WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

COMMITTEE NOTICES ...

- *Committee Reports* ... *CR*

**

- *Executive Sessions* ... *ES*

**

- *Public Hearings* ... *PH*

**

- *Record of Comm. Proceedings* ... *RCP*

**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

- *Appointments* ... *Appt*

**

Name:

- *Clearinghouse Rules* ... *CRule*

**

- *Hearing Records* ... *HR* (*bills and resolutions*)

**

- *Miscellaneous* ... *Misc*

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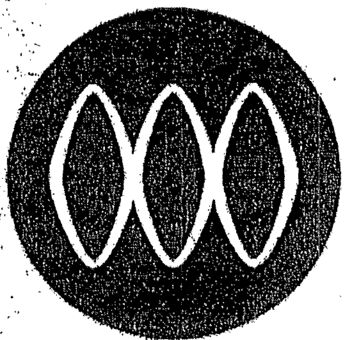
(misc. 2005 documents)



A MILLIMAN GLOBAL FIRM

Milliman

Consultants and Actuaries

The Illinois Senate Judiciary Committee Medical Malpractice Insurance Hearing

Springfield, Illinois

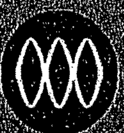
March 3, 2005

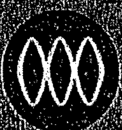
Presented by:
Richard S. Biondi, FCAS

Milliman Studies

Evaluated reductions to medical malpractice losses from caps for:

- Physicians
- Hospitals

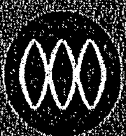




Milliman Studies

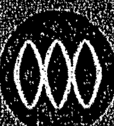
Evaluated reductions to medical malpractice losses from caps for:

- New York
- Pennsylvania
- Florida
- Wyoming
- Maryland



Main Data Sources

- National Practitioner Data Base
  - Physicians Only
  - All Paid Claims
  - Countrywide
- Florida Department of Insurance Data Base
  - Only Commercially Insured Claims
  - Physicians & Hospitals
  - More Detail per Claim
  - Florida Only
- Texas Department of Insurance Data Base
  - Commercial, Bodily Injury Liability Claims
  - Indemnity Payments Over $10,000
  - Physicians & Hospitals
  - Texas Only

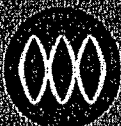


Other Data Sources

- Physicians Insurance Association of America
  - Countrywide Only
- Annual Statements
  - All Insurers Consolidated
- Rate Filings
- US Government (e.g. census) Data

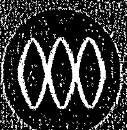
New York – Effect of Cap on Non-Economic Damage

Cap on Non-Economic Damage Award	Physicians Only (Loss & ALAE) Limits $1.3 million primary +$1 million excess	Hospital Only (Loss & ALAE) Unlimited Coverage	Combined Hospital and Physician
$250,000	24%	23%	24%
$500,000	16%	16%	16%
$750,000	11%	13%	12%
$1,000,000	8%	10%	9%

Milliman


Pennsylvania – Effect of Cap on Non-Economic Damage

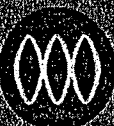
Physicians Only			
Cap on Non-Economic Damage Award	Primary (Loss & ALAE) $500,000/ occurrence	Excess (Mcare) (Loss Only) $500,000 xs $500,000	Total Covered Limits (Loss & ALAE)
$250,000	11%	42%	18%

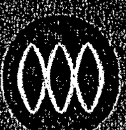


Florida – Effect of Cap on Non-Economic Damage

Cap on Non-Economic Damage Award	Physicians Only (Loss & ALAE) Limits following current distribution	Hospital Only (Loss & ALAE) Unlimited Coverage	Combined Hospital and Physician
$250,000	17%	29%	20%
$500,000	9%	22%	12%
$750,000	5%	17%	8%
$1,000,000	3%	14%	6%

In Sept. 2003, Florida passed non-economic cap of $500K-$1million for physicians and $750K-$1.5 million for hospitals. Florida estimated a savings of 5.3%.

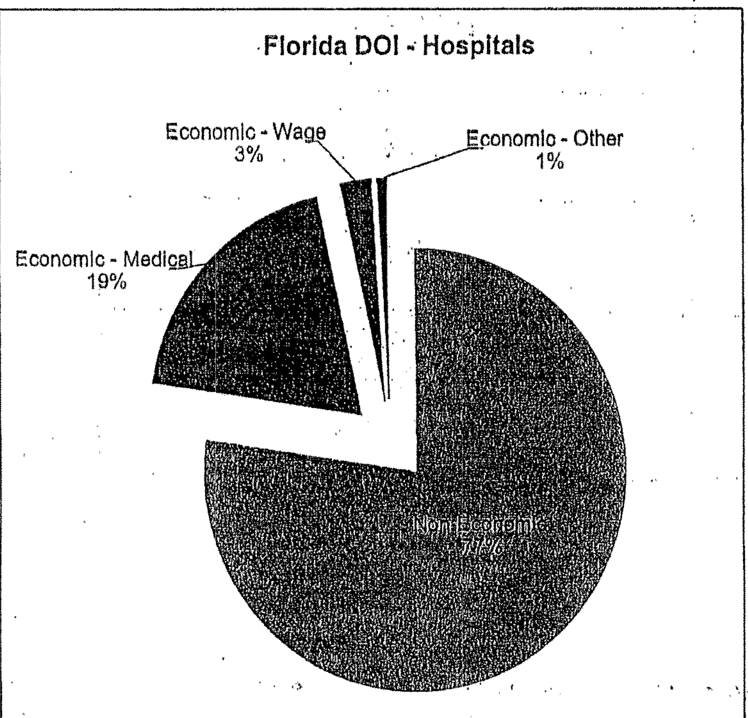


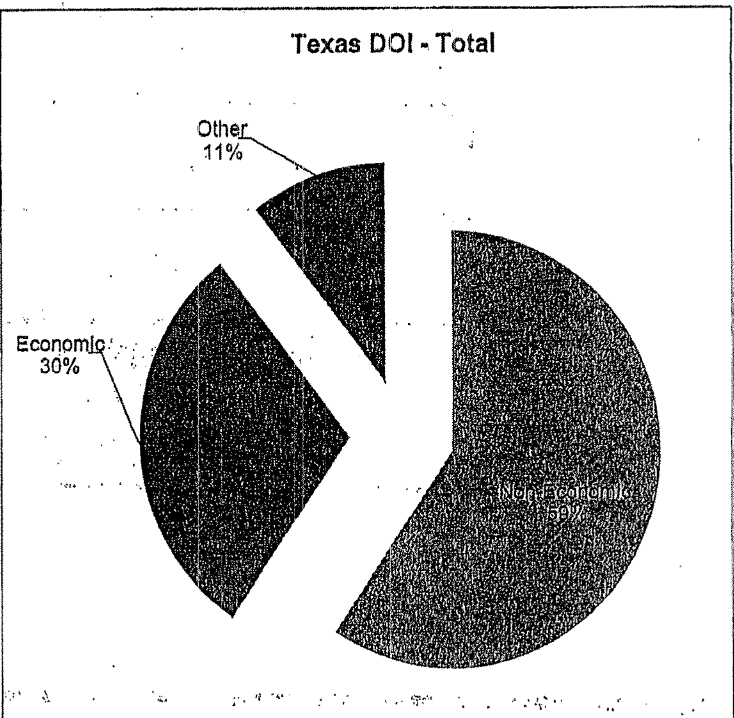


Wyoming – Effect of Cap on Non-Economic Damage

Cap on Non-Economic Damage Award	Physicians Only (Loss & ALAE) $1 Million Limit
250,000	15%
350,000	11%
500,000	7%
1,000,000	2%

Percentage Split in Indemnity Cases (all years combined)





Comments of Mark Deaton, Illinois Hospital Association, Regarding the Medical Liability Crisis
Illinois House of Representative – Judiciary Committee (Civil Law)
February 23, 2005

Good morning, Chairman Fritchey and members of the committee. My name is Mark Deaton. I am the general counsel of the Illinois Hospital Association.

The 200 hospitals of the Illinois Hospital Association appreciate this opportunity to discuss a serious and growing threat to access to health care by the residents of Illinois – the cost and availability of medical liability coverage.

The most important word this session will be the word "meaningful." It seems that every one, from the President of the United States to the Governor of Illinois to legislators on both sides of the aisle want to enact "meaningful" medical liability reform.

Of course, the key question is, "What is meaningful reform?"

IHA's answer is fairly simple. Reform is "meaningful" if it will make medical liability coverage more available and more affordable for hospitals and doctors. In other words, reform has to be "meaningful" to the actuaries who analyze the Illinois market and make pricing and coverage decisions.

If a reform does not help attract insurers back to Illinois or mitigate the cost of coverage, it is not meaningful. It is pointless – and perhaps even harmful – to pass anything other than "meaningful" reform.

The Committee is right to focus first on the causes of the medical liability crisis. As in medicine, the proper treatment follows from the proper diagnosis of the problem.

We're all familiar with the *symptoms* of the crisis:

- Skyrocketing insurance premiums are causing physicians to retire early, limit their practices, or leave the state entirely. Between 2000 – 2003, 37% of Illinois counties lost physicians. AMA Masterfile.

- Women with difficult pregnancies are struggling to find and maintain relationships with their obstetricians.

- Patients with serious brain injuries are waiting longer to find brain surgeons to treat them. (The last remaining brain surgeons have left southern Illinois).

- Fewer doctors are available to treat emergencies of all kinds in hospital emergency rooms throughout the state. (Trauma patient transfers to St. Louis from Illinois have increased by more than 50% since 2002).

- Every hospital stay costs more. The Hospital Sisters Health System operates 8 hospitals in Illinois and 5 hospitals in Wisconsin. The system's cost of medical liability is $3.56 per patient day in Wisconsin and $18.53 per patient day in Illinois ... 5 times higher in Illinois.

Before we can talk about a solution to the problem of medical liability costs, we have to understand what's causing the problem ... *and what's not causing the problem.*

There are those who will tell you that this crisis has been caused by "greedy insurance companies that are gouging customers to make up for losses in the stock market."

This is a great soundbite. It seems intuitive. Let me tell you why it is wrong....

First – Let's look at how Illinois hospitals insure for medical liability....

Of the 200 or so hospitals in Illinois, about 70% are either self-insured or covered by risk pooling trusts that they own and control (collective self-insurance).

42 hospitals are covered by the Illinois Provider Trust (IPT), an entity created by the Illinois Hospital Association back in 1979. Let me tell you a little about IPT ...

- IPT is an entity known as a Religious and Charitable Risk Pooling Trust.

- IPT is governed by the Religious & Charitable Risk Pooling Trust Act, which is part of the Illinois Insurance Code, enacted in 1977. [215 Illinois Compiled Statutes 150]

- Under Illinois law, a Religious & Charitable Risk Pooling Trust can only cover 501(c)(3) charitable organizations (e.g., churches or hospitals), units of local government, and hospitals operated by units of local government.

- Religious & Charitable Risk Pooling Trusts are regulated by the Illinois Department of Insurance.

- IPT is owned and governed by the hospitals that it insures.

- IPT does not hold any surplus – only reserves that its actuaries say are needed to cover losses.

- **IPT does not invest in the stock market – never has.**

- IPT's premiums are based on one thing only – expected losses.

So, we come back to the question of causation ... if hospitals are not maximizing profits for shareholders or gouging to make up for losses in the stock market, why are their medical liability costs skyrocketing?

The answer is unpredictable increases in verdicts and settlements.

Insurers really do only one thing – make predictions. The entire business of insurance amounts to them predicting how much they'll have to pay out and charging enough to make that payout.

How do they make those predictions? By looking at history and trends.

If something is not predictable it is not insurable. How much do you charge for a policy when you can't predict how much you'll eventually pay out? When an insurer can't rely on history and trends, it's lost.

Here's what the Illinois Provider Trust is seeing...

In the **20 years** from its founding in 1979 through 1999 it paid out **4** claims in excess of $1,000,000.

In the last **<u>5</u> years** (2000-2004), it has paid **<u>15</u> claims** in excess of $1,000,000.

In terms of dollars, those 4 claims between 1979 and 1999 totaled **$10 million.**
The 15 claims since 2000 totaled **$50 million.**

Same hospitals. Roughly the same number of claims per year. Same kinds of injuries.

Cases are simply settling for double, triple, and quadruple the amount they were reserved for.

Cases that were reserved for $500,000 are settling for $3 – 4 million.

Every new record verdict raises the floor and pulls settlements up.

In short, in today's world of medical liability, "history is bunk."

Predictability – the foundation of insurance – has disappeared.

This is the situation confronting IPT and CHRP and the actuaries of all those self-insured hospitals. They're not trying to *make up* for losses in the stock market. They're trying to *keep up* with unpredictable verdicts and settlements.

- The percentage of medical liability payments over $500,000 has risen by 135% in Illinois since 1994. During the same period, medical inflation rose by about 53%.

- Approximately 37% of all Illinois medical liability payments were over $500,000 in 2004 – but only 18% of payments in neighboring states were this high.

- According to the Illinois Department of Insurance (11/10/03), premiums are being increased because insurers are losing money on the doctors that they insure. In 2002 ISMIE had an underwriting loss of 39 cents for each dollar of premium that was collected. Six of the top eight insurers in Illinois in that year showed underwriting losses – some much higher than ISMIE's. <u>All of these companies were losing money on their core business – not on investments</u>.

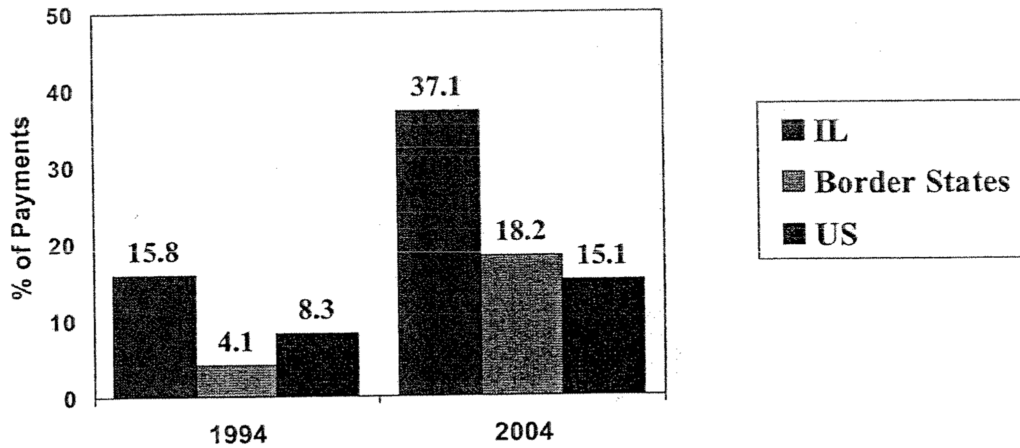
- According to a U.S. Government Accounting Office report in June 2003, the single greatest factor driving up premiums is the cost of claims. The undercharging argument fails to address the root cause of the problem: an out of control liability system.

In conclusion, I commend and thank the House Judiciary Committee for devoting substantial time to exploring the causes and solutions for the medical liability crisis afflicting Illinois' hospitals, doctors, and residents.

When we meet again to discuss potential solutions, IHA's recommendations will be driven by our belief that "meaningful" reforms will be those that inject predictability into the system – reasonable caps on non-economic damages and periodic payment of future medical damages.

See charts below.

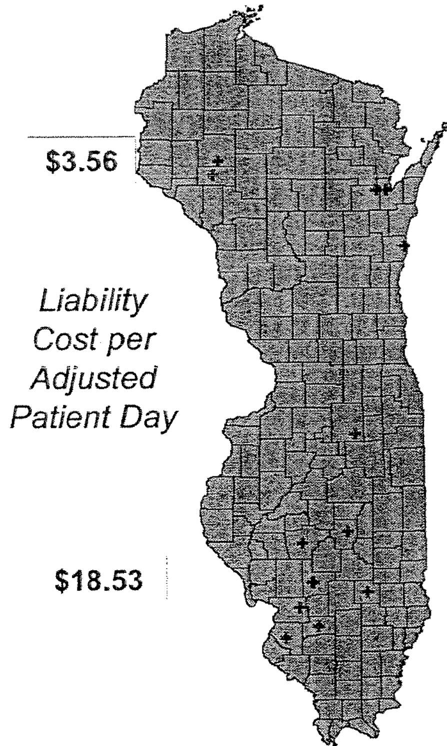
In 2004 Almost 40% of IL Medical Liability Payments Exceeded $500,000



Notes: "Border States" include IA, IN, MO and WI.

Source: National Practitioner Data Bank Public Use Data File, 12/31/2004,
US Department of Health & Human Services, Health Resources and Services
Administration, Bureau of Health Professions, Division of Practitioner Data Banks

Liability Cost per Patient Day Was 5 Times Higher in Illinois in 2003



One Hospital System's Experience:

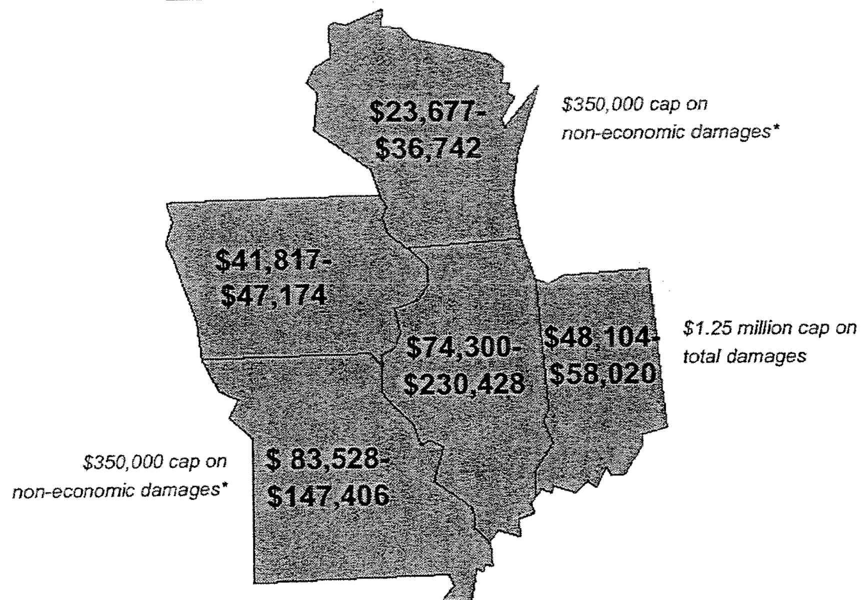
Wisconsin	Illinois
5 Hospitals	8 Hospitals
$1.0 Million	$10.1 Million

Source: Hospital Sisters Health System, 4/2004

Note: an "adjusted patient day" is a measure of utilization that reflects a combination of inpatient days and outpatient volume.

Premiums for Illinois Physicians Far Exceed Those in Border States

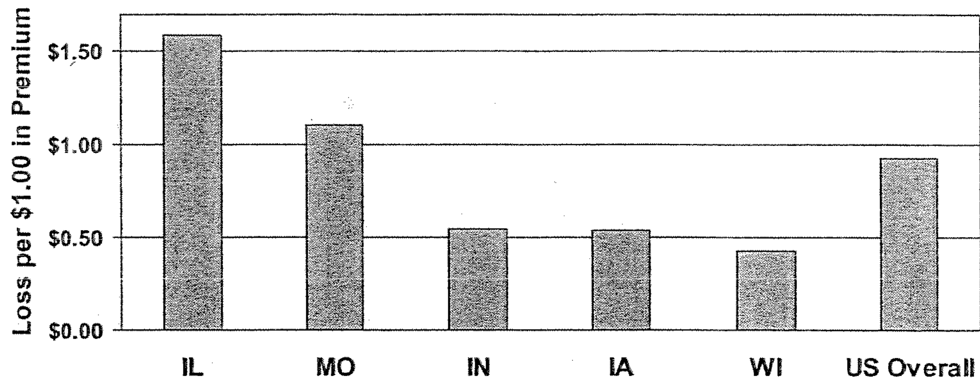
OB/GYNs



Source: Medical Liability Monitor Rate Survey, 2004

* Damages in both WI and MO are adjusted for inflation.

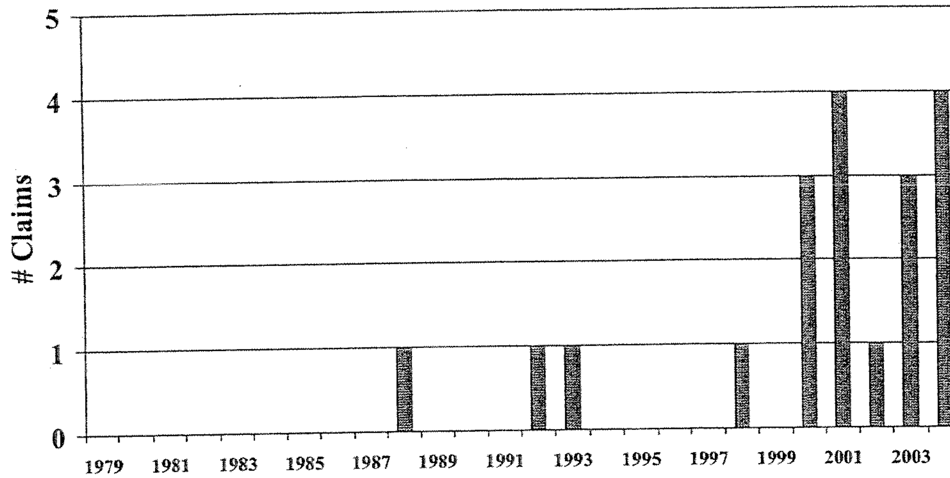
Illinois Insurers Incurred $1.59 in Losses for Each $1.00 in Premiums Collected in 2002



Source: Illinois Department of Insurance, 2003

Note: Incurred losses as a percentage of premiums earned, 2002

Illinois Provider Trust
Number of Claims with Indemnity $1 Million or More

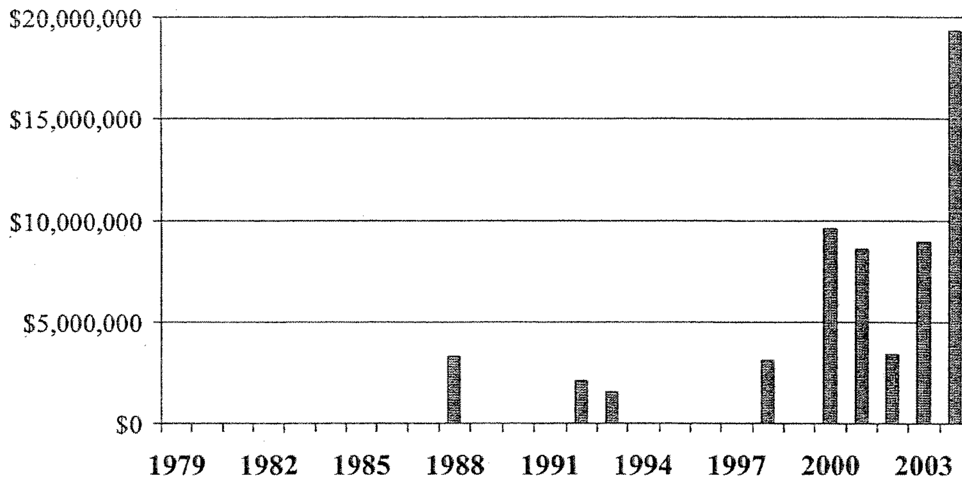


In the first **20 years** of IPT's existence, from its founding in 1979 through 1999, it paid out **4** claims in excess of $1,000,000.

In the past **5 years,** 2000-2004, it has paid **15** claims in excess of $1,000,000.

In 25 years of operation, IPT has paid 19 claims in excess of $1,000,000 – 15 of those in the past 5 years.

Illinois Provider Trust
Losses on Claims with Indemnity $1 Million or More



The 4 claims in excess of $1 million between 1979 and 1999 totaled **$10 million.**
The 15 claims excess of $1 million since 2000 totaled **$50 million.**

Comments of Max Brown Regarding the Medical Liability Crisis
Illinois House of Representatives-Judiciary Committee (Civil Law)
February 23, 2005

Good morning, Chairman Fritchey and members of the committee. My name is Max Brown. I am the Vice President and General Counsel at Rush University Medical Center in Chicago.

The medical malpractice crisis in Illinois is forcing doctors to move out of state, leave the practice of medicine or curtail the performance of certain high-risk procedures. The public is not aware of the impact this crisis is having on not-for-profit hospitals in Cook County.

Today there is no major medical center in Cook County that has commercial insurance coverage under $15 million per claim. Some are already at $20 million per claim. And others expect to be bumped in the near future to $25 million per claim. And this is without aggregate protection. What does this mean?

This means that every claim brought by a patient has to be paid out of the hospital's own pockets. If a hospital gets hit with a $20 million verdict, that hospital has to come up with that money, not an insurance company. And, if it gets hit with another $20 million verdict or another or another, all of that has to be paid by the hospital from its own operating funds. Even hospitals with endowment funds are legally barred from using restricted funds to pay off medical malpractice claims.

It works like the deductible on your car insurance. But instead of a $500 deductible, wouldn't you be horrified to learn that your deductible had risen to $50,000? What would you do? What if you had a large family? What if you had teenagers learning to drive? What would happen if you were in an automobile accident? Could you come up with the $50,000? What if one of your children were involved in an accident? Could you come up with another $50,000? Or another? At what point would you have to reduce access to the family car? Or stop driving altogether?

Cook County now bears the shame of being known as the "worst" county in the nation for defendants in medical malpractice actions. Jury awards in this county are four to five times what they were just a few years ago. Each year doctors and hospitals have paid out huge amounts of money to settle cases in order to avoid being hit by juries for even larger amounts of money. The non-economic loss awards given by juries have been staggering and punitive.

Last year in Cook County, the jury awards of more than $5 million against hospitals and doctors amounted to a total of $123 million. Eighty percent of that amount was for non-economic losses. In one of the awards (which was for $30 million), the non-economic losses represented 100 percent of the verdicts. This means that in this case the plaintiffs suffered no economic loss as a result of their injury. Can there really be any question that

there is a need for caps on non-economic awards? Or why a majority of U.S. states have already imposed such caps to save their hospitals from being sued out of business?

No one is suggesting that injured patients do not have the right to sue or have their suits submitted to juries -- or that they should not be fairly compensated. They should. Or that they are not entitled to compensation for the pain and suffering they may have endured. They are. However, the crucial question for the citizens of Illinois is this: "How can we see to it that hospitals offer fair compensation to injured patients and survive in order to take better care of us and our families in the future?"

The hospitals in Cook County are among the very best in the country. Some are large academic medical centers and others are small community hospitals, but we all have one thing in common. We are not-for-profit. That means that we have no shareholders and we make no profit. Any money that is left over after paying expenses goes right back into improving facilities and patient care. This difference is called an "operating margin." Operating margins of not-for-profit hospitals are relatively small, sometimes no more than 2 or 3 percent of revenues. As not-for-profit hospitals in Cook County we also have one more thing in common. Our operating margins are quickly disappearing and being consumed by medical malpractice costs. Today area hospitals are left with fewer and fewer dollars to improve facilities and patient care.

But we have not yet suffered the full impact of the medical malpractice that is headed toward Cook County. When will that happen? It will occur when all the lawsuits that have been filed during these past three years of high deductibles proceed to trial. That will happen in 2007 and 2008. That is when we will witness the full brunt of this destructive force. In the absence of tort reform, some hospitals may have no alternative but to curtail services, limit access or stop care altogether. The system will not stand under the strain. It will buckle and collapse. Some hospitals may not survive. It will take decades for us to recover what will be lost.

February 23, 2005 9:00 a.m.

Testimony Presented to the

Illinois House of Representatives
Committee on the Judiciary I- Civil Law Committee

Hearing on Medical Malpractice

February 23, 2005

Kenneth Skertich

Trust Administrator, the Chicago Hospital Risk Pooling Program (CHRPP)

ILLINOIS HOUSE JUDICIARY COMMITTEE – TESTIMONY FEBRUARY 23, 2005

Good morning Chairman Fritchey and members of the Committee. I am Ken Skertich, Trust Administrator of the Chicago Hospital Risk Pooling Program, commonly referred to as CHRPP. I have been associated with the Program since its inception in 1978. With me today are Doug Nishimura and Tony Bloemer of Milliman USA, the global actuarial firm which functions as the independent actuary for CHRPP. These gentlemen will be available to answer questions during the question and answer period. We thank you today for the opportunity to speak on behalf of our membership. I will be directing my comments to the Committee from the perspective of hospitals. Although most of the issues are germane to both physicians and hospitals, some issues impact hospitals more adversely than physicians. CHRPP does not insure physicians unless they are **employed** by the hospital.

I would like to start by providing you with a short background and description of CHRPP to place my comments in the proper context. CHRPP is an Illinois Trust that was developed in 1978 by the Metropolitan Chicago Healthcare Council, commonly referred to as MCHC, under the enabling legislation, the Illinois Religious and Charitable Risk Pooling Trust Act of 1977, and as such, is subject to the requirements of the Act, specific sections of the Illinois Insurance Code and to regulation by the Illinois Department of Insurance. The purpose of the Act was to enable not-for-profit corporations exempt from taxation under section 501 of the Internal Revenue Code to pool their risks from the imposition of legal liability. Membership in these pooling arrangements is limited to corporations provided a Certificate of Authority by the Secretary of State. The trust pools and self-insures the malpractice risk of its current 16 community-based hospital members that are located in the greater metropolitan Chicago area.

I have attached a list of those hospitals to my written testimony. CHRPP does not have any profit motive nor a need to satisfy shareholders. The Trust is operated **at cost** and any surplus is returned to its members at the end of the year. Likewise, if the Program does not maintain appropriate funding at the required actuarial determined levels, an assessment is required from the members. The member hospitals provide services on an annual basis to over 818,000 in-patient days, 1.9 million outpatient visits, 460,000 emergency room visits and 21,000 new-born deliveries.

From the inception of the trust, there has been a strong Board commitment and emphasis on proactive risk management. From the very beginning, the focus has been on the clinical aspects of patient care. We staff a team of highly qualified nurses dedicated to supporting proactive initiatives within our member hospitals. The members are required to implement Board approved recommendations researched and developed by our staff. Activities include on-going review of patient care through review of medical records, policies, practices and procedures. Finding are then analyzed and presented back to hospital departmental representatives in an educational format to reinforce strong practices and provide recommendations for on-going internal quality improvement.

Data has been collected on the Program for the last 26 years. The data includes over 5,000 claims from 30 hospitals in the Chicago area. It represents one of the largest sources of hospital medical malpractice data in the Chicago area. It allows us to track information such as:

- Historical changes in claim size
- Historical changes in large losses

- Changes in the frequency of claims including large losses

My understanding is that the purpose of today's hearing is for the Committee to receive testimony that relates to the **cause or causes of today's healthcare liability problem in Illinois**. The quick and easy answer is to look to the substantial increase over the recent years in the costs associated with liability protection, either through self-insurance funding, pooling amongst members, the purchase of commercial insurance, or the purchase of coverage through non-traditional alternative means. Even before considering the cost factor, there looms the problem of the lack of available markets to insure the medical liability risk. These two factors have been described in the industry over the past 35 years as the lack of **availability** of insurers to underwrite the risk and the lack of **affordability** by the consumer to purchase the coverage when it does exist in the marketplace.

But to merely pass off the problem as one of lack of capacity and affordability is to identify the **effect** of the problem, but not the true underlying root cause. There are numerous individual components that contribute to the cause which would require more time than we have here today to adequately address. But of the multiple contributing causes, a few stand out more significantly than others.

Over the past 5 years, the growth in settlements and verdicts is the foremost contributing cause. This growth, or **severity** of claims, is coupled with the number of claims, or **frequency** of claims. These two factors, frequency and severity, drive the premiums established by commercial insurers and the funding levels established by actuaries for self-insured hospitals or programs like CHRPP. The annual number of claims filed against

CHRPP members has remained relatively constant over the past several years. But the total **amount** of annual payments made by CHRPP hospitals and the **average size** of each payment has increased substantially over the last 5 years.

At this time, I would like to share some additional Program statistics compiled by our actuary that illustrate how this current crisis, if left unchecked, will likely continue on its run-away course.

The average settlement for CHRPP hospitals has risen from $180,000 in 1994 to $470,000 in 1999 to $1,010,000 in 2004. This represents an increase cost of 461% over ten years and 115% over five years. Assuming the trend in the last 5 years continues, the average cost of a medical malpractice claim will be $2,500,000 in 2010 and $5,400,000 in 2015. CPI has increased by roughly 2.5% annually since 2000. The rate of increase for CHRPP's losses has been 17% annually, 14.5% percentage points more than the CPI annually.

In terms of large malpractice settlements/verdicts, the largest claim at the end of 1994 was $5,000,000, at the end of 1999 $12,000,000 and at the end of 2004 the largest claim was $22,400,000. This represents an increase of 348% over ten years and 87% over five years. Assuming the trend in the last 5 years continues, the largest medical malpractice claim will be $47,000,000 in 2010 and $88,000,000 in 2015.

In terms of the frequency of large settlements/verdicts, in 1994, two claims closed in excess of $1,000,000. In 1999, six claims closed in excess of $1,000,000 and in 2004, ten claims closed in excess of $1,000,000. This represents an increase in claims in excess of

$1,000,000 of 400% over ten years and 67% over five years. Assuming the trend in the last 5 years continues, the number of claims over $1,000,000 will be 18 in 2010 and 31 in 2015.

If we look at the **funding cost per "average" CHRPP hospital,** the "average" CHRPP hospital has roughly 150 average annual occupied beds and 2,000 deliveries a year. The average annual contribution was $1,000,000 in 1995, was $2,000,000 in 2000 and is $6,000,000 for 2005. The average contribution has increased 500% over the last ten years and 200% over the last five years.

If we look at the **estimation of future costs,** the spiraling rate of increase in medical malpractice costs makes it difficult to determine the future cost of claims. Actuaries use the past as a predictor of the future. Because the hospitals must book liability for all claims that have occurred and not just those that have been reported, actuaries need to estimate ultimate losses on an occurrence basis or when the event has actually happened. For example a baby born today could file a lawsuit 23 years after birth. Assuming the average severity of $1,000,000 in 2004 and an inflation rate of 17% the average claim of $59,000,000 would need to be booked now, though the claim may not be paid until 26 years from now.

In the last 5 years, CHRPP has experienced a 100% increase in the costs associated with the defense of lawsuits. Historically, CHRPP has closed 65% of its claims **without** payment. Therefore, only 35% of the claims have been finalized in a settlement or verdict. To further magnify these results, it should be noted that in a portion of those cases, the decision **to settle** was made in lieu of incurring the expense of a lengthy trial. In cases that were taken to verdict, CHRPP prevailed 64% of the time compared to 36% of the time for the plaintiff.

CHRPP has incurred $64 million in legal expenses for lawsuits that have closed during the previous 10 years. Of this amount, nearly half, $31 million, was attributed to 1,800 non-meritorious lawsuits. In the previous 3 years we have paid nearly as much in defense costs as we paid in the first 7 years. The wasted time and money to defend these baseless lawsuits adds significantly to the problem. If reform is enacted, the rights of patients to seek redress in the court system must be balanced with the rising concern of non-meritorious claims and the associated costs.

What causes these exorbitant run-away verdicts? I believe that they can be attributed to the excessive amount of money requested by plaintiffs. In some jurisdictions, a plaintiff's attorney cannot suggest an amount to a jury, but in Illinois, such suggestion is allowed. In recent years, I have sat in courtrooms in the Daley Center and heard plaintiff's attorneys ask juries to return verdicts of $30, $40, $50, $60 and $70 million. There is little doubt in my mind that individual members of society sitting on a jury and largely unfamiliar with the process are greatly influenced by these suggestions. The effect and consequence of these excessive verdicts cause a natural escalation in the amount of settlements. There is little doubt that hospitals cannot continue to sustain the impact of these escalating settlements and awards without altering the services that they provide to the citizens of this state. There are several solutions to these runaway verdicts: (1) establish reasonable limitations on recovery for non-economic damages (2) allow for juries to be informed that awards are not taxable, (3) allow for structured awards, such as annuities, that would more efficiently provide for future care of injured plaintiffs and reduce the medical liability costs, and (4) reform the apparent agency laws to protect hospitals from liability for harms that they did not cause. **The**

proposed legislation in the House (HB705) and the Senate (150) contain all of these provisions. I urge this committee to seriously consider these two bills.

Some telling statistics can be found in a recent publication of the *Illinois Jury Verdict Reporter* that clearly illustrates the magnitude of the problem. The average verdict in Cook County in 1998 was $1.07 million compared to the average verdict in 2003 of $4.45 million, a 314% increase. More telling, the average verdict for **non-economic damages** was $3.12 million, a 247% increase since 1998 and representing 70% of the awards. CHRPP's data reveals that for the last 6 verdicts which exceeded $1 million, 76% was awarded for non-economic damages.

What does all of this mean to hospitals located in metropolitan Chicago area? Today there are no primary hospital professional liability insurers in Cook County, other than CHRPP. All of the commercial insurers that provided primary coverage have long ago exited Cook County. This crisis is not about mismanagement of insurance companies as the critics of tort reform would like us to believe. Simply stated, these companies do not exist in this market. They have walked away. The affect of this withdrawal is that hospitals have been forced to self-insure, or pool their risks and purchase excess or reinsurance at high attachment points. Typically, hospitals that self-insure in Cook County retain an actuary to determine how much they will need to fund to cover their claims. The dilemma is that only scarce excess insurance markets are available and these markets will not insure a hospital unless it carries a deductible of $5 - $10 million for each claim, and in some instances the markets have forced hospitals to retain $15, $20 and $25 million **per claim**. Without being able to transfer the risk to insurers, the hospitals are literally being forced to become their own insurers placing their assets at

great risk. Hospitals are now forced to staff and operate sizable insurance operations in-house. Time will only tell what effect the strain of operating under these conditions will have on the hospitals and their delivery of healthcare. In an op-ed in the Chicago Tribune last week, Max Brown, General Counsel for Rush University Medical Center in Chicago, opined that "In the absence of meaningful tort reform, some hospitals may have no alternative but to curtail services, limit access or stop care altogether. The system will not stand under the strain. It will buckle and collapse. Some hospitals may not survive. It will take decades for us to recover what will be lost". A very dire and realistic forecast indeed!

To further illustrate the magnitude of the problem, I would like to provide a short description of CHRPP's last three years of experience in dealing with the reinsurance markets regarding their **attitude** toward the metropolitan Chicago area malpractice risk. CHRPP annually approaches the domestic and foreign reinsurance markets to support the limits of liability that it provides to its members. Reinsurance is merely the transference of all or part of the risk assumed by the insurer, CHRPP, to another insurer called a reinsurer. During the course of this year, visits were made to the reinsurers offices domestically and in foreign countries to explain CHRPP's operations and to present its historical claim data. Forty-nine (49) reinsurers received a proposal and staff personally visited 25 companies. In addition, a number of companies sent representatives to our offices to review and discuss Illinois tort law, realistic anticipated tort reform, risk management initiatives and interviews with management. Although impressed with our operation, 46 markets declined to underwrite our Program due to the severity of claims in metro Chicago area. The total lack of predictability of jury awards, and the unfavorable tort law which creates the "deep pocket" for hospitals, were the two most cited reasons for their declination. CHRPP received a combined 114%

increase in its reinsurance costs for the years 2003 through 2005, compared to years 2000 through 2002 from the few reinsurers willing to support the Program.

In further discussions with all of the reinsurers, the Chicago metropolitan area was described as the least desirable jurisdiction in the United States to invest their company's capital. With other more favorable jurisdictions, we were unable to convince all but three of them to underwrite our member's risks. An interesting point to ponder – If medical liability insurance was a profitable venture in the Chicago area, why are there no takers? It is hard to argue risking capital in an unfriendly business environment that creates enormous variations in settlements and verdicts. The lack of predictability makes it almost impossible to price their product with any degree of logic. Self-insured hospitals, System's and programs like CHRPP face the same dilemma.

What is the effect on medical care due to the increase in malpractice awards? As stated earlier, the average CHRPP hospital has seen its malpractice expense increase by $4,000,000 over the last five years. In simple terms, the annual salary of an RN is $57,000. A $4,000,000 increase in malpractice expense, for example, equates to 70 less nurses from delivering patient care at each hospital. I relate these facts to illustrate the reality of the effect of the current tort laws of Illinois and the resulting excessive verdicts. Hospitals cannot continue to sustain the impact of these escalating settlements and awards without altering the services they provide to the citizens of this state.

In closing, I am grateful for the opportunity to speak about what is a critical issue for all healthcare providers and their patients. I am also encouraged with the growing public

discussion and debate on how to reform the medical malpractice system. However, to achieve meaningful medical malpractice reform, the public must understand the issue and its impact on providers and patients alike, and most importantly, be willing to engage the issue. Your Committee today has provided a meaningful step in that direction. MCHC and its members thank you for your leadership and stand ready to work with you and your constituents to achieve a solution to this critical patient care issue.

CHRPP Hospitals

Northwest Community Hospital – Arlington Heights, IL

Victory Memorial Hospital – Waukegan, IL

Norwegian American Hospital – Chicago, IL

Swedish Covenant Hospital – Chicago, IL

Holy Cross Hospital – Chicago, IL

Elmhurst Memorial Hospital – Elmhurst, IL

Sherman Health System – Elgin, IL

Rush Copley Memorial Hospital – Aurora, IL

LaRabida Children's Hospital – Chicago, IL

Rush Oak Park Hospital – Oak Park, IL

Vista Health – Provena/St. Therese Medical Center – Waukegan, IL

Gottlieb Memorial Hospital – Melrose Park, IL

Rush North Shore Medical Center – Skokie, IL

Centegra Health System

- **Memorial Medical Center – Woodstock, IL**
- **Northern Illinois Medical Center – Woodstock, IL**

Thorek Hospital & Medical Center – Chicago, IL