to balance the needs of patients, physicians, and hospitals.

TOTAL LOSS PAYMENTS – Connecticut

Information Source National Practitioner Data Bank

\$ Millions

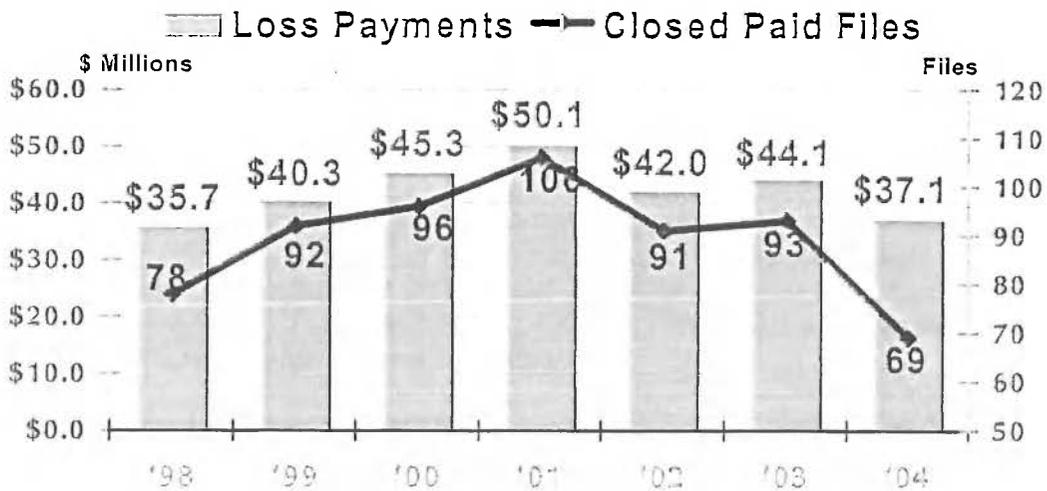


Cost per Loss—Average Severity

The critics of Tort Reform have produced no credible data refuting the increase in loss payments that the State has been experiencing. As a matter of fact they have consistently disregarded this data to forestall meaningful Tort Reform. Recently the Office of Legislative Research requested that CMIC provide information regarding the Company's total loss payments. At a legislative hearing this information was presented by Tort Reform critics without adequate explanation inaccurately reaching the conclusion that because CMIC's total loss payments were down there was no justification for an increase in insurance premiums.

On the contrary, as indicated by the chart below, the decrease in total loss payments is due to a drop in the number of cases closed in 2004. In 2004, 69 cases were closed with payment as compared to 93 cases closed with payment in 2003. The key point however is that while the total loss payments may have decreased due to the number of cases closed, the average payment per case has increased dramatically. In 2004, the average loss payment was \$538,000, 14% higher than in 2003.

It is too simplistic to say that just because loss payments on closed and paid files went down from \$44.1 million in 2003 to \$37.1 million in 2004 that premiums should not go up if payments are going down. There is one case from 2003 where the verdict was \$10 million and the Offer of Judgment interest was \$6 million. If this case had been paid in 2004 the total would have been \$53.1 million or 20.4% more than was paid out in 2003. Rates have to be based on potential future payouts as well as what has been paid in the past.



Cost per Loss	
Average Loss Payment	
\$443,000	\$451,000
\$465,000	\$475,000
\$461,000	\$474,000
\$538,000	

WHAT MUST BE DONE

The Solution to the Problem is to Stabilize Loss Payments. Reasonable restraints on non-economic damages have proven to be the most effective method to stabilize and potentially lower malpractice premiums as the most recent rate rollback actions by malpractice insurers in Texas has shown.

Pre-Litigation Screening of Cases for Merit

An independent panel of experts should be created to pre-screen malpractice cases and determine whether there is a Good Faith Basis to bring a malpractice suit against a physician or hospital.

The current process for filing a certificate of good faith prior to pursuing action against a health care provider does not serve as a useful tool in preventing cases that have no merit. In many cases physicians who should not be included in the litigation are named in the lawsuit only to be dismissed 4-5 years into the litigation process adding additional costs for defense and anguish for the physician included in the lawsuit on a meritless basis.

Revise Offer of Judgment Statute

There is no justification for the extraordinary penalty of 12% per year imposed by Connecticut's prejudgment interest statute. This statute imposes severe penalties on defendants who want to defend cases and financial windfalls for plaintiffs. In 2003, a jury awarded \$10,000,000 in non-economic damages to a plaintiff. Because an Offer of Judgment had also been made an additional \$6 million in Offer of Judgment in interest was added to the award. The judge in the case refused to reduce the damages, and therefore this case is on appeal. This type of contingent financial penalty only increases the costs of providing medical malpractice insurance for the insurer and the physician.

In addition, do you know what our potential exposure in this case might be? Interest is accruing at \$1,200,000 per year while we have this case on appeal. If we are not successful in reversing the decision and it takes two years to conclude the appeal we will have to pay out an additional \$2,400,000. This makes a total exposure of \$18,400,000 on just this one case alone.

In addition, there is currently no requirement that the plaintiff provide the information necessary for the defendant's insurer to make a decision regarding the proposed offer. Without the needed documentation, it is impossible for the insurer to determine whether the Offer of Judgment should be accepted.

Attorney's Fees

The contingency fee arrangements mandated by the 1986 Tort Reform Act should be made mandatory and binding on all attorneys who bring malpractice cases. Currently, certain plaintiff's firms are charging fees higher than that specified by the

law by having their clients agree to pay higher fees through signed waivers. An exhibit identifying specific such cases obtained through probate courts is attached as the final page.

I want to call your specific attention to the first case on the list, #6287, Mercede v. Kessler, where the attorney's fee amounted to \$2,841,666.67. If you follow the state statute, §51-251c, the attorney's fee would have been \$444,167.00. Thus, the attorney's fee in this case amounted to \$2,397,499.67 more than the statutory limit, which the General Assembly had prescribed.

Periodic Payments of Future Damages

The 1986 Tort Reform Act included a provision for periodic payment of *future* damages, which exceeded \$200,000. This provision was subsequently changed. Periodic payments are generally made through structured settlements with high quality insurance companies to guarantee their security.

The financial benefits are two-fold. First the amount of the award, when placed through a structured settlement, frequently provides a significantly higher financial payout to the plaintiff than the original award. Secondly, the insurance company can save money by purchasing the structure at a slightly lower cost than a lump-sum payment.

Sincerely,



Denise Funk
Chief Executive Officer and Executive Vice President

- 1) Case 6287: Estate of Jaclyn Mercede v. Marilyn Kessler, MD et al. (Stamford)
Total settlement \$8,525,000.00
Silver, Golub, & Teitell, LLP
Attorneys Fee: (one-third) \$2,841,666.67
- 2) Case 5911: Estate of Vinerena Labbadia v. Robert Morrison, MD et al. (Stamford)
Total settlement \$1,550,000.00
Silver, Golub, & Teitell, LLP; Pat Labbadia, Esq.
Attorneys Fee: (one-third) \$516,666.66
- 3) Case 4216: Estate of Shibani Abbhi v. AMI, et al. (Stamford)
Total settlement: \$2,000,000.00
Jacobs & Jacobs, PC
Attorney's fees and costs: \$377,649.77
Correspondence in file indicated that attorney's fee was \$360,000.00, the statutory rate, and that litigation expenses accounted for \$17,549.66.
- 4) Case 3307: Estate of Angel-Lynn Vargas v. Yale-New Haven Hospital, et al. (Bridgeport)
Total settlement : \$990,000.00
Silver, Golub, & Teitell, LLP
Front cash/ Attorney fees + litigation expenses: \$390,000.00
Could find no documentation in file detailing this fee or itemizing specific expense amounts, this appears to be a 1/3 attorney fee.
- 5) Case 3185: Dominica Hill v. Lloyd Mitrer, et al. (Bridgeport)
Total settlement: \$1,187,500.00
Koskoff, Koskoff, & Bieder PC
Attorneys fee: (one-third) \$395,833.33
- 6) Case 3613: Estate of Kathleen Daur v. Joel Blumberg, MD (Greenwich)
Total settlement: \$1,600,000.00
Koskoff, Koskoff, & Bieder PC
Attorneys fee and costs: \$573,489 (this appears to indicate a 1/3 attorney fee)

PROSELECT INSURANCE COMPANY

WRITTEN STATEMENT REGARDING SENATE BILL 1052
"AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE"

Before the Joint Committee on Judiciary
April 8, 2005

ProSelect Insurance Company (ProSelect) is a Massachusetts domiciled medical malpractice insurance company that has operated in Connecticut since 1997. As of December 31, 2004, we insured approximately 2,982 practitioners including physicians and dentists and 20 institutions such as hospitals and clinics.

Although Senate Bill 1052 contains some important patient safety measures and proposes further examination of caps on noneconomic damages, ProSelect has serious concerns about Section 8 of the bill which changes the current rate review system from file and use to prior approval for rates in excess of 10% and permits insureds to request a public hearing without requiring a good faith basis. We believe such a proposal would adversely impact medical malpractice insurers and the market. Specifically, it may cause insurers to artificially suppress rates, impedes the ability to properly respond to changed loss conditions, and may result in a loss of coverage options for high risk specialties. Moreover, it would build no further accountabilities into the system while increasing costs, inhibit competition in the traditional insurance market, and contribute to an increased reliance on alternative risk mechanisms such as risk retention groups and captives.

Because the public hearing process is undefined and insureds can request a hearing without setting forth a good faith basis, many insurance companies may request a rate change below actuarial indications to avoid the unpredictability and arbitrariness of the process. This would result in artificial rate suppression. Such suppression jeopardizes the financial strength of insurance companies and could eventually result in a destabilization of the market. It may also increase the likelihood that insurers will not have adequate capital to pay future claims. By its nature, medical malpractice insurance is a long tail line of insurance. Our data indicates that it takes approximately five years from the time we collect premium to the time an incident or claim is reported. This time lag makes it especially important that adequate rates are collected in the present.

Moreover, the proposal interferes with an insurer's ability to effectively respond to the fluidity of the market and changes in the loss environment. For instance, court decisions that affect the treatment of damages or litigation rule changes that increase defense costs create a need for rate increases. Insurers must have an ability to immediately respond to changed circumstances. This rate review process which has long and undefined time lapses between the submission of rates and decisions and interjects unpredictability into outcomes will diminish an insurer's ability to properly react and collect the premium necessary to support the risk.

The proposal could also cause insurers to reconsider covering high risk specialties. An unpredictable and unstable rate process might lead to reconsideration of insuring specialties that generate higher claims and increased costs. By insuring lower risk classes, insurers are more likely to fall below the rate hearing triggers.

Additionally, Section 8 builds no further accountabilities into the system and increases the cost of doing business in the state. Current law affords insureds aggrieved by rate increases with proper recourse. Additionally, the Commissioner has the authority to call a hearing in circumstances that merit it. (C.S.A. § 38a-678). Moreover, the Commissioner can make a statement of charges against a carrier whenever the Commissioner has reason to believe that the insurer engaged in any method of competition or practice that is unfair or deceptive. (C.S.A. § 38a-818). Section 8 creates no further accountabilities. However, it increases the cost of doing business in the state. Because the process requires a hearing upon request without regard to probable cause or good faith, insurers will almost always be subjected to a hearing to defend its rates. This is costly. The absence of detail on the timing of the rate hearing, its length, and the process prevents us from providing an estimate on the increase. Additionally, it may increase costs to the state if additional resources and staffing are needed at the Department of Insurance to support the review and hearing process.

All of these consequences work against creating a competitive and healthy medical malpractice insurance market in Connecticut. As the regulatory environment becomes more onerous medical malpractice insurers may not be interested in entering Connecticut and many insurers currently in the market may decide to allocate less capital. This decreases competition and capacity in the market. Additionally, decreases in competition in the admitted market causes an enhanced reliance on alternative risk mechanisms such as risk retention groups and captives. Notably, such mechanisms are not subject to this rate regulation. Given that the Connecticut market is becoming more dominated by alternative risk mechanisms, the state should be particularly sensitive to creating an unstable regulatory environment for admitted insurers. As of 2003, only about 52% of the medical malpractice market had coverage through traditional insurers.

A healthy insurance market, linked closely to the ability to maintain adequate rates, is essential to the continued availability and affordability of medical malpractice insurance. Any reforms must take into consideration this delicate and complex balance.

Thank you for your consideration.



Connecticut Business & Industry Association

TESTIMONY OF
ERIC GEORGE
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION
BEFORE THE
JUDICIARY COMMITTEE
LEGISLATIVE OFFICE BUILDING
APRIL 8, 2005

My name is Eric George. I am associate counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents 10,000 businesses across the State of Connecticut, ranging from large industrial corporations to small businesses with one or two employees. The vast majority of our members, about 90 percent, are employers with fewer than 50 employees.

CBIA supports those provisions in SB 1052 regarding collateral source benefits. Specifically, section 2 of SB 1052 affirmatively states that either party to a medical malpractice action may introduce evidence of collateral source benefits and allows the opposing party to introduce evidence of amounts paid to secure the right of such collateral source benefits.

This proposal will help ensure that while the aggrieved party is appropriately compensated, that such compensation is not duplicative as to other sources of compensation such aggrieved party may have received related to such action (i.e. – payments of insurance claims).

Thank you for considering my remarks and I urge this committee to support these provisions in SB1052.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TESTIMONY PRESENTED BEFORE THE JUDICIARY COMMITTEE April 8, 2005

Wendy Furniss, R.N.C., M.S., Chief, Bureau of Healthcare Systems 509-7406

Senate Bill 1052 - An Act Concerning Medical Malpractice

The Department of Public Health supports Senate Bill 1052, but respectfully requests revisions to specific sections of the bill. The Department provides the following comments for the Committee's review and consideration.

Senate Bill 1052 requires the Department of Public Health to establish written guidelines for physician investigations, including but not limited to initial screening guidelines and a system for prioritization, and proposes the adoption of written guidelines for use in the physician disciplinary process. Enactment of this proposal would also revise the physician profiling reporting requirements and establish mandatory continuing education requirements for physicians. The proposal not only supports the Department's initiatives toward proactively addressing issues related to physician oversight, it would also support implementation of the Governor's budget recommendations concerning medical malpractice.

Physician investigations are currently prioritized in that the most serious patient care issues are investigated first. As additional complaints are received, they are reviewed to determine which cases should take precedence. When appropriate, the Department reviews office practices and procedures, and obtains medical records and other information pertinent to the investigation. The investigation process has been updated to include a classification system to triage complaints according to scope and severity, and a new electronic tracking system has been developed. The Department will also continue to revise procedures to expedite the processing of medical malpractice complaints.

The creation of disciplinary guidelines would be helpful both to the Connecticut Medical Examining Board (CMEB) as well as to the Department in its efforts to settle cases, since such guidelines would provide consistency and predictability. General guidelines, based on the outcome of the deficient practice, could be developed similar to the Centers for Medicare and Medicaid (CMS) enforcement guidance for nursing homes. In this type of system, thresholds are established, such as actual harm to a patient vs. potential harm, and a menu of remedies offered for each level of harm, to be individualized to the situation, with the goal of attaining and maintaining compliance/safe practice. The CMEB and the Department should work jointly to develop such guidelines and to update them on a regular basis. However, the Department respectfully requests that the guidelines be adopted by the Department, with the advice and assistance of the Board.

Senate Bill 1052 also requires hospitals and outpatient surgical facilities to develop and implement protocols, no later than October 1, 2005, for accurate patient identification procedures for use prior to surgery, which shall be made available to the Department upon request. The Department would be required to prepare a report describing such protocols for the General Assembly not later than October 1, 2005. Protocols would be reviewed at the time of inspection and/or investigation; however, the Department will not have reviewed them all as of October 1, 2005. The Department recommends that the initial report be due October 1, 2006.

The current physician profile law does not require physicians to report adverse licensure actions taken in other states, nor does it require physicians to periodically update information previously submitted to the



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Page 2 of 2
Department of Public Health
Senate Bill 1052
April 8, 2005

Department concerning hospital disciplinary actions, and medical malpractice judgments, arbitration awards and settlements. In addition to clarifying existing physician profile filing requirements, this proposal requires physicians to report additional information on the profile (e.g., name of professional liability insurance carrier, policy number and an indication as to whether the practitioner is actively involved in patient care), and revises the existing physician profile statutes to require physicians to report any changes or updates in mandatory reporting information, and to add adverse licensure actions taken in other states to the list of mandated reporting items. The Department requests that the committee consider requiring physicians to report whether they are actively practicing in the profession in line 597, rather than indicating whether they are currently providing direct patient care services.

Physicians are not currently required to complete mandatory continuing medical education as a condition of license renewal. Most physicians who have medical staff privileges at a hospital, participate in managed care plans, and/or maintain national board certification, participate in continuing education activities. This proposal would establish minimum requirements for completion of continuing medical education for all physicians as a condition of license renewal. The educational requirements contained in this proposal address current health care trends, and should qualify toward meeting any other continuing education requirements that physicians may be required to complete.

This proposal would also prohibit the Department from renewing the license of a physician who has not completed the required continuing education activities. The Department requests the opportunity to submit substitute language that would eliminate the need to collect and maintain documentation from over 14,000 licensed physicians, but would continue to hold physicians accountable. The Department requests that the committee consider deleting the word "specialty" in line 528 to allow physicians to complete a wider variety of courses related to the practice of medicine, that may or may not be related to their area of expertise, and the word "and" just before the phrase "risk management" in line 533 to clarify that the required risk management course is not related to infectious diseases. The Department requests that the committee include the Department of Public Health and local departments of public health to the list of qualifying continuing education providers. The Department also requests the opportunity to submit substitute language related to the reinstatement of a lapsed license. As currently drafted, the Department would be required to re-license a physician who submits evidence documenting completion of continuing education activities, regardless of the length of time elapsed since leaving active practice or whether the physician meets any of the other requirements for reinstatement.

Thank you for your consideration of the Department's views on this bill.

Jonathan G. Greenwald, M.D.
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(203) 866-7000

Fellow, American College of Physicians

Fellow, American College of Cardiology

April 8, 2005

TESTIMONY GIVEN TO THE JUDICIARY COMMITTEE re: SB1052

Ladies & Gentlemen of the Judiciary Committee:

I am Jonathan Greenwald, an internist and cardiologist practicing in Norwalk since 1966. I am a member of the CSMS, and I am NOT a lawyer.

The CSMS puts establishment of mandatory pre-trial screening panels at the top of its list of legislative initiatives (front page of March 2005 issue of ACTION, a publication of the CSMS). SB 1052 makes no mention of such panels.

In section 1, paragraph (a), SB 1052 still harkens back to a good faith certificate. Yes, it amends the gfc so that the physician who files the opinion of the case with the court must be from the same discipline as the defendant. Nevertheless, that's not effective reform, because, with a relatively minimal effort, a plaintiff's attorney can still find a single voice out there in the void who will back the case. That's a fact, which can't, in GOOD FAITH, be denied by any of you.

For the last 11 months, I have studied this segment of the malpractice process – i.e. the pre-litigation phase – and have reworked it many times along the way. I was very appreciative of the professional guidance given by my ex-State Rep., Ken Bernhard, and I also received input from then rep., and now Senator, Robert Duff, of Norwalk. Naturally, I wrote it in non-legalese.

I presented it in detail before both the insurance/real estate and public health committees during their public hearings. At the close of testimony on SB 1333, which has its own version of pre-litigation screening that I find unsatisfactory (see Appendix I), Richard Newman, president of the CTLA, had a chance to read my proposal, and was glad to see that it is characterized by an even playing field.

Each of you on the committee should be getting a copy of my full proposal (Appendix I), which has been endorsed by the CSMS. I will only speak its main points, which are:

Mandatory prelitigation of all Connecticut malpractice cases.

Regional panels, which consist, of two attorneys and two physicians plus a non-voting moderator.

The panel's finding – whether in favor of the plaintiff, or the defendant – or neither (i.e. deadlocked at 2-2) MUST be reported to the court, or to the settlement hearing.

Regardless, of whether the case settles or goes to the court, the panel's finding MUST be introduced as evidence.

I urge you to weigh my proposal very seriously, flesh out the details, translate it into the minimal degree of requisite legalese, and then incorporate it into SB 1052 as replacement for the current section 1, paragraph (a). By so doing, for the first time, REAL TEETH will reside in the pre-litigation phase of the malpractice process in Connecticut, not to mention the country.

Thanks for hearing me. Anytime I can help, or answer your questions, don't hesitate to get in touch with me.

JGG/lt

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April 8, 2005

Appendix I, to Testimony given to the Judiciary Committee re: SB1052

FULL PROPOSAL

- 1) Legislation MUST result in MANDATORY prelitigation of all malpractice cases brought in Connecticut.
- 2) This is to be effected through ENOUGH standing panels, whose sole purpose is to determine whether negligence, malfeasance, and causation are or are not present in sufficient measure to determine that the case DOES or does NOT have merit.
- 3) Each panel will consist of two physicians and two attorneys, with a moderator to manage the proceedings. The moderator has no vote.
- 4) None of the five aforementioned individuals are to have any connection to the case.
- 5) The attorneys and physicians are not employees or officials of any state or local governing body, but all must be residents of Connecticut.
- 6) Whether or not the physicians and the attorneys on the panel must be from a county different from where the alleged malpractice occurred, how they are rotated on and off the panels, who keeps the master lists of attorneys and physicians, whether they volunteer or are appointed, how their special areas of expertise are taken into consideration regarding a particular case – all these and other details are to be spelled out in the final draft of the legislation.
- 7) At the conclusion of their deliberations, the four voting members of the panel must decide the merits, or lack thereof, of the case. A 4-0 or 3-1 vote supporting the plaintiff will be duly recorded as a finding in favor of the plaintiff. A 4-0 or 3-1 vote against the plaintiff will be duly recorded and reported as a finding in favor of the defendant. A case receiving two affirmative and two negative votes will be duly recorded and reported as a finding in favor of neither side. (This is the beauty of having an even number of voting members.)

- 8) The moderator will send the finding to the venue of dispute resolution, whether that be by settlement or in the court.
- 9) Regardless of whether the case settles or goes to court, the panel's finding MUST be introduced as EVIDENCE.

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Fellow, American College of Physicians

April 8, 2005

Fellow, American College of Cardiology

Appendix II, to Testimony given to the Judiciary Committee re: SB1052

I want to comment on the portion of ANOTHER bill, SB1333, that concerns the pre-trial process.

- 1) It envisions a single pretrial "medical" screening panel, apparently for the entire state, consisting of ten members drawn from the legal and medical societies, expandable when and if necessary, serving four-year terms, with either side to the dispute allowed to disqualify up to three members of this panel, and then it goes on to say that the judge "may select three of the remaining panel members to review the allegations and make a finding".
- 2) The finding "shall" (stronger than "may", but not as forceful as "must") be admissible in evidence at any subsequent Trial. There is no mention of "settlement" as the venue of dispute resolution.
- 3) However, the trier then determines "what, if any weight should be afforded the finding"!!
- 4) "Negligence" is in the wording of SB 1333, but "causation" is not, and both are critical elements in a malpractice case.

Well, if we collectively want to say that the wording of this portion of SB1333 goes beyond what has been offered in previous years, that is fair enough. However, can any of us say that this wording has TEETH with a capital "t"? I don't think so.

Please see Appendix I to my formal testimony offered this date.

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STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of Susan F. Cogswell
Insurance Commissioner of the State of Connecticut
before
the Judiciary Committee
Friday, April 8, 2005

Senate Bill 1052 – An Act Concerning Medical Malpractice

Senator McDonald, Representative Lawlor and members of the Judiciary Committee, my name is Susan F. Cogswell, and I am Commissioner of the Connecticut Insurance Department. I am here to speak in support of Senate Bill 1052 – An Act Concerning Medical Malpractice.

Currently, there are three traditional insurance companies writing physicians and surgeons medical malpractice liability coverage in Connecticut. I would like to clarify that there are companies writing malpractice liability insurance for other medical specialists in Connecticut, for example, dentists and nurses, but that it is the physician and surgeon specialty which is in crisis.

Last year, the Insurance Department explored the reasons why malpractice insurance companies were not offering policies in Connecticut. As part of this effort, the Department surveyed a number of companies writing medical malpractice in states other than Connecticut. What we found is that insurance companies were withdrawing from the medical malpractice market nationwide.

The trend is toward smaller regional carriers and provider-owned medical malpractice insurers, such as Connecticut Medical Insurance Company ("CMIC") here in Connecticut. Some of the insurance carriers indicated that this trend is based upon the overall insurance and legal environment of a state or states, as well as, the insurance company's ability to control exposures. Companies indicated to us that they were not interested in writing medical malpractice insurance in Connecticut unless there was significant tort reform.

Alternative markets have also been increasing in Connecticut in the form of risk retention groups, captives and self-insurers. For example, one of the leading writers of medical malpractice insurance in Connecticut for 2004 was MCIC VT Inc., a risk retention group, which covers hospitals in the state. This group wrote about \$47 million of premium as compared to our local mutual, CMIC, which wrote about \$52 million in premium. However, the cost drivers that originally created the need for the alternative markets have not been addressed. Therefore, if the market is allowed to continue in its present state with no meaningful reform, some of these

alternatives offering medical malpractice insurance liability, when faced with a few large claims, could potentially become insolvent.

Governor Jodi Rell's medical malpractice reform plan, as contained in Senate Bill 1052, would put stricter requirements on insurance companies to ensure that rates do not rise any higher than absolutely necessary.

The Department supports the prior rate approval provision which is contained in the Governor's bill. Prior rate approval requires any company offering professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants be subject to prior approval. The proposal requires that companies seeking a rate increase of 10% or greater notify the Department and policy holders 60 days in advance of the effective date of the rate. This proposal also enables insureds to request a public hearing.

Currently, medical malpractice companies operating in Connecticut submit their rates to the Insurance Department prior to their effective date. This allows the Department time for actuarial review and analysis in advance of the rates going into effect. Putting prior rate approval into statute would, therefore, codify current practice.

Governor Rell's legislation also provides for periodic payments of medical malpractice judgements of \$200,000 and over. This provision can be expected to result in cost savings to insurers because of investment income earned over the time period when the payments are made.

The Governor's bill also provides for reducing the "Offer of Judgment" penalty assessed on defendants for failing to settle certain lawsuits from 12 percent of damages to the prime rate. We believe this will have an impact on reducing costs.

These initiatives will aid in stabilizing the medical malpractice marketplace in Connecticut and, hopefully, make it an attractive place for companies currently doing business and, more importantly, attract new companies to the marketplace.

I ask the Committee to act favorably upon Senate Bill 1052 – An Act Concerning Medical Malpractice. Thank you for your time and I would be happy to answer any questions you may have.

C W E A L F



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Judiciary Committee
Testimony by Alice Pritchard, Executive Director
Connecticut Women's Education and Legal Fund
Committee Bill 1052

April 8, 2005

Good afternoon. My name is Alice Pritchard and I am the Executive Director of the Connecticut Women's Education and Legal Fund. CWEALF is a statewide non-profit organization dedicated to empowering women, young girls, and their families to achieve equal opportunities in their professional and personal lives.

I am here today to address the issue of medical malpractice. First, while there is no doubt that problems regarding medical malpractice insurance are dilemmas facing everyone in the medical profession, they are especially harmful and single out women who comprise the rising number who are in the OB/GYN field and those who depend on OB/GYNs for their primary health care. Second, we are concerned about the provision in this bill regarding the potential for amending the current statutory provision to impose caps on noneconomic in medical malpractice lawsuits damages in the future. This provision would have a disproportionate effect on women who have been injured, and would deprive some women of equal justice under the law.

Often lost in the debate over malpractice reform is the impact on women's employment and health. Over a third of OB/GYNs are women, and the majority of part-time workers are women. Also, many women use their OB/GYN for primary medical care, making it difficult for women to find or keep their OB/GYN physicians. This crisis affects every patient, even those whose physicians remain in practice. With fewer health care providers offering full services, the workload has increased dramatically for those who still do. Further, physicians facing higher premiums are likely to practice defensively and, among other things, order more tests than necessary.

These clearly are critical problems that must be resolved in order to preserve health care for women. However, we believe that solutions must be found that do not impose caps on non-economic damages for those who have been the victims of medical malpractice. New section 12(b) would provide that not later than July 1, 2008, Connecticut's Insurance Commissioner shall examine professional liability insurance rates in the state for physicians and surgeons, hospitals, advanced practice registered nurses and physician assistants to determine whether such rates have decreased in excess of fifteen per cent from October 1, 2005. If the commissioner determines that such rates have not decreased in excess of fifteen percent, the commissioner shall convene a working group to determine the appropriate revisions to Section 52-572h of the general statutes to establish caps on noneconomic damage awards. While reform is needed, it is not fair to look to the victims of medical malpractice to curb the rising costs of malpractice

insurance. In fact, there is empirical evidence that caps on damages do not lead to lower premiums.

Connecticut has long had policy that adequately compensates victims of malpractice, and this history would be altered by the implementation of caps. Doctors, insurers, and lawyers should be held responsible for finding a better way to deal with the rising costs of medical malpractice insurance, not injured patients.

We ask you to pass legislation that is fair to all parties, and seek alternative measures which would not put the responsibility and burden of the situation on injured patients. We urge you to address this critical issue as soon as possible and ensure that OB/GYNs and the women who depend on them for care do not bear the brunt of reform.



**Connecticut Academy
of Family Physicians**

Statement concerning Senate Bill 1052 –

An Act Concerning Medical Malpractice

Judiciary Committee

April 8, 2005

Good afternoon Senator McDonald, Representative Lawlor and members of the Judiciary Committee. My name is Dr. Stephen O'Brien. I am a family physician, and I have been practicing in Enfield, CT for more than 25 years. I am the President of the Connecticut Academy of Family Physicians, and I am here today to speak to you on my own behalf and that of our 400 active physicians members, and our 200 student members. While we like many of the provisions in Senate Bill 1052, we strongly urge this committee to make sure that any reforms that are in serious consideration for passage be demonstrated to pass independent actuarially scrutiny. Doing so will assure that any reform that is passed is truly meaningful.

Today, I have cancelled a full schedule of patients, some of whom have had those appointments scheduled for more than three months, to come and testify. I'm hopeful that they will understand that my need to reschedule for another day is based on my feeling that coming here today is critically necessary. It is for their sakes and the sakes of all Connecticut families that I am here. For the reasons that I am about to discuss, passage of meaningful reform is now more important than ever.

While many people believe that the medical malpractice crisis is only a crisis affecting neurosurgeons and OB/GYNs, let me assure you that is not the case. First, like OB/GYNs, many of my family physician colleagues deliver babies. Not as many as a few years ago though. 27 years ago in Putnam, all nine family physicians in the town provided obstetrical care. Three years ago, there were only six family physicians still doing OB, and today, there are only three and all three are seriously considering whether or not this will be their last year. A year and a half ago my grandson was lovingly guided into this world by an extraordinary family doctor. That physician ceased delivering babies on December 31, 2004. My next grandchild, due in August, will be delivered by one of the few Obstetricians left to accept new patients. Those changes in practice are directly tied to the escalating cost of professional liability insurance.

Like all other specialties, some family physicians have moved to other states and some of us are considering early retirement. Many of you know my good friend Neil Brooks, a family

(OVER)

physician from the Rockville area, who because of rising medical malpractice rates was forced into early retirement. Dr. Brooks is not alone. I may only be a few steps behind him.

Our specialty has been blessed with many female family physicians. Nearly half of the graduates from family practice residency programs are women. Many of them desire to practice part time while establishing their own families, but because of the incredible jump in malpractice premiums over the past few years most cannot cover their expenses with part time practices. With 50% of our med school classes comprised of women, where are they to seek careers that will provide them with a reasonable living during their early practice years. It won't be in family medicine or obstetrics that is for sure. Recently, I was challenged by a medical student interested in pursuing a career in family medicine when I gave a speech, which sounded quite negative about our future. I apologized and promised that I would try to be more positive so that I didn't scare off future family doctors. That promise is so difficult to keep.

The average age of family docs in this state is in the mid 50's. Where will we get physicians to replace us when there are much better places to go? If I moved to another state and went into semi-retirement I could reduce my professional liability premium from the current \$35,000 a year to somewhere in the range of \$10,000. That differential alone makes semi-retirement an attractive option, but I couldn't do it remaining in Connecticut. The time-honored tradition of "cutting back" while ramping up a colleague that will take over the practice can no longer be considered. This dilemma facing a lot of my contemporaries is making us need to consider whether the devotion to our patients remains a viable choice. A serious physician shortage is just around the corner.

The reason I chose medicine rather than some other profession is because medicine had an ethic that called for self-discipline, self-sacrifice, and service to others. I believe that most physicians did the same. That ethic prompts us to put our patient's needs ahead of our own. We get up in the middle of a night's sleep to attend a patient in need; we miss our daughter's birthday parties or our son's athletic events because a patient is in need; we miss dinner at home with our family night after night because a patient is in need. Marriages are strained or fractured by the tugging between our duties to family and patients.

Now the threat of litigation hangs over every encounter with our patients. The days of fearing a malpractice suit because of a surgical procedure gone wrong have been replaced with the fear of "failure to diagnose" cancer, heart disease or stroke. Now we are facing the very real threat that no level of care and concern in the diagnosis and treatment of our patients will satisfy the expectations of a population that sees early detection and cure of all ailments as achievable.

In this litigious climate, when physicians refuse to perform high-risk procedures or care for high-risk patients, will you wonder why? When physicians who deliver babies stop, and women can no longer find obstetrical care will you wonder why? When radiologists refuse to read mammograms; when neurosurgeons stop operating on serious brain tumors; when surgeons refuse to take care of serious trauma cases as "too risky", will you wonder why? When primary care physicians dismiss from their practices people who refuse to stop abusing their bodies with food, drink, drugs or other substances will you wonder why? The people of Connecticut will not look kindly on those who sit by while the medical care they cherish crumbles around them.

I am afraid time is running out. You might not feel it, but changes are taking place. Those changes are threatening the very health of our state. Consider this a very personal issue for you and your family. I'm sure you have a caring and competent physician who is doing his or her best to keep you and those you love healthy. Support the ability of that physician to continue in your care and that of your constituents. I urge you, now is the time to pass meaningful medical malpractice reform. There is just so much at stake.

I would be happy to answer any questions.

For more information, please contact:

Steven O'Brien, M.D., President
The Connecticut Academy of Family Physicians
Mark Schuman, Executive Vice President
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TESTIMONY OF
J. KEVIN KINSELLA
VICE PRESIDENT
HARTFORD HOSPITAL
BEFORE THE
JUDICIARY COMMITTEE
Friday, April 8, 2005

SB 1052, An Act Concerning Reforms Related to Medical Malpractice Insurance

My name is J. Kevin Kinsella, Vice President of Hartford Hospital. I am here to testify on SB 1052, An Act Concerning Reforms Related to Medical Malpractice Insurance.

The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire system for delivering healthcare in this state. Since 2002, Hartford Hospital's medical liability insurance costs have increased from \$5,961,635 to \$12,029,827, or 101.8%. In addition, the premium increases experienced by the doctors who serve the hospital have a direct, detrimental effect on Hartford Hospital. These escalating insurance premiums threaten and compromise our ability to deliver patient care many ways, for example:

The malpractice crisis has significantly impacted the Ob-Gyn Department at Hartford Hospital. Over the past three years, six excellent physicians, in the prime of their careers, have discontinued providing obstetrical services due to the crippling costs of malpractice premiums. Each has accounted for about 100 deliveries each year. Two of these physicians were recently named in Connecticut Magazine in their "best doctors" edition. It is disheartening and detrimental to the care of women to lose such highly regarded doctors. Two additional physicians are planning to stop obstetrics over the next year, and many others are contemplating the same step.

In addition, physician practices cannot add new members as malpractice premium costs makes it impossible. This year, an excellent graduating resident who has received her entire undergraduate, postgraduate and residency training in Connecticut, is unable to find a position of employment in Hartford. Applications to Ob-Gyn residency training programs are at an all time low. The future care of our women is in the balance and the outlook is abysmal unless the malpractice crisis is resolved.

Hartford Hospital believes that our medical liability system requires a measure, or combination of measures, that will promote predictability, efficiency, and fairness for all parties in medical malpractice litigation. While the proposed bills contain measures that could possibly improve Connecticut's medical liability system, Hartford Hospital continues to believe that a reasonable cap on non-economic damage awards is a necessary component of an effective reform package.

I appreciate the substantial work and thought that legislators have devoted to this problem, and we will continue to work with you in any way we can to address this important issue in the best interests of patient care.

TESTIMONY OF
RICHARD E. PUGH
PRESIDENT & CEO
BEFORE THE JUDICIARY COMMITTEE
FRIDAY, APRIL 8, 2005
On

SB 1052 An Act Concerning Medical Malpractice
And
SB 1364 An Act Concerning Reform Related to Medical Malpractice Insurance

My name is Richard Pugh, President/Chief Executive Officer of New Milford Hospital, in New Milford, Connecticut. I appreciate the opportunity to provide my concerns on the subject of medical liability insurance reform.

The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire system for delivering healthcare in this State. Since 2001, New Milford Hospital's medical liability insurance costs have increased by 480% and we are considered to be a good risk hospital. These increases take away resources that could otherwise be applied to enhance patient care.

In addition, the premium increases experienced by the doctors who serve the hospital have a direct, detrimental affect on New Milford Hospital. These escalating insurance premiums threaten and compromise our ability to deliver patient care in the following ways:

- *We lost 20% of our OB Staff this past year because annual insurance premiums offered were well over \$100,000.*
- *We have a group of 5 orthopedic surgeons who had to scramble to find insurance when their insurer went out of business. They are paying \$425,000 in annual premiums for the group.*
- *Our primary care physicians are experiencing a doubling of premium.*
- *One of our pediatric groups reduced their coverage from \$2 million/\$5 million to \$1million/\$4 million because premium increases were escalating, and they are now worried about their exposure because of this forced reduction.*
- *These are but a few examples that I could list just from our own experience.*

While we appreciate that there are a number of facets to liability reform, it is as clear as can be, that the most important thing we can do to adequately reform the system is to adopt a reasonable cap on non-economic damages. The unpredictability of litigation outcomes in the State of Connecticut is the major driver, or at least a significant contributing factor, to these outrageous premiums.

We want patients compensated appropriately for malpractice cases and done so fairly, under economic damages. They deserve nothing less. But, we can't let others attempt to drive the process beyond reasonableness and destroy a medical system that is the best in the world and does so much good for so many people every day.

Hospitals and health care are losing physicians weekly. If we wait for physicians to leave in larger numbers, it will be too late to undo the irreparable damage that will harm access to quality physicians because they will have walked away from medicine. And, will have done so at a time when there is already a shortage of physicians.

It will soon be too late to put the system back on its feet if we don't recognize and address the root issue to meaningful medical liability reform.

We look to you not just for action. We look to you for vision before your actions. Please have the vision to accept the fact that we must have the predictability of a reasonable maximum cap on non-economic damages if we are to preclude a major deterioration in the supply of quality physicians for your constituents.

Testimony of Richard E. Pugh, President/CEO of New Milford Hospital
April 8, 2005

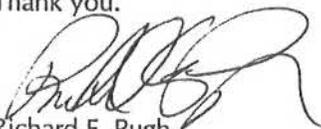
Page 2

SB 1052 An Act Concerning Medical Malpractice

SB 1364 An Act Concerning Reform Related to Medical Malpractice Insurance

I appreciate the substantial work and thought that legislators have devoted to this critical and complex problem. We will continue to work with you in any way we can to address this important issue in the best interest of patient access to good patient care to the citizens of Connecticut.

Thank you.



Richard E. Pugh

TESTIMONY
OF
Alfred A. Lerz
President & CEO
Johnson Memorial Hospital
Before the Judiciary Committee
Friday, April 8, 2005
On
SB 1052 An Act Concerning Medical Malpractice
And
SB 1364 An Act Concerning Reforms Related To Medical Malpractice Insurance

My name is Alfred A. Lerz, President/Chief Executive Officer of Johnson Health Network in Stafford Springs, Connecticut. I appreciate the opportunity to testify on the subject of medical liability insurance reform.

The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire system for delivering healthcare in this state. Since 2001, Johnson Health Network's medical liability insurance costs have increased from \$145,000 to \$1,359,000, or 837%. In addition, the premium increases experienced by the doctors who serve the hospital have a direct, detrimental effect on Johnson Health Network. These escalating insurance premiums threaten and compromise our ability to deliver patient care in the following ways:

During the time period from 2001 to 2005, malpractice premiums at Johnson Health Network increased over 837%, or more than 1.2 million dollars, despite the fact that not one judgment had been issued against the Hospital.

These escalating liability insurance costs have a direct, detrimental effect on Johnson Memorial Hospital. To absorb the increase, the Hospital had to reduce staff, modify employee benefits, suspend the introduction of new services and equipment, and postpone repairs to its physical plant.

As with other Connecticut hospitals, in addition to the problems associated with increasing medical liability insurance costs, Johnson Health Network is struggling to:

- Absorb inadequate levels of reimbursement from Medicare and Medicaid programs, as well as from managed care payers. All have not kept pace with healthcare inflation, and there have been increased payer denials and delays in payment.

- Compete with non-hospital providers not regulated and governed by the same rules as hospital providers
- Absorb investment losses, due to the stock market decline
- Deal with labor inflation and workforce shortages
- Offset increased fringe benefits: pension, health, dental, life, disability, and Workers Compensation costs
- Absorb higher than inflation-increased costs for professional and general liability insurance, pharmaceuticals, blood, and utilities, etc.
- Absorb new costs associated with bio-terrorism planning, for which no hospital is prepared

Johnson Health Network believes that our medical liability system requires a measure, or combination of measures, that will promote predictability, efficiency, and fairness for all parties in medical malpractice litigation. While the proposed bills contain measures that could possibly improve Connecticut's medical liability system, Johnson Health Network continues to believe that a reasonable cap on non-economic damage awards is a necessary component of an effective reform package.

Johnson Health Network appreciates this Committee's substantial work on this critical issue and the legislature's recognition that this problem goes well beyond the interests of any particular individual, profession or institution, reaching much broader questions about how much we, as a state, value a secure healthcare infrastructure that provides all members of the general public with access to appropriate medical care, whenever they need it. We will continue to work with you in any way we can to address this important issue in the best interests of patient care.

Connecticut State Medical Society**Testimony****SB 1052****SB 1354****Judiciary Committee****April 8, 2005**

Distinguished members of the Judiciary Committee, I am Maureen Sullivan Dinnan Attorney at Neubert, Pepe and Monteith in New Haven, CT. I provide counsel to the Connecticut State Medical Society regarding regulatory matters and issues involving the Department of Public Health. I am here to give testimony on SB 1052 and SB 1354.

SB 1052

The CSMS is supportive of goals of Sections 9 and 10 as each section acknowledges the importance the Medical Examining Board. Sections 9 and 10 require the establishment of guidelines for disciplinary matters against physicians from the filing of the petition through dismissal or sanction. CSMS consider this an important step in improving access to and the operation of physician review in Connecticut for both the physicians and the public.

At the present time, physicians feel that they have little understanding of what is factored into the Department's decision-making as to when, how and to what extent to investigate petitions made against physicians or how terms of Consent Orders are determined.

Section 9(4) does present concern regarding when a DPH investigation should be broadened to include sampling patient records and conducting additional interviews of other patients. This may have patient privacy implications and create additional negative impact on a physician's practice in situations where there has yet to be a finding of wrong doing on the part of the physician. If the necessary precautions and restrictions are not addressed, this may foster the appearance of a hunt to find problems and create an unnecessary burden on a physician practice.

Section 9(4) also provides for review of performance and discharge data from hospitals and managed care organizations. CSMS seeks to strengthen the ability of peer review processes and fears this section will thwart that goal. Currently CSMS has asked that whistleblower protections for healthcare providers who come forward to raise concerns or report suspected deviations of standards of care be added to any medical liability solution. The Connecticut Medical Society has serious concerns regarding any measure which may erode peer review protected documents pursuant to Conn. Gen. Stat. Sec. 19a-17b. Currently if the investigation exceeds 18 months or goes to a hearing, the documents will not be protected by confidentiality provisions.

We have further concerns as to how Managed Care Organizations will respond to such requests and whether physicians will be dropped or scrutinized simply because DPH requests information.

Section 9(5) also presents concerns as it will be very difficult to protect and insure confidentiality of provider identifiable information when the Department may be seeking performance data regarding a specific physician or interviewing a patient regarding care rendered by a specific physician.

We ask that Section 10 include a guideline as to when a respondent may access the Board during the negotiation of a Consent Order and before a hearing. Currently the department has a compliance conference but it is limited to an attorney for the DPH. Respondent deserve access to the CT Medical Examining Board without the threat of a Statement of Charges being filed.

The Board needs to have a presence and give advice regarding the stages in the investigation where it is currently excluded as well in the disciplinary process before the stage of a hearing. Section 10 provides for this presence of the CMEB in identifying conditions that the Board may consider in allowing alternative from the guidelines based on the case findings. We appreciate this important inclusion.

The Medical Society wants to work collaboratively and in cooperation with the Department and the Board to evaluate and develop these guidelines which we believe will generate positive change in our systems. Our physician members will be profoundly impacted by any guidelines. Therefore, we ask that the legislature provide a role for professional organizations in the development and ongoing evaluation of these guidelines.

Section 16 - CSMS supports providing additional details to the DPH including the name of a physician's liability carrier. CSMS has great concerns with DPH entering policy numbers and carrier names to the publicly accessed physician profiles. The profile is to give patient's information regarding qualifications and backgrounds of physicians. Our concern for the potential for identity theft is widespread. Acknowledgement of coverage is important but identification of specific identifiable information is not prudent.

Section 18: CSMS supports continuing education for physicians. We have previously testified before other committees to ask for the opportunity to be involved in the establishment of appropriate CME requirements. In fact Public Health last week approved two proposals which we support with modifications. CSMS has worked with the DPH over the past years in the development of an appropriate program of CME and commits to continue in its efforts to achieve this goal.

SB 1354: Section 1 provides for a copy of a summons and complaint to be filed with the Connecticut Medical Examining Board no later than five days after service of process. The language is unclear as to the impact of this change. If filing the complaint initiates an investigation by the Department, then this provision will have far reaching implications for medical liability actions and exacerbate the current medical liability situation in CT. As we all know the filing of a suit does not indicate that a deviation from a standard of care has occurred. Based on this proposed change - we may see settlement amounts and jury verdicts increase along with the weakening of a DPH process we all are attempting to strengthen.

Thank you for your kind attention. I welcome your questions.

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**State Of Connecticut
GENERAL ASSEMBLY**



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THE STATUS OF WOMEN**

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**Written Testimony of
Leslie J. Gabel-Brett, Ph.D.
Executive Director**

**Permanent Commission on the Status of Women
Submitted to the
Judiciary Committee
April 8, 2005**

Re: Medical Malpractice Insurance Reform

**R.B. 1364, AAC Reforms Related to Medical Malpractice Insurance
H.B. 1052, AAC Medical Malpractice**

Thank you for this opportunity to submit written testimony regarding medical malpractice reform. The Permanent Commission on the Status of Women has testified in the past on this topic for two reasons: First, because rapidly rising medical malpractice premiums have disproportionately affected obstetrician/gynecologists (OB/GYN's) who provide vital reproductive health care to women; and second, because caps on non-economic damages would disproportionately harm female patients who are victims of malpractice. The rapid rise in medical malpractice premiums is a serious women's health care issue that requires an effective solution.

We support a balanced, comprehensive approach to reform that includes litigation reforms, stronger oversight and investigation of complaints against providers and new requirements for continuing medical education, incentives to increase patient safety, and prior rate approval for insurance premiums. We do not support caps on damages awarded to injured patients nor provisions that will likely lead to such caps.

For this reason, we oppose Section 12 of H.B. 1052 that would require the commissioner of the Insurance Department to develop a proposal for caps on non-economic damages in three years if premiums have not decreased more than 15% by that time. While we understand that this is a compromise provision, we believe it is a self-defeating one. The insurance industry has a strong investment in the establishment of statutory caps on damages. They have the ability to raise and lower premiums as dictated

by their business interests. Holding out the promise in statute that caps will be enacted after three years if premiums decrease will create a very strong business incentive to keep premiums high in order to trigger that provision.

We oppose caps on non-economic damages because we believe they will unfairly harm female patients who are victims of medical malpractice. Empirical research conducted by law professor Lucinda Finley on gynecological malpractice cases over the past ten years in California and Florida shows that non-economic damages comprised approximately 75% of women's total awards. The reason is that the harm suffered by women in these cases include impaired fertility or sexual functioning, miscarriage, incontinence, and disfigurement of intimate areas of the body and these consequences, while very significant, are not directly related to economic losses. Finley concludes that capping non-economic damages will have a discriminatory impact on women patients that will be "the greatest when women experience the most profound sort of harm to their sexual and reproductive lives."

As you know, women earn approximately 25% less than men earn; limiting damages to primarily economic damages perpetuates this inequality in the face of injuries caused by malpractice. That is, the cashier gets little compared to the CEO even if the cashier has suffered the same or more serious injury. (This analysis applies, of course, regardless of the gender of the individuals – it is unfortunately true, however, that women are disproportionately represented in low-wage occupations compared to men.)

Women also have a longer life expectancy and are more likely to be old and poor. The tort system has two important purposes - on the one hand, to compensate victims of negligence or intentional harm and, on the other hand, to deter negligent or intentionally harmful behavior. For older, poor victims of malpractice with very modest streams of income, there would be little compensation and *no deterrence against malpractice* in their medical care because the economic risk is so low.

In addition to the reforms proposed in these two bills, we urge you to consider government sponsored re-insurance or "no fault" compensation funds to help spread the risk and ensure that patients who have been injured and need expensive medical care can obtain it. One of the factors driving up the cost of insurance is the rising cost of health care itself. When an individual has a serious medical injury – whether it is caused by malpractice or not – the costs of the necessary health care may create an impossible burden for the individual and his or her family to bear. In some cases, a patient would choose a fair compensation plan administered by a government fund instead of rolling the dice and suing the health care provider. When no such fund or assistance is available, the tort system is often the only recourse available.

Thank you for addressing this urgent problem.

**Statement
Insurance Association of Connecticut**

Judiciary Committee

April 8, 2005

SB 1052- An Act Concerning Medical Malpractice
SB 1364, An Act Concerning Reforms Related to Medical
Malpractice Insurance

The Insurance Association of Connecticut (IAC) has concerns with several sections contained within SB 1364-An Act Concerning Reforms Related to Medical Malpractice Insurance and SB 1052- An Act Concerning Medical Malpractice. HB6811

First, IAC supports both bill's attempt to address the problems plaguing our offer of judgment statutes. However, SB 1364 fails to sufficiently resolve the issues concerning time, information and interest lacking in our current statutes. Although SB 1054 makes the sufficient change to the offer of judgment statutes, it SB 1052 improperly limits the scope of the proposed changes to medical malpractice claims.

Offers of judgment are used in all types of civil claims including automobile accidents, slip and fall cases and medical malpractice cases. Excessive costs associated with offers of judgment are not limited to medical malpractice claims. Any changes that are made to the offers of judgment statutes must not be limited to one class of cases within the civil system.

The initial purpose behind the offer of judgment statutes was to induce early settlement and reduce litigation in all types of civil matters. A 2000 Law Revision Commission report, a copy of which is attached hereto, and a report commissioned by the Program Review and Investigations Committee for the 2004 legislative session, concluded that offers of judgments are not working in all types of civil matters.

One important way to improve the effectiveness of the offer of judgment statute is to provide all defendants with the opportunity for adequate knowledge prior to having to respond to an offer. This will result in a fairer and more effective settlement process. At two separate public hearings within the past year, a representative of the Connecticut Trial Lawyers agreed that it in making a decision on whether or not to settle a case that it was only fair to have all the information one would need. SB 1364 fails to assure that the respondent has adequate information and time to properly assess an offer. SB 1364 merely provides additional time to respond to an offer without requiring the filing party to provide any information. Changes made to the statute should require

plaintiffs, in all types of civil matters, to provide all the information needed by the defendant to assess the offer before a response is required. SB 1054 attempts to provide such information to the respondent, but limits its scope to medical malpractice claims. HB 6811, also on today's agenda, puts forth a reasonable solution that addresses all the procedural inefficiencies of our current statute. SB1052

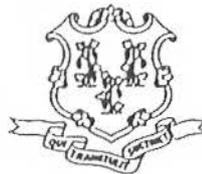
Additionally, the interest rate contained within our offer of judgment statute is unsound and lacking procedural parity, chilling the defendant's right to litigate. Both reports found the rate to be excessive. The IAC supports SB 1364's attempt to lower the current interest rate of 12%, however, we do not support SB 1364's nonsensical application. The original purpose of offers of judgments was to induce early settlement, why then would one seek to reward a party who fails to respond to an offer such that a jury awards more than double the offer? Would it not make more sense to reduce the initial interest to 4% and permit one to recover a greater amount should the judgment be more than double the offer, as long as the respondent as been provided all the information needed to respond to the offer? The IAC supports SB 1054's approach to reduce the current interest rate, however, any flexible rate should be capped at a rate of no more than 8%. SB1052

Finally, the IAC is opposed to section 5 of SB 1364 which seeks to allow a party to waive the statutory contingency fee scale while tolling the statute of limitations. Statutes of limitations are designed to provide a finite time in which one can assert their rights and protect parties from limitless litigation. Defendants, whose rights are protected by the statute of limitations, are not parties to the plaintiff/attorney relationship. Contingency fee agreements, if not subject to the statutory limits, are a business decision between a plaintiff and their lawyer. Why then should the right of the defendant, not a party to the plaintiff's business relationship, be impacted while a plaintiff and their attorney hammer out the terms of their business relationship?

The IAC urges rejection of sections 3, 4 and 5 of SB 1364 and strongly urge that any proposal regarding offers of judgment be amended to guarantee that all respondents in all civil matters are given adequate information and time to respond to offers and the interest be reduced to be more reflective of the economic market.

REPRESENTATIVE ARTHUR J. O'NEILL, CHAIRMAN
 WILLIAM R. BREETZ
 REPRESENTATIVE ROBERT FAIR
 JON P. FITZGERALD
 ROBERT W. GRANT
 REPRESENTATIVE MICHAEL P. LAWLOR
 MICHAEL W. LYONS
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 JUDGE ELLIOT N. SOLOMON
 PROFESSOR COLIN C. TAIT
 PROFESSOR TERRY J. TONDRO
 I. MILTON WIDEM
 SENATOR DONALD E. WILLIAMS, JR.

Connecticut General Assembly



CONNECTICUT LAW REVISION COMMISSION
 STATE CAPITOL
 ROOM 509A
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 (860) 240-0220
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DAVID D. BIKLEN
EXECUTIVE DIRECTOR

DAVID L. HEMOND
CHIEF ATTORNEY

JO A. ROBERTS
SENIOR ATTORNEY

January 26, 2000

Senator Donald E. Williams, Jr.
 Representative Michael P. Lawlor
 Co-Chairs, Judiciary Committee
 Room 2500
 Legislative Office Building
 Hartford, Connecticut 06106

Re: Report Concerning Offers of Judgment

Dear Senator Williams and Representative Lawlor,

By letter dated May 13, 1999, you requested that the Law Revision Commission review the laws concerning offers of judgment with an eye to recommendations to improve the effectiveness of that process. The Commission reviewed that issue and sought comment from the plaintiff's and defendant's bar and from the judiciary. The Commission's report is enclosed. The Commission found that procedures that might improve the effectiveness of the process, such as increasing penalties and mandating offers, would at best have only a marginal impact and, primarily because of their chilling effect on the rights of parties to litigate, were unsupported by the participants in the litigation process. Because of the way in which cases are prepared and litigated, no jurisdiction has crafted an offer of judgment process that effectively reduces court dockets or moves cases. More technical concerns are also reported on.

If you have any questions or further directions on this matter, please give me a call.

Very truly yours,

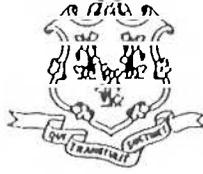
David D. Biklen

cc: Representative Arthur J. O'Neill, Chairman

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REPRESENTATIVE ARTHUR J. O'NEILL, CHAIRMAN
 WILLIAM R. BREETZ
 REPRESENTATIVE ROBERT FARR
 JON P. FITZGERALD
 ROBERT W. GRANT
 REPRESENTATIVE MICHAEL P. LAWLOR
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Report of the Connecticut Law Revision Commission to the Judiciary Committee Concerning Offers of Judgment

Prepared by David L. Hemond

January 19, 2000

The Connecticut Law Revision Commission was requested by Senator Donald E. Williams, Jr. and Representative Michael P. Lawlor, Cochairs of the Judiciary Committee, by a letter to David Biklen dated May 13, 1999, to undertake a review of the laws concerning offers of judgment. In particular, they asked that the review consider appropriate revisions so that the process would induce early settlement of matters prior to litigation. The letter requested that recommendations be made prior to the 2000 legislative session.

The Commission has now completed its review. The Commission finds that offers of judgment have not proven effective either in Connecticut or in other jurisdictions and that proposals to strengthen the process do not have the support of either the plaintiffs or defendants bar. More, specifically, the Commission reports as follows:

CURRENT LAW

Current Connecticut law on offers of judgment is governed by parallel provisions in the Connecticut General Statutes and in the Rules for the Superior Court contained in the Connecticut Practice Book. The law restricts offers to actions involving contracts or suits for money damages. Offers are filed with the Clerk of the Superior Court.

The basic rules are as follows:

Offers by the plaintiff (Rules 17-14, 17-15, 17-16, 17-17, 17-18, CGS 52-192a)

1. The plaintiff may make an offer at any time before the trial begins.
2. The defendant must accept the offer within 30 days and before the verdict or a potential penalty for failure to accept may apply.

3. If the defendant does not accept and the plaintiff recovers equal or more than the offer, the plaintiff recovers an additional 12% from the date the complaint was filed and up to \$350 attorneys fees, except that if the offer was made more than 18 months after the complaint was filed, the plaintiff only recovers the 12% from the date the offer was filed, plus up to \$350 attorney fees.

Offers by the defendant (Rules 17-11, 17-12, 17-13, CGS 52-193, 52-195)

1. The defendant may make an offer at any time before evidence is offered.
2. The plaintiff must accept the offer within 10 days or a potential penalty for failure to accept may apply.
3. If the plaintiff does not recover more than the offer plus interest, the plaintiff does not recover any costs accruing after the offer and must pay the defendant's costs accruing after the offer plus up to \$350 attorney's fees.

The statutes and rules concerning offers of judgment are intended to provide fair incentives to induce the parties to settle their claims prior to trial, thus bypassing the risks, vagaries, and costs to the judicial system and the parties of the trial itself.

The current incentive for a defendant to accept a plaintiff's offer is the possibility that the defendant will be required to pay 12% interest from the date of the complaint and attorney's fees up to \$350.

The incentive for a plaintiff to accept a defendant's offer is the possibility that the plaintiff will be required to pay the defendant's costs accruing after the date of the offer and attorney's fees up to \$350 because the plaintiff's judgment was less than the defendant's offer, notwithstanding that the plaintiff has "won" the case.

Current law, by providing the plaintiff with punitive interest if the defendant fails to settle for an amount less or equal to the amount ultimately awarded - but no comparable benefit for defendants where a plaintiff inappropriately fails to settle - conveys a litigation advantage to plaintiffs.

Connecticut cases have addressed offer of judgment issues as follows:

Blakeslee Arpaia Chapman, Inc. v. EI Constructors, Inc., 239 Conn. 708, 687 A2d 506 (1997).

In this primary case resolving the construction of the Connecticut statute, the Connecticut Supreme Court ruled that:

1. There is no equal protection problem with the statutory offer of judgment scheme that provides an interest penalty on behalf of plaintiffs but no comparable penalty on behalf of defendants because the plaintiffs and defendants are not similarly situated. Writes the majority opinion, "As long as the disparate treatment is, as here, rationally based, we may not judge the wisdom, desirability or logic of the legislative determination."

2. Use of the term "defendant" in the statute reasonably and logically should be interpreted to include the plural "defendants". Therefore the statute allows either submission of a unified offer of judgment to all defendants or individual offers of judgment to each defendant individually. "If the plaintiff files a unified offer of judgment that is not accepted, each defendant will be subject to offer of judgment interest only if the ultimate judgment rendered against that particular defendant equals or exceeds the amount of the offer." Ramifications of allowing the plaintiff this option are also discussed in the Superior Court case of *Cocozzo v. Wickes*, noted below.

3. Amendments allowed to the plaintiff's complaint after a plaintiff's offer of judgment do not invalidate that earlier offer. See also discussion of *Lutynski v. BB and J Trucking, Inc.*, below.

4. There is no stay of interest during a period informally staying a proceeding because of other litigation.

***Shawhan v. Langley*, 249 Conn. 339 (1999)**

In this case, the Connecticut Supreme Court concluded "that section 52-192a permits a plaintiff to file only one offer of judgment as to a particular defendant."

This ruling precludes further use of an offer of judgment once an initial offer has been rejected. Given that the public policy of the offer of judgment is to provide the parties with an inducement to settle and to remove litigation from the courts where possible, it is unclear what policy this "one offer" rule advances.

***Lutynski v. BB and J Trucking, Inc.*, 229 Conn. 525, 642 A2d 7 (1994)**

In this case, the Connecticut Supreme Court affirmed an Appellate Court decision which had held that a plaintiff's offer of judgment survived a later amendment of the claim and that the award of interest was mandatory and did not depend on an analysis of the underlying circumstances of the case. Those appellate decisions reversed the trial court finding that allowing the plaintiff to amend the claim superseded the effect of the earlier offer. As noted in the trial court opinion, survival of the effect of the offer beyond the amendment of the claim has disturbing implications because the ultimate trial is based on claims that were not before the defendant at the time that the offer was made.

***Cocozzo v. Wickes*, 1999 WL 417315**

In this Superior Court case, Judge Radcliffe questions the ramifications of Connecticut's rule allowing the plaintiff the option of a unified offer or individualized offers in the context of certain negligence cases. Thus, he writes: "Although a change in the offer of judgment statute requiring unified offers of judgment in cases involving vicarious liability, respondeat superior, or automobile owner/operator negligence where permissive use is admitted might be a welcome alteration, any change should come from the General Assembly, or a reexamination of *Blakeslee*."

THE LAW REVISION COMMISSION REVIEW

The Law Revision Commission assembled a review committee consisting of Representative Robert Farr, I. Milton Widem, Professor Colin C. Tait, and Joseph Selinger, Jr. and invited participation from experienced litigators and the Judicial Department. The review examined whether the existing statute has the desired effect of fairly inducing early settlement; if not, why not; and what changes would improve the process. The review committee and the Commission reached the following conclusions:

The current rules have only a peripheral impact on litigation

Review of available writings concerning offers of judgment, as well as the committee discussions, disclose that Connecticut's rules, and alternative variations on the rule in other jurisdictions, have only a peripheral impact on litigation. The fundamental weakness of the system is the fact that, necessarily, the vast majority of cases are settled before litigation, commonly "on the court house step" when parties first seriously evaluate the merits of their cases in the light of the costs of actual litigation. When a case is settled, the possible penalty provided by a plaintiff's offer of judgment is not invoked and, at most, was a possible factor that was considered. Moreover, for the interest penalty to be a settlement factor, the initial offer of judgment must have been low enough so that the defendant felt a significant risk. Since an early plaintiff's offer that is made before a full evaluation of the case is likely to "highball", the risk to the average defendant from the offer of judgment is slight.

Offers of judgment by defendants are also ineffective because nothing in the statute induces a defendant to make an offer early. The nature of litigation, which relies on discovery to provide evidence for evaluating the value of a claim, is such that a defendant would be unlikely to make a realistic early offer. However, under Connecticut's rule, a defendant gains the same benefit from an offer of judgment made late in the litigation as from one made early. Thus, in the typical case, if a defendant bothers to make an offer, he makes the offer just prior to actual litigation.

In short, the rules for plaintiffs and for defendants concerning offers of judgment do not have any substantial beneficial effect in inducing early settlement or in reducing litigation. In the context of the case as a whole, the rules merely provide a minor factor in settlement discussions as the case approaches trial. This experience, that offers of judgment are relatively ineffectual, has been sufficiently universal that some commentators have suggested abolition of Rule 68, the federal version of the rule. The offer of judgment rule seems to owe its continued existence primarily to the sense that "it can't hurt" and that it sends the right message.

The Commission reviewed alternative approaches and floated several trial balloons for consideration by representatives of the plaintiffs and defendants bar. More specifically, a Commission staff draft suggested mandating that parties make an early offer and counteroffer - tied to the completion of discovery - and that the penalty for an inappropriate refusal to settle include actual attorney's fees and litigation costs. Copies of those proposals are available from the Commission office on request. Commission advisors opposed or expressed a noted lack of enthusiasm for those suggestions. Moreover, even the experience of the state with the strongest offer of judgment statute, Alaska, which invokes a variation of the English rule for the award of

attorneys fees, has been equivocal. In the light of these dynamics, there does not appear to be any politically feasible basis under which the statute can be made to work effectively.

That said, there remain several issues for consideration. None of these matters, however, hold out the prospect of making this statute viable.

Procedural parity and other issues

As noted above, the existing statute provides a 12% interest penalty against a defendant that fails to accept an offer that was less than or equal to the award. There is no comparable penalty for a plaintiff's failure to accept a defendant's offer. This lack of "procedural parity" between the parties was litigated in the *Blakeslee* case and found to not constitute a constitutional violation because plaintiffs and defendants "are not similarly situated". Judge Borden, however, strongly dissented in that case, noting that "the majority has put all of the weapons created by section 52-192a in the hands of the plaintiff, with practically no risk, and all of the exposure on the defendant."

In Commission discussions, the current rule, predictably, was strongly defended by plaintiffs attorneys and roundly criticized by representatives of defendants. Plaintiffs argue that the interest is necessary to "level the playing field" in negotiations because during the interval between the claim and the trial the defendants are holding the plaintiff's money and earning interest on it. Moreover, it is not unfair to note that the interest penalty is the only meaningful settlement inducement in the existing statute - although its effect is limited.

The Commission, however, finds that the interest penalty is unsound. Lack of procedural parity - potentially chilling one party's right to litigate, but not the other's - is disturbing even if it does not violate constitutional due process criteria. The judicial process cannot prejudice a case and should remain procedurally neutral. Other plaintiff's tools, such as prejudgment remedies, are justified only by the need to protect property in the event of an ultimate award. Even those remedies require a judicial process before they may be invoked.

The argument that the interest penalty is necessary to level the playing field fails because Connecticut law already provides for interest in the context of the judgment. While interest, per se, is often not awarded individually in the context of tort litigation, that is because the award is intended to include full compensation for all damages, past and future (including any losses - such as lost opportunity costs - incurred after the tort but before the award). If, in fact, as argued by the plaintiffs' bar, interest is a necessary component of damages but is not currently being awarded, the proper remedy would be to more explicitly require interest for all such awards. There is, in any case, no rationale under which a plaintiff should have to make an offer of judgment to obtain access to justly due compensatory interest.

Given that the interest awarded under the offer of judgment statute is a penal award to induce settlement, it could, nevertheless, be justified if a comparable procedural inducement was provided on behalf of defendants. However, there is no such comparable interest penalty that can logically be imposed since, in the case of a defendant's verdict there is no consistent award on which an interest penalty could be based. The plaintiff's failure to settle is most egregious when the plaintiff recovers nothing.

In short, while the interest penalty provides what little effectiveness (on behalf of plaintiffs) that the statute has, it lacks a sound rationale.

The Commission also reviewed a lesser procedural issue concerning the "one offer" rule. As noted, the current statute has been construed to limit parties to the making of a single offer. See *Shawhan v. Langley*, 249 Conn. 339 (1999). The "one offer" rule does not appear to advance any rational policy. Because the statute assumes that acceptance of an offer is preferable to litigation, that benefit applies whether the offer that is accepted is a first offer, second offer, or one of multiple offers. Indeed the single consensus appearing among the Commission advisors was that such a restriction was unnecessary. A limited amendment removing that restriction is therefore in order. The Commission cannot represent, however, that such a limited change will result in significant benefit to the effectiveness of the statute.

TESTIMONY OF
PATRICK J. MONAHAN
VICE PRESIDENT AND GENERAL COUNSEL
CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
JUDICIARY COMMITTEE
Friday, April 8, 2005

SB 1052, An Act Concerning Medical Malpractice

SB 1364, An Act Concerning Reforms Related To Medical Malpractice Insurance

My name is Pat Monahan, and I appreciate the opportunity to testify on behalf of the Connecticut Hospital Association on SB 1052, An Act Concerning Medical Malpractice and SB 1364, An Act Concerning Reforms Related To Medical Malpractice Insurance.

Rising malpractice insurance premiums continue to endanger Connecticut's healthcare infrastructure. Through written testimony and in legislative meetings at hospitals throughout the state, hospitals' chief executive officers, other healthcare representatives, and members of hospitals' medical staffs have outlined some of the specific ways in which increases in liability insurance premiums affect the ability of a hospital to deliver care. Increased insurance costs have diverted funds from patient care and quality improvement, reduced the number and availability of physicians in specialty service areas, seriously hampered the ability to recruit physicians in nearly all specialties, and compromised hospitals' ability to ensure adequate on-call and emergency department coverage.

Protecting the general public's continued access to quality healthcare when and where they need it continues to be the most important reason for enacting effective and expedient reforms. We continue to believe that a reasonable limit on non-economic damage awards would be the most effective single component of any meaningful legislative reform package. While we recognize that SB 1052 does not contain such a provision, we appreciate the inclusion of Section 12, which would trigger a mechanism for establishing caps on non-economic damage awards in three years if other measures do not succeed. SB 1364 does not have any provision for caps.

CHA is supportive of other measures described in SB 1052 and SB 1364, including a stronger good faith certificate requirement, support for use of periodic payments, and improved offer of judgment provisions. We strongly support the provisions of SB 1052 relating to pretrial screening and a change in the collateral source rule. We continue to believe that meaningful reform measures must effectively change the way the current system functions. We would like the opportunity to continue to work with you on

language to most appropriately implement these and other reform measures under consideration.

We appreciate the substantial thought and effort that you are devoting to the serious problems associated with escalating liability insurance premiums, and we remain committed to working with you to achieve reform that preserves and protects our public's access to appropriate medical care.

I also take this opportunity to reaffirm Connecticut hospitals' commitment to providing the highest quality care to each and every patient, 24 hours a day, everyday. This commitment to patients is not new; it has been and remains the cornerstone of every Connecticut not-for-profit hospital's mission.

Thank you for your consideration of our testimony.

PJM:jaf

TESTIMONY OF
PATRICK CHARMEL
PRESIDENT AND CHIEF EXECUTIVE OFFICER
GRIFFIN HOSPITAL
BEFORE THE
JUDICIARY COMMITTEE
Friday, April 8, 2005

SB 1052, An Act Concerning Medical Malpractice

SB 1364, An Act Concerning Reforms Related To Medical Malpractice Insurance

My name is Patrick Charmel, President/Chief Executive Officer of Griffin Hospital located in Derby, Connecticut. Thank you for the opportunity to testify on the subject of medical liability insurance reform.

The medical liability insurance crisis has had an adverse impact on Griffin Hospital's ability to fulfill its mission in that it has consumed financial resources that otherwise could have been used to deliver direct patient care, to develop new programs and services responsive to the needs of those we serve, to acquire technology to improve patient safety, and to enhance our ability to diagnose and treat disease, and to maintain or replace aging facilities.

Despite an exemplary claims record, Griffin Hospital has seen its liability insurance premium double from \$1,080,000 in 2001 when the crisis began to \$2,150,000 this year. To put this \$1,000,000 premium increase in perspective, it is equivalent to half of the hospital's annual drug budget. It would pay for the entire cost of a hospital-wide picture archiving computer system to digitize, display, store and retrieve diagnostic radiology images. Such systems have been shown to improve diagnostic accuracy and improve physician access to important clinical information. It would cover the investment required to convert to an electronic medical record from our error prone paper medical record keeping system. It can equip three operating rooms with state of the art laparoscopic video surgery and patient monitoring equipment, and most importantly the \$1,000,000 could have been used to hire 15 additional registered nurses to provide a higher level of patient care and to provide a better working environment for our nurses who shoulder an ever-increasing burden.

The hospital has been forced to make tradeoffs to fund its rapidly increasing malpractice premiums. Tradeoffs that have adversely impacted our ability to fulfill our mission. If given the choice, I believe the public would be willing to limit its right to recover damages in cases of medical negligence if it meant that dollars saved on malpractice premiums as a result would be invested in improved patient care and safety.

Resources are expected to become more scarce due to a rapidly deteriorating operating environment. Increased medical liability insurance costs along with dramatic increases in the cost of drugs, blood products, fuel oil, and employee pensions have resulted in

hospital operating cost inflation that has exceeded general inflation by a factor of three. To cover higher operating costs, hospitals have demanded higher fees from managed care organizations that in turn have raised the premiums they charge employers for employee health insurance coverage. Those premiums have risen more than ten percent per year over the last four years. Employers facing relentless competition in their businesses have not been able to pass their premium increases on to their customers in the form of higher prices for the goods and services they sell. In response employers have begun to drop employee health insurance coverage or impose high co-pays or deductibles on their employees. Increasing patient responsibility for the cost of care has resulted in a dramatic increase in uncollectible accounts and bad debt. Griffin's bad debt expense doubled from \$4,000,000 in 2003 to \$8,000,000 in 2004. As more employers move to high deductible plans, the problem will only get worse. Employers are demanding an end to rising employee health insurance premiums. Medicare hospital payment cuts are inevitable due to record setting federal budget deficits and the State's Medicaid payments to hospitals which cover only 70% of the cost of providing care are likely to remain inadequate into the foreseeable future.

Given the growing scarcity of resources to fund the delivery of needed health services, it is time to adopt a more rational medical liability system to balance the needs of society at large with the needs of the select few that are harmed by the care they receive. To reform Connecticut's medical liability system, I believe that a series of measures that promote predictability, efficiency, and fairness for all parties involved need to be adopted. Furthermore, measures adopted must have a proven record of effectiveness in reducing health care liability insurance premiums. Unfortunately many of the measures included in SB1057 and SB1364 have no record of effectiveness. I encourage you and your fellow legislators to consider adding a reasonable cap on non-economic damages to the reform measures.

SB1052

I appreciate the substantial work and thought that legislators have devoted to this problem, and we will continue to work with you in any way we can to address this important issue in the best interests of patient care.

TESTIMONY
OF
Laurence Tanner
Chief Executive Officer
New Britain General Hospital
Before the Judiciary Committee
Friday, April 8, 2005

SB 1052 An Act Concerning Medical Malpractice
And
SB 1364 An Act Concerning Reforms Related To Medical Malpractice Insurance

My name is Laurence Tanner, President/Chief Executive Officer of New Britain General Hospital in New Britain, Connecticut. I appreciate the opportunity to testify on the subject of medical liability insurance reform.

The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire system for delivering healthcare in this state. Since the year 2000, New Britain General Hospital's medical liability insurance costs have increased from \$280,000 to \$ 1.7 million; a six fold increase. At the same time, the amount of coverage that we are receiving for these dollars has actually decreased. I would add that during this period of unprecedented cost increases, the frequency of claims has remained essentially flat meaning that the amount of the awards is driving these premium costs, not the number of lawsuits. In addition, the premium increases experienced by the doctors who serve the hospital have a direct, detrimental effect on our hospital. These escalating insurance premiums threaten and compromise our ability to deliver patient care in a number of ways.

We have had several doctors either relocate outside Connecticut or abandon their clinical practice directly due to this crisis and we feel that this trend is escalating. We had one general surgeon relocate out of state. One of our two neurosurgeons abandoned practice entirely. Both of these physicians indicated that malpractice costs were the sole reason for their decision. So far (and I would emphasize the words "so far") one of our OB/GYN physicians has given up delivering babies. In addition, several members of our OB/GYN medical staff have indicated to us that they have plans for relocating outside the area as early as next year. Financial stipulations within their malpractice policies will allow for such moves without substantial financial repercussions. I strongly believe this is only a small measure of what will happen not only in our service area but statewide if serious measures to address this issue are not taken.

In addition to the issues described above, the cost of malpractice in Connecticut (and its relationship to the comparable cost in other states that have enacted serious reforms) is posing serious challenges to our ability as a hospital to recruit physicians into our area. Our physician manpower studies have clearly documented that we have a medical staff that already is depleted and is aging rapidly. We face daunting recruitment challenges across virtually all specialties. Our efforts in this regard are already seriously hampered by this issue and I believe we will have a real crisis relative to access to care if we fail to address malpractice reform or even if we simply wait too long to act.

New Britain General Hospital believes that our medical liability system requires a measure, or combination of measures, that will promote predictability, efficiency, and fairness for all parties in medical malpractice litigation. While the proposed bills contain measures that could possibly improve Connecticut's medical liability system, we continue to believe that a reasonable cap on non-economic damage awards is a necessary component of an effective reform package. A cap on non-economic damages is working in other states and I believe that Connecticut should seriously consider incorporating this concept as well.

I appreciate the substantial work and thought that legislators have devoted to this problem, and we will continue to work with you in any way we can to address this important issue in the best interests of patient care.

Thank you for your attention.



Connecticut Business & Industry Association

TESTIMONY OF
ERIC GEORGE
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION
BEFORE THE
JUDICIARY COMMITTEE
LEGISLATIVE OFFICE BUILDING
APRIL 8, 2005

My name is Eric George. I am associate counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents 10,000 businesses across the State of Connecticut, ranging from large industrial corporations to small businesses with one or two employees. The vast majority of our members, about 90 percent, are employers with fewer than 50 employees.

Thank you for the opportunity to comment on several of the bills that you are considering related to medical malpractice reform. In general, I offer my comments on the following bills: SB 1052, SB 1362, SB 1364, and HB 6811.

It is relevant to know why CBIA, and the employers we represent, care about the medical malpractice crisis. The escalating cost of healthcare is the number one concern of our members with respect to the overall cost of doing business in Connecticut. Several studies and reports have indicated that skyrocketing medical liability premiums and the practice of "defensive medicine" are driving up the cost of healthcare and jeopardizing access to healthcare:

- In December of 2003, the Connecticut Program Review and Investigations Committee issued a report entitled "Medical Malpractice Insurance Rates", wherein the committee identified the escalation in the cost of individual malpractice claims as a significant contributor to the medical malpractice crisis.
- In April of 2002, PriceWaterhouseCoopers issued a report entitled "The Factors Fueling Rising Healthcare Costs," wherein they identified "litigation and risk management" as among the clearly identifiable healthcare cost drivers, accounting for \$5 billion in additional healthcare spending nationwide between 2001 and 2002, and went on to state that "the threat of litigation is a significant driver in the

unnecessary use of treatments and medicine, which not only add to the cost of healthcare, but may actually dilute its quality”;

- In August of 2003, the U.S. General Accounting Office stated in a report entitled “Medical Malpractice: Implications of Rising Premiums on Access to Health Care” that healthcare provider actions taken in response to malpractice pressures (that is, “defensive medicine”) have limited access to healthcare and that reforming the medical malpractice system would affect premiums and costs; and
- On July 24, 2002, the U.S. Department of Health and Human Services stated in a report entitled “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System” that medical malpractice reforms would reduce healthcare costs and would increase access to healthcare.

Ever-increasing healthcare costs are (i) jeopardizing the ability of employers to continue to provide healthcare benefits; (ii) chilling employers’ ability to hire new workers or expand their businesses; and (iii) leading to increased numbers of uninsured. In other words, rising healthcare costs are having a detrimental effect on Connecticut’s employers, employees and the number of uninsured, as well as the viability of our state’s economy.

With that, CBIA is interested in several of the concepts encompassed in these bills.

1. Offers of Judgment: CBIA supports HB 6811 as this measure sets reasonable standards for when an offer of judgment can be made, what information must be shared, and establishes a more reasonable rate of interest for such offers. It is clear from Connecticut businesses’ experience that offer of judgment interest can unfairly penalize defendants and impede settlement.

HB 6811 lowers the interest rate on offers of judgment in an attempt to correct the inequities that the current interest rate creates. We recommend setting the interest rate at 4 percent. The lower rate would help eliminate the clear incentive that exists today for the plaintiff to throw out an offer of judgment before necessary facts are at hand, as doing so can bring in high returns.

HB 6811 corrects a second problem with the current system by requiring plaintiffs to be able to substantiate their offers of judgment prior to such offers being filed. There are many reasons why civil disputes take time to conclude such as factual complexities that require substantial discovery or expert testimony, as well as other factors. Requiring an offer of judgment to include related and supporting documentation will help improve the current system.

2. **Protective Orders**: CBIA supports preserving Connecticut's system of protective orders as current law, recognizing the need to balance the broad scope and potentially invasive nature of discovery, gives courts the discretion to issue protective orders upon a showing of good cause. Protective orders are used to protect a party from annoyance, embarrassment, oppression, or undue burden or expense. Pursuant to the Connecticut Practice Book, a party seeking the protective order must specify the particular document it seeks to protect and why, making a factual showing of the harm it would sustain if information was disclosed - even if the harm from disclosure is obvious. Any harm alleged in the affidavit that is speculative or theoretical is insufficient to establish good cause.

Ultimately, and appropriately, the decision to enter a protective order rests with the court. It calls for analysis of three factors: (i) whether or not the moving party possesses a cognizable interest entitled to legal protection; (ii) whether or not unrestricted disclosure would lead to a clearly defined and serious injury to warrant judicial intervention; and (iii) whether the countervailing interests militate against a protective order or weigh in favor of limiting its scope. Other parties to the action can and do argue against the issuance of the order during the discovery process. We are not aware of any evidence suggesting that judges have abused this discretion to the detriment of the public's right to know.

Additionally, under current law, court records are available to both the public and the media. The Connecticut Practice Book was amended in 1995 to provide that the court cannot order that the public or the news media be excluded from any portion of a proceeding or that any files, affidavits documents or other materials on file with the court be sealed or their disclosure limited unless it is determined that the public's right to know is outweighed by the need to protect the confidentiality of the information. The

information contained in the record more fairly and completely addresses the issues being litigated because it has been regarded fully by all parties.

Be aware that Connecticut manufacturers invest millions of dollars in research and development and stripping courts of their discretion to protect the confidentiality of trade secrets and other proprietary information would place Connecticut manufacturers in a marked disadvantage in the global marketplace.

Finally, confidentiality promotes settlement of suits and cooperation during discovery, reducing the number of time-consuming and costly trials and discovery disputes. The elimination of our protective order system would reduce a party's incentive to settle by allowing the terms of that settlement to be publicized.

3. Disclosure of Policy Limits. CBIA opposes SB 1362, which permits an insured's policy limits as opposed to a claim's actual value to drive plaintiff's settlement negotiations.

Since defendants have no opportunity to review evidence regarding damages prior to a lawsuit, this bill puts them at a serious disadvantage in the negotiation process. Current law requires plaintiffs and defendants to disclose information, including insurance policy limits, in discovery, and this helps ensure an even playing field.

CBIA is also concerned that SB 1362 encourages the targeting of deep pockets, unfairly penalizing corporate defendants that typically maintain high insurance policy limits. Forcing defendants to disclose private information simply makes it easier for plaintiffs to decide how much to sue a company for. The amount of insurance a person or company chooses to purchase is confidential and should have no influence on the actual value of a claim. Disclosing policy limits will only inflate the value of claims and increase liability costs over time.

CBIA urges this committee to move forward to refine the proposals endorsed above and to reject those as to which we have communicated our concerns. We believe that such actions will help improve our medical liability system.

Thank you for considering my remarks.

Penny Q. Seaman
The Connecticut Medical Society
Judiciary Committee
April 8, 2005

SB515 SB514

My name is Penny Seaman. I am a trial attorney with the firm of Wiggin and Dana. I am here today at the request of the Connecticut Medical Society to speak to you about several bills that propose changes to certain aspects of the litigation of medical malpractice actions. I will limit my comments to three specific topics: collateral sources, periodic payments and bifurcation of trials.

1. Collateral Source Payments – SB 1052 and SB 6814

Collateral source payments refer to payments made on behalf of a claimant by someone other than the defendant. Under our statute, collateral sources are defined in a way that effectively limits them to payments made under a health or accident insurance policy to plaintiff's treating physicians or other health care providers. At the time of the trial in a tort action, the plaintiff can introduce evidence of medical bills, but evidence of collateral source payments cannot be introduced to the jury. The jury cannot be told that all of the medical bills were paid by insurance, or that the plaintiff received disability payments, worker's compensation payments or other income replacement payments. Similarly, the jury cannot be told that plaintiff received money from another party who the plaintiff claimed was responsible for his injury. The only effect that such payments have is that, after the jury returns a verdict, the judge reduces the economic damages award by the amount of the medical bills paid by insurance.

The Connecticut Medical Society supports changes to the collateral source rule that would allow a jury to be advised of other payments made to, or on behalf of, the plaintiff. Such a change would allow the jury to make its decision being fully informed of all the facts. SB 1052

proposes a change to the collateral source rule, but the change is not likely to have much effect on current practice.

The Bill allows for the introduction of evidence of any other award that the plaintiff received at a separate trial against another healthcare provider for the same injury. Such a situation would rarely, if ever, occur. First, the law allows a single recovery for a single injury. Therefore, a plaintiff who has been awarded and collected damages for an injury cannot sue a different defendant to collect damages from him for the same injury. Moreover, under tort reform, the most likely scenario is that all of the potential defendants are involved in the same action and the jury is asked to apportion responsibility among them.

For a change to the collateral source rule to have impact, the rule should allow for the introduction of evidence of settlements that the plaintiff has received from any other person for the same injury. The jury should also be advised of payments of medical bills by insurers, and of replacement income that plaintiff has received as a result of the same injury.

2. Bifurcation of Proceedings – SB 515

SB 515 addresses bifurcation of a trial. When a trial is bifurcated, the jury first receives evidence and renders a decision on liability. If the jury finds for the plaintiff on liability, the same jury then receives evidence and renders a decision on damages. There are several benefits of a bifurcated trial. First, such trials are more cost effective because, if the jury decides that there is no liability, they never have to hear the evidence on damages. This makes the trial shorter, which preserves judicial resources and avoids wasting the time that the jury would otherwise spend on issues that are not relevant to the verdict. In addition, in sophisticated tort claims, much time and expense is attributable to damage evidence. Both parties often have several expert witnesses on damage issues and the presentation of such evidence can be very

I was diagnosed incorrectly, medicated incorrectly, and lapsed into a coma.



Fred and Bonnie Frank

I was 37 years old and at the top of my career when this happened to me. I was probably 8th in the nation in my field; national and international recruiting. Twenty years ago I contracted a virus and was hospitalized. I was diagnosed incorrectly, medicated incorrectly and lapsed into a coma for two and one half months. That one sentence seems an inadequate way to describe an event that was so profound for my entire family and myself. My wife will go to heaven, no questions asked. My oldest son, at the age of twelve, had to become the "man" of the house. My income had disappeared.

Two and one half months in a coma means that everything atrophied. When I came out of it I had to learn to do everything again; even breathing and talking. I was in rehabilitation therapy for countless months in the hopes of getting back into society. And as soon as I could, I began to volunteer for whatever was in front of me, including coordinating the building of dugouts for my sons' baseball team. I am a doer, an activist.

Eleven years later (and bill collectors never stop asking for their money) I was able to get a job with

Connecticut Independent Living Center of Fairfield County. Today I am President of the Bridgeport Kiwanis, Treasurer of the CT Association of Centers for Independent Living and a member for a litany of other civic organizations.

I know I serve as a role model for people with disabilities because I haven't let mine stop me. I believe in giving back. Personal integrity has been an important asset but eighty percent of my come back had to do with malpractice outcomes. When my malpractice case was litigated there was no damage cap. A legislated cap would have made my emergence as a contributor to our society impossible. When it comes to integrity, the medical profession must do a better job policing itself and acknowledge mistakes when they happen. Otherwise the victim pays twice.

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Quality Healthcare is a Right

Because of poor judgement she was born with cerebral palsy

Five years ago Sydney was born. Because of poor judgment she was born with cerebral palsy.

Sydney has been deprived of many of the activities that are experienced by other children. Sydney has yet to enjoy and probably will not ever enjoy any individual activity and pleasures that we all take for granted. She cannot dress herself; she cannot walk by herself, she cannot feed or communicate very well; she cannot brush her own teeth or bathe herself and she cannot even go to the potty by herself.

On the other hand, she gets to participate in many activities that children with normal physical development don't experience. Sydney gets to have two hours every week of speech therapy, two hours each week of physical therapy; two hours each week of occupational therapy and 45 minutes of aqua therapy and another hour of hippotherapy.

If Sydney were to be compensated for her loss of play time, family time and school time at a modest \$10.00 an hour, her total lifetime compensation would be more than the proposed cap and that's only a very small part of her pain and suffering.

I do not believe that there is a limit on the amount that is due to an individual that has been put into a prison within their own body or has suffered other permanent injury due to the negligence of a medical professional. I do believe that the insurance companies have done a great job in playing the doctors against the injured patient. They get to enjoy their profits and generous salaries at the expense of the physician or the injured.

Recently, many doctors have said that they have been forced into early retirement due to rising insurance premiums. In my industry, trucking, I have seen many trucking companies close operations due to exorbitant insurance increases. Just four years ago the average yearly premium per truck was about \$4500 and today that premium is about \$10,000 - a 220% increase. Yet 15 of the top 25 paid executives in the Hartford area are in the insurance industry with 2002 compensations of up to \$9.58 million with an average increase of 149% in only one year.

The insurance industry is the ultimate beneficiary while both permanently injured patients and good doctors are being financially penalized.

Brian Reich



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*"My chance for a cure
was thwarted..."*



"Mary Dietmann with her children, Laura and Chris, and husband, Carey."

My name is Mary Dietmann.

My name is Mary Dietmann. I am a 42-year old full-time mother and a part-time nursing instructor. I am a victim of medical malpractice.

Today I am battling metastatic breast cancer because the medical system failed me more than four years ago in a series of repeated errors.

In April of 1998, at the age of 36, I found a small mass in my right breast during a self examination. I reported it to my gynecologist. My gynecologist referred me to a radiologist for a mammogram, but he failed to properly refer me to a surgeon for further examination and biopsy, nor did he properly advise me of the need for a follow-up examination.

Compounding my gynecologist's mistakes, my radiologist wrongly reported this diagnostic mammogram as showing no abnormalities when, in fact, the mammogram showed a suspicious lesion in my right breast that should have immediately triggered additional diagnostic tests and treatment.

Only a year later, when I returned to the gynecologist in April of 1999, did the gynecologist refer me to a surgeon when he noticed the small nodule in my breast. Upon examination, the surgeon failed to recommend a biopsy or a follow-up exam. Instead he sent me to a radiologist for an ultrasound of the breast. The radiologist from the same group that misread the prior year's mammogram again missed the clear abnormality on the ultrasound.

Again, my chance for a cure was thwarted by the doctors' negligence.

Not until February of 2000, when I went to the surgeon with dimpling in my breast, was the cancer diagnosed.

By March of 2000, when I finally had a mastectomy at the age of 38, it was already too late; the cancer had spread to 9 out of my 14 lymph nodes.

Because my doctors repeatedly failed to diagnose an obvious cancer at an early and treatable stage, I have endured a limitless amount of pain, suffering, humiliation, physical debilitation, hair loss, and most of all, loss of my life expectancy. Today, I hang on to every day of my life, not knowing when I might have to say goodbye forever to my husband, children, family and friends.

Despite being a nurse myself, and having many friends in the medical community, I ardently oppose efforts by politicians to severely restrict damages in catastrophic cases like mine. If there is any good that can come from my suffering, I hope that my case can convince officials that the answer to rising malpractice costs is to tackle the huge problem of medical error and malpractice instead of blaming the victims.

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QUALITY HEALTHCARE IS A RIGHT

Was there prescription error and bad medicine practiced? Absolutely!

From May 8th until our mother died on June 23rd 2004, we had someone with her 24 hours a day. We had to. We could make sure medication arrived on time and that it was the right medication. **We were the continuity of care that patients so desperately need yet are not getting in today's hospitals.**

Confusion over prescription's, differences in what physicians said they were prescribing and what was given, lack of communication on how the drugs were to be delivered, specialists prescribing drugs without a comprehensive understanding of medical history, weekend "blackouts" of care, confusion over who had the ultimate medical responsibility – all were the order of the day.

In today's medical delivery system our family had to understand and coordinate her care in the hands of a pulmonologist, cardiologist, vascular surgeon, primary care physician, colorectal surgeon, and an infectious disease specialist. Add to that the ever-changing nursing staff, and hospital residents and doctors covering for other doctors. With our mother, we lived in a bureaucratic healthcare maze that challenged and frustrated us and put her at great risk. Among all those health "care givers" there was little understanding of the whole person that was my mother. **Many times it seemed to be "diagnoses's by specialty.**

Our mother has died. Was there prescription error and bad medicine practiced? Absolutely. Does this rise to a medical malpractice lawsuit? It may not. But one way our family can go forward and honor our mother is to let the public know that they are at risk. Even with 24 hour advocates it is often not enough. **We must demand coordinated care, computerized prescription entry and for the elderly, computerized patient care.** If doctors cannot talk to each other, perhaps the computer can.



Stephanie Theresa Lukas

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Quality Healthcare is a Right

Twice I asked the doctor to do an ultra sound... He looked at me like I was crazy.



Todd Milhomme — 4 1/2 years old

*"Why should he
and the rest of us
pay for the mistake
that doctor made"*

Twenty five years ago I was pregnant with our third child. But in the course of my pregnancy I became convinced that I was carrying more than one baby. Twice I asked the doctor to do an ultra sound, he looked at me as if I was crazy. When I experienced a lot of pain at 7 and one half months, the doctor said I should be induced. My labor began and he quickly realized there was something wrong. He called in a specialist and that specialist said to my husband "It's too late, he's already induced her, but she is carrying triplets. Two more weeks and they would have been fine."

Two of my sons died that day. But Todd lived. Since then he has lived with cerebral palsy and learning disabilities.

It is important for you to know that when there is a victim like Todd, the entire family is impacted. I have been a machinist, a department manager and when Todd could work, I worked with him as a janitor. But many times I have had to leave jobs because I had to spend so much time getting Todd what he needed within our school systems, at doctors' offices, physical therapists to say nothing of the struggle to get him job coaches and support from social service agencies. Health providers and public institutions seem always to find a reason to not do something rather than provide a helping hand.

We built an apartment for Todd in our basement. We want to see him be able to live as independently as he can. For a while he had a job at a mushroom farm earning \$7.50 an hour. He liked this work. But the farm was closed and his new job, working on a work crew outside, pays just \$4.25 an hour. That's not even minimum wage, but I have to fight for him even to get that.

My two older daughters have been wonderful. We are a close-knit family and support each other in every way we can. We have to fight to get what Todd needs and he needs a lot. We know the costs of malpractice, not just to one victim but to the family members. Capping awards would only make these situations so much worse. I think doctors just don't want to be sued. I would like to see them be as responsible as we have had to be.

I am against capping malpractice awards because taking away Todd's right to confront the doctor responsible for his condition would victimize Todd twice. Why should he and the rest of us pay for the mistake that doctor made?

Sharon Milhomme

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When a doctor destroys the life of his patient he also destroys the lives of her family.



**Agnes Elizabeth Kaldus,
Greenwich Connecticut**

I was crazy about Manhattan. I would get off at Grand Central Station and think I was in Heaven, but very often I would drive into the City. I was a member of the Met. I loved the opera. I was a walker, walked all over town, but mostly in the mornings around the track at a nearby school. I traveled extensively, across the country by car and flew to many countries in Europe. But that's all over now. I'm confined to a wheelchair, in diapers and in pain, all of this because of a flawed diagnosis and incompetence.

On Memorial Day weekend, 1999, my friend and I had plans to spend a nice day. When she called on me to go out, I had garbled speech. She tried to contact my family but no one was home. So, she took me to the hospital. Barbara, who is my sister, arrived shortly thereafter. A neurologist suspected meningitis and asked if he could do a spinal tap saying I may have bleeding to the brain and would be dead within 24 hours. Barbara consulted with an older sister, Caroline, who held a very important position at the hospital at one time. Caroline said that we must trust the doctor and O.K. the request. Immediately after the spinal tap, I had great pain and was sedated. The neurologist and attending nurse disappeared. Barbara heard from the doctor four days later.

My family arrived the next day at the hospital to find me sedated but still in great pain. Barbara telephoned her concern about the great pain I had in my spine to my medical doctors the next morning. My family was pleading with everyone to do something for me. Nothing was being done.

Four days later the neurologist telephoned Barbara to say he wanted to do a further test on my spine because he couldn't get anyone to do an MRI. Barbara said that another sister had been the x-ray technician in charge of that department for over thirty years. Said to mention her name and everyone would come running. When Barbara arrived at the hospital, I was on a gurney going to have an MRI. Shortly thereafter, a concerned neurological surgeon arrived and asked permission to do an laminectomy. He said he didn't know if he could save me medically but that I was paralyzed and incontinent.

At the hospital I was being transferred from the bed to a chair via a lift when the lift collapsed. I fell and received a large hematoma on my head. Several weeks later, I was transferred to a rehab hospital where I was to receive intense physical therapy. The physical therapy was limited because I had bedsores and phlebitis. They were anxious for me to leave. Then I went to a very pretty nursing home. The prescribed doctor hardly ever visited me and later I learned from the local paper, that he had been arrested for being on drugs. A water pipe broke and gushed in through the light fixtures over my bed and saturated my entire room. I was yanked out of bed fast. A few days later I ended in the hospital with an infection. I was transferred to a local nursing home receiving good care despite my frequent returns to the hospital for infections and seizures from over medication. With the first seizure, I bit my tongue in two.

This neglectful episode has taken a toll on my entire family. When a doctor destroys the life of his patient he also destroys the lives of her family. My sister has devoted herself to my care. She is now suffering from a serious back problem and stress. Her husband, although he has had two cancers, problems with his heart and replacement of three joints, takes me out as often as he can along with Barbara. My retirement income, all my personal treasures, and money received from the sale of my home, pays for the costly expenses of the nursing — over \$10,000 a month. I now have one room instead of a beautiful home.

Again the holidays are approaching and it is so sad. I was considered a good cook and loved to prepare dinners for my friends and family. Holidays were always such a beautiful family gathering. Now I am in a wheel chair and limited to where I can go.

The doctors complain that their insurance costs have increased. If that is so, the obvious reason is because there are too many mistakes being made by careless doctors. I don't know of any doctor who has left his profession because he couldn't afford the increase. Most doctors have a beautiful house, backcountry with all the amenities' boats, fancy cars and second homes. I would like one of them to take my place in the wheelchair in diapers for one week and see how it is.

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Quality Healthcare is a Right

When mistakes are made hospitals need to tell the truth.

*Testimony before the Insurance Committee
March 4, 2004*

I was born between the wars in a small village in France, near Grenoble. By the time I was 2, both my parents had died and my brother, sister and I were raised by an aunt and uncle. Then the war came and the Germans took over the countryside. My Aunt died because the Germans had a curfew and when her appendix burst the doctor could not go to the small clinic nor come to our house.

But the end of the war brought a new beginning for me. I married and moved to the United States. My husband was very special, not just to me but to his fellow employees at Pitney Bowes and to our relatives and to the good friends we made here. He always had a game he would make up and all our guests would enter in and play. We built a chalet on the side of a hill in Stamford and it reminded me of my origins. We both loved to work outside and garden. We planted trees, built walls and enjoyed our sylvan retreat.

The day before my husband had surgery to remove benign tumors, he rebuilt the railing on our deck. The next day he went in for surgery. Twenty days later he died of an infection, malnutrition and dehydration.

I knew that there was a problem with my husband's condition several days after the surgery when he developed a fever. Whatever caused the lack of continuity in his care, he became severely dehydrated, and just deteriorated before my eyes. After he died, it took me months to obtain his records. The hospital said they would provide them, but just kept stalling and stalling.

We must do something about the quality of our health care in our hospitals. There are too few nurses, and the system of rotating them means that they do not observe the changes in a patient from day to day. Who is in charge? The doctor who runs in for a few minutes in the morning? He or she may not even be the doctor



who did the surgery. Patients are supposed to bring their own advocates but can they be there every day every minute? Isn't that the job of the hospital?

When mistakes are made hospitals need to tell the truth. Please don't tell me that my husband's surgery was successful. What is happening in our hospitals is the fault of the hospitals and the doctors who commit the errors. The public must be told about what is happening in our hospitals.

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*At birth, Tony was given
only 24 hours to live...*



TONY JOHN SABIA

Berry Werth wrote a 370 page book called *Damages*. This book is about the Sabia Malpractice case, the story of what happened to my son Tony – and our family.

My wife Donna went into labor on April 1, 1984. We were expecting healthy twin boys, Michael James Sabia was still born and Tony John Sabia (Little Tony) was barely clinging on to life. Little Tony was given only 24 hours to live, But he did live and now is severely disabled, unable to feed himself, speak, or let us know his needs. Something had gone very wrong. The doctors had known the boys were growing in utero at different rates, but they never considered that this was a high risk pregnancy or delivery.

We always believed that we should take care of Tony at home, and at the beginning it put a severe strain on our family emotionally and financially. I worked two jobs, day and night just to make ends meet, but still fell behind. Finally two years after he was born we contacted a lawyer about filing a medical malpractice lawsuit against the doctor and the hospital. We needed help! I worked so much I missed my kids growing up, my family, my wife, and some things you can never get back. Just think, a doctors lives with it 5 minutes, 5 days, 5 months, maybe even years, but a family... well it's for life.

It took nearly seven years to resolve this lawsuit, and during that time my family worked hard trying to make ends meet. It didn't work, we just sank deeper and deeper into debt. I saw first hand the big institutions that we were up against. Knowing each of them would fight to protect their own turf. Little Tony didn't seem to matter to these people, not any of the doctors or the insurance companies. Each postured and threatened in order to serve their own needs, and not the needs of my family.

At the beginning I wanted justice! I wanted some kind of acknowledgement that the hospital, doctors, and nurses had screwed up. Instead my family had to settle without that acknowledgement. But financial settlement has eased our burden. If any of those people involved, hospital, doctor, nurse, etc.... had to walk in our shoes for one week they would understand that it isn't about the money, it was about survival for my family!! Some of the institutions stated "Why should we pay, when he's going to die anyway!" Needless to say Little Tony has had 8 major surgeries in his life and has survived. This does not include the numerous Emergency room and hospitalizations he's had during his life. On April 1, 2005, Tony will be 21 years old. What a big difference from only 24 hours to live.

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I want my life back.



MARILYN JASMIN

My husband died of a massive coronary when he was just 41 years old. Our youngest had turned two and I had no idea how I would raise our five children. But I was fortunate and found another wonderful man – we have been married now for thirty years and he helped me raise the children. They are smart and good people. We have a close warm family; nineteen grandchildren-and they all live in CT.

But what happened to me in May 2002 has changed everything. I am an insulin dependent diabetic and I needed back surgery. The surgeon did an excellent job and everything was fine but he had to go

out of town just after the operation. Three days later I was shipped to a nursing home for recovery, a little bit earlier than planned because the hospital was crowded.

He says he gave orders to give me antibiotics to prevent infection but the nursing home says that they never got those orders.

Six days after the operation I woke up screaming in pain and was ambulated back to the hospital. When the surgeon saw me, I was immediately taken into surgery and filleted like a fish. He scraped and scraped to get the infection out.

Thirty years of savings are now gone and my poor, dear husband, at 74 has gone back to work. Our lives have been turned upside down and I am in pain all the time. Since that day I was returned to the hospital, I have never walked unaided. And now, because of the massive dosages of antibiotics I had to take, I have other medical complications. Now I take prednisone and percocet for the pain. I fall and need a wheelchair.

I can't turn off the pain.

I can't turn off the money problems.

I wish you could have seen me when I was younger. I am so ashamed of how I look now. The steroids have added 60 pounds and it makes it even harder to get around. I wish you could have seen my house when I could clean. I wish you could have seen the garden. I want my life back.

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*I continue to
be haunted by
my experience.*

I am a victim of incompetent and negligent anesthesia during my Caesarean on March 9, 2003. The anesthesia team consisted of an MD and a Certified Registered Nurse Anesthetist (CRNA) who failed to diagnose inadequate spinal anesthesia. I did my best to convince the nurse anesthetist who was sitting next to me that I was in pain and that the right side of my abdomen was not numb.

At first she told me that I was just feeling pressure. I persisted with my complaints and she suggested that I breathe through it. I was paralyzed with fear and pain as she dismissed my complaints. As my surgery progressed I said that the anesthesia was wearing off but was ignored.

In the recovery room, I told the CRNA that I could feel my feet. She saw me move them, too. She continued to dismiss my complaints. In addition to suffering incomplete anesthesia during surgery, I had to wait for pain medication after surgery because the anesthesia team failed to place an order for the proper medication, Demerol, until after I arrived in the recovery room. Before surgery I informed the MD that Morphine did not work for me and that I required something else. They failed to place the order before surgery and then had great difficulty locating the Demerol in the building. Throughout ordeal, no one asked about my comfort.



Denise Heinen

When I told the OB about my experience, he too dismissed my complaint. I wrote a letter to the hospital administration and they told me that no one perceived my pain. I filed complaints with the DPH and they chose to do nothing.

"Current anesthesia standards were met," they all said. But current standards do not require anesthetists to

assess and record pain as a vital sign at the same interval as pulse and blood pressure. Solution: Change the standard!

I continue to be haunted by my experience. I now suffer from serious tremors. How could two people, the MD and CRNA, disregard my pleas when their very job is the alleviation of pain?

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My faith and trust in physicians have all but disappeared.

The dictionary defines "frivolous" as "lacking in seriousness, without importance." This is my experience with a "frivolous" malpractice incident in the hands of "healthcare professionals."

It was supposed to be a relatively simple out-patient procedure, and I was assured I'd be home in two hours. I entered the hospital for the placement of a "central Line" necessary for IV antibiotics for the treatment of advanced Lyme disease.

The line, inserted by a radiologist, caused me excruciating pain immediately. I screamed. The line had been forced out of my vein, hitting nerves. He continued threading the line through my upper arm, despite my repeated screams. I began to lose feeling in my hand. The doctor removed the first line and inserted a second, this time supposedly correctly. But when I tried to move my arm it flopped lifelessly on the table. I feared I was paralyzed, as did the doctor, who then removed the second line as well. I was suddenly left alone, in tremendous pain, and terrified.

In the recovery room the nurses quickly assessed that I was injured, and ignored me. Eight hours passed. They gave me nothing for pain although I asked repeatedly. I wasn't allowed to make or receive phone calls. I left the hospital, relieved to be going home to seek help. But I was leaving with permanent nerve damage in my hand and a blood clot forming in my chest. I am alive today only because the clot was large enough to lodge inches from my heart, averting a pulmonary embolism.

The only follow-up by the hospital were the efforts to protect itself.

Getting medical help for my injuries turned out to be as painful emotionally as it was physically. For two years, I persevered, seeing 18 specialists. Seventeen wanted nothing to do with me because of the cause of my injuries. Only one tried to help. The doctor who injured me was paid \$5,000.

Six months later I had to go through the same procedure and was petrified. At that time the clot was discovered. I was told that it was "stable." Ten months later I was told to go to the intensive care unit "for the weekend" to dissolve the clot." But another doctor advised me that the risks were too great. I had had a close enough brush with death. So my "stable" clot remains.

When I asked my HMO for an "explanation of benefits" for this "error" and its consequences, it was 49 pages long.



Jeanne Konecny

The financial cost to my HMO? A total of \$28,506 – all caused by a doctor who was never held accountable.

But even more serious than the cost was the falsification of my hospital records. Almost all of the specialists whitewashed the rest of my records. I had a case, but hiring the 6 medical experts to support it proved too costly. So "frivolous lawsuits" sounds more like an oxymoron to me than the reality of medical "errors."

My faith and trust in physicians have all but disappeared. "Do no harm?" Injuries happen and no one is held accountable, no one is responsible, and seemingly no one has a conscience. This has changed me for the rest of my life. My pain reminds me every day.

CT Center for Patient Safety

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Quality Healthcare is a Right

Her death has never been explained and many questions remain.



Mary Ann Piccolo

No one will listen. I cannot understand why doctors either promised to get experts and specialists and then didn't, nor can I understand why all of the institutions we dealt with were asked to test and treat this woman carefully because of her retardation and then didn't. No one seems to care that I believe my little sister didn't need to die. She died on September 15, 2001 of pneumonia and why she died has never been explained to me.

Mary Ann required special care. She was just six years old when it was confirmed that she was mentally retarded and that was in 1962. While she suffered two epileptic seizures as a child, Phenobarbital was highly effective in treating her. She had only two seizures in 15 years.

My mother and I became very concerned when Mary Ann's behavior changed. She had hot flashes, vomiting, and was sometimes disoriented. Something was going on and we wanted to know what it was. We notified and inquired at the DSS, the DMR and two hospitals for guidance. We were ignored. Even her caseworker ignored us. On June 11, 2001 she began to rock her head back and forth and slipped into a coma. Three months later she died.

The two doctors who treated her told the state of Connecticut Department of Public Health that a seizure had caused her pneumonia. We asked for an investigation. But we were kept in the dark. No doctor spoke with us after her death and the funeral director, stranded in Florida due to 9/11 had her embalmed even though I told him I was consulting with an attorney because I had many questions.

Her death has never been explained and many questions remain. I am as angry at the bureaucratic indifference to her death as I am to the poor care she received. Was it because she was retarded? We were her advocates but even then it didn't help save her life.

I am devoting my life to trying to expose the flaws in our healthcare system. Something must change.

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My name is Benita Toussaint.

I am a mother of four whose life was turned upside down in 1988. My problems began when I was pregnant with another child. My water broke in the fifth month of the pregnancy and I was admitted to the hospital. By the following day I was running a high fever and the doctor said I would have to be induced. My labor was induced by an untrained intern. The baby died and the placenta would not come out. The doctor punched and punched my stomach and finally put me under.

After that I could not hold a pregnancy. I had two more pregnancies and the last of the three was in 1991. This time, the physician mistakenly tied my left ovary and Fallopian tube to a stomach wall. Afterward the pain I experienced for the next 13 years was enormous.

Because of the continuing pain, I was told to go see an orthopedic surgeon. He referred me to a psychiatrist. No one would listen to me about the pain. In our healthcare world, you just keep getting handed off to yet another doctor who won't listen and answer questions.

Finally this past year, 2003, fifteen years after my initial problem began, I was told that the nerve root had grown together and my left ovary and fallopian tube were creating the pain I had been experiencing all these years. In March 2004, another doctor found the harm that had been done to me and had made me so ill. But I still suffer pain and anguish.

How could people so profoundly harm another individual under the guise of care?

How could people so profoundly harm another individual under the guise of care?



Benita Toussaint II

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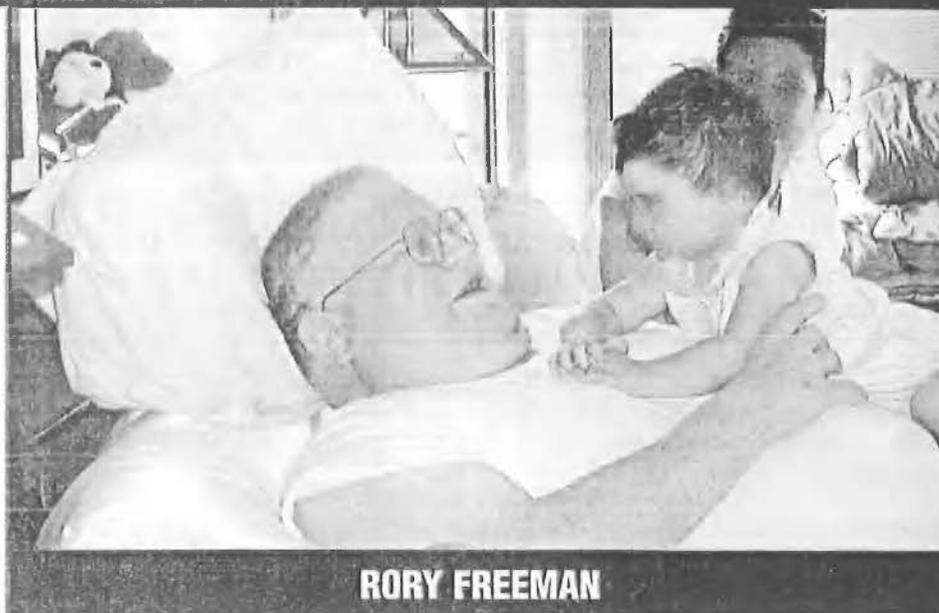
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Quality Healthcare is a Right

"When malpractice occurs it is just the beginning"



RORY FREEMAN

I have always been a fighter and so has my husband, Rory. I have even thought about going to law school to be a more effective advocate and somehow try to do something to change the system.

This all began over 10 years ago when Rory was just 37 and our kids were eight and three. Rory slipped and fell on his back. This began our odyssey through the healthcare industry. Let me be clear. We have had some wonderful physicians to whom we will always be grateful. But we have had incompetent doctors whose arrogance has led to flawed decisions.

Briefly put, a neurosurgeon performed the wrong type of operation, operated on the wrong spinal levels and failed to relieve spinal cord compression and further injured an already injured spinal cord. As a result Rory suffered paralysis, bowel dysfunction, bladder dysfunction, intra operative brain damage, multiple strokes and short term memory loss. Excruciating and disabling pain has led to depression.

As awful as that sounds, it does not really convey the depth and breadth of this experience for our family. Rory is confined to a hospital bed most of the time and that wonderful mind of his, which had a photographic memory, now has cognitive short term memory problems. And our children have grown up not being able to camp or hike or do all those wonderful things kids do with their father.

What I have learned;

- When malpractice occurs it is just the beginning. Because of that error, bad things just keep happening. Rory gets pneumonia about twice a year now. When he has been in rehab or the hospital he sometimes gets staph infections which continue to weaken him. A staph infection that was introduced to his system during his original surgery, continues to recur from time to time, and smaller insults to his system often have grave consequences.
- When one thing goes wrong a hundred things go wrong. You can only do what you can do. Problems continually crop up and We both work to solve them one problem at a time.
- There is no normal - only what has become normal to us. We now have a severely limited access, as individuals and as a couple and as a family, to the texture and diversity that life has to offer.

What we have lost is priceless. Yet it is grossly unfair to place a restriction on our right to justice and recovery in the face of this profound loss. Victims' full access to the courts must be preserved. And every effort must be made to reduce situations of malpractice in the first place.

— Lisa Freeman

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Quality Healthcare is a Right

*She is a prisoner in her own body.
There is no escape.*



Jennifer Manganello

My daughter Jennifer became significantly disabled following a spinal fusion four years ago. Because her case is still in litigation, I cannot discuss the details of the surgery. She was fifteen years old at the time.

As a result of the surgery she is primarily wheelchair bound and has very little endurance.

Secondary to the nerve damage along the thoracic and lumbar region of the spine, she suffers from a neurogenic bladder, chronic and recurrent urinary infections and reflux from high pressure into the kidneys. Complications have intensified and she was recently diagnosed with end-stage kidney disease. She now requires regular kidney dialysis to stay alive.

Since her original surgery, she has had many hospital stays.

One was for suicidal depression. She is a prisoner in her own body. There is no escape.

Never to run again, work after school, never mind attending school on a regular basis. Who can put a value on that?

She cannot work and cannot live independently. Who will care for her in the years to come?

It is wrong to try to solve this problem of medical malpractice rates by limiting patients' rights. Jennifer's non-economic damages may make the difference between a future with some quality of life and one of a dismal existence in a tax-supported care setting.

Susan Manganello

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Quality Healthcare is a Right

Elizabeth, Patrick, and Mary Ellen Ladd celebrate Peter's first birthday.



"...how disability impacts quality of life."

Our son Peter is 2 years old. He has cerebral palsy, a seizure disorder and a gastrostomy tube in his stomach because of feeding difficulties. He is still unable to roll over, sit, or hold on to objects. He needs adaptive equipment including very expensive feeding chairs, strollers and standers. For tube feeding, Peter requires special medical equipment and a nutritional supplement that costs almost \$200/month. Most of these supplies are not covered by insurance.

We believe that his birth injuries were caused by the negligence of the two doctors who were involved in his delivery. Obvious warning signs were ignored and, as a result, Peter has a lifelong disability.

Doctors are calling for caps on non-economic or "pain and suffering" damages. They say that \$250,000 is enough to compensate Peter for a lifetime of limited abilities and extraordinary challenges. They say that a cap is fair because injured patients will still be paid for economic losses like medical expenses. Well, capping non-economic losses is severely limiting and discriminatory to children (as well as to many women and the elderly) because children are not wage earners.

Non-economic losses are not just about transient or recurrent pain and suffering. They are about compensation

for *permanent disability* and how *disability impacts a person's quality of life*. And they are about *accountability for negligence*.

Everyone needs to pay attention to what caps really mean to the thousands of people out there who are going to be the victims of medical malpractice in the years ahead. If they could visit our home and see what life after medical malpractice is really like they would never accept a future in which their recovery for "pain and suffering" – lifelong disability - would be limited to \$250,000.

We need to continue to make negligent doctors accountable for their actions. Hospitals and doctors must enact the kinds of system reforms that have been shown to prevent medical error. 5% of doctors nationwide commit over half of all malpractice. Why are they still practicing?

Legislators must act – not to limit victims' rights, but to require the medical community to reduce medical error.

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Quality Healthcare is a Right

"My father went in for a routine surgery... eleven days later he was dead."



Rudolph A. Passero, Jr.

It's called Polycythemia Vera, the Mediterranean sickle cell disease, an over-abundance of red blood cells. But that's not what killed my father. What killed him was bad medicine and careless decision-making. Based on the recommendation of his primary physician and his urologist, my father went in for a routine surgery to remove his prostate. Eleven torturous days later he was dead.

My Dad's name was Rudolph Anthony Passero, Jr., or Rudy for short. He had been a dentist in Norwalk for many years, and was an important part of the community. He always participated enthusiastically in the many events in which my brother and I were involved. We miss him very much.

At a pre-operation appointment, he informed his urologist that he had Polycythemia Vera and wanted to know if that effected surgical procedures. The physician insisted that it didn't matter; no special measures needed to be taken.

But it did matter. Soon after the first surgery, it became clear that there was a lot of bleeding. The blood of people with PCV doesn't clot like normal people but the doctors didn't take this into consideration, even as he continued to bleed internally. My father's stomach was badly distended. Strapped to a hospital bed in the recovery room, he repeatedly told my brother and mother that he felt he was not getting enough oxygen.

Over the course of two days and two additional exploratory

surgeries, his problems grew and his health deteriorated rapidly. The doctors knew that there was bleeding but not the extent. He was put into intensive care and on a respirator and lingered in a confused and irritated, drug induced state. Whisked off to a quiet floor in the hospital, my mother, brother or I was by his bedside for more than a week. We were repeatedly urged to take him home, even though he could hardly get out of bed with assistance. On a beautiful summer Sunday, he died of a pulmonary embolism, a large blood clot, ironically, that the doctors say dislodged itself from his leg.

Standard procedure, prior to surgery, for anyone with Polycythemia is to perform a course of blood work over several weeks to prepare the patient's blood to handle the trauma of surgery. A family friend found this information on an internet web site and sent it to us. Sadly it arrived after my dad had died. No one, not his primary physician, surgeon, nor the hospital, has ever explained what happened.

I want to see change in the system. I would like to see mandatory continuing physician education and evaluation to ensure that the pre-operative procedures that might have saved my father's life are known and practiced. Computerized data bases of patients and their conditions, medications and standard courses of care might also be a positive step to improving outcomes.

Most importantly, I want to see accountability. A readily accessible, up-to-date database of doctors and their history of patient care including malpractice settlements, jury awards and actions would help patients make more informed decisions about their health care providers. Doctors with previous settlements or actions, according to the research submitted to the CT General Assembly, often have multiple infractions. This information may have helped our family to be more informed consumers of our health care services instead of blindly trusting the opinions of our doctors who apparently did not do their homework. The medical establishment has waited long enough to institute change. Now it is time to legislate it.

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Quality Healthcare is a Right

It seems that the way to reduce the cost of malpractice is to stop tragic injuries like hers from happening in the first place.



Katty Chavarria

*she is a bright little girl
trapped in a body that
won't work for her.*

Katherine, we call her Katty, was born almost five years ago on January 1, 1999. She was our first child and my husband rushed me to the emergency room when I went into labor. I had been diagnosed with a separation of the placenta, bleeding and indications of fetal distress when I was eight months pregnant. But the obstetrical staff gave me a labor-inducing drug, pitocin, and delayed performing a caesarean section. My baby suffered severe oxygen deprivation with resulting brain damage and cerebral palsy.

Katty was in intensive care for two months and has already had two surgeries. She has serious reflux problem and has to be suctioned frequently. She'll never be able to eat-she has what they call a G tube for eating. I can't just leave her because I never know what she might need and I am the one who knows how to do it.

But she is a bright little girl trapped in a body that won't work for her. She gets very frustrated and cries and carries on. But she is smart. We can see her mind working and she has had enough body control to begin to learn how to sign. She can "sign" daddy, hungry, apple, goodbye. I was told she would probably just lie on the floor for most of her life. But that's not true. She is smart and she follows a lot of what is going on around her. She is amazing. She will never be able to cross a street, write her name or live a normal life. But she is still amazing.

Katty faces a lifetime of extraordinary challenges because of her reduced capabilities. Restricting a jury from compensating Katty for the way her life was changed is wrong. It seems that the way to reduce the cost of malpractice is to stop tragic injuries like hers from happening in the first place.

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Quality Healthcare is a Right

I was told it was minor surgery and I would be bringing her home in an hour.



Sadie Cole



My wife Sadie was 36 years old when she went to the hospital to have her tubes tied. I was told it was minor surgery and I would be bringing her home in an hour. It turns out, Sadie had monitors on during the surgery but nobody was paying attention to her blood pressure which had dropped dangerously and damagingly low. Now she is in a coma. And has been in this persistent vegetative state since July 1998.

This should not have happened. Two summers ago the same anesthesiologist was negligent in another case; yet another woman in a coma. The Department of Public Health has concluded that he suffers "from a psychiatric or neurological illness that disables him." But if everyone had paid attention, this physician would never have been allowed to practice unsupervised. Earlier in his career, he had passed out during surgery. He moved to another state, and practiced with supervision. And then he returned to CT. Didn't the hospital check? Didn't the practice he joined

look into his background? Surely nurses and other physicians had noticed he had problems.

Yet no one spoke up. Five percent of the doctors are responsible for over 50 percent of malpractice payouts. CT's Medical Examining Board ranks 40th in the country in getting rid of bad doctors. Their silence is profoundly dangerous.

My family found out tragically that the medical profession is silent about its own problems. And they are silent when a tragedy happens to us. This is a broken system.

I go see my wife everyday and our children visit her often. We hope that someday she will wake up.

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Quality Healthcare is a Right

Matthew Gersz

On January 16, 2001 our family was devastated by the loss of our beautiful son, Matthew David Gersz, at the age of 22. Matt was our first born son and the first grandchild on both sides of the family. You can imagine the joy he brought into all of our lives. From the beginning, he had that cheshire-cat grin and that gleam in his eyes. He always loved joking around, making others laugh and teasing his brother, Peter. He loved all sports and was a good athlete himself. He was a kind, thoughtful, and loyal friend and he had many, from all walks of life. He had a girlfriend, Heather, who he loved dearly, and when he wasn't with her in Boston, he loved family gatherings, going to the movies, fishing, and his favorite activity—going out to eat.

Things began to change for Matt, when at the age of 19, he was in a serious car accident. He was hit broadside by a drunk driver, who left the scene on foot. Matt's injuries were life threatening and he was hospitalized for 13 days. We were overjoyed when Matt fully recovered and he returned to work a few months later. Later that year we noticed changes in Matt. This is when he began seeing Dr. Khu. Matt was given huge amounts of narcotics and controlled substances for scoliosis, a condition that wasn't an issue for Matt. We had no idea he could be prescribed the amounts given, especially since he had no condition to warrant their use. Confidentiality

laws prevented us from obtaining his medical treatment. Family concerns and pleas with Dr. Khu to stop prescribing, were ignored.

Matthew saw Dr. Khu on Jan. 16, 2001, the day of his death, and was given 4 prescriptions, 2 of them post-dated. Matthew died soon after at home. The doctor was charged with manslaughter, reckless endangerment, and post dating scripts. It was at this time that a complaint was filed with the Department of Public Health. We found the two and a half year ordeal with the DPH completely inadequate. We weren't notified of upcoming hearing dates, and when we arrived the hearing would begin late (unprepared lawyer) postponed, excused early and so on. I also provided the attorney with valuable printouts of actual prescriptions where Dr. Khu clearly exceeded recommended dosages on numerous occasions, of which this material was never presented. Most importantly, though, I was refused my request to make a statement. I thought it would be important to let the panel know that my son was perfectly healthy, and didn't require any medication, especially opiates. This past December the panel met with the board. A new committee member suggested the removal of his license. He was immediately shot down by a committee veteran who said, "taking away a doctors license is too draconian". The decision the board recommended was a permanent restriction on his license. He can no longer treat chronic pain patients. We were disappointed with this decision as it still puts the public at risk. On Jan 22, 2004 the courts had to do what DPH failed to do, and banned him from practicing for a year. Why the different outcome, when they had the same facts? The truth is the DPH only investigates 8% of complaints against physicians and health care facilities. They are there to protect the health of Connecticut residents. Instead they are putting the public at risk by failing to act promptly and appropriately against these egregious abuses.

I want to see our legislature demand changes. We need a professional, impartial staff to review the cases. We need to insist that physicians file adverse event reports as hospitals are required by law to do. Bad doctors should not be allowed to practice.

Although our family will never recover from the loss of someone so precious to us, it is my hope that these changes will have prevented other families from experiencing the grief we are enduring.

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QUALITY HEALTHCARE IS A RIGHT

Proposed Amendments to SB 1062 SB 1052
To allow
**Joint Negotiations by Non-Integrated Physicians and
Health Benefit Plans**
On behalf of the Connecticut State Medical Society
Gregory J. Pepe, Esq.
Neubert, Pepe & Montieth, P.C.

Before you today are many many proposals developed to assist Connecticut's physicians in making their medical liability premiums more affordable. Everyone agrees that in recent years the skyrocketing increases in costs that physicians are forced to pay have put Connecticut's health care system in a crisis situation. You will hear a number of people testify about how the crisis is adversely affecting large numbers of physicians who are unable to continue to practice at all or in a particular specialty, such as obstetrics, or continue to perform higher risk procedures because doing so will make the costs of obtaining coverage virtually impossible.

This crisis, coupled with virtually no increases, ... and in some instances, actual decreases, in physician's managed care reimbursements, has created the metaphorical "perfect storm" of catastrophes in Connecticut's medical community. This situation is in dire need of legislative solutions that go beyond our attempts at tort reform in order to address this unbalanced situation. Today I would like to offer comments regarding a proposal, ... **HB 6759 AAC Cooperative Healthcare Arrangements**... that has been before several committees over the past several years and this session has had two public hearings (one in the Insurance and Real Estate Committee and the other before the Labor and Public Employees Committees). HB 6759 was recently approved by the Labor and Public Health Committees and referred to this committee.

We have opened discussions with the Connecticut Attorney General towards securing the approval of such legislation and ask this committee to consider amending the final medical liability malpractice proposal with additional relief for doctors aimed at permitting balanced and fair negotiations with Managed Care Organizations. Such negotiations do not regularly occur in today's managed care environment, and are necessary to ensure that doctors and other health care providers receive fair and adequate reimbursement of exceptional costs that they incur while providing access to all manner of medical procedures for their patients.

Similar legislation has passed in at least two other State legislatures in recent years as part of those State's comprehensive approach to reform.

Let me take a moment to outline what HB 6759 would do and the impact it can have on giving the physicians the ability to fairly and with state oversight the ability to recoup the extreme costs of securing mandated coverage for medical liability coverage.

Federal law allows states to develop their own regulatory schemes in areas where the federal government has already developed a regulatory scheme, under a doctrine that is referred to as "state action. This bill applies that doctrine for the purpose of enabling collective negotiations by nominally competing physicians, of certain terms and conditions of a physician's provider contracts with health benefit plans.

The lack of meaningful bargaining power by non-integrated physicians has created a number of difficulties which threaten to curtail access to certain kinds of healthcare services, and compromise the quality of care received by Connecticut residents from their physicians. Some examples have been widely reported in medical journals ... radiologists are increasingly limiting annual mammograms, neurologists are restricting the types of high risk procedures they will undertake, and many OB/GYNs are restricting their practice to GYN and curtailing the delivery of babies ... all this in order to afford an adequate level of insurance coverage for some of the medical services they are trained to do, and want to provide to their patients.

Joint negotiation of the type being proposed in this bill will be permitted in instances where the state, acting through the office of the attorney general, either: (i) finds that a health plan has significant market power, enabling it to virtually dictate the terms of provider agreements to physicians or (ii) finds that negotiations on fee-related issues have been one-sided in favor of the health benefit plan or have not occurred due to the market power of the health benefit plan.

Definitions

For purposes of the Statute, a number of new statutory definitions are being proposed to both implement the purpose of the statute, and assist the State in the implementation of its purpose.

Role of the Attorney General

Any physicians or physician organizations seeking to negotiate the terms and conditions (including fees) with health benefit plans, in concert with or on behalf of more than one non-integrated physicians, shall need to comply with the following procedures;

- (a) File an application with the Attorney General's office which provides:
 - (i) The name and address of the negotiator;
 - (ii) The names and addresses of the physicians represented by the negotiator;
 - (iii) The relationship of the represented physicians to the total population of physician in a geographic area;
 - (iv) The health benefit plan with whom the representative intends to negotiate;
 - (v) The subject matter of the negotiations;
 - (vi) The anticipated impact of the negotiations;
 - (vii) The benefits both to the physicians and to their patients of the anticipated impact of the negotiations

(b) Within 45 days of the filing of an application, the Attorney General shall either (i) approve the filing and permit the requested negotiation; (ii) disapprove the filing as incomplete or deficient, in which case the applicant shall be permitted to re-file an application which corrects such deficiencies; or; (iii) disapprove the filings as not authorized pursuant to the statute, in which case the applicant shall not be permitted to re-file an application for (180) days.

Prohibited Actions

Group actions to boycott or cease services to a health benefit plan shall not be an action authorized under the statute.

Rule Promulgation

The Attorney General shall be authorized by the statute to implement such rules and procedures as are necessary or convenient to implement the provisions of the statute, including the filing of application fees.

Certain Joint Negotiations Authorized Without Need for Application to the

Attorney General – Negotiation by non-integrated physicians over certain terms and conditions of their provider agreements with health benefit plans are permitted under the statute, without the need to apply to the Attorney General; those terms include the following:

- (a) Practices and Procedures relating to preventive health care services;
- (b) Practices and Procedures related to Clinical Integration and disease management programs;
- (c) Clinical referral procedures;
- (d) Patient education programs;
- (e) Administrative procedures, including methods of claims submissions, credentialing procedures, and coding procedures;
- (f) Dispute resolution procedures;
- (g) Utilization Review programs;
- (h) Quality Programs;
- (i) Physician selection criteria and de-certification procedures, including the terms for inclusion in so-called “tiered networks”.

Thank you for your time and attention. On behalf of Connecticut’s physicians, I urge you to amend SB 1052 and consider this unique opportunity to help Connecticut’s physicians struggling under the weight of extreme increases in the costs they incur for medical liability coverage.

TESTIMONY OF
Christopher Hartley
Senior Vice President
Saint Francis Hospital and Medical Center
BEFORE THE
JUDICIARY COMMITTEE
Friday, April 8, 2005

SB 1052, An Act Concerning Medical Malpractice

SB 1364, An Act Concerning Reforms Related To Medical Malpractice Insurance

My name is Christopher Hartley, Senior Vice President of Saint Francis Hospital and Medical Center in Hartford, Connecticut. I appreciate the opportunity to testify on the subject of medical liability insurance reform.

Since 2000, Saint Francis Hospital and Medical Center's medical liability insurance costs have increased from \$3.2 million in 2000 to \$9.1 million in 2005 or an increase of 180.5% over these five years. Hence, the rapid increase in medical liability insurance premiums is not just a problem for physicians but is a significant economic problem for hospitals, employers and consumers as well.

More importantly, the current medical malpractice crisis is significantly reducing access to needed health care for many of the patients who use Saint Francis Hospital and Medical Center.

Let me now outline some of the ways the current medical malpractice crisis is reducing access to needed health care services:

- Saint Francis is finding that a significant number of its OB/GYN and family medicine physicians have been forced to curtail or eliminate the amount of prenatal and delivery room care they provide in response to the escalation of malpractice insurance premiums.
- Many of our physicians, particularly those in internal medicine, general surgery, neurology and orthopedic surgery, are finding it increasingly difficult to recruit new partners from out of state into their practices because of the perception that Connecticut is a state that has high malpractice premium costs and a legal environment unfriendly to physicians. This means many practices are being forced to wait more than a year for necessary physician partners. Such delays in recruitment create physician shortages that often result in longer wait times by patients for a wide variety of diagnostic services. The delay in receiving routine diagnostic care in turn extends the time that passes before appropriate treatment can begin for patients who are identified as needing further follow-up care.

- As a major teaching affiliate of the University of Connecticut School of Medicine, Saint Francis participates in the training of residents and fellows in a wide range of specialties including family medicine, internal medicine, general surgery, pediatrics, cardiology and hematology/oncology and orthopedic surgery. Saint Francis also operates its own independent residency and fellowship training programs in OB/GYN, dentistry and colorectal surgery. More and more of these excellent new physicians are having to locate outside of Connecticut given the high cost of obtaining medical malpractice insurance in this state. This problem has become even more acute since 2003 as this is when the American Medical Association (AMA) added Connecticut to its list of at least 20 states in a "full blown medical liability crisis".
- Many physicians with specialty training who currently cover our busy emergency department as part of a voluntary rotation system are seeking to reduce or eliminate their emergency room coverage or move to an outpatient-only practice mode to reduce the liability risk associated with hospital emergency department coverage. Particularly hard hit are specialties such as neurology, neurosurgery, orthopedic surgery and trauma surgery.

Saint Francis believes that our medical liability system requires the legislature to pass a combination of improvement measures this session that will promote predictability, efficiency, and fairness for all parties in medical malpractice litigation. While the bills being proposed to the legislature at this juncture contain many reform measures that could possibly improve Connecticut's litigation process, Saint Francis continues to believe that a reasonable cap on non-economic damage awards is a necessary component of any effective malpractice tort reform package. We also feel that this crisis is too real and apparent to delay a cap on non-economic damages for three years as proposed in SB1052.

I appreciate the substantial work and thought that legislators have devoted to this problem, and Saint Francis will continue to work with you in any way we can to address this important policy issue in a way that meets the interests of patient care.

Lastly, we recognize that all parties participating in this debate share the same goal: To preserve access to high quality health care for all citizens of Connecticut, and to make sure that the health care that is delivered in Connecticut is provided in a safe and cost-effective fashion.



M. JODI RELL
GOVERNOR

005817

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

**Testimony of Cristine A. Vogel, Commissioner
Office of Health Care Access
Before the Judiciary Committee
Friday, April 8, 2005**

Good afternoon, Senator McDonald and Representative Lawlor, and all Members of the Judiciary Committee. I am Cristine Vogel, the Commissioner of the Office of Health Care Access. I am here today to testify in support of S.B. 1052 "An Act Concerning Medical Malpractice." My testimony and concerns about medical malpractice insurance relate specifically to issues of access to care for our citizens.

The mission of the Office of Health Care Access is to ensure that all citizens in Connecticut have access to a quality health care delivery system. To that end, there exist some areas of weakness in our delivery system, if the issues of medical malpractice insurance remain unchanged. Most notably are the concerns that physicians will be leaving the Connecticut market and recruiting will become even more difficult than it is at present.

Some of my thoughts regarding access relate to not only the private physician practicing in the community, but to our hospitals. Some of the hospitals are experiencing difficulties and significant cost in recruiting medical staff. The reasons vary, but even without taking into consideration the medical malpractice expense, the on call schedule of specialists, the decreasing number of available physicians looking to relocate, and the quality of life issues facing younger physicians, all play a role in recruitment.

We have all heard of the concerns with the obstetricians retiring or limiting their scope of practice. There will be an impact to access for office obstetrical care during pregnancy, and also once arriving at the hospital for labor and delivery services. Our hospitals are the health care safety net and they may need to rethink how they continue delivering services to meet patient demand and maximize their resources, in order to preserve access.

Reducing the medical errors and improving patient safety will decrease the number of malpractice claims. All hospitals should have protocols and performance measures to address patient safety. Some hospitals are beginning to computerize more of their medical records, pharmacy programs, and operating room information. This will have a positive impact on the reduction of errors. Reducing errors and improving safety will improve patient satisfaction and improve the quality of care provided to our citizens.

I thank you for the opportunity to express my concerns regarding access, and if you have any questions, I would be pleased to answer them.

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Connecticut Section

Judiciary Committee

PUBLIC HEARING TESTIMONY

ON

Various Bills re: Medical Malpractice Insurance

Friday, April 7, 2005

Maryanne McDonnell, MD

SB1052

Senator McDonald, Representative Lawlor, members of the Judiciary Committee, my name is Maryanne McDonnell and I am the current chair of the CT section of the American College of Obstetrics and Gynecology. Members of the Judiciary Committee,

I am the current chair of the CT section of the American College of Obstetrics and Gynecology. I am also in private OBGYN practice in Manchester, CT. I would like to bring you up to date on how the ongoing professional liability insurance crisis continues to impact OB and their ability to provide complete women's health care services throughout the State.

I continue to hear of additional OBs who have left or who are planning to leave the State to practice elsewhere. One example of this is Dr. Brad Wolk who gave up his practice in Tolland after 12 years to move to another state. There also continue to be more doctors who give up obstetrics for a "GYN only" practice in order to save on insurance rates. I would like to give you a few examples of how OBGYNs are struggling to keep their doors open. First, in Greenwich, two OB practices merged so that three of the physicians could drop OB. This was done as a cost saving measure, which allowed for continued OB services, but there are now fewer OB doctors to take care of the same number of patients. Second, many of you are familiar with the OB group from Windham, CT that almost had to close their doors last January. This past year, in

order to avoid a repeat of that situation, the group has had to sell their practice. They also were forced to close an office, lay off employees, freeze remaining staff salaries and decrease pension contributions. All of this was done to insure that they would continue to have insurance coverage. Third, is the experience of my own group. Last year GE Medical Protective insured us. As many of you are aware, the Company proposed a 90% increase in their rates for 2005. For our group, this would have meant that our insurance would cost approximately \$180,000 per MD for the year. At the time we had to give serious consideration to three out of our six doctors giving up OB. If this had happened, we would have had to arrange cross coverage with other OBs in the community in order to continue to provide obstetrical services to our patients. Fortunately, we were able to secure a policy with another insurance company that allowed us to go through a risk management evaluation and set our rate based on that favorable evaluation at approximately \$100,000 per MD. This allowed us to afford coverage for the group with only one of the doctors going to GYN only. As these examples illustrate, aside from the increase in the size of the premiums, there is also the uncertainty of not knowing if your current insurance plan will even be available from one year to the next.

As OBs in practice continue to face these issues, there is also strain placed on the field for new OBGYNs. My colleagues in academic medicine continue to report that they see fewer medical students choosing OBGYN as a specialty. They have a more difficult time filling OBGYN residency slots with top candidates. And, fewer OBGYN residents choose to stay in CT upon completion of their training. In the long run, this could be the most devastating impact of the current crisis.

As you evaluate the legislation that is before you, I ask that you consider each item for its ability to control cost and stabilize the available insurance market. To pass legislation that neither provides true reform nor is proven to have an impact on the problem would be a disservice to our community. The proposed legislation that is now before you does contain many necessary changes to our current tort system. However, I am not sure they would be sufficient to have any significant impact on the current crisis. In addition to the changes contained in this current bill, consideration should also be given to: a pretrial screening panel (that is both mandatory and discoverable), allow for the disclosure at a trial of any other settlements the plaintiff may have accepted from other sources for a particular injury, and consideration of a

separate medical court system to adjudicate medical malpractice cases. If effective reform measures are passed, then it would allow OBGYNs to again have patient care as their only focus, compared with having to spend so much time wondering if they will be able to provide women's health care services from one year to the next. Thank you for your time.

SB1052

The following is testimony I would like to give regarding the malpractice crisis.

My name is Marc Storch. I live in Westport, Connecticut. I have been practicing OBGYN for 32 years and have delivered 8,000 babies. I stopped OB last year finding it unprofitable to pay the \$150,000 malpractice premium. Eight OB's have stopped in our area over the last few years. My profession is sinking fast. Quality of care is declining.

Action must be taken now:

1. Hopefully medical courts would decrease the 6-7 year wait to trial.
2. Caps or a schedule of injury (i.e. woman's comp) would hopefully cut down on outrageous awards-\$100,000,000 awards
3. Limits on malpractice lawyer's fees. Some firms collecting outrageous fees (i.e. 50% of \$10 million awards and up).
4. More oversight of HMO companies, some CEOs have become billionaires and their companies recording record profits.
5. Yes, more oversight of doctors to cut down on medical errors.
6. 95% increase in malpractice premiums this year for one of the malpractice companies in Connecticut.

Action must be taken now. Please help save my profession

STATEMENT OF
FITZHUGH C. PANNILL III
BEFORE THE JUDICIARY COMMITTEE
CONNECTICUT GENERAL ASSEMBLY

APRIL 8, 2005

Good Afternoon.

SB 1052

I am Doctor Fitzhugh Pannill, a Fellow of the American College of Physicians and a member of the Connecticut State Medical Society. I greatly appreciate the opportunity to speak to you today and thank you.

I graduated from Johns Hopkins, trained in general internal medicine and geriatrics and have been in practice with Southbury Medical Associates since I left the Yale Faculty in 1997. Our practice has served the Southbury community since 1978, taking care of people ages 18 to 103, in the office, hospital, nursing homes and at home.

I am here representing myself, and my partners, but most importantly, I am representing my patients, who tell me daily that they would be lost if I left practice. They turn to me for advice on all aspects of their medical lives from what to do about a child who drinks too much, how to handle their aging parents in New Jersey, and whether they should buy medications from Canada. After seeing a specialist, they see me, because they didn't have enough time to get all their questions answered and didn't understand the answers they did get. I am the only physician who sees them in the hospital every day, calls them when they are at Yale or U Conn, follows them from nursing home to assisted living facility and sees them at home if they can't get into the office.

While I used to think the hardest part of medicine was knowing the right test, drug or diagnosis, I have found the hardest part of medical practice in 21st century Connecticut is our daily struggle to pay the staff, collect the bills from insurers and Medicare and pay our rapidly increasing malpractice insurance bill.

Malpractice insurance cost me \$3400 a year when I left Yale. When our rates rose to \$20,000 each in 2002, we had to switch to one of the only two other available carriers.

Last year we each paid \$15,000 (despite no claims or suits), and our rates have doubled in two years. Overhead and staff salaries costs consume 65% of our revenues: malpractice insurance accounts for more than six percent of overhead and close to 15 percent of my take home pay. If our insurance costs continue to double every year, as they have, we

will soon pay \$40,000, over 20 per cent of our overhead. Some internists already pay \$30,000.

While we pay rates similar to many specialists, they have far more revenue from procedures and surgery.

Unfortunately, we not do procedures or fancy tests except throat cultures and EKGs. Medicare and the HMOs have fixed our rates and do not increase them as insurance costs rise.

The only way we can increase our revenues is to see more patients. As we refuse to shorten our appointment times, and have a hard time working more hours, the revenues of our practice have been stagnant.

It's no surprise that more and more students and residents are becoming ophthalmologists and orthopedists. Many who choose primary care move to other states with similar reimbursements but far lower malpractice costs.

It is a shame, because the practice of primary care internal medicine with patients who you know and befriend for years is the most satisfying career I can imagine or recommend to you, your children or mine or anyone else. I have been privileged as few other professionals could have been, to be a part of patients' lives and to make a difference.

Yet, if there is no control of these rapid increases in malpractice insurance costs, I, and other general internists will be forced to quit practice or work for an institution.

I hope you can find a fair and equitable solution to this crisis that will allow primary care physicians to continue caring for their patients and stay in practice. I thank you for your time, and my patients will thank you for finding a solution.

Fitzhugh C. Pannill III, M.D., F.A.C.P.
Southbury Medical Associates
22 Old Waterbury Road
Suite 201
Southbury CT 06488

Testimony of John Fleming; April 8, 2005 Judiciary Committee

SB105a

Members of the Committee

I am, by training, a Physician Assistant. I am not myself a victim of medical malpractice. But I am here because my sister-in-law died unnecessarily in the hands of our healthcare system. Because of my professional background I was in a unique position to research the circumstances surrounding her death. My brother sued and won his case.

In addition to representing my brother's experience, I am here as a practitioner. I see first hand what happens in our hospitals. Some mistakes happen through no one's fault. In some circumstances there are bad outcomes because the risks are high. But there are bad doctors and bad systems causing untold injuries and deaths every day.

Within the medical community people learn to look the other way. They learn stay away from certain physicians and avoid particular hospitals for certain procedures.

A few years ago a well-known New York surgeon was involved in a car accident and taken by ambulance to a hospital that had no trauma team. Knowing he was in trouble, he demanded to be taken to another hospital. He suspected that his spleen was ruptured and he knew that without immediate intervention he would die. Emergency room staff paged the doctor on call who was out on Long Island Sound. They said he would be "right in."

The injured surgeon's continued pleas were met with silence. He bled to death just as the on-call physician was finally preparing for surgery. Hospitals have a term for injuries and deaths resulting from error - "adverse events." This was probably not even considered an adverse event.

Doctors are asking you to limit what their patients can collect in damages when they injure them. They are demanding limits on patients' rights without demanding, from their own profession, the delivery of a quality product - good and safe healthcare. Victims are not the cause of malpractice costs. Malpractice is the cause. Reduce the malpractice and the costs will go down.

Dr Lucian Leape from Harvard is one of our country's leading experts on quality of care and safety for patients. He says that the medical societies need to understand that doctors are like the rest of us. Ten percent are alcoholics or addicts, one percent is psychotic and the rest can at any time be going through a divorce, losing a spouse or seeing a parent or even a child die. All potential contributors to conduct that for most people may impact only them. But doctors' conduct, individually and collectively, impacts us all.

The medical community and legislatures can act now to protect the citizens entrusted to them. Much can be done. Medical journals are filled with articles on changing systems, establishing standards, requiring continuing education, meaningful peer review, drastically changing the procedures of the medical examining boards and providing help for doctors and nurses who face the life problems we all face.

I urge the you and your fellow legislators to really confront the problems behind the high premiums - the fallibility and complexity of our healthcare delivery system which seems to be working at cross purposes with its mission - to first do no harm.

□

April 8, 2005 Judiciary Committee

SB 1052

My name is Elizabeth Reed and I'm honored to be here to speak on behalf of those who have died as a result of avoidable medical error; those who can no longer speak, but who desperately need to be heard. My husband died tragically twelve years ago at the age of 47, leaving behind myself and two young sons. His death was due to medical malpractice.

When a patient dies due to medical error, the consequences of the death are devastating to the entire family. Child psychologists agree that children who lose a parent grieve repeatedly as they revisit the loss at different stages of development. I have seen that happen to our children who are now 19 and 21. The spouse also revisits the grief throughout the remainder of his or her life, regardless of whether they remarry. The loss is life defining and hugely traumatic. The medical community and healthcare industry does not want to talk about these consequences.

Rather, they collectively refer to what happened to my husband as an "adverse event". This insensitive terminology is yet another indication of the refusal of healthcare leaders to accept accountability and responsibility for these tragic and avoidable deaths.

The medical malpractice bills before you today do not deal with the malpractice itself but with what happens after that malpractice and there is a lawsuit against the practitioner or the hospital.. These bills do not choose to address vitally important changes that need to occur in order to avoid more such unnecessary tragedies. Very simply put, a shocking lack of communication caused my husband's death. In addition, various specialists felt *no moral obligation* to speak with my husband or me when a disagreement occurred regarding his treatment. One arrogant specialist was allowed to directly cause his death and not one other specialist dared to speak up in spite of the fact that they disagreed with him. Very simply put, my husband and I both were deliberately misled and also made to feel very foolish when questioning some of the decisions being made. It's unforgivable.

Ironically, we had the **most extensive insurance coverage available**. Thus, the doctors involved did not need to be concerned as to whether the hospital would be fully paid for running extensive tests. But the tests were not run and my husband died.

Our hospitals and medical societies have now had years to deal with the problems of preventable deaths such as the one I have just described.

They have failed miserably.

The United Kingdom has moved to a system of computerized patient entry. If our Connecticut hospitals had made use of that kind of technology twelve years ago, my husband would have had a much better chance of being alive today. It is appalling to find that we still do not even have computerized prescription entry. I find myself wondering why it is that so little accountability is asked of our hospitals and doctors when so very much is at stake.

Article after article in medical journals and in our national press and on television have documented the simple steps that must be taken in order to avoid the most obvious of the preventable deaths that occur in our hospitals or after patients are released. And they have also documented the system changes that must happen to decrease the numbers of those deaths. I know that it is too late for my husband, myself, and our children. Yet, I ask you to make these significant changes happen now so that others do not have to die so tragically and unnecessarily.

I am speaking up in memory of my husband and my children's wonderful father. I do not want him to have died in vain.

005826

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SB1052

Those who oppose reform of the medical tort system use as justification The Institute of Medicine's report that 44,000 to 98,000 accidental deaths due to medical errors occur each year in our U.S hospitals. That data was extrapolated from two large studies: one conducted in Colorado and Utah by the Utah-Colorado Medical Practice Study and the other in New York by the Harvard Medical Practice Study. Those who opposed reform of the medical legal system use this data to promote themselves as champions of patient safety and as vindication for what they feel is the solution to the problem-more litigation and higher awards. The tort system is not a solution and falls far short of its intended goal which is to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice.

The group of researchers at the Harvard School of Public Health, led by Troyen Brennan, Lucien Leape and others, has contributed greatly to our understanding of medical errors and medical malpractice. Through their research of malpractice claims and injuries in New York, they discovered that only 2% of negligent injuries resulted in claims and only 17 percent of claims appeared to result from negligence. Their group compared this to a policeman who regularly gives out tickets to those who go through green lights and ignore those who go through red lights. On the whole, deterrence of medical negligence by the tort system is characterized as limited at best and may have negative consequences such as physicians avoiding high risk specialties like obstetrics, ordering excessive tests, retiring early or avoiding high risk procedures.

The system is far too costly. On average the administrative cost and legal cost take up 60% of the insurance premium dollar leaving only 40% for the patient. Contrast that to workman's compensation where 30% of the premiums go to administrative and legal expenses and 70% goes to the patient. The tort system is far too slow with the average claim taking 30 months to resolve. The tort system does not promote safety. In fact, there is a conflict of cultures between the safety movement which is a nonpunitive, systems oriented, cooperative strategy and the punitive, individualistic, adversarial approach of tort law. There is a better way.

My suggestion for solution to the badly broken medical litigation system is the Institutes of Medicine's proposal: Patient-Centered and Safety Focused, Nonjudicial Compensation. A specific characteristic of this system is the replacement of tort liability with an alternate no-fault system [under most circumstances] that would replace the determination of negligence with the determination of avoidability. The standard of avoidability is more permissive than that of negligence. This system would create an atmosphere of transparency where medical errors could be openly shared between institutions without fear of recrimination. The state could implement one of three options on a demonstration basis:

[1] Early Disclosure and Compensation-The State would provide health care providers with immunity from lawsuits [under most circumstances], if a timely offer was made to compensate an injured party with full payment for economic damages and a scheduled payment for pain and suffering.

[2]Administrative Determination of Compensation- The State would set up classes of avoidable injuries and establish an administrative board to resolve claims related to those injuries. The board would establish a schedule of compensation for the actual net economic lost, plus a schedule of compensation for pain and suffering.

[3]Special Health Care Courts- The State would establish a special court for adjudications of disputes over injuries allegedly caused by health care providers using judges with expertise and experience in healthcare who would make binding rulings on causation, compensation, standards of care, and related issues.

Wyoming Senator Michael Enzi has introduced Senate Bill 1518: The Reliable Medical Justice Act that would provide grants to 6 or 7 states to conduct demonstration projects using one of these models. If this bill is enacted, Connecticut should apply for the grant.

An example of a no-fault system that works is The Swedish Patient Compensation System [PCI] that provides compensation to more patients than the United States and at lower cost. In Sweden, three questions must be answered before a patient receives compensation: [1] an injury resulted from treatment, [2] the treatment was medically justified, and [3] the outcome was unavoidable. If the answer is yes to the first question and no to either the second or third questions, the patient receives compensation. On average, it takes 6 months to resolve a claim and 40% of the claims receive compensation. The number of claims per physician is at least 50% higher than in the United States. The cost is roughly \$2.38 per capita or .16% of health care cost with administrative costs of 14-18%. The PCI pays claims based on avoidable injuries and not on an adverse outcome caused by medical care that was justified and conformed to medical standards. The PCI is financed by premiums paid by the Swedish County Counsels who raised their contributions through income taxes and a flat nominal charge for outpatient's visits to general practitioners and the premiums paid by private physicians and dentists.

Patients who believe they have been injured are encouraged to apply for compensation using forms available in all clinics and hospitals and, in contrast to our present medical tort system, doctors and other health care personnel are actively involved in 60% to 80% of claims, alerting patients that a medical injury has occurred and assisting them in filing claims - the sort of assistance U.S. doctors provide to worker's compensation claimants. Patients, if not satisfied with the compensation, retain the right to sue through a tort liability system. However, patients seldom appeal because they almost always fair better under PCI. Physician discipline and complaints against physicians are handled through the Medical Responsibility Board which is separate from the PCI. One feature of the Swedish system that could be adopted in Connecticut is a schedule of payments for non-economic damages. The schedules would be based on age of the patient and severity of the injury and could be developed by a team of experts using judicial experience. This would bring predictability to compensation for patients with avoidable injuries and would be more equitable than a single cap. Using information gleaned from Sweden and other no fault countries such as New Zealand, Quebec, Canada and Australia and from the Institute of Medicine, a State sponsored no-fault demonstration project could be started at one of our selected provider organizations [e.g., hospitals, large medical groups, and closed panel health maintenance organizations] that have demonstrated their willingness and ability to detect, disclose and prevent medical errors and have entered into voluntary contractual agreements with patients that establish the terms of compensation.

I am suggesting a long term solution to the medical malpractice conundrum. Once each decade during my 33 years of practice, a medical malpractice insurance crisis occurred and resulted in a mixture of tort reforms which varied from state to state. In my opinion the current crisis is by far the worst. My practice of 5 obstetrician /gynecologists and 2 midwives have gone through draconian measures to stay in business. We have closed an office, frozen staff salaries, decrease physician salaries by 35% , sold our practice to Women's Health Connecticut [a good move but resulted in tens of thousands of dollars in legal costs], laid off 4 employees that included a well respected nurse midwife, significantly decreased pension contributions to our employees and physicians and required us to increase our line of credit to \$500,000. I have given up obstetrics and major surgery to reduce costs to our practice. I sacrificed my practice so my younger partners would have less of a drop in income and hopefully stay as the only obstetricians /gynecologists at Windham Memorial Hospital. Our group includes a Connecticut Magazine Top Doc, 5 board certified physicians who trained at prestigious institutions, 2 midwives who trained at Yale and Columbia and my self who in 2004 was voted Physician of the Year at Windham Memorial Hospital and in 2003 was voted by the Consumers Research Council of America as one of the nations top obstetricians and gynecologists.

Clearly the tort system for medical liability is not working .Instead of getting rid of bad doctors, it hurts good doctors, creates access problems for our patients and does not fairly compensate those who have been injured though medical error.

I have provided you with copies of the Institute of Medicines Report on medical liability taken from the 2002 report "Fostering Rapid Advances in Health Care, Learning from Systems Demonstrations" and copies of Senator Enzi's bill S.1518. and a copy of my testimony. Thank you for listening.

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Testimony of

Neil Vidmar, Ph.D., Russell M. Robinson II Professor of Law, Duke University
Law School, and Professor of Psychology, Duke University

April 8, 2005

(SB1052)

before the

Connecticut Committee on the Judiciary
of the General Assembly
of the State Of Connecticut

I thank you for the opportunity to address the Committee on the Judiciary about medical malpractice litigation. I want to state from the outset that I am appearing here because I believe I might provide the Judiciary Committee with some insights bearing on medical malpractice litigation. I am author of a book on medical malpractice litigation, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets and Outrageous Damage Awards* (University of Michigan Press, 1995) and subsequent empirically based scholarly articles on this subject. I am lead author of an article on medical negligence claims in Florida that will appear in the *DePaul Law Review* (2005). The article has received nationwide attention because it provides the first truly systematic profile of medical malpractice litigation. I am familiar with the research of other scholars and it is generally consistent with my findings.

I am not affiliated with any organization that has a direct interest in this issue. Although I am a professor at Duke Law School, the opinions that I offer today are my professional opinions and not necessarily those of Duke University. I am receiving an honorarium from the Connecticut Trial Lawyers Association for taking the time to travel to Connecticut and prepare remarks for today's testimony.

Summary of Main Opinions Offered in This Testimony

1. Doctors in some states are having difficulty in obtaining affordable medical liability insurance. The problem involves identifying the cause or causes of the problem: is it the tort system as some claim or is there another cause or causes?
2. The debate about tort reform has largely ignored the patients who are negligently injured because of medical negligence. Many suffer catastrophic medical and economic losses.
3. Tort reform advocates have ignored the difficulties that the negligently injured persons have in obtaining compensation for their losses.
4. Existing empirical evidence does not support the proposition that recent changes in medical malpractice jury verdicts and settlements are responsible for the liability insurance problem.
5. Claims that litigation costs have increased over the years are not consistent with our findings in Florida or with findings in other jurisdictions.
6. Caps on so-called "pain and suffering" often place a heavy burden on disadvantaged members of society.
7. In many instances the economic burden of caring for patients who are injured through negligence but who do not receive compensation through the tort system falls upon the taxpayers through Medicaid, Medicare and welfare.

In this submission to the Connecticut General Assembly's Committee on the Judiciary I summarize findings from my book, *Medical Malpractice and the American Jury* (1995) and findings from various research articles that I have published in scholarly journals by myself or with colleagues plus research published by other authors and organizations. These sources may be consulted for additional details and documentation.

I acknowledge that doctors in some states have had very serious problems obtaining medical liability insurance. However, I question whether developments in the tort litigation system have brought on the problem. In particular, I assert that tort reform advocates have unfairly portrayed the role of trial by "judge and jury". In addition I assert that plaintiff lawyers play a crucial role in helping injured patients receive compensation. I also draw attention to the crucial fact that the current tort system debate and calls for tort reform have ignored the plight of patients injured through medical negligence.

I. The Incidence and Costs of Medical Negligence

Sometimes explicitly, but more often tacitly, debates about medical malpractice contain the arguments that medical negligence is relatively infrequent¹ and that injuries and the consequent financial losses of patients are exaggerated.

Medical Injury Due to Negligence Is Not Infrequent

The Harvard study of medical negligence examined hospital records of 31,000 patients and concluded that one out of every 100 patients admitted to hospital had an actionable legal claim based on negligence. Some of these patients' injuries were minor or transient, but 14 percent of the time the adverse event resulted in death and 10 percent of the time the incident resulted in hospitalization for more than six months, with seven of those ten persons suffering a permanent disability. Generally, the more serious the injury the more likely it was caused by negligence. Subsequent research involving the states of Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.² These findings are consistent with earlier research reported by Danzon who estimated that on average one in twenty hospital patients incurred an injury due to medical error.³ A still earlier study in California estimated that compensable injuries due to negligence occurred in one in 125 hospitalizations.⁴

In 2000 The Institute of Medicine produced a report that relied on these studies and other data consistent with the above findings.⁵ It concluded that each year 98,000 persons die due to medical negligence and that many other patients sustain serious injuries.

There are good reasons to believe that the Harvard study may have underestimated the incidence on medical negligence. The Harvard data were based on hospital records. Lori Andrews conducted a study in a large Chicago area hospital⁶ and studied actual incidence of negligent events in hospital wards and discovered that many injuries were not recorded on the records as required, especially when the main person responsible for the error was a senior physician. Other research is consistent with the Andrews findings.⁷

In 2004 Healthgrades, Inc., a company that rates hospitals on health care for insurance companies and health plans, studied Medicare records in all 50 states for the years 2000 to 2002. Healthgrades concluded that the Institute of Medicine report figure of

98,000 deaths was too low, that a better estimate was 195,000 annual deaths. It estimated that there were 1.14 million "patient safety incidents" among 37 million hospitalizations. Healthgrades further concluded that "Of the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incidents," and that "[o]ne in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died."⁸

The estimates from these various studies have been contested as being too high⁹ but there is no serious question that medical negligence not only occurs, but it occurs at a substantial rate. Many patients die and others are seriously injured.

Injuries Have High Costs

One only needs to consider an example or two in order to appreciate the cost of a serious injury. A woman in her forties, divorced, with two dependent children, enters a hospital with a high fever. A feeding tube was improperly inserted into her lung, necessitating partial removal of the lung. In the recovery room bleeding from the surgery was discovered and she was rushed back to the operating room where another tube was improperly inserted in her other lung. The woman is paralyzed from the chest down and will have to spend the rest of her life in a nursing home. What will be the cost of her medical care and lost income for the next three or more decades? As a second example, what is the cost associated with a child born blind, deaf, retarded and requiring constant attention to avoid bed sores and other illnesses, especially when experts predict that she could live for decades?¹⁰

In a country without universal health care the medical costs must often be born by the plaintiff's family or by taxpayers in the form of Medicare and Medicaid. And in the case of a patient who was the major wage earner that lost income not infrequently must also be born by taxpayers in the form of welfare payments.

More than a dozen years ago Sloan and van Wert, two economists, conducted systematic assessments of economic losses in a sample of Florida cases involving claims of medical negligence occurring as a result of birth-related and emergency room incidents.¹¹ Even though those researchers offered the caution that their assessment procedures probably underestimated losses, severely injured parties' economic losses were, on average, between \$1.4 and \$1.6 million in 1989 dollars. If we adjust for inflation using the consumer price index¹² these figures in 2004 dollars translate roughly to about \$2.25 million. The losses of persons who survived an emergency room incident were estimated at \$1.3 million, or \$ 2.1 million in 2004 dollars. For persons who died in an emergency room incident the loss to their survivors was estimated at \$0.5 million, or \$0.8 million in today's dollars. Moreover, there was considerable variability around the means of these estimates: some patients had much higher economic losses.

Sloan and van Wert cautioned that a major share of past losses was covered by collateral sources, such as insurance or Medicare. However, even if future medical expenses, including nursing care, are covered by collateral sources, and this is not

guaranteed by any means, loss of income and other expenses, such as care giving by family members resulting in diminished income from those family members, will not be covered. Sloan and van Wert's estimates, moreover, did not consider non-economic losses, such as pain and suffering or loss of consortium.

Non-economic Losses (i.e. "Pain and Suffering") As a Component of Awards

There are some injuries that are very harmful to the patient but defy ordinary economic accounting. At a recent Congressional hearing¹³ Heather Lewinski, a seventeen-year-old young teenager, courageously testified about her psychological pain as a result of egregious medical malpractice when she was eight years old that has left her face permanently and horribly disfigured and subject to drooling. She described how other children made fun of her as she advanced through her teenage years. She had had one self-initiated date and it was a disaster. She told about her belief that she will never marry and have children and will have to concentrate on a career raising and training dogs because they do not discriminate on the basis of human appearances. Unfortunately, despite her apparent intelligence and warm personality and the unfairness of her condition Heather is probably right—I saw her face, as did others who tearfully heard her testimony. If Heather lives to be 78 years old, an award of \$250,000—the limit for non-economic damages in many tort reform packages-- would mean she would be compensated at the rate of \$3571 per annum for her shattered life.¹⁴ When we were conducting research in North Carolina, a young mother of two children was rendered permanently blind. Several others lost sexual functions. It may be true that these latter patients sustained injuries that are "non-economic," but is it fair to characterize the injury as just "pain and suffering" and legislatively limit the amounts they may recover instead of allowing a jury of peers to decide what the injury is worth?

There is often conceptual confusion in the mind of the public about non-economic damages. They are very often simply characterized as "pain and suffering. Indeed, " pain and suffering" developed as an element of damages to compensate people for their physical and emotional suffering but, under law, jurors are also often instructed to consider such things as monetary compensation for disfigurement, loss of parental guidance, loss of parental companionship, loss of moral training from parents, loss of marriage prospects, loss of consortium (e.g. companionship and sexual congress), emotional distress, mental anguish, and loss of enjoyment of life.¹⁵ In calculating non-economic damages juries are instructed that there is no fixed formula to determine the proper amount and that they must apply their collective wisdom and common sense, being neither stingy nor generous.

II. Trial By Judge and Jury

Trial by judge and jury is at the center of the controversy about medical malpractice and the tort system. Juries are accused of being pro-plaintiff, incompetent to evaluate the experts who testify at trial, moved by sympathies for persons with severe injuries regardless of negligence, and to be overly generous or erratic in making damage awards.¹⁶

Low Plaintiff "Win Rates" at Trial

Nationwide statistics from numerous government and academic studies indicate that doctors win between 70% and 80% of medical negligence cases that go to jury trial. Additionally, there is empirical evidence that plaintiff win rates have not increased since at least the early 1990s.¹⁷

Severe Injuries Do Not Forecast A Favorable Jury Verdict for the Plaintiff

Moreover, jury verdicts are not correlated with severity of injury, that is, patients with severe injuries or diseases are not likely to prevail at trial just because they are sad cases. This finding counters the claim that juries give money to plaintiffs just because they are sympathetic to injured plaintiffs. In interviews with North Carolina jurors who decided medical malpractice cases I found that jurors viewed the plaintiffs' claims with great skepticism.¹⁸ Their attitudes were expressed in two main themes: first, too many people want to get something for nothing and second most doctors try to do a good job and should not be blamed for a simple human misjudgment. Indeed, these attitudes were even expressed in some cases in which jurors decided for the plaintiff. Jurors who decided against the doctor sometimes expressed concern that the verdict might have an adverse effect on the doctor's practice. This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence.

Jury Verdicts Are Consistent with Neutral Medical Experts

An important study of medical malpractice litigation compared jury verdicts with the judgments of doctors hired by an insurance company to review the medical records and provide a neutral assessment of whether they believed medical personnel had acted negligently.¹⁹ These decisions were confidential and could not be obtained by the plaintiff or used at trial. The research team compared these neutral ratings with jury verdicts for those cases that went to trial. Jury verdicts tended to be consistent with these neutral assessments. Moreover, the study also found that judgments for the plaintiff were not correlated with the severity of the plaintiff's injury. These results, therefore, also contradict the "plaintiff sympathy" claim.

Judges Agree with Civil Jury Verdicts

Note that I have used the term "trial by judge and jury" because that is truly a fact, a fact that is either unknown to some critics or ignored by them. The trial judge presides over the trial and hears and sees the same evidence as the jury. Before the jury's verdict can be recorded as a legal judgment the judge must agree that the evidence was sufficient to support the verdict. If the judge disagrees on the issue of negligence she or he can set all or parts of the verdict aside.

Several studies have asked trial judges to make independent assessments of who should have prevailed in civil cases over which they have presided.²⁰ These judge assessments have then been compared to the jury verdict in that case. Although the

research has not specifically focused on malpractice juries, the findings indicate that there was high agreement between the judge and the jury. Moreover, in instances when the judge would have decided differently than the jury, the judges usually indicated that nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence. Other studies have asked large national samples of judges to draw on their professional experience with juries and give a general opinion about jury decisions.²¹ The overwhelming number of these judges give the civil jury high marks for competence, diligence and seriousness, even for complex cases. These studies are thus consistent with the other studies that compared the judge's opinion with specific jury verdicts.

Assertions About Anti-doctor Attitudes and "Deep Pockets" Are Not Supported

Closely related to the claim of jury sympathy is a claim that juries are more likely to render verdicts against doctors, hospitals and corporations, not because they are seen as negligent but only because the jurors perceive them as having the ability to pay large awards a so-called "deep pockets" effect. A number of research studies have assessed this hypothesis and find no support for it.²² This general finding includes experiments that specifically tested for a deep pockets effect in medical malpractice cases.²³

Awards Are Proportional to Injury Seriousness

Bovbjerg, Sloan and Blumstein found that the magnitude of jury awards in a sample of medical malpractice tort cases was positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia.²⁴ Later research by Sloan and van Wert²⁵ provides a plausible explanation for this variability, namely that economic losses vary considerably within each level of injury severity. For instance, the economic loss for a quadriplegic who is 40 years old with a yearly income of \$200,000 and a family with three young children would ordinarily be much greater than an identical quadriplegic who is retired, widowed, 75 years old, has no dependents, and whose annual income never exceeded \$35,000.

In a study of medical malpractice verdicts in New York, Florida and California I and two colleagues also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.²⁶ Daniels and Martin found a similar pattern.²⁷

Outlier Awards Tend To Not Withstand Post-Verdict Adjustments

Despite the substantial evidence indicating that ordinarily juries are conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled "outlier awards." Nevertheless, research evidence indicates that these verdicts seldom withstand post-verdict proceedings. In our study of malpractice verdicts in New York, Florida and California, my co-authors and I asked what happened to the outlier awards.²⁸ There are four main processes by which awards are reduced: the judge reduces the award verdict through the legal mechanism of *remittitur* or judgment not withstanding the verdict; the case is appealed and a higher court reduces the award; the

parties set a high-low agreement, and, most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict.

Plaintiffs are willing to negotiate lesser amounts for three main reasons. First, many plaintiffs need or want the money immediately rather than wait for the years it will take to get the money if the case is appealed. Second, there is always a risk that an appeals court will reduce the award or even overturn the verdict. Third, most of these outlier awards greatly exceed the medical provider's insurance coverage. While plaintiffs and their lawyers could attempt to foreclose on the defendant's assets, they are extremely reluctant to do so.²⁹ Therefore, the plaintiff negotiates a settlement around the defendant's insurance coverage. High-low agreements, too, usually take cognizance of the upper limits of insurance coverage.³⁰

My colleagues and I were able to empirically explore the fate of many of the outlier awards. We found that some of the largest malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict.³¹ These findings about these reductions are consistent with other research.

Injured Claimants Often Receive Less Than Actual Economic Losses

Debates about medical malpractice reform often ignore the lives and financial effects of injuries suffered by plaintiffs. In their study of birth and emergency room injury awards, Professor Sloan and his colleagues compared the plaintiffs' economic losses to the amount actually received.³² On average, including cases that were settled as well as cases that went to trial, plaintiffs received only 52 percent of their losses. Plaintiffs in cases that went to trial did better than plaintiffs in settled cases, ultimately receiving 22 percent more than their estimated economic losses. Cases that go to trial before juries are usually different than cases that are settled so precise comparisons are not possible. Plaintiffs settle at a discount to avoid the costs and uncertainties of trial by judge and jury as well as the fact that they receive needed money immediately rather than months or years later. Nevertheless, the Sloan data do suggest that plaintiff lawyers, on average served their clients well when cases did go to trial.

After conducting their detailed analyses Sloan et al. concluded that:

"...few claimants received payments far above the mean for their stage of resolution categories. The fact that even plaintiffs who were successful at verdict received payments only moderately higher than economic loss contradicts the notion that courts make very excessive awards in medical malpractice cases."³³

III. Too Much Focus on Jury Verdicts

The Action is In Settlements, Not Jury Verdicts

In very recent research my colleagues and I have been studying closed medical malpractice claims in the state of Florida.³⁴ Florida has required medical liability insurers to file detailed reports of closed medical malpractice claims with the Department of Health since 1975. In this research we centered on cases closed between 1990 and 2003. A total of 21,809 claims were closed with a payment to the claimant during those fourteen years. We found that 20.2 percent of paid claims were settled without the claimant even resorting to a lawsuit, 6.3 percent of claims were settled in arbitration and 70.8 percent settled before a jury verdict, leaving just 2.7 percent that resulted from a jury verdict.

To pursue this insight further we singled out cases involving a million dollars or more. We found that 10.5 percent were settled without a lawsuit and 4.6 percent were settled in arbitration, 77.4 percent were settled before or during trial and *only 7.6 percent resulted from a jury verdict*. Put in the obverse *more than 92 percent of claims with million dollar payments were settled without a jury*. Going further we found that 37 of the 831 million dollar cases resulted in payments over \$5 million. Only two were settled following a jury trial. Five of the 831 cases exceeded \$10 million dollars but only one was the result of a jury trial. Of the remaining four cases over \$10 million, one was settled in pre-litigation negotiations, and three settled before a trial had commenced.

Perhaps Florida is different than other states. It is hazardous to generalize because each state has its own unique set of laws and legal culture. Nevertheless, it is interesting to observe that a recent empirical study of Texas closed-claim files is consistent with our Florida findings.³⁵ Some less systematic data from North Carolina seems roughly consistent with the Florida findings. I compared data on verdicts and settlements reported in the *North Carolina Lawyer's Weekly*, a publication of the North Carolina Trial Lawyers Association.³⁶ The data are not systematic and tend to report only large cases, but they show some interesting patterns. As early as the first part of the 1990s decade there were verdicts and large settlements exceeding \$1 million. Over the period from 1990 through 2002 the number of million-dollar- plus settlements exceeded the number of million-dollar- plus jury verdicts by a factor of over three to one. The mean, or average, amounts of \$1 million plus settlements were comparable to the jury awards. A statistical test on the data indicated that the distributions and the magnitudes of payments for jury verdicts and non-jury settlements were not statistically different from one another. In short, the North Carolina findings also indicate that most of the payments exceeding a million dollars involved settlements rather than jury trial.

These findings have a major implication. Whether we are talking all cases or just million dollar cases the process by which claims are paid in Florida (and, it appears, also in North Carolina) involves the negotiation table, not the jury room. In Florida settlement exceeded jury trial by a factor of more than nine to one in million dollar cases. We need to learn why these cases were settled rather than put before juries. Was it a fear of juries that caused defendants to settle? Alternatively, was the negligence and severity of loss so clear in most of the cases that it made no sense to go to trial, incurring heavy litigation costs in the face of a likely win for the patient? At this point we cannot say which of these opposing explanations are correct. Both could be correct to some degree. At the very least the findings strongly suggest that all of the emphasis on jury verdicts appears misplaced.

Shadow Effects: Frivolous Litigation

Claims about frivolous litigation are based, in part, on findings that in medical malpractice cases doctors prevail in approximately 70 percent of cases that go to trial and that as many as 50 percent of cases filed against health care providers ultimately result in no payment to the plaintiff.³⁷ Additionally, opponents of medical malpractice litigation argue that jury verdicts, especially those involving larger awards, encourage lawyers to file lawsuits in cases that are not meritorious because doctors and liability insurers will settle claims, not out of merit, but rather out of fear of a large and unjustified award if the case goes before a jury. These claims are not supported by research evidence.

Liability Insurers Tend to Not Settle Frivolous Cases

In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: "We do not settle frivolous cases!"³⁸ The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.

Transaction Costs in Defending Claims

Tort reform advocates are correct in their assertion that there are transaction costs in defending not only claims resulting in payment but also claims that eventually result in no payment. Our study of Florida, however, found little evidence that transaction costs rose risen substantially over the past decade. The Texas study did find that defense costs involving large claims rose steadily from 1998 to 2002. However, the authors of that report concluded that these rises were not of sufficient magnitude to create an insurance cost crisis.

IV. Negligently Injured Patients, Caps and Societal Costs

As stated at the beginning of this writing there is a problem in doctors obtaining liability insurance, *but the focus on tort reform has ignored the plight of patients who are badly injured through medical negligence and it has also ignored who ultimately pays for the patient's medical costs and lost income.* Additionally plaintiff lawyers have been vilified as greedy predators who run up the costs of health care while seeking only their own personal welfare.

In a forthcoming article in the Loyola Los Angeles Law Review³⁹ I describe the difficulties that a patient injured from medical negligence has in obtaining compensation. Without lawyers who are willing to risk their own finances in funding the cases these injured parties would not receive any compensation. Without the pain and suffering component to awards many would receive substantially less than their actual economic losses.

Research by Lucinda Finley has examined the consequences of caps on the allocation of plaintiff recoveries in California, Florida and Maryland by looking at jury verdicts and calculating the discrepancy between what the jury awarded and the amount the plaintiff would recover under caps.⁴⁰ She found that the major effects would fall most heavily on children, women and elderly people because their losses are more likely to be non-economic losses, albeit often devastating and tragic.

David Studdert and his colleagues conducted a study of California jury verdicts to assess the impact of California's \$250,000 cap on non-economic damages and concluded as follows:

Plaintiffs with the most severe injuries appear to be at highest risk for inadequate compensation. Hence, the worst-off may suffer a kind of "double jeopardy."

Analysis of proportional reductions shows that the burden of caps tends to fall on injuries that cause chronic pain and disfigurement but do not lead to declines in physical functioning that would generate lost work time or high health care costs.... Notwithstanding their limited economic impact, the injuries involved are by no means trivial.⁴¹

The findings raise questions about the fairness of caps on negligently injured persons.

However, even if there is some unfairness, we need to consider if that is a price to be paid if the effect of caps is to reduce doctors' liability insurance premiums so that they can continue serving the public health needs. This is a fair cost-benefit analysis but the problem is that research does not support the proposition that caps will reduce those premiums. In a 2003 report the Government Accounting Office concluded that there was no solid evidence to support the proposition. While some states with caps had lower premiums than states without caps, some states without caps had premiums that were lower than the capped states. A report by Weiss Ratings, a respected insurance analyst, found that caps on pain and suffering did not result in insurers reducing doctors' insurance premiums. In 2003 GE Medical Protective Company, the nation's largest medical malpractice insurer, reported to the Texas Department of Insurance as follows: "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%."⁴² The company also said that a provision in the Texas law allowing for periodic payments of awards would provide a savings of only 1.1%. Medical Protective eventually raised the rates on its physician policyholders.⁴³ In California, which has had a cap of \$250,000 since 1975, GE Medical Mutual sought an increase of 29.2 percent rate hike in liability insurance premiums. In short, caps on pain and suffering do not appear to be the answer to lowering doctors' liability insurance premiums.

More About Medicare and Medicaid and Private Insurer Liens

In a study of the Indiana Medical Malpractice Act Kinney et al. reported anecdotal data bearing on the economic losses incurred by some patients injured by medical malpractice.⁴⁴ A 43-year-old woman who lost function in her left arm and both

legs and both bladder and bowel control during an operation in 1981 and was consequently confined to a nursing home was eventually awarded an annuity of \$400,000 in 1987. After litigation expenses, lawyer fees and Medicaid liens the woman reported that the remaining balance would not cover her nursing home expenses for one year.

In research leading to *Medical Malpractice and the American Jury* I investigated a case involving a child suffering a brain injury at birth who died two and a half years later. The county had paid for his medical expenses during his brief life, approximately \$900,000 in today's dollars. The county government claimed that entire amount on behalf of its taxpayers.

Liens against medical malpractice payments are a largely unnoticed, un-discussed, and under-researched issue in the medical malpractice controversy, but Professor Herbert Kritzer has recently examined the importance of claims against a plaintiff's recovery in a study of plaintiff lawyers in Wisconsin.⁴⁵ Rules and practices differ from state to state, but in Wisconsin health insurers who pay for medical expenses of an injured person are very aggressive in seeking to recoup their money from any settlement or jury award. My preliminary research in North Carolina and Florida suggests a similar pattern.

These third-party, include Medicare and Medicaid. In addition if the patient's medical expenses were covered by his or her own health insurance prior to the settlement with the doctor's liability insurer, the health insurer frequently seeks to be reimbursed. Kritzer found that these third party claims occur in small cases as well as large ones. He also uncovered the fact that these third parties are often very involved in negotiations with the plaintiff's lawyer at early stages of lawsuits. I have conducted some interviews with North Carolina lawyers on these matters in preparation for a study of subrogated claims and found evidence of similar third-party activity in North Carolina.

While we do not yet have comprehensive, representative data on the frequency and magnitude of liens against medical malpractice settlements, they raise some important questions about how much the injured party actually recovers and how often Medicare, Medicaid and health insurers are in effect silent plaintiffs through their third party claims. I have argued that as taxpayers we are "silent plaintiffs" in these cases because we ultimately pay for Medicare, Medicaid and welfare.

V. Public Policy Issues

The issue of damages caps and other proposed tort reforms raise important public policy choices. The evidence that caps reduce liability insurance premiums is at best shaky.⁴⁶ But assume that caps do have some small effects on these premiums some of the time. On the one hand negligently injured patients may not get full compensation for their injuries—or perhaps no compensation if a lawyer cannot afford to take their case. In such instances the patient may have to rely on taxpayer-supported help from Medicare, Medicaid and welfare (not to mention the indignity to a person who was a hard working citizen). Who should pay: The negligent health care provider's liability insurance or

taxpayers? These are not easy choices, but they need to be faced directly by legislators who should consider the needs and circumstances of the negligently injured patients, who are among their constituents.

I thank the Connecticut Judiciary Committee for allowing me to present these views.

¹ See e.g. Paul Weiler et al., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION* (1993) reporting that doctors tend to admit that injuries occur but are reluctant to ascribe the result to negligence, at 124-129.

² E.J. Thomas et al. *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 *MEDICAL CARE* 261 (2000).

³ Patricia Danzon, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* (1985) at 20.

⁴ California Medical Association, Donald Mills, ed., *MEDICAL INSURANCE FEASIBILITY STUDY* (1977).

⁵ Linda Kohn, Janet Corrigan and Molla Donaldson, eds., *To Err Is Human: Building a Safer Health Care System*, Institute of Medicine (2000) at <http://books.nap.edu/catalog/9728.html?onpi_newsdoc112999>; Lucian Leape, Institute of Medicine *Medical Error Figures Are Not Exaggerated*, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 95 (2000).

⁶ Lori Andrews, *MEDICAL ERROR AND PATIENT CLAIMING IN A HOSPITAL SETTING* (1993).

⁷ See Lucian Leape, Institute of Medicine *Medical Error Figures Are Not Exaggerated*, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 95 (2000) citing R.W. DuBois and R. Brook, *Preventable Deaths: Who, How Often and Why?* 109 *ANNALS OF INTERNAL MEDICINE* 582 (1988) and K.K.B. Kirkland et al., *The Impact of Surgical-site Infections in the 1990s: Attributable Mortality, Excess Length of Hospitalization, and Extra Costs*, 20 *INFECTIOUS CONTROL AND HOSPITAL EPIDEMIOLOGY* 725 (1999).

⁸ Reuters News, *Report Says 195,000 Deaths Due to Hospital Error*, July 27, 2004.

⁹ For criticism of the Harvard study or controversy over some of the findings see Rodney Hayward, and Timothy Hofer, *Estimating Hospital Deaths Due to Medical Errors*, 286 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 415 (2001); Clement McDonald et al., *Deaths Due to Medical Error Are Exaggerated in Institute of Medicine Report*, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 93 (2000).

¹⁰ Both of these examples are based on cases that formed part of the data set analyzed in Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995).

¹¹ Frank Sloan and Stephen van Wert, *Costs of Injuries*, Chapter 7 in Frank Sloan et al., *SUING FOR MEDICAL MALPRACTICE* (1993) at 139, 140.

¹² http://www.orst.edu/Dept/pol_sci/fac/sahr/cv2001.pdf. Inflation in medical costs is generally higher than the consumer price index, see <http://rehphome.tripod.com/infbond.html>. Thus, conversion by the CPI underestimates economic losses by some unknown degree.

¹³ Hearing before the Subcommittee on Oversight and Investigations of the Committee of Energy and Commerce, 108 Congress, February 10, 2003 at 60.

¹⁴ If she were to invest the money wisely, the amount would be higher. Jurors are often instructed to consider this possibility and reduce the award to "present value," that is, consider what the award given today will be worth in the future.

¹⁵ Ronald Eades, *JURY INSTRUCTION ON DAMAGES IN TORT ACTIONS* 321 (3rd Ed.) (1993); Thomas Koenig and Michael Rustad, *IN DEFENSE OF TORT LAW* (2001).

¹⁶ See Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995).

¹⁷ See Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995) and Carol DeFrances and Marika Litras, *Civil Trial Cases and Verdicts in Large Counties, 1996*, BUREAU OF JUSTICE STATISTICS BULLETIN, NCJ 173426 September 1999. Thomas Cohen and Steven Smith, *Civil Trial Cases and Verdicts in Large Counties, 2001*, BUREAU OF JUSTICE STATISTICS BULLETIN, April 2004 NCJ 202803

¹⁸ Neil Vidmar, *MEDICAL MALPRACTICE* at 169-171.

¹⁹ Taragin *et al.*, *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 *ANNALS OF INTERNAL MEDICINE* 780 (1992). Other research bearing on judgments of medical negligence is reported in Henry Farber and Michelle White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 *JOURNAL OF LEGAL STUDIES* 77 (1997); Frank Sloan *et al.* *SUING FOR MEDICAL MALPRACTICE* (1993) at Chapter 6

²⁰ Harry Kalven and Hans Zeisel, *THE AMERICAN JURY* (1966); Larry Heuer and Steven Penrod, *Trial Complexity : A Field Investigation of Its Meaning and Effects*, 18 *LAW AND HUMAN BEHAVIOR* 29 (1994).

²¹ These surveys are reviewed in Neil Vidmar *et al.*, *Amicus Brief: Kumho Tire v. Carmichael* filed in The Supreme Court of the United States, October Term 1998 (reprinted in 24 *LAW AND HUMAN BEHAVIOR* 387 (2000)).

²² For a review of this research see Valerie Hans, *BUSINESS ON TRIAL* (2001).

²³ Neil Vidmar, *Empirical Evidence on the "Deep Pockets" Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 *DUKE LAW JOURNAL* 885 (1994).

²⁴ Randall Bovbjerg *et al.*, *Valuing Life and Limb in Tort: Scheduling Pain and Suffering*, 83 *NORTHWESTERN LAW REVIEW* 908 (1989).

²⁵ Sloan and Van Wert, *supra*, note 22.

²⁶ Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 *DE PAUL LAW REVIEW* 265 (1998).

²⁷ Stephen Daniels and Joanne Martin, *CIVIL JURIES AND THE POLITICS OF REFORM*, 127-129 (1995).

²⁸ Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 *DE PAUL LAW REVIEW* 265, 287 (1998).

²⁹ Tom Baker, *Blood Money, New Money and the Moral Code of the Personal Injury Bar*, 35 *LAW AND SOCIETY REVIEW* 257 (2002).

³⁰ Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania*, January 28, 2002 (unpublished report).

³¹ Vidmar *et al.*, *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 *DE PAUL LAW REVIEW* 265, 287 (1998).

³² Frank Sloan *et al.*, *SUING FOR MEDICAL MALPRACTICE* (1993)

³³ *Id.* at 195.

³⁴ Neil Vidmar, Paul Lee, Kara MacKillop, Kieran McCarthy, and Gerald McGwin, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, *DEPAUL LAW REVIEW* (in press).

³⁵ Bernard Black *et al.*, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*

³⁶ Testimony of Neil Vidmar before the North Carolina House Blue Ribbon Task Force on Medical Malpractice, Raleigh, NC, January 7, 2004. The same data have been used by the North Carolina Trial Lawyers Association and by Medical Mutual of North Carolina, a doctor-owned liability insurer.

³⁷ Neil Vidmar, *MEDICAL MALPRACTICE* at 40-41 reviewing statistics from studies on settlement rates.

³⁸ *Id.* at Chapters 7 and 8.

³⁹ Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy*, Forthcoming, *LOYOLA LA LAW REVIEW* (2005)

⁴⁰ Lucinda Finley, *The Hidden Victims of Tort Reform*, 53 EMORY LAW JOURNAL 1263, 1281, 1286, 1308-1312 (2004).

⁴¹ David Studdert et al, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54 (2004). A footnote omitted in the above quotation references Frank Sloan and C.R. Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOCIETY REVIEW 601 (1990) which also pointed out a similar inequity in pre-1990 cases.

⁴² See <http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>

⁴³ THE NATION, October 26, 2004.

⁴⁴ Elanor Kinney, William Gronfein and Thomas Gannon, *Indiana=s Medical Malpractice Act: Results of a Three Year Study*, 24 INDIANA LAW REVIEW 1275 (1991) at 1276-1277. Indiana's statute limits total recovery of all losses, economic and non-economic, in medical malpractice cases to \$750,000.

⁴⁵ Herbert Kritzer, *RISKS, REPUTATIONS AND REWARDS, CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES* (2004).

⁴⁶ See <http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>: Medical Protective Insurance filing: "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%."

SEC. 3. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

SEC. 3990. STATE DEMONSTRATION PROGRAM TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

(a) **IN GENERAL**- The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

(b) **DURATION**- The Secretary may award up to 7 grants under subsection (a) and each grant awarded under such subsection may not exceed a period of 10 years.

(c) **CONDITIONS FOR DEMONSTRATION GRANTS**-

(1) **REQUIREMENTS**- Each State desiring a grant under subsection (a) shall--

(A) develop an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations that may be 1 of the models described in subsection (d); and

(B) establish procedures to allow for patient safety data related to disputes resolved under subparagraph (A) to be collected and analyzed by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, in accordance with guidelines established by the Secretary.

(2) **ALTERNATIVE TO CURRENT TORT LITIGATION**- Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)--

(A) makes the medical liability system more reliable;

(B) enhances patient safety; and

(C) maintains access to liability insurance.

(3) **SOURCES OF COMPENSATION**- Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods may provide financial incentives for activities that improve patient safety.

(4) **SCOPE**- Each State desiring a grant under subsection (a) may establish a scope of jurisdiction (such as a designated geographic region or a designated area of health care practice) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative.

(d) **MODELS**-

(1) **IN GENERAL**- Any State desiring a grant under subsection (a) that proposes an alternative described in paragraph (2), (3), or (4) shall be deemed to meet the criteria under subsection (c)(2).

(2) **EARLY DISCLOSURE AND COMPENSATION MODEL**- In the early disclosure and compensation model, the State shall--

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Reliable Medical Justice Act (Introduced in Senate)

S 1518 IS

108th CONGRESS

1st Session

S. 1518

To restore reliability to the medical justice system by fostering alternatives to current medical tort litigation, and for other purposes.

IN THE SENATE OF THE UNITED STATES

July 31 (legislative day, JULY 21), 2003

Mr. ENZI introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To restore reliability to the medical justice system by fostering alternatives to current medical tort litigation, 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 'Reliable Medical Justice Act'.

SEC. 2. PURPOSES.

The purposes of this Act are--

(1) to restore reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors; and

(2) to support and assist States in developing such alternatives.

`(A) provide immunity from tort liability (except in cases of fraud, or in cases of criminal or intentional harm) to any health care provider or health care organization that enters into an agreement to pay compensation to a patient for an injury;

`(B) set a limited time period during which a health care provider or health care organization may make an offer of compensation benefits under subparagraph (A), with consideration for instances where prompt recognition of an injury is unlikely or impossible;

`(C) require that the compensation provided under subparagraph (A) include--

 `(i) payment for the net economic loss of the patient, on a periodic basis, reduced by any payments received by the patient under--

 `(I) any health or accident insurance;

 `(II) any wage or salary continuation plan; or

 `(III) any disability income insurance;

 `(ii) payment for the patient's pain and suffering, if appropriate for the injury, based on a capped payment schedule developed by the State in consultation with relevant experts; and

 `(iii) reasonable attorney's fees;

`(D) not abridge the right of an injured patient to seek redress through the State tort system if a health care provider does not enter into a compensation agreement with the patient in accordance with subparagraph (A);

`(E) prohibit a patient who accepts compensation benefits in accordance with subparagraph (A) from filing a health care lawsuit against other health care providers or health care organizations for the same injury; and

`(F) permit a health care provider or health care organization that enters into an agreement to pay compensation benefits to an individual under subparagraph (A) to join in the payment of the compensation benefits of any health care provider or health care organization that is potentially liable, in whole or in part, for the injury.

`(3) ADMINISTRATIVE DETERMINATION OF COMPENSATION MODEL-

 `(A) IN GENERAL- In the administrative determination of compensation model--

 `(i) the State shall--

 `(I) designate an administrative entity (in this paragraph referred to as the 'Board') that shall include representatives of--

 `(aa) relevant State licensing boards;

 `(bb) patient advocacy groups;

 `(cc) health care providers and health care organizations; and

 `(dd) attorneys in relevant practice areas;

 `(II) set up classes of avoidable injuries that will be used by the Board to determine

compensation under clause (i)(II) and, in setting such classes, may consider 1 or more factors, including--

- `(aa) the severity of the disability arising from the injury;
- `(bb) the cause of injury;
- `(cc) the length of time the patient will be affected by the injury;
- `(dd) the degree of fault of the health care provider or health care organization; and
- `(ee) standards of care that the State may adopt and their breach;

`(III) modify tort liability, through statute or contract, to bar negligence claims in court against health care providers and health care organizations for the classes of injuries established under subclause (II), except in cases of fraud, or in cases of criminal or intentional harm;

`(IV) outline a procedure for informing patients about the modified liability system described in this paragraph and, in systems where participation by the health care provider, health care organization, or patient is voluntary, allow for the decision by the provider, organization, or patient of whether to participate to be made prior to the provision of, use of, or payment for the health care service;

`(V) provide for an appeals process to allow for a review of decisions; and

`(VI) establish procedures to coordinate settlement payments with other sources of payment;

`(ii) the Board shall--

`(I) resolve health care liability claims for certain classes of avoidable injuries as determined by the State and determine compensation for such claims; and

`(II) develop a schedule of compensation to be used in making such determinations that includes--

`(aa) payment for the net economic loss of the patient, on a periodic basis, reduced by any payments received by the patient under any health or accident insurance, any wage or salary continuation plan, or any disability income insurance;

`(bb) payment for the patient's pain and suffering, if appropriate for the injury, based on a capped payment schedule developed by the State in consultation with relevant experts; and

`(cc) reasonable attorney's fees; and

`(iii) the Board may--

`(I) develop guidelines relating to--

`(aa) the standard of care; and

`(bb) the credentialing and disciplining of doctors; and

`(II) develop a plan for updating the schedule under clause (ii)(II) on a regular basis.

`(B) APPEALS- The State, in establishing the appeals process described in subparagraph (A)(i)(V), may choose whether to allow for de novo review, review with deference, or some opportunity for parties to reject determinations by the Board and elect to file a civil action after such rejection. Any State desiring to adopt the model described in this paragraph shall indicate

how such review method meets the criteria under subsection (c)(2).

`(C) TIMELINESS- Any claim handled under the system described in this paragraph shall provide for adjudication that is more timely and expedited than adjudication in a traditional tort system.

`(4) SPECIAL HEALTH CARE COURT MODEL- In the special health care court model, the State shall--

`(A) establish a special court for adjudication of disputes over injuries allegedly caused by health care providers or health care organizations;

`(B) ensure that such court is presided over by judges with expertise in and an understanding of health care;

`(C) provide authority to such judges to make binding rulings on causation, compensation, standards of care, and related issues;

`(D) provide for an appeals process to allow for a review of decisions; and

`(E) at its option, establish an administrative entity similar to the entity described in paragraph (3)(a)(i) (I) to provide advice and guidance to the special court.

`(e) APPLICATION- Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

`(f) REPORT- Each State receiving a grant under subsection (a) shall submit to the Secretary a report evaluating the effectiveness of activities funded with grants awarded under such subsection at such time and in such manner as the Secretary may require.

`(g) TECHNICAL ASSISTANCE- The Secretary shall provide technical assistance to the States awarded grants under subsection (a). Such technical assistance shall include the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States. States not receiving grants under this section may also use such common definitions, formats, and data collection infrastructure.

`(h) EVALUATION-

`(1) IN GENERAL- The Secretary shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to the appropriate committees of Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

`(2) CONTENTS- The evaluation under paragraph (1) shall include--

`(A) an analysis of the effect of the grants awarded under subsection (a) on the number, nature, and costs of health care liability claims;

`(B) a comparison of the claim and cost information of each State receiving a grant under subsection (a); and

`(C) a comparison between States receiving a grant under this section and States that did not receive

such a grant, matched to ensure similar legal and health care environments, and to determine the effects of the grants and subsequent reforms on--

(i) the liability environment;

(ii) health care quality; and

(iii) patient safety.

(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS- Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed \$500,000 per State to provide planning grants to such States for the development of demonstration proposals meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which current law would not prohibit the adoption of an alternative to current tort litigation.

(j) DEFINITIONS- In this section:

(1) HEALTH CARE SERVICES- The term 'health care services' means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to--

(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

(B) the assessment of the health of human beings.

(2) HEALTH CARE ORGANIZATION- The term 'health care organization' means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

(3) HEALTH CARE PROVIDER- The term 'health care provider' means any individual or entity--

(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(4) NET ECONOMIC LOSS- The term 'net economic loss' means--

(A) reasonable expenses incurred for products, services, and accommodations needed for health care, training, and other remedial treatment and care of an injured individual;

(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

(k) AUTHORIZATION OF APPROPRIATIONS- There are authorized to be appropriated to carry out this section such sums as may be necessary. Amounts appropriated pursuant to this subsection shall remain available until expended.



American College
of Physicians

Testimony for Submission

Connecticut Chapter

**Health & Public Policy
Committee**

Robert McLean, MD, FACP
Chairman

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April 8, 2005

Dear Members of the Judiciary Committee,

On behalf of almost 2000 members of the Connecticut Chapter of the American College of Physicians, I urge you to enact meaningful legislative professional liability insurance reform. Meaningful reform must be based on actuarially sound data which will lead to real reductions in exorbitant premiums which doctors of all specialties are currently paying for liability insurance.

I will leave some of the actuarial data and insurance company rate-setting issues to others providing such pertinent data. I would like to emphasize for you how the current professional liability crisis in Connecticut is affecting internal medicine physicians (primary care internists and medical sub-specialists) and not just higher-risk doctors like neurosurgeons and obstetricians.

Over the past several years, professional liability insurance rates being paid by internists have increased from around \$10,000 per year to almost \$30,000. As a percentage of practice revenue, internists are sometimes seeing greater increases in liability insurance premiums than the higher risk specialists. Such huge increases to the cost of maintaining a practice are a factor contributing to internists in our state considering retirement or career changes at an earlier age and also realizing that part-time practice as a first step to winding down their practices is financially untenable. The frightening medical liability climate is also one factor discouraging medical students from entering primary care specialties like internal medicine.

In total, fewer internists will be practicing, and Connecticut will see increasing problems with patients finding access to primary medical doctors. Much of the publicity surrounding the problem has focused on higher risk specialties, and you must realize that the problem with access to medical care will affect everyone as there are fewer primary care doctors as well.

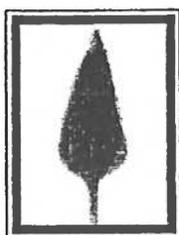
I urge you to follow the lead of several other states such as Texas, Ohio, and West Virginia and enact meaningful professional liability reform this session.

Respectfully,

A handwritten signature in black ink, appearing to read 'Robert McLean', is written over a printed name and title.

Robert McLean, M.D., FACP

Chairman, Health & Public Policy Committee, CT Chapter, ACP



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Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation

SUMMARY DESCRIPTION

Demonstrations in this category would create injury compensation systems outside of the courtroom that are patient-centered and focused on safety, while also addressing provider concerns about rapidly rising liability insurance premiums. Specific characteristics of this non-judicial approach to malpractice reform are replacing tort liability with alternative systems for ensuring that patients who have experienced avoidable injuries receive timely, fair compensation from responsible parties; limiting financial exposure for health care providers; promoting apology and non-adversarial discussions with patients; encouraging provider organizations to report and analyze medical errors; rewarding providers that put in place effective programs for reducing medical injury; and involving patients in safety improvement efforts.

Prompt federal action to provide incentives for adopting this approach—coupled with appropriate state legislation—has the potential to produce immediately measurable benefits in terms of provider access to affordable, high-dollar liability coverage; gains in administrative efficiency once criteria for compensation are fully developed, allowing quicker payments to be made to many more injured patients; and longer-term improvements in patient safety and stabilization of insurance markets. The Department of Health and Human Services (DHHS) would issue a Request for Proposals (RFP) to the states and select four to five of those that apply for demonstration projects in this category. The demonstrations would be designed to ascertain a reform's effect on the number and nature of claims filed and associated total costs, as well as to permit comparison of claim and cost information across all the demonstrations. All of these components would be part of the overall evaluation of the demonstrations. If successful, the reforms could continue indefinitely.

Liability

The committee suggests that participating states implement one of two options on a demonstration basis:

- *Option 1: Provider-Based Early Payment*—Under this approach, the federal government would provide reinsurance on a shared-cost basis to self-insured or experience-rated provider groups that voluntarily agree to identify and promptly compensate patients for avoidable injuries. States would prospectively set limits on non-economic damages, including pain and suffering, for identifiable classes of avoidable injuries.
- *Option 2: Statewide Administrative Resolution*—Under this approach, states would grant all health care professionals and facilities, however organized, immunity from tort liability (under most circumstances) in exchange for mandatory participation in a state-sponsored, administrative system established to provide compensation to patients who have suffered avoidable injuries.

Both options are compatible with the Administration's recent proposal related to liability reform, which caps noneconomic damages and supports the concept of "early offers" of compensation (U.S. Department of Health and Human Services, 2002). However, both options also differ in certain respects from the Administration's proposal and do not depend on its enactment.

BACKGROUND

For the first time in nearly 20 years, the United States is facing a broad-based crisis in the availability and affordability of malpractice liability insurance for physicians, hospitals, and other health care providers. The American health care system has undergone dramatic changes since the last malpractice crisis two decades ago (Abraham and Weiler, 1994; Sage, 1997). Reforms to address the current situation

should therefore take into account a number of new concerns and constraints: (1) increased sensitivity among providers and the public to substantial rates of medical error and the need to improve patient safety at a system level; (2) lower margins and reduced provider capacity resulting from private- and public-sector cost containment, which increases vulnerability to "liability shocks"; and (3) organizational and technical innovations in health care financing and delivery, including provider integration and consolidation, that have affected the dynamics of litigation as well as expanding the range of public policy responses to a liability insurance crisis.

There is widespread agreement that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error (Bovbjerg et al., 2001). Most instances of negligence do not give rise to lawsuits, and most legal claims do not relate to negligent care (Localio et al., 1991). Many injured patients do not know they have suffered an injury resulting from error, and those who go through the legal process often do not even recover the cost of their continued health care (Sloan et al., 1991). A few plaintiffs and their attorneys, however, win large sums that may be disproportionate to their injuries or unrelated to the defendant's conduct. Prolonged, adversarial haggling over claims by plaintiffs' attorneys and liability insurers alienates both providers and patients, and generates legal fees and administrative expenses that consume more than half the cost of liability insurance premiums (Kakalik and Pace, 1986).

The apparent randomness and delay associated with this pattern of accountability not only prevent severely injured patients from receiving prompt, fair compensation, but destabilize liability insurance markets and attenuate the signal that liability is supposed to send health care providers regarding the need for quality improvement. Fear and distrust breed inefficient "defensive medicine," and lead to missed opportunities for information exchange and apology that might avoid lawsuits in the first place. Unfavorable economic conditions and catastrophic events external to the health care

system add to the effects of legal uncertainty on liability insurance premiums, particularly for high-dollar coverage that depends on global reinsurance markets.

The shortcomings of the current malpractice system therefore come from three directions, all of which have contributed to the present crisis: inefficient and inequitable legal processes for resolving disputes, problematic responses by clinicians to the threat and cost of liability, and volatile markets for liability insurance. Although some states face greater insurance instability than others as the result of different legal standards, public expectations, and professional cultures, no state is immune to the threat of service interruptions affecting physicians, hospitals, and other health care providers.

The current liability insurance crisis provides a compelling case for reform. However, approaches that focus narrowly on reducing the number and value of legal claims (e.g., limiting damage awards) may lower liability insurance premiums but do nothing to improve patient safety or produce prompt and fairer compensation for patients who are injured. The systemic problems noted by the Institute of Medicine (IOM) in *To Err Is Human* and *Crossing the Quality Chasm* (Institute of Medicine, 2000, 2001) strongly suggests the need to create a legal environment that both fosters high-quality patient care and relieves financial strain and administrative burden for health care providers. The committee believes that replacing tort liability with a system of patient-centered and safety-focused non-judicial compensation—linking claims resolution to organization-based error disclosure and safety improvement processes—can best accomplish these goals. Such systems would cap providers' financial exposure at reasonable levels, both directly by limiting damages and indirectly by providing affordable umbrella coverage. They would also encourage and oversee health care organizations' efforts to identify, compensate, and reduce errors in cooperation with patients. In combination, these improvements should enhance patient safety and enable a greater number of patients with valid claims to receive

compensation, while simultaneously stabilizing liability insurance markets by decreasing the unpredictability associated with high-dollar, outlier cases (Studdert and Brennan, 2001a; 2001b).

Approaches intended to compensate more injured patients by using a standard of "avoidability" rather than the narrower tort standard of "negligence" raise appropriate concerns about increased cost. Rigorously testing such systems on a demonstration basis would allow policy makers to determine the total cost of compensating medical injuries outside the courtroom. Further, by gathering, analyzing, and comparing claims and cost data across participating states, policy makers would gain insight into how definitions of avoidable injury and the generosity of the compensation packages selected influence total cost. Finally, policy makers would obtain important information about the possible dollar benefits of reducing the incidence of avoidable injuries.

Through the demonstrations in this category, states would have the opportunity—and the incentive—to select one of the two non-judicial claims resolution options outlined above. All participating states will refine the technical and scientific underpinnings of such a system through an expert or participatory process, depending upon the state's preference. States would build on well-developed, but untested proposals such as "ACEs" ("avoidable classes of events," also called "accelerated compensation events"), early offers of settlement, and scheduled ranges of allowable damages for pain and suffering. ACEs identify, in scientifically rigorous fashion, situations in which injuries that typically are preventable occur, such as giving a patient two drugs that are known to interact (Tancredi and Bovbjerg, 1991). Early offer systems protect defendants from additional liability if they reliably and promptly acknowledge problems and offer fair compensation (O'Connell, 1982). Damage schedules ascertain reasonable levels of compensation for pain and suffering on the basis of jury awards for injuries of defined severity and cap damages at those

Liability

amounts rather than imposing a one-size-fits-all limit (Bovbjerg et al., 1989).

States would need to create centralized mechanisms to ensure the identification, disclosure, and analysis of avoidable injuries, as well as voluntary, confidential reporting of "near misses." The way in which such mechanisms would be operationalized will be left up to the states, necessitating resolution of important policy issues. The federal government might play a role by helping to develop consistent definitions and data reporting standards, thereby reducing the need for each state to reinvent the wheel and allowing for comparisons across states. States also would help health care providers communicate more effectively, both internally and with patients, when errors occur by encouraging apology and the use of facilitated discussion procedures such as mediation (Cohen, 2000; Sage, 2002). Finally, states would engage in sustained efforts to educate the public with respect to the trade-off involved in replacing tort liability with administrative remedies for avoidable medical injury: faster, fairer, surer compensation but forgoing a jury trial.

Some states might choose to phase in non-judicial approaches to compensation, beginning with selected provider organizations (e.g., hospitals, large medical groups, and closed-panel health maintenance organizations [HMOs]) that have demonstrated their willingness and ability to detect, disclose, and prevent medical errors and have entered into voluntary contractual agreements with patients that establish the terms of compensation (Havighurst, 1995; O'Connell, 1986; Sage et al., 1994). Other states might want to move more quickly by establishing comprehensive state-wide systems of administrative claims resolution with mandatory participation by all health care providers in the state (e.g., physicians, nurse practitioners, hospitals, nursing facilities).

The former approach has the advantage of building on the IOM's earlier recommendations regarding the optimal structure and conduct of high-quality health care organizations (Institute of Medicine, 2000, 2001). Specifically, this approach creates incentives for physicians and

hospitals to join together to form well-managed clinical entities that bear primary financial responsibility for avoidable errors and have the medical know-how to minimize patient injury. The strength of the latter approach is that it gives all health care providers equal, immediate access to relief from the current liability crisis and does not depend upon particular organizational forms (e.g., integrated group practice) that may not be well developed in many jurisdictions.

The workers' compensation system is the most familiar example of substituting administrative claims resolution for tort liability on a state-wide basis (Fishback and Kantor, 2000; Kramer and Briffault, 1991). Experience with workers' compensation demonstrates that no-fault systems can enhance predictability and improve access to compensation. It also confirms the importance of maintaining safety incentives (e.g., through self-insurance or experience rating) and establishing reasonable injury thresholds and clear categories of compensable injury that reduce waste and discourage fraud.

Non-judicial approaches to compensating unexpected medical injuries are the norm in New Zealand, Sweden, and elsewhere (Bovbjerg and Sloan, 1998; Danzon, 1985, 2000). Similar programs were debated intensively in Colorado and Utah in the mid-1990s, but were not adopted (American College of Physicians, 1995; Petersen, 1995). The committee believes the time is now ripe for successful implementation of such approaches in the United States because of two contributions by the emerging science of patient safety. First, human factors engineers have shown that non-punitive approaches encourage the detection of avoidable injuries and foster systems for continuous improvement, which suggests that resolving malpractice cases without a determination of fault will help rather than harm quality (Institute of Medicine, 2000). Second, as more health care providers accept their responsibility to disclose errors to patients, capping liability at defined amounts—an essential attribute of any affordable non-judicial system—will likely

result in more rather than fewer patients receiving compensation.

GOALS

The demonstration projects in this category would have the following goals:

1. Improve the malpractice system for patients
 - Make compensation for injury more predictable, timely, and fair.
 - Promote honesty, transparency, and trust in clinician-patient relationships.
 - Prevent liability concerns from compromising the availability of health care services for patients.
 - Put patients and physicians, not lawyers and courtrooms, at the center of a reformed system
2. Enhance patient safety
 - Promote robust reporting of errors in a safe environment.
 - Promote system-level responsibility for errors through organization-based financial incentives for improvement, such as self-insurance and experience rating.
 - Involve patients in safety improvement efforts.
3. Maintain access to liability insurance
 - Improve predictability of liability costs
 - Increase affordability of high-dollar liability coverage.
 - Decrease the administrative costs of resolving disputes.
4. Assess cost impact
 - Generate definitive data regarding error rates, claims rates, compensation costs, and administrative costs under various state systems for identifying avoidable

errors and related compensation formulas.

- Analyze and compare data within and across states.

DEMONSTRATION ATTRIBUTES

Both liability reform options outlined earlier require the following actions by participating states, with federal grants for up-front costs and technical assistance, as well as waiver authority if necessary:

- *Infrastructure*—The state would develop and maintain objective indicators of avoidable errors (ACEs), relying on experts, a broader and more participatory process, or a combination of the two. The state also would develop and maintain fair, consistent methods (schedules) for calculating economic harm and reasonable compensation for pain and suffering. Both the ACEs and the schedules would need to be updated on a regular basis, with ACE categories expanding over time to encompass the large majority of avoidable injuries. There also would need to be centralized collection of data related to the state-level demonstrations. To help states in developing ACEs and damage schedules, DHHS should provide support for related grants to the Health Resources and Services Administration (HRSA) or the Agency for Health Care Research and Quality (AHRQ).
- *Legal environment*—States would need to authorize statutory or contractual modifications of tort liability to reflect the terms of the option they select, as well as to create clear, narrow exceptions to the malpractice reform (e.g., intentional harm). The state would also need to protect from legal exposure individuals and organizations acting in good faith to implement the demonstration approach (e.g., health plans and employers negotiating group contracts on behalf of enrollees). And to make the demonstration affordable, states would need to prevent

health insurers, disability insurers, and other parties who pay costs incurred by patients suffering compensable injuries from suing health care providers to recover those payments (i.e., barring subrogation claims). Finally, states would need to ensure that apologies and other systematic communications, such as mediated discussions between providers and patients following the occurrence of an avoidable injury, do not increase providers' financial liability or legal exposure.

- *Patient safety reporting systems*—States would establish oversight mechanisms to verify the detection of injuries and disclosure to patients. The specifics of these mechanisms would depend on whether the claims resolution system operates at the state-wide or institutional level (i.e., upon the demonstration option selected). These mechanisms would build upon existing state reporting requirements. States would also need to establish mechanisms for collecting and analyzing patient safety data, including voluntary, confidential reporting of near misses. Federal legislation currently under consideration by Congress would aid this process if enacted. The collection and reporting of patient safety information would need to rely on computer-based monitoring systems within health care institutions. With time and experience, these systems could be linked to decision support and knowledge management systems that would help prevent errors from occurring in the first place. Federal technical assistance would be available for these activities.
- *Education*—The states would be charged with educating the public about the benefits and costs of liability reform, which offers faster, fairer, surer compensation on the one hand but requires waiving the right to a court trial on the other. States would also need to work with the principal stakeholder groups (e.g., consumer organizations, health care providers) to build familiarity with and trust in the public policy goals of the option

selected, and to allay concerns about the constraints imposed by the demonstration.

Option 1: Provider-Based Early Payments

Eligibility

A variety of health care provider organizations could participate in such a demonstration, including hospitals, academic health centers, large medical groups, closed-panel HMOs, and skilled nursing facilities. Independent physicians might decide to affiliate with provider organizations (sometimes called "channeling") in order to participate in a demonstration and receive liability protection.

Participating Provider Responsibilities

Provider organizations would first need to self-insure their liability risk, or purchase experience-rated primary coverage so that the organization benefits (or not) from how well they reduce the number of avoidable injuries. They would also need to inform patients about their participation in the demonstration, providing contractual notice of modified liability (perhaps through payers at the point of health insurance enrollment) (Moore and Hoff, 1986; O'Connell and Bryan, 2000-2001). It is likely that mandatory patient participation as a condition of treatment would best serve the goals of the demonstration for states adopting the provider-based early payment option. However, a state might choose, for legal, political, or other reasons, to allow patients to opt out of the reformed system at the time of health insurance enrollment or hospital admission (i.e., pre-injury), or might modify the early payment system in special situations (e.g., emergency care).

Should a specific avoidable event (ACE) cause injury, providers would need to notify patients promptly; express regret; and tender payment for both net economic harm (medical care, lost wages, lost domestic production, with collateral source offset) and capped, scheduled noneconomic harm (pain and suffering). Provid-

ers also would be permitted, but not required, to tender similar payments in other cases of avoidable medical injury that do not fit into an ACE category, thereby gaining immunity from suit. Because providers would be required to comply with external oversight and error reporting obligations, states would be able to monitor early payment practices to determine the circumstances under which providers are voluntarily tendering or not tendering early payment. In terms of patient safety, providers would need to offer patients meaningful opportunities to participate in efforts designed to reduce error (e.g., mediated discussions with patient safety committees regarding their experiences).

Government Responsibilities

The state would protect participating provider organizations from tort liability in cases where payment is promptly tendered. States, either directly or through intermediary organizations, would ensure that organizations reliably inform patients in all instances of avoidable injury. The federal government would provide reinsurance or other umbrella coverage as an incentive for provider organizations to self-insure and channel coverage for affiliated physicians, with shared-risk corridors or similar safeguards against moral hazard. The federal government should consider whether additional funds should be made available in the event that the early payment system is more expensive than the current system.

In addition to the general support described above, DHHS might provide technical assistance to states establishing oversight mechanisms for captive insurance companies or risk-retention groups formed by provider organizations. Finally, DHHS would create "safe harbor" protection under the antikickback statute so that hospitals and other provider organizations can offer shared, subsidized liability coverage to affiliated physicians.

Option 2: Statewide Administrative Resolution

Eligibility

All licensed health care providers (professional and institutional) within a state (or large geographic area within a state) would participate. States might explore including health plans and other potentially liable parties as well.

Provider Responsibilities

Providers, along with the state, would notify patients about the state's modified liability system and give them related information. No pre-injury opt-out would be available under this option. Providers also would need to set up systems to detect errors and disclose them to patients and to provide related apologies. For injuries to patients that fall within the scope of the demonstration, providers or their liability carriers would be responsible for paying amounts determined by the publicly administered adjudication system in the manner authorized by that system.

Government Responsibilities

States would need to create a publicly administered adjudication system, with each state having latitude to determine how it will do so. Key elements of such a system include the following:

- Compensation criteria based on avoidability (e.g., expansion over time of established ACEs categories)
- A definition of compensation that combines net economic harm (medical care, lost wages, lost domestic production, with collateral source offset) and capped, scheduled noneconomic harm (pain and suffering)
- Injury thresholds (days of hospitalization, days of disability, total economic loss)

- An administrative system of adjudication for determining eligibility and compensation in individual cases
- A consumer and provider appeals mechanism
- A multidisciplinary expert panel, including consumer representatives to oversee the system

DHHS would provide start-up funding for the administrative adjudication system, with the understanding that there will eventually be a transition to a provider surcharge with federal matching funds. This might be done using HRSA or AHRQ grants to states in amounts sufficient to cover the operating costs of calculating payments and resolving disputes, as well as initial expenses associated with defining compensable events and developing damage schedules.

As states develop the infrastructure needed for the demonstrations, they would need to work with stakeholder groups, including consumer advocacy groups, to anticipate and avoid state constitutional challenges and other implementation delays. The states would also need to put in place a system for funding compensation payments that maintains financial incentives for safety improvement within health care organizations, possibly modeled on workers' compensation systems that segment employers according to size and structure into tiers of class-rated individual risk, commercially insured (experience-rated) risk, and self-insured risk. Pooling of individual risks might best be handled in the long run by a state fund supported by physician surcharges and administered by private entities under contract to the state. For practicality, however, demonstration sites should encourage liability carriers that currently insure individual clinicians to accept essentially all applicants, with discounts for meaningful patient safety activities.

Finally, the federal government would guarantee fiscal neutrality from the state's and its providers' perspectives to account for the possi-

bility that a comprehensive system that identifies and compensates avoidable injury may be more expensive than the current patchwork system of tort litigation. As part of this guarantee, appropriate maintenance-of-effort and other design safeguards would need to be in place.

REFERENCES

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"I avoid procedures with complications or high risk."

"I cannot see ER patients anymore."

"I carefully select procedures I will perform based on risk/reward ratio."

"I have resincted new Medicare patients to my practice."

"I must simply see more patients in the same time period – rush, rush, rush."

"I stopped seeing 100 nursing home patients"

"I do not treat patients anymore. I give 2nd opinions."

"I will consider practicing on a year to year basis."

"I am looking for alternative career options."

"I have stopped delivering babies."

Medical Malpractice Crisis – CSMS Membership Survey Data
Physician Perspectives
September 18, 2003
Connecticut State Medical Society

005863

Impact on Access

FACT:

Physicians in Connecticut are changing the way they practice medicine because of increasing medical liability insurance costs.

Increasing rates coupled with a dramatic reduction in insurers (reduced from 8 to 2 since 2000) has forced physicians to cease or modify the care their patients receive.

Left unchecked, skyrocketing rates and fewer insurers will have an even greater impact on the delivery of care in the future.

005864

The number of active physicians in Connecticut has decreased over the last 5 years.

1998 - 8,458 active patient care physicians in CT

2003 - 7,000 active patient care physicians in CT

Note: Number of active patient care physicians is less than the number of licenses held. This reflects retirees and physicians who are no longer practicing but continue to renew their license to maintain the title of MD.

Source: AMA / HHS 1998, CSMS 2003 Estimate

Since 1997 there has been a 21% drop in American medical school grads applying for ObGyn residencies .

Since March, almost 10% of the 1151 ObGyn residency spots went: UNMATCHED

Source: American College of Obstetricians and Gynecologists

Between 1987 and 1998 the total number of medical school graduates in Connecticut fell by 1%ⁿ.

Source: Yale School of Medicine, UConn school of Medicine

005865

Medical liability insurance rates have adversely impacted the delivery of care to underserved populations.

30% of the CT Doctors who responded to a recent survey are no longer accepting Medicaid patients due to increases in medical liability insurance costs.

44% of physicians have reduced or eliminated pro-bono medical care.

Source: Connecticut State Medical Society Survey, 12/31/2002

005866

There are 32 communities in CT with physician shortages:

Ansonia	Bristol	Bridgeport
Bozrah	Danbury	East Hartford
Enfield	Franklin	Griswold
Hartford	Killingly	Lisbon
Meriden	Middletown	Montville
Stamford	Sterling	New Britain
New Haven	New London	Norwalk
Norwich	Plainfield	Preston
Sprague	Stratford	Torrington
Vernon	Voluntown	Waterbury
West Haven	Windham	

Source: US DEPARTMENT OF HEALTH & HUMAN SERVICES January 2003

005867

Medical liability rates have changed the way physicians care for patients in Connecticut.

61% of physicians have increased the number and frequency of tests to avoid claims

48% of physicians have held off upgrading medical technology because of the rapidly increasing medical liability insurance rates

Source: Connecticut State Medical Society Survey, 12/31/2002

Lack of competition among medical liability insurers has left physicians without coverage.

Some practice groups are being asked to cover a \$250,000 deductible prior to obtaining coverage

The state's largest insurer no longer meets certain hospitals physician's privilege requirement

Remaining insurers are dictating what services can be provided

Source: Connecticut State Medical Society Survey, 12/31/2002 / CMIC

005868

The Implications of potential claims are limiting patient access to care in Connecticut.

Mike Deren, MD, a Thoracic Surgeon in New London avoids performing esophago-gastrectomies or first rib resections for thoracic outlet syndrome because of the high incidence of lawsuits associated with both.

Patients presenting with these conditions are referred to Boston. No physicians at Lawrence Memorial Hospital in New London will perform this procedure. He can locate no Connecticut providers to accept his referrals.

Like many CT physicians Dr. Deren feels he has no alternative but to be more selective in accepting high-risk patients in an attempt to limit his exposure to claims which would raise his medical liability insurance even further.

The doctors behind the numbers:

Charlene Li, MD – (Family Physician) Windsor

A family physician who, due to medical liability premiums, had to drop her coverage from \$2 million / 5 million (\$44,900 per year) to \$1 million / 3 million (\$30,000). Additionally she reduced the salaries of her practice physicians from \$125,000 to \$90,000, while increasing individual physician target patient hours from 30 to 35. She previously delivered 30 babies a year. She will stop delivering babies on 12/31/03.

Mary Ellen Humes, MD (Obstetrician) – Stamford

In order to obtain insurance and remain in practice she became employed by a local temp agency that was insured and then hired herself from the temp agency.

005870

Robert Chmielewski, MD – Bristol

Considered one of the top ObGyns in the country, he has stopped delivering babies due to unaffordable medical liability insurance. Although he has never experienced a claim (25 year) his rates increased 35% in 2002.

Michael Krinsky, MD – (Neurosurgeon) Bloomfield

His medical liability insurance rates have increased by 130%.

Mark Fisherkeller, MD – (Cardiologist) Willimantic

Although he has never had a claim (28 years) his medical liability rates increased 60% this year.

Peter Auerbach, MD – (Obstetrician) Groton

He has been forced to limit his scope of practice and refers patients requiring more complex procedures to other physicians. He is strongly considering leaving practice this year.

Douglas Gerard, MD – (Family Physician) New Hartford

He is the only primary care physician in the New Hartford area. Although he has not had a claim (17 years) his 2002 premium increased by 40% and his 2003 premium increased by 100%. Dr. Gerard longer accepts Medicaid.

Frank Anderson, MD - (Gastroenterologist) Norwich

He recently relocated from California, a state with caps on non-economic damages, and is considering moving back. Over the last 8 years in California, premiums for his specialty have increased 25% compared to 400% in Connecticut.

Neil Brooks, MD - (Family Physician) Vernon

On May 2nd he ended a 32 year career with Rockville family physicians as a result of his inability to afford a part-time medical liability insurance policy. He would have to work 15 hours each day just to pay the premium. Dr. Brooks has also been forced to stop volunteering in a local clinic because his insurance refuses to cover him in that setting.

Ruth Schleiffer, MD – (ObGyn) South Windsor

She is a single mother and a full-time ObGyn who is attending law school part-time. Because of the increased financial strain of practice and the fear of being sued, she has decided to leave the medical profession.

Kolala Sridhar, MD (Gastroenterologist) – Norwich

The medical liability insurance premiums for his four physician practice increased from \$23,695 in 2001 to \$110,386 2002.

Craig Conoscenti, MD (Pulmonologist) – Norwalk

He gave up practice due to unaffordable medical liability rates. He now works for a pharmaceutical company.

The Connecticut State Medical Society has additional information regarding other physicians who have ceased or altered their practice as a result of several studies of the issue.

Certain specialties have been hit especially hard by medical liability insurance rate increases.

<u>2003 increases</u>	<u>5 Year Cumulative Increases</u>
Neurologists - 72%	340%
Internal / Family Practice - 55%	210%
Radiologists - 40%	180%
Gastro / Cardiologists - 55%	126%
OB / Neurosurgery - 30%	118%
Pathologists - 30%	222%

?

As a result many specialists no longer take referrals of high risk patients, perform high-risk surgery or deliver babies.

Source: US Department of Health & Human Services

005875

Drivers of Medical Liability Insurance Premiums

FACT:

While most Connecticut physicians will never go to trial, the majority of physicians have at least one claim filed against them over the course of their career. (In fact, Connecticut has some of the most respected physicians in the country)

Technology has increased patient expectation for success.

The number of malpractice suits have remained steady.

Recent precedent-setting jury awards have forced physicians to settle more frequently and at larger amounts.

Source: CMIC

005876

Facts about Connecticut Physicians:

Less than one in 100 doctors are accused of malpractice each year.

Only 7% of all claims come to trial.

More than 80% of those cases that go to trial are won by the physician.

Certain high-risk specialties are more likely to receive a claim.

The average ObGyn In Connecticut can expect to be sued 2.53 times over the life of his or her career.

Sources: Connecticut State Medical Society

FIAA 12/09/2002

FIAA 12/09/2002

American College of Obstetricians & Gynecologists

005877

CT's average patient payouts are the fourth highest in the nation at \$432,536.

The fact is CT ranks seventh in the nation on total patient payouts. (21.2% per capita payout)

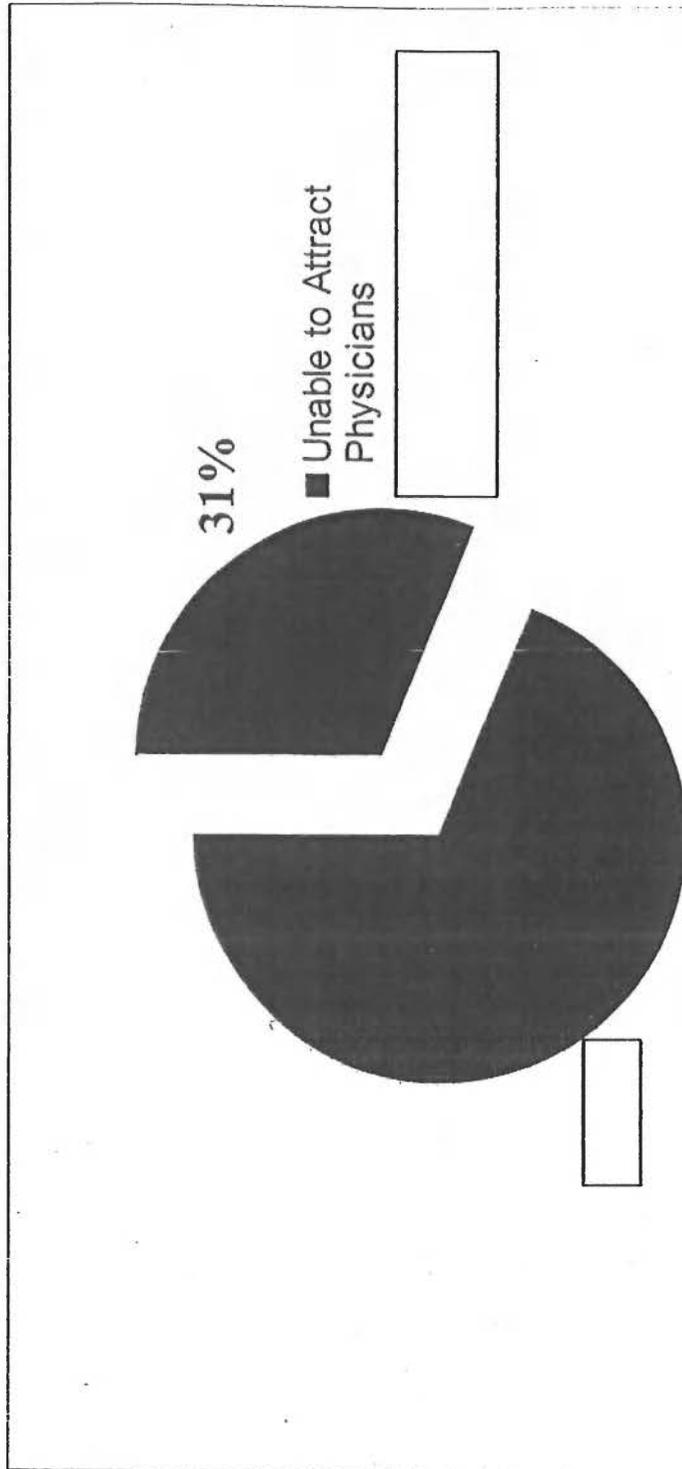
States that fall in the top ten in average patient payouts and total patient payouts are:

Have no meaningful cap on non-economic damages

Designated by AMA as "crisis states"

Are experiencing significant impacts on access

31% of family physicians have been unable to attract or recruit new physicians for their practices due to increased cost of medical liability rates and/or deductibles.

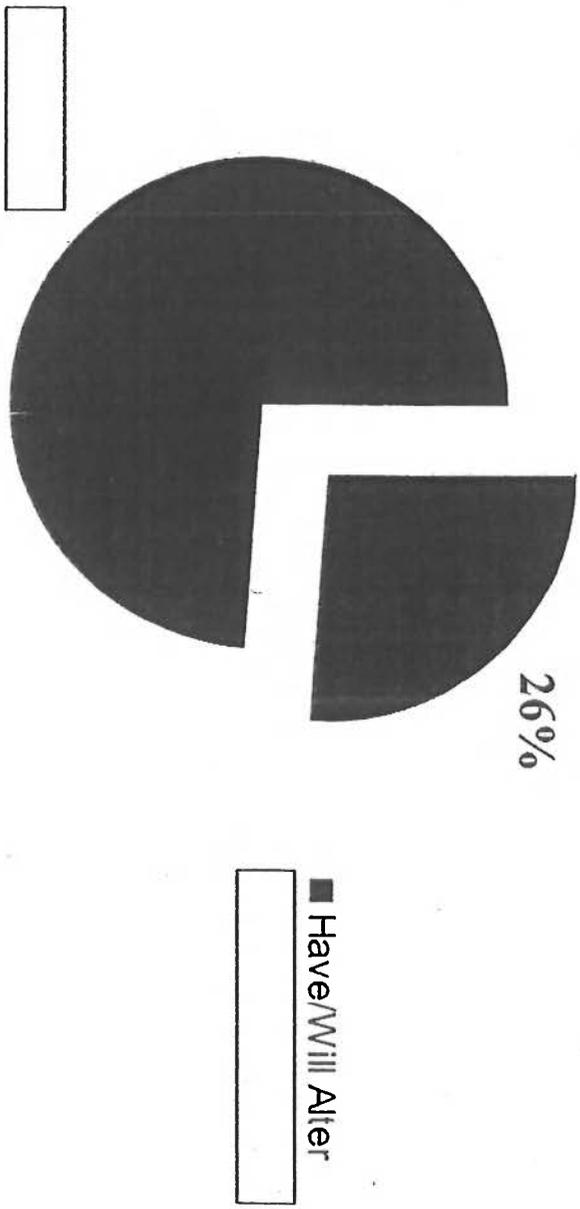


59% of family physicians have increased the number of tests they order so they are protected from being sued.

■ Increased Tests to Avoid
Lawsuits

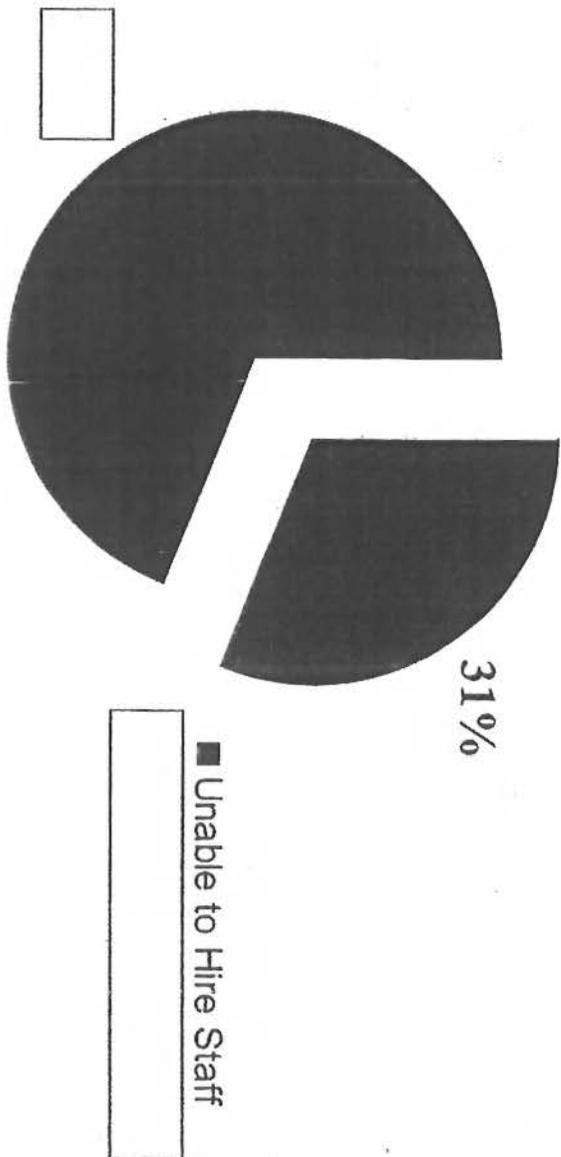


26% of family physicians have already or will – within the next year - alter the scope of their practices when it comes to performing high-risk procedures.



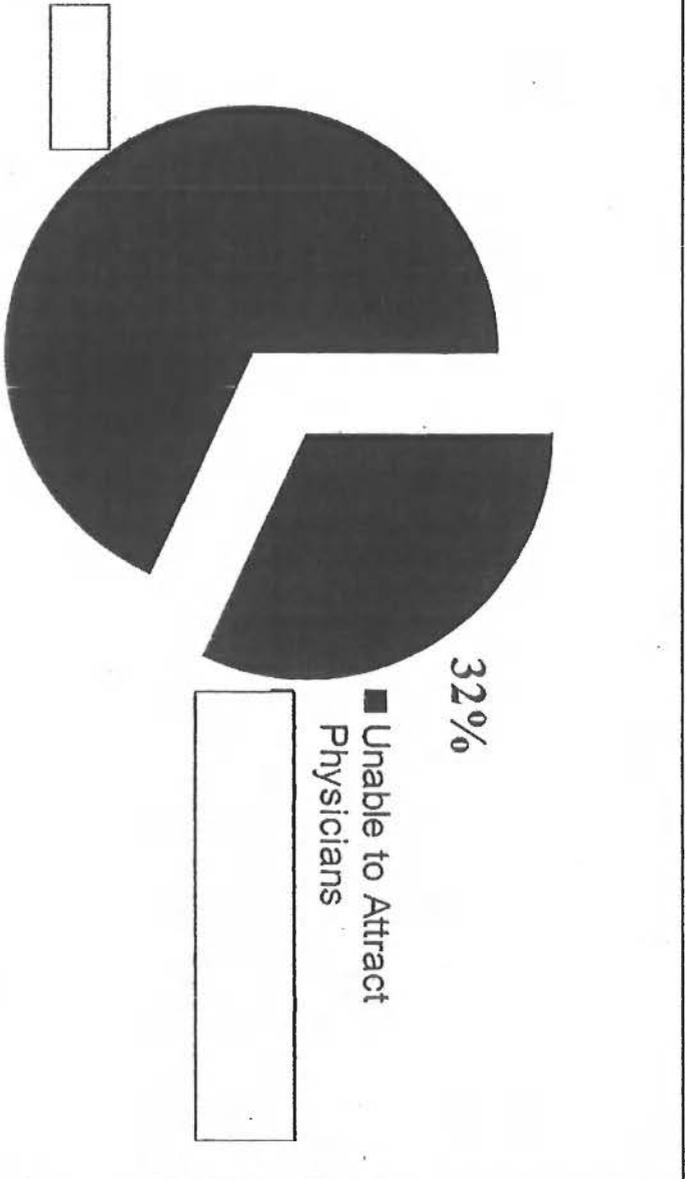
Source: CSMS CT Physician Survey, August 2003

31% family physicians have been unable to hire needed staff as a result of increased cost of medical liability premiums and/or deductibles.



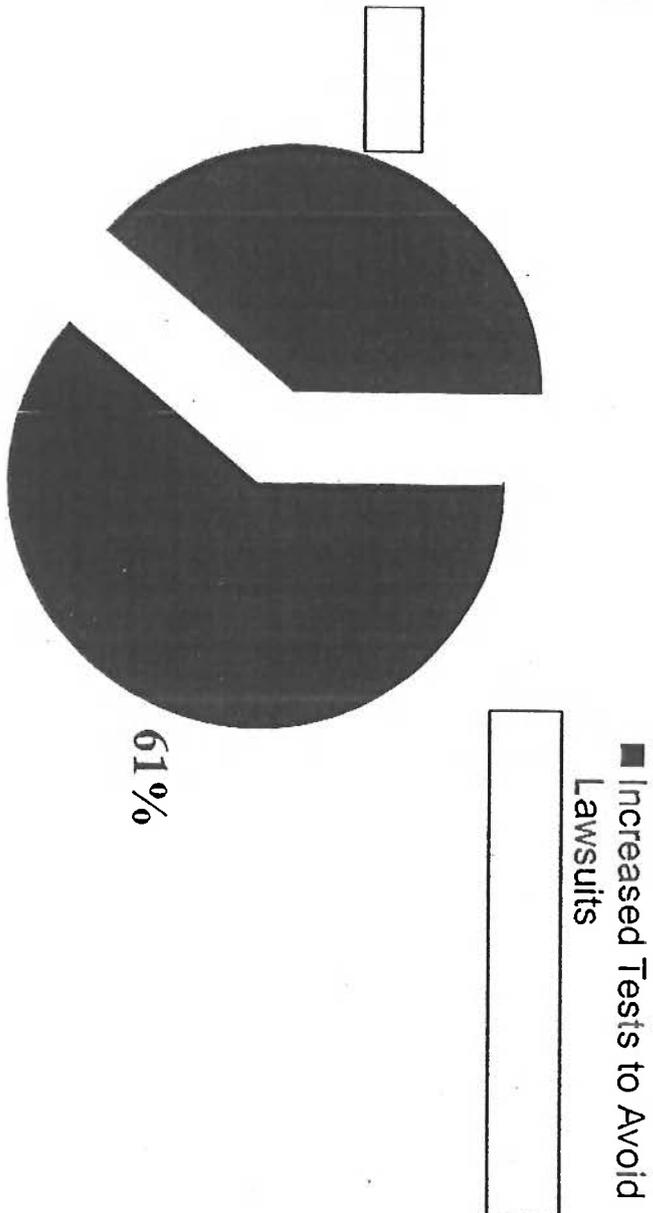
Source: CSMS CT Physician Survey, August 2003

32% of internists have been unable to attract or recruit new physicians for their practices due to increased cost of medical liability rates and/or deductibles.



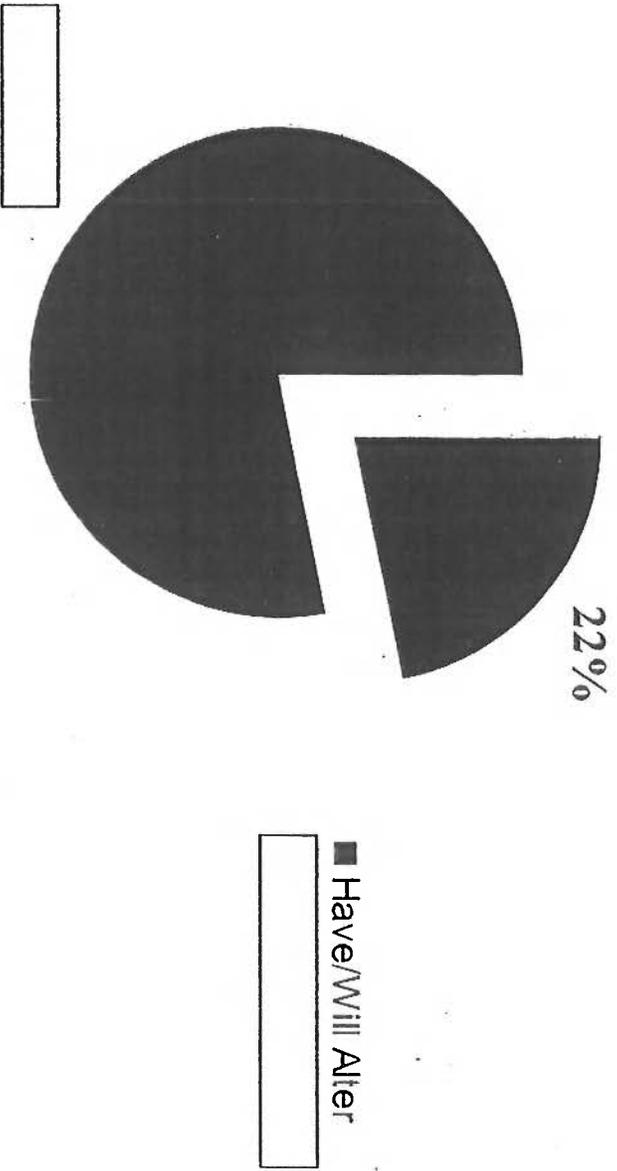
Source: CSMS CT Physician Survey, August, 2003

61% of internists have increased the number of tests they order so they are protected from being sued.



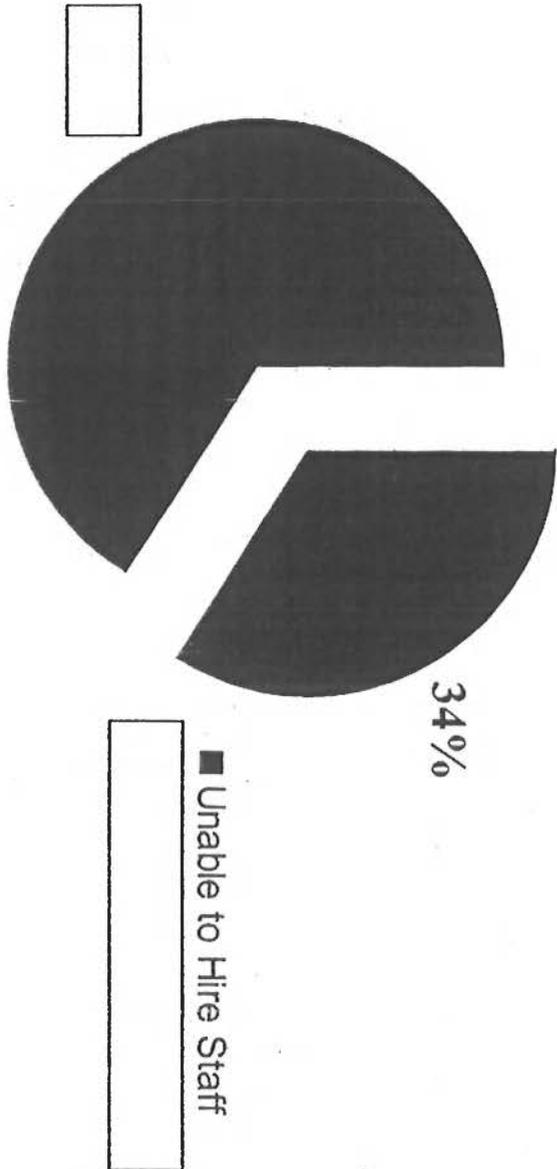
Source: CSMS CT Physician Survey, August 2003

22% of internists have already or will – within the next year - alter the scope of their practices when it comes to performing high-risk procedures.



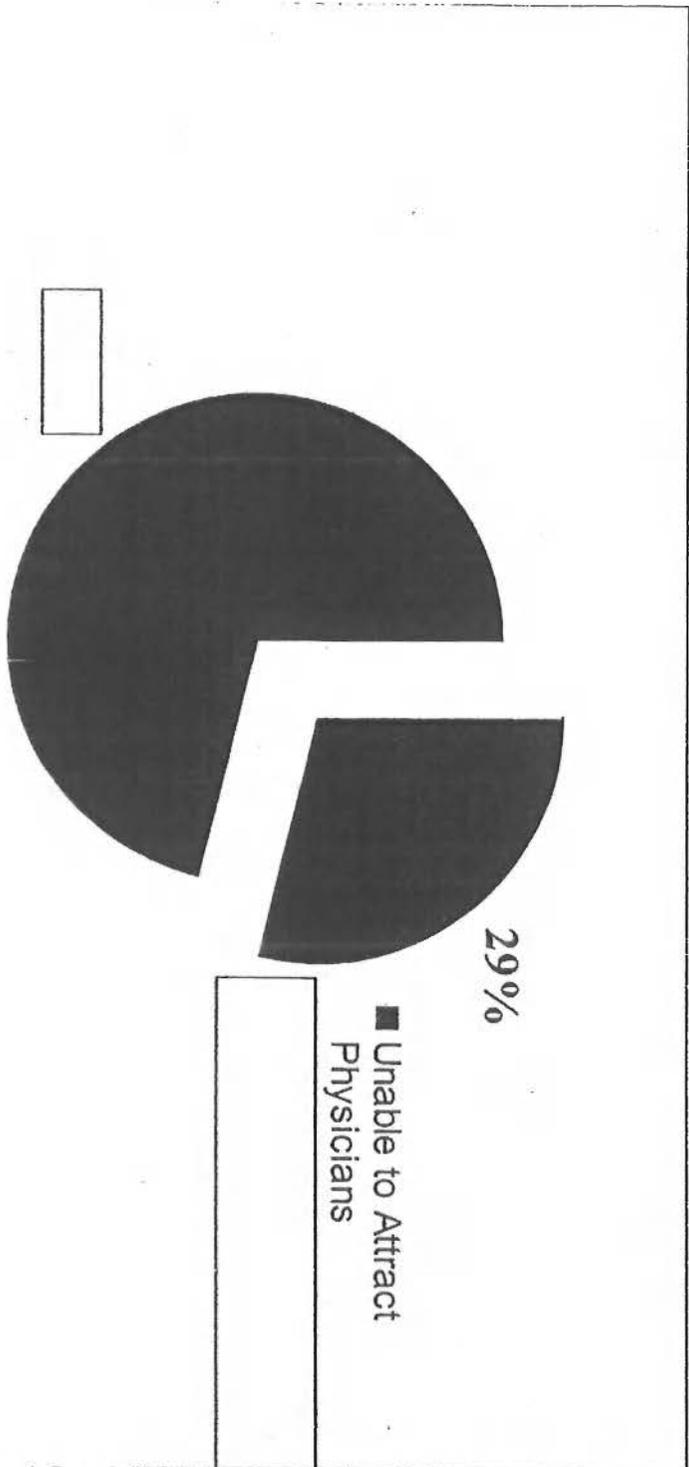
Source: CSMS CT Physician Survey, August 2003

34% of internists have been unable to hire needed staff as a result of increased cost of medical liability premiums and/or deductibles.



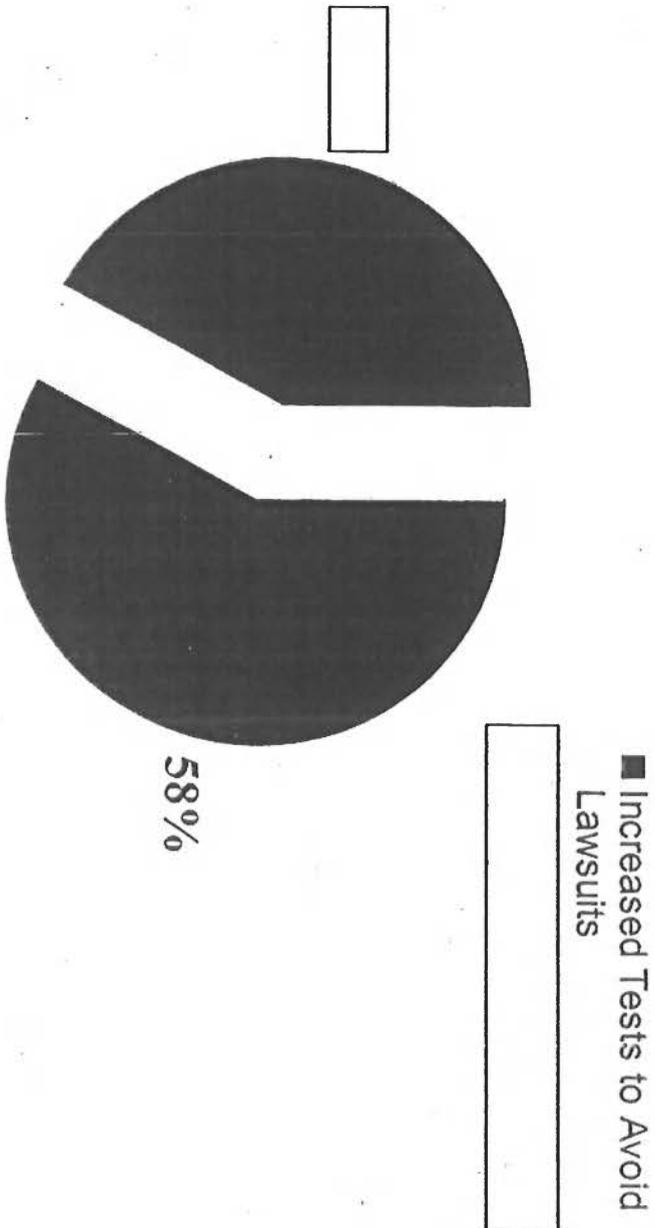
Source: CSMS CT Physician Survey, August 2003

29% of ObGyns have been unable to attract or recruit new physicians for their practices due to increased cost of medical liability rates and/or deductibles.



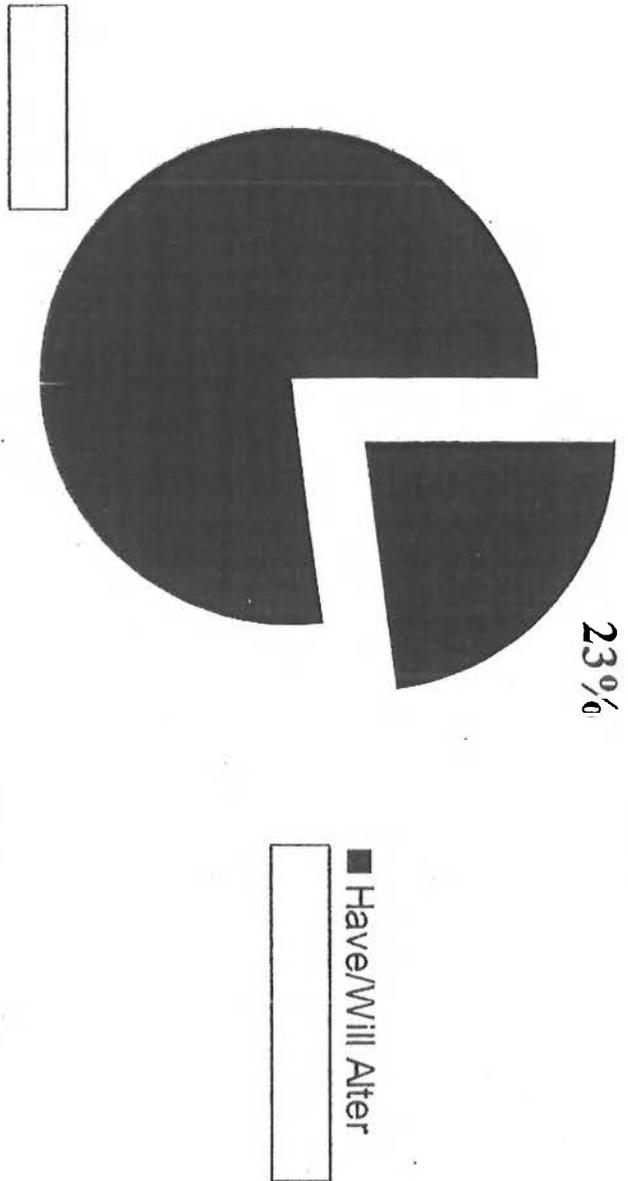
Source: CSMS CT Physician Survey, August 2003

58% of ObGyns have increased the number of tests they order so they are protected from being sued.



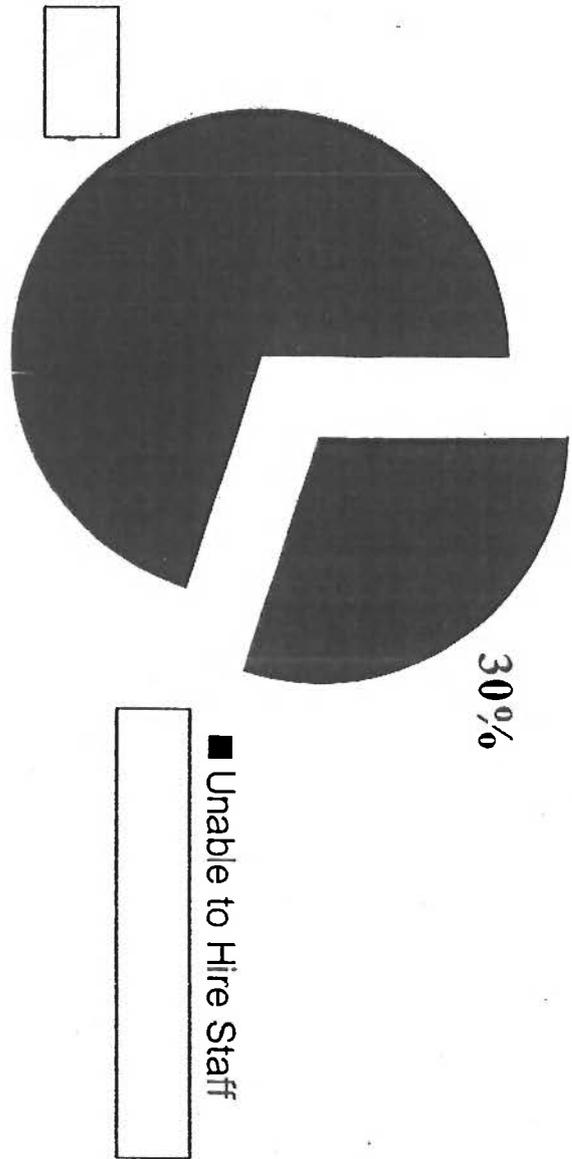
Source: CSMS CT Physician Survey, August 2003

23% of ObGyns have already or will – within the next year - alter the scope of their practices when it comes to performing high-risk procedures.



Source: CSMS CT Physician Survey, August 2003

30% of ObGyns have been unable to hire needed staff as a result of increased cost of medical liability premiums and/or deductibles.



Source: CSMS CT Physician Survey, August 2003

It is time to act – CT Patients Need Your Help

FACT:

Medical liability insurance rates must be stabilized to ensure patients have access to care in Connecticut.

Rates are forcing physicians to change the way they provide care.

These changes are dramatically impacting patient care in Connecticut and will continue to get worse.

Two-thirds of Connecticut residents believe the legislature needs to resolve this problem immediately.

Source: Research 2000 CSMS Survey, 03/2003

A Cause

For Action

Connecticut Families
Search for Justice

Project of
Connecticut Center for Patient Safety and
Connecticut Patients' Rights Group

*A Cause
For Action*

Connecticut Patients' Rights and the Connecticut Center for Patient Safety deeply appreciate the courageous individuals and families who have shared their stories and relived the painful experiences that changed their world forever.

This book is dedicated to them and to those whose stories remain untold.

Our hope is that it gives voice to the suffering these people have sustained.

Our wish is that we have done justice to their sorrow.

Our purpose is to break the silence that confronted these victims of medical malpractice, and to expose the manner in which they were treated by the healthcare industry.

Contents

- *Kate Govoni*
- *Andiemei Meder*
- *Rory Freeman*
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- *Peter Ladd*
- *Rudy Passero*
- *Katty Chavarria*
- *Sadie Cole*
- *Matthew Gersz*
- *Laura Seckley*
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"I want to see responsible parties held accountable"



Kate Govoni

My wife Kate died suddenly at age 41 after a routine allergy shot in a doctors office. Our then four-year old son was sitting next to her and screamed when she collapsed from anaphylactic shock. Our one-and-one half year old daughter was downstairs in the lobby with her nanny. No one in the 14-doctor medical practice could revive Kate, in part because there was no intravenous epinephrine available. It took three calls to 911 to get an ambulance and amazingly enough, it was only when paramedics arrived that an emergency tracheotomy was performed. By then though, it was too late.

A couple of hours later, the allergist walked me to my care and was so remorseful and emotionally drained that he offered to check with his malpractice insurer to see what he could do for me and my kids. If that wasn't a

tacit admission of liability and responsibility I don't know what is. But nothing ever became of that gesture. The result is four-plus years of litigation with no end in sight.

It seems to me that if a physician is willing to accept responsibility for a patient's death by settling a case early but can't invoke the protection of his insurance policy, the insurer can be found in breach of his contractual obligation, not to mention laws designed to protect patients and insurance customers.

What compounded the absurdity of this case was the fact that two poorly trained investigators for the state department of Public Health did little to probe the root cause of this tragedy and eventually whitewashed the matter.

I want to see the responsible parties held accountable.

Steve Govoni

CPR-Connecticut Patients' Rights Group,

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1-800-251-7444 www.neprg-ct.com

Quality Healthcare is a Right

*We need
to know when
error happens.*

Four years ago my three-year-old daughter, Andie Mei died during a procedure to insert tubes in her ear to help with chronic ear infections. The doctors' errors were compounded by the fact that the alarm on the monitor was not being operated in a reasonable and customary manner.

This has been an enormous tragedy for our family. We have a small Christmas tree in our living room to remind us of the bright light she brought to our lives.

Andie Mei's death is neither an exception nor an aberration. Complacency, arrogance and simple negligence claim the lives of patients every day. It is critical for health-care customers to know and understand for their own safety. The public must begin to act to protect their own interests.

Rosemary Gibson wrote a book about medical malpractice called the Wall of Silence about medical malpractice. Silence is exactly what confronted us when this disaster happened. My daughter entered surgery in the morning and was declared dead that night. No one apologized; no one admitted a mistake had happened. It took years for the Department of Public Health and the Medical Examining Board to address the problem.

When they did act, it was inadequate. We lost a child. But the physician who practiced such bad medicine was fined just \$5,000 and placed on probation. It is little wonder that CT ranks 40th in the country in getting rid of bad doctors. Only 5% of the doctors commit 50% of the errors. Yet the system is set up to protect its own. It puts the public at enormous risk.

I do not know if the anesthesiologist has committed other errors. I also do not know the history of the surgeon who did the



operation. He has left the state and no action has been taken against him. When serious malpractice happens, the physicians often do leave the state and set up practice elsewhere. Because these doctors are no longer a threat to a state's residents, Departments of Public Health don't act because their responsibility for the public health stops at the state line. The National Practitioners Data Bank, which can only be accessed by hospitals and Departments of Health, has a 61% error rate.

We need to know when error happens, how it is handled and in what hospitals or

surgical centers. We need to be able to choose doctors based on their malpractice history. As a society we can do this. Because the public needed to have confidence in the US airline system, the industry conceived a strict quality control method. When a plane crashes, or there is even a near miss, there is a national organization that analyzes the crash. We need to have the same system to address medical error. More people are dying unnecessarily in the hands of our healthcare system than on our roads. That is the tragedy.

— George Meder

CT Center for Patient Safety

CT PATIENTS' RIGHTS GROUP

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Quality Healthcare is a Right

"I knew something was wrong . . . I kept asking for a doctor"



Laura Seckley with her little sister, Rebecca

**"They just want
to pretend that it
didn't happen"**

On September 5, 1997 our daughter Laura was born. Due to negligence our beautiful child will have a lifetime of kidney transplants and disability.

I knew something was wrong during the delivery. I kept asking for a doctor. But the midwife, believing she had more experience than the physician who had only had his license for three months, did not call him. The nurse knew something was wrong, too. But instead of saying something or getting me and my baby some help, she just changed the medical records to show that she notified the midwife of my daughter's tachycardia (rapid heart beat.)

A series of medical errors and judgments led to Laura's damaged kidneys, significant scarring and her projected lifelong need for kidney transplants. This has had a profound effect on my husband and me. I am very afraid to leave her; afraid that something else might happen. My husband is clinically depressed and has had a difficult time with my fear and his beautiful daughter's disability.

Our hope for Laura's future now rests on our ability to hold these people accountable in court. We resent recent moves by doctors and hospitals to limit our rights and blame us for their problems.

I have read a lot since this all happened to us. And what I don't understand is why hospitals don't try to do a better job. If you hurt someone, you need to ask yourself, what went wrong? But the hospitals and the nurses and the doctors just want to pretend that it didn't happen. It is always someone else's fault. I read the Leapfrog Group's recommendations for hospital change. I also read that nothing has been done. Why?

I want our legislature to take some kind of action; mandate that hospitals change procedures. No one there seems to be in charge.

Christie Seckley

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Quality Healthcare is a Right

"I don't know why he did nothing while Mia was suffering her injuries"

Mia House was my baby, the youngest of my eight children. She went into Norwalk Hospital to have a Caesarean section. This was Mia's first child. While she was under anesthesia, Mia was not getting enough oxygen and the doctor who should have been watching did not notice. Mia suffered severe brain damage.

Mia's baby's name is Kayleb. Thankfully, Kayleb was not hurt like Mia. As little Kayleb's grandmother, I will raise her. When I bring Kayleb to the hospital to visit Mia, she cannot hold Kayleb, she cannot speak, and she cannot respond in any way.

Kayleb is still too young to know that, unless we are blessed with a miracle, her mother will not be a part of her life. Someday, though, Kayleb will wonder why her mother is confined to a hospital bed and unable to speak. The answer is why I am here.

The doctor who should have been making sure she got enough oxygen, her anesthesiologist, is named Jay D. Angeluzzi.

I don't know why he did nothing while Mia was suffering her injuries.

But, I do know that he injured another woman in the same way before. Her name is Sadie Kinder Cole. Her husband Herman and Sadie's children suffer as we do. They also have had the heart torn from their family.

After Mia was injured, we learned that Dr. Angeluzzi has been in and out of



Mia & Baby Kayleb



psychiatric facilities over the years because of substance abuse. His medical license was on probation in Massachusetts. He even had to leave work because he was unable to function. Despite this, his medical license here in Connecticut was never restricted in any way. The hospital never did anything to protect his patients. That is why Dr. Angeluzzi was able to neglect Mrs. Cole and cause her severe brain damage. We know all of this because Sadie's husband Herman Cole fought the hospital in court to find out the truth.

After injuring Mrs. Cole, you would think that someone from the State would stop Dr. Angeluzzi. You would think that the hospital would protect it's patients from this man. You would be wrong. Mia was hurt because the people who should have protected my daughter from this doctor didn't respond to the Cole

family's complaints. Despite his psychiatric problems and the way he devastated Mrs. Cole, Dr. Angeluzzi's medical license and hospital privileges were never restricted.

I am here today because I don't want another family to suffer as we have. Without Mr. Cole's persistence, we still might not know why Mia was hurt. If Norwalk Hospital or the State responded to Mr. Cole, Mia would be at home right now caring for little Kayleb -- holding her daughter in her arms as I once did with Mia. Instead, I will raise Kayleb and she will never know my lovely daughter Mia as she once was.

I ask you, please, protect patient's families. Do not let Mrs. Cole's and my daughter Mia's suffering be in vain.

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Quality Healthcare is a Right

I agreed to undergo "minimally invasive" surgery. It was supposed to be "routine"...



Gus Velez

*I was dealt a
terrible blow that
will change my
entire life.*

I write to you today because last year I was a young man with a promising future as a Financial Analyst and upcoming marriage. Then, I was dealt a terrible blow that will change my entire life.

I had an inflamed colon and agreed to undergo "minimally invasive" surgery to correct it. It was supposed to be "routine." I would be in and out in a few days. But the doctor made a horrible blunder. During the surgery the doctor sewed up my aorta, the main artery in my body, stopping blood flow to both of my legs. As a result of that catastrophic error, both legs had to be amputated above the knee.

In medical terms it was an aortic transection with resultant bilateral trans femoral amputation. Translated, that means I have lost two legs and am confined to a wheelchair. What happened to me can be said in one sentence, but the implications of that event fill pages.

My fiancé has become the main breadwinner. I want to work again but I doubt if I will be able to do more than part time for quite awhile. This physical therapy is a lot harder than anything I did on the rugby field. The pain is ongoing and at times excruciating.

This didn't just impact me and my fiancé, my entire family has been affected. My brother and sister had a restaurant that my father had financially committed to. When the focus of the family became my disability and needs, they closed the restaurant and they all suffered financially. But they also got pretty depressed because they wanted to help me, to change the outcome of what had happened to me, and of course, they could not.

I need to tell people what happened to me because I want the public to know that we have healthcare professionals who are incompetent and a system that fails to do anything about it.

Gus Velez

CPR-Connecticut Patients' Rights Group,

a Chapter of the New England Patients' Rights Group.

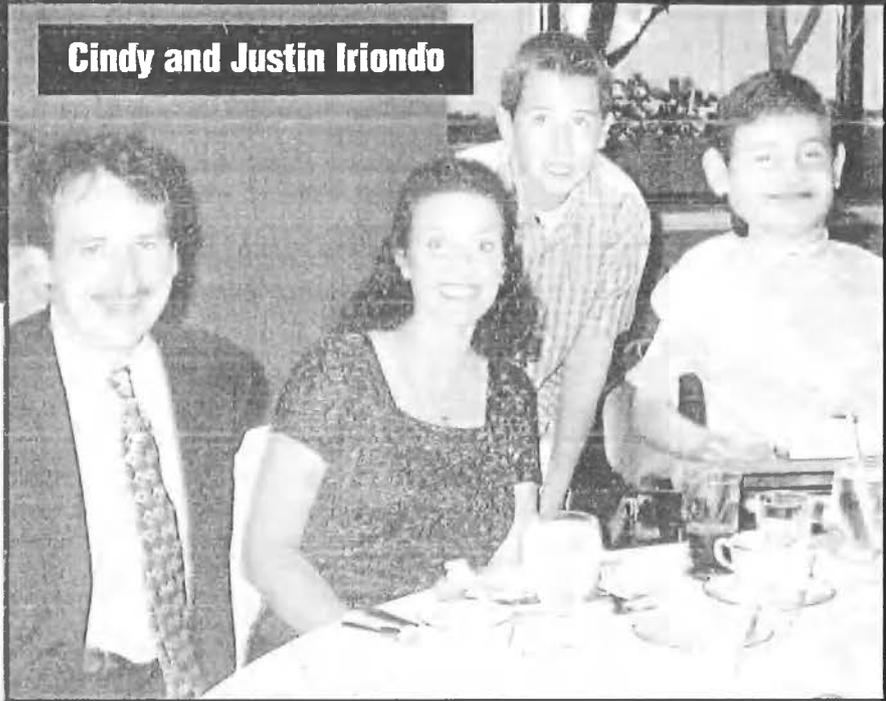
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Quality Healthcare is a Right

*The proposed cap
hurts only the victims...
upon whom physicians
have inflicted
irreparable harm.*

Cindy and Justin Iriondo



My son, Justin, now 13, became a quadriplegic at the age of 5. Justin now requires care 24 hours a day. Through no fault of his own, Justin needs someone to feed him, dress him and take care of all his personal needs. In addition to his not being able to use his arms or his legs, his bowels and bladder no longer function. He does not have enough strength in his diaphragm to cough. A tracheotomy tube has to be suctioned several times a day and monitored constantly for blockages.

Justin had a slow growing tumor inside of his spinal cord. After a week of mild symptoms, he was admitted to the hospital when the symptoms became more severe. The tumor was diagnosed the next day and surgery was scheduled for a later date. Justin's condition became slowly worse. Although he was not moving any part of his body, was not eating, and had not gone to the bathroom for over 20 hours, no action was taken to determine if here had been a change in the spinal tumor until Justin stopped breathing and slipped into a coma. At this point, he was put into intensive care, where it was determined the tumor had swelled, compressing his spinal cord. Justin was paralyzed from the neck down.

Justin was in intensive care for 50 days. Imagine the fear he had when he awoke from a coma, unable to move his body. Imagine my pain and helplessness when I looked into his scared eyes, unable to tell him everything would be okay.

Totally dependent upon those around him, Justin must have complete trust in his care givers. He is at the mercy of anyone who comes in contact with him. Justin now watches from the sidelines at the soccer fields on which he used to play, no longer a participant.

Justin has, and will continue, to face many obstacles in his lifetime. He has already undergone (6) surgeries (two of which were in excess of 8 hours). He will watch as his friends get their drivers' licenses and begin to date. Although a jury decided in July of 2003 that Justin deserved economic and non economic damages to provide financial resources for his future, he will wonder, just as I do, who will take care of him when his father and I are no longer able to do so.

Those in support of capping non economic damages argue that it is needed to save the healthcare industry. Caps on damages are not going to solve the numerous problems within our healthcare system. This "reform" will benefit the insurance companies and protect offending physicians at the expense of the victim. It is incomprehensible to me that a physician would want the pain they afflicted on others to cause further injustice.

Some physicians are threatening to stop practicing in Connecticut and move to another state to avoid paying higher premiums. I currently pay \$9,984.60 per year for health insurance for my family of four. This equates to 22.18% of my salary... there is no cap to the increases that I will have to pay to protect my family.

If the goal truly is to reform the healthcare industry, we need to seek reform in all areas and not target only the weakest - the victims of malpractice. Perhaps legislation should be proposed to place a cap on the amount of insurance premiums and not on the victims of malpractice, who are left to pick up the pieces.

The proposed cap hurts only the victims... upon whom physicians have inflicted irreparable harm.

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Quality Healthcare is a Right

Proposed Amendments to SB 1062 SB 1052
To allow
**Joint Negotiations by Non-Integrated Physicians and
Health Benefit Plans**
On behalf of the Connecticut State Medical Society
Gregory J. Pepe, Esq.
Neubert, Pepe & Montieth, P.C.

Before you today are many many proposals developed to assist Connecticut's physicians in making their medical liability premiums more affordable. Everyone agrees that in recent years the skyrocketing increases in costs that physicians are forced to pay have put Connecticut's health care system in a crisis situation. You will hear a number of people testify about how the crisis is adversely affecting large numbers of physicians who are unable to continue to practice at all or in a particular specialty, such as obstetrics, or continue to perform higher risk procedures because doing so will make the costs of obtaining coverage virtually impossible.

This crisis, coupled with virtually no increases, ... and in some instances, actual decreases, in physician's managed care reimbursements, has created the metaphorical "perfect storm" of catastrophes in Connecticut's medical community. This situation is in dire need of legislative solutions that go beyond our attempts at tort reform in order to address this unbalanced situation. Today I would like to offer comments regarding a proposal, ... **HB 6759 AAC Cooperative Healthcare Arrangements**... that has been before several committees over the past several years and this session has had two public hearings (one in the Insurance and Real Estate Committee and the other before the Labor and Public Employees Committees). **HB 6759** was recently approved by the Labor and Public Health Committees and referred to this committee.

We have opened discussions with the Connecticut Attorney General towards securing the approval of such legislation and ask this committee to consider amending the final medical liability malpractice proposal with additional relief for doctors aimed at permitting balanced and fair negotiations with Managed Care Organizations. Such negotiations do not regularly occur in today's managed care environment, and are necessary to ensure that doctors and other health care providers receive fair and adequate reimbursement of exceptional costs that they incur while providing access to all manner of medical procedures for their patients.

Similar legislation has passed in at least two other State legislatures in recent years as part of those State's comprehensive approach to reform.

Let me take a moment to outline what **HB 6759** would do and the impact it can have on giving the physicians the ability to fairly and with state oversight the ability to recoup the extreme costs of securing mandated coverage for medical liability coverage.

Federal law allows states to develop their own regulatory schemes in areas where the federal government has already developed a regulatory scheme, under a doctrine that is referred to as "state action. This bill applies that doctrine for the purpose of enabling collective negotiations by nominally competing physicians, of certain terms and conditions of a physician's provider contracts with health benefit plans.

The lack of meaningful bargaining power by non-integrated physicians has created a number of difficulties which threaten to curtail access to certain kinds of healthcare services, and compromise the quality of care received by Connecticut residents from their physicians. Some examples have been widely reported in medical journals ... radiologists are increasingly limiting annual mammograms, neurologists are restricting the types of high risk procedures they will undertake, and many OB/GYNs are restricting their practice to GYN and curtailing the delivery of babies ... all this in order to afford an adequate level of insurance coverage for some of the medical services they are trained to do, and want to provide to their patients.

Joint negotiation of the type being proposed in this bill will be permitted in instances where the state, acting through the office of the attorney general, either: (i) finds that a health plan has significant market power, enabling it to virtually dictate the terms of provider agreements to physicians or (ii) finds that negotiations on fee-related issues have been one-sided in favor of the health benefit plan or have not occurred due to the market power of the health benefit plan.

Definitions

For purposes of the Statute, a number of new statutory definitions are being proposed to both implement the purpose of the statute, and assist the State in the implementation of its purpose.

Role of the Attorney General

Any physicians or physician organizations seeking to negotiate the terms and conditions (including fees) with health benefit plans, in concert with or on behalf of more than one non-integrated physicians, shall need to comply with the following procedures;

- (a) File an application with the Attorney General's office which provides:
 - (i) The name and address of the negotiator;
 - (ii) The names and addresses of the physicians represented by the negotiator;
 - (iii) The relationship of the represented physicians to the total population of physician in a geographic area;
 - (iv) The health benefit plan with whom the representative intends to negotiate;
 - (v) The subject matter of the negotiations;
 - (vi) The anticipated impact of the negotiations;
 - (vii) The benefits both to the physicians and to their patients of the anticipated impact of the negotiations

(b) Within 45 days of the filing of an application, the Attorney General shall either (i) approve the filing and permit the requested negotiation; (ii) disapprove the filing as incomplete or deficient, in which case the applicant shall be permitted to re-file an application which corrects such deficiencies; or; (iii) disapprove the filings as not authorized pursuant to the statute, in which case the applicant shall not be permitted to re-file an application for (180) days.

Prohibited Actions

Group actions to boycott or cease services to a health benefit plan shall not be an action authorized under the statute.

Rule Promulgation

The Attorney General shall be authorized by the statute to implement such rules and procedures as are necessary or convenient to implement the provisions of the statute, including the filing of application fees.

Certain Joint Negotiations Authorized Without Need for Application to the Attorney General – Negotiation by non-integrated physicians over certain terms and conditions of their provider agreements with health benefit plans are permitted under the statute, without the need to apply to the Attorney General; those terms include the following:

- (a) Practices and Procedures relating to preventive health care services;
- (b) Practices and Procedures related to Clinical Integration and disease management programs;
- (c) Clinical referral procedures;
- (d) Patient education programs;
- (e) Administrative procedures, including methods of claims submissions, credentialing procedures, and coding procedures;
- (f) Dispute resolution procedures;
- (g) Utilization Review programs;
- (h) Quality Programs;
- (i) Physician selection criteria and de-certification procedures, including the terms for inclusion in so-called “tiered networks”.

Thank you for your time and attention. On behalf of Connecticut’s physicians, I urge you to amend SB 1052 and consider this unique opportunity to help Connecticut’s physicians struggling under the weight of extreme increases in the costs they incur for medical liability coverage.