today? We know compensation to patients injured by medical errors is neither prompt nor fair. We also know verdicts with huge awards that do not match the severity of injuries or the conduct of the defendants destabilize the insurance markets. This sends premiums skyrocketing, which forces many physicians to curtail, move, or drop their practices. This leaves patients without access to necessary medical care.

Finally, we know litigation does nothing to improve quality or safety. In fact, the constant threat of litigation drives the inefficient and costly practice of defensive medicine and also discourages the exchange of information about preventable health care errors that we could use to improve the quality and safety of patient care.

The current medical liability crisis and the shortcomings of our medical litigation system make it clear that this is the time for a major change. We need a medical justice system that promotes accountability and fairness instead of discouraging them.

Regardless of how we vote on this legislation before us, we all ought to start working toward replacing the current medical tort liability scheme with a more reliable and predictable system of medical justice. We need a system that restores rationality to the way in which we compensate the injured and learn from mistakes. We need a system that restores the trust that patients and providers used to have in each other. It is incumbent upon all of us to strive for such a system so that we may raise the overall standard of health care in this country.

The legislation we are considering today is an important step in the short term toward making the medical justice system work better for everyone, not just a fortunate handful of personal injury lawyers. I urge my colleagues to join me and vote for this bill.

I ask unanimous consent that at 2:15, Senator KYL be recognized to speak for up to 15 minutes to be followed by Senator FEINSTEIN for up to 25 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 having arrived, the Senate will stand in recess until the hour of 2:15.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH.)

PATIENTS FIRST ACT OF 2003—Motion to Proceed—Resumed

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. REID. Mr. President, if the Senator will yield just for a brief second, it is my understanding the Senator from Arizona has authority to speak up to 15 minutes, followed by a 25-minute speech by the Senator from California. Is that true?

The PRESIDING OFFICER. That is correct.

Mr. REID. I ask unanimous consent that following the statement of the Senator from California, Senator CORNYN be recognized for 30 minutes, followed by Senator HOLLINGS for 30 minutes, and following Senator HOLLINGS, I ask that Senator VOINOVICH be recognized for up to 30 minutes, and then he would be followed by a Democrat.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Arizona.

Mr. KYL. Mr. President, I am pleased to address one of the most important issues I think we are going to be talking about all year. I hope our colleagues will permit us to conclude our debate with a vote so we can actually adopt some legislation to deal with this crisis of lawsuit abuse in the United States. Some call it medical malpractice reform. Whatever you call it, we have to deal with it.

Unfortunately, what we have heard is that some of our colleagues are going to prevent us from having a vote on the bill that is before us, S. 11. It is a bill that addresses one of the most fundamental problems we have, and that is access to available quality medical care by a lot of people in our society today. We need to reform this flawed medical malpractice system which is prohibiting people from getting the quality medical care they need and deserve.

We debated just before the Fourth of July recess Medicare reform to provide prescription drug benefits to all of our senior citizens. We took a lot of time talking about why our senior citizens needed access to care and how we were going to improve that access. But all of that will go for naught, it will do no good, if there are no hospitals and there are no pharmacists, if there are no physicians and other health care providers—or an insufficient number of those providers—to help those people in need, whether they be senior citizens or others, because of the high cost of malpractice premiums and therefore the inability of these providers to continue to serve the people in their communities.

Last year, the American Medical Association released a study on this lawsuit abuse problem. It concluded that 12 States were having a full-blown crisis and that 30 States were seeing serious problems in terms of the ability of physicians and hospitals to stay in practice to take care of their patients.

Today, just a year later, that study has been updated and the AMA has now concluded that 19 States are having a full-blown crisis in dealing with the medical malpractice insurance rates just for physicians. Let me give some examples of how this is affecting different communities around the country so you can see it is truly a nationwide problem.

In my State of Arizona, health care providers have experienced dramatic increases in their insurance rates. Between 2001 and 2002, two hospitals in Phoenix saw a threefold increase in their malpractice premiums, paying more than $1.7 million. Meanwhile, in Winslow, AZ, the hospital premiums have more than doubled, to $1.8 million.

Some of you know the town of Winslow, AR, from a famous song by the Eagles. It is a town with great history and rich in tradition in Arizona but it is not very big. It doesn't have the patient base to support a hospital that has to pay almost $2 million a year in medical malpractice premiums. It is not just in my State of Arizona. Methodist Hospital in south Philadelphia recently closed its maternity ward and prenatal program because of its medical liability insurance rates. Greenwood Hospital in Mississippi was unable to keep its level II trauma center rating because the neurosurgeons in the area had left citing the high cost of liability insurance.

I spoke with a woman whose husband had been very seriously injured in an automobile accident in Mississippi. She told the story of how—because of the lack of physicians and because of the high cost of premiums—her husband has suffered so terribly as a result of that accident and the inability to get quick medical attention.

Back to my home State of Arizona, the Copper Queen Community Hospital in Bisbee, AZ, was recently forced to close its maternity ward because the family practitioners in that community were looking at a 500-percent premium increase. Expectant mothers now must travel more than 60 miles to the closest hospital, which is either in Sierra Vista or in Tucson. According to the recent news accounts, four women have since had to deliver babies en route.

To cite the news accounts, Time magazine has a June 9 cover story about the doctor being out and why so many patients are losing doctors to the rising cost of malpractice.

This is now truly a national event.

In the Time magazine piece dealing with this question of physicians having to leave the practice, there is a particularly interesting story about a woman in Arizona whose name is Vanessa Valdez. The title of the story is ''Taking the Highway to Have a Baby.'' The story points out that Vanessa has to drive about 50 miles to see her OB/GYN and to have a baby. She lives in the town of Douglas, which is on the Arizona-Mexico border. But there is no obstetrician within an hour's drive to deliver her child. There were six family practitioners in that community but they couldn't afford the soaring malpractice premiums. As a result, the hospital was forced to close its delivery room, and suddenly rural Cochise County has but one delivery room for the 118,000 residents. That is in Sierra Vista, 50 miles from Valdez's home of Douglas.

This is beautiful country. It is a great place to live. But it is no place to live if you are going to get sick or you know you are going to have a baby because you have an hour's drive to get to a doctor. That is not right. It is not as if this is out in the middle of nowhere and you chose to live there with all of the attendant risks involved. No. There are a lot of communities in this area but none of them had physicians able to continue to practice because of the medical malpractice premiums they had to pay.

One other example: Nevada was very much in the news last year because of the crisis in that State. Nevada's top level trauma center was recently closed for 10 days after 58 orthopedic specialists in Las Vegas temporarily quit because of the skyrocketing insurance costs. Also, a lot of the physicians delivering babies and performing high-risk surgeries have indicated that they won't be able to continue to practice without some kind of relief.

Ultimately, this destructive lawsuit abuse hurts the patients. Yes. The doctors can't make it, so they leave. But ultimately it is the patients who are the ones who suffer.

Therefore, we are trying to deal with that through legislation that will make it a little bit more difficult for this kind of lawsuit abuse to occur so that the insurance companies won't have to charge quite as high a rate, so the physicians and hospitals can stay in business, and so the people of the communities can continue to be served.

Also, the threat of lawsuit abuse often forces doctors to perform a lot more in the way of tests and surgeries and other kinds of treatments than they otherwise would do simply to protect themselves from a claim that they weren't doing enough for the patients—sometimes expensive tests, sometimes invasive procedures.

All of this is called defensive medicine—trying to do everything they can to make sure some smart lawyer out there doesn't try to pick at what they did and find some kind of fault with it and find a client who is willing and able to hire a lawyer to bring a lawsuit against the doctor.

That is another effect of this lawsuit abuse. Another is the fact that a lot of times doctors are no longer willing to perform risky procedures that may be necessary to really help somebody or even save somebody's life. Obviously, the more serious the condition, frequently the more risky the procedure. You want to be served by a physician who is willing to go to the mat for you in that case. But if the physician is looking at a big medical liability suit, if the result doesn't happen to work out right, then that physician is going to be less likely to try to treat you.

All of this results in an inferior quality of medical care for American citizens, which is wrong. It is not at all uncommon for these lawsuits to be brought and the lawyers to get over half the settlement. That is wrong. That is one of the issues with which this legislation deals.

The Congressional Budget Office determined that the House bill, which passed and which was pretty similar to S. 11, would reduce direct Federal spending for Medicare, Medicaid, and other Federal health programs by almost $15 billion over the next 10 years. Since the Federal Government is a payer for many of the medical services, particularly for our seniors who are indigent, it is a saving to the Federal Government as well for this lawsuit abuse to be addressed. Because employers will pay less for health insurance for their employees and more of the employees' compensation will be in the form of taxable wages and other fringe benefits, including, of course, money that could be plowed back into greater health care for the employees, the Congressional Budget Office estimated that enacting this legislation would increase Federal revenues by about $3 billion over the next 10 years as employees receive higher wages.

Just a note about the legislation itself, there are a lot of different ways you can do this. I had actually cosponsored a bill somewhat different than this. But the basic idea is the same, even though we might want to change specific provisions of this legislation. It basically sets sensible limits on the noneconomic damages that can be obtained in these lawsuits. The noneconomic damages are those damages that go above and beyond the bills that have to be paid. When you get sick and the physician allegedly committed malpractice, you had to go to another doctor to get the problem resolved. Those are economic damages as you lost wages, and any other expenses that you have. And those economic losses are fully compensated. But above and beyond that, you are entitled and juries will award substantial damages for noneconomic losses, mostly called pain and suffering because of what you had to go through. Certainly people recover something for their pain and suffering. The question is how much.

In order to avoid lawsuit abuse, some States—for example, the State of California has put a $250,000 limit on those noneconomic damages. That is precisely what this legislation does as well. However, states with higher caps can keep those under this legislation too. It also reserves punitive damages for cases that justify it. Part of lawsuit abuse is very large punitive damage awards which have nothing whatsoever to do with either the economic or noneconomic losses but nevertheless help to enrich the lawyers.

There are some other features of the legislation as well. But the point I wanted to make is whatever the specifics of the legislation, we need to act.

I hope our colleagues will permit us to conclude the debate and have a vote on this legislation so we can get together with the House of Representatives, which also passed a bill, have a conference committee work out any differences, all have a chance to vote on that, and then hopefully have a bill we can send to the President.

If we are never able to have a vote on this, it is not just the doctors, hospitals, and other providers that are going to suffer; it is the American people because they will not have access to the quality of medical care which they need and deserve. I hope we cannot only debate this legislation but also permit it to come to a vote so we can address this serious crisis in America today.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I wanted to use 12 minutes of the Senate's time to discuss my reaction to this bill and my general thinking about the subject of medical malpractice insurance premiums.

I think it is pretty clear that medicine is at a crossroads. I think it is pretty clear that something has to be done. My own State of California was at the crossroads 28 years ago. A bill was passed through the legislature called the Medical Injury Compensation Reform Act, known as MICRA. MICRA had a rough road initially. It had a number of court challenges. Finally, it was sustained by the California Supreme Court.

What we saw—I will go into this in more detail later on—was that premium costs began to settle down. In fact, I think it is fair to say that the California medical profession is very pleased with the MICRA bill as it stands today.

The problem I have—and I am probably one of the few on my side of the aisle who is not opposed to the issue of caps because I think in this situation they are helpful, but my problem is with the bill that is before us today because that bill is nearly identical to the bill passed out of the House and, frankly speaking, it is not one that I can support.

This bill before us sets a $250,000 cap for noneconomic damages in medical malpractice suits. Now, this can be applied not only to suits against doctors but to suits against HMOs, nursing homes, and medical product manufacturers. It is a very broad provision. This cap would even apply for extraordinary cases. I will give you one: A youngster, Jessica Santillan, a 17-year-old who died after doctors mistakenly transplanted the wrong kidneys into her body.

So under this bill, suits against drug and device manufacturers also, such as the makers of the weight loss drug Phen-Fen, the Dalkon shield contraceptive device, faulty heart valves, and other products that have caused innocent deaths, would be limited to $250,000 in noneconomic damages. I find that unacceptable.

Secondly, this legislation would severely limit the availability of punitive damages not only for doctors but

also for manufacturers. In general, punitive damages are capped at the greater of $250,000 or twice economic damages in this bill. But the bill also wipes out any punitive damages in several different types of lawsuits against medical product manufacturers. It would immunize the manufacturer or seller of drugs from punitive damages for any packaging or labeling defect on their product. So, presumably, if a drug package label had mistakenly directed a patient to take 10 pills a day instead of 1 pill a day, a patient could not sue for punitive damages, regardless of the harm caused or the basis of the mistaken direction.

It would also limit the availability of punitive damages against any manufacturer or distributor of medical products if the product complied with FDA regulations. Let me give you an example: a product such as the Bjork-Shiley artificial heart valve. It originally received FDA approval, but these valves broke in an estimated 619 patients and led to hundreds of deaths. Under this bill, they would be immune from any punitive damage case. I think that is wrong.

This FDA exemption, in a sense, sets a downward and unacceptable course. If a company has an FDA-approved product on the market and then learns of a dangerous complication presented by that product or a failure of that product, it should have the incentive to remove that product from the marketplace as soon as possible. I think to provide an exemption if the product has FDA approval creates a disincentive to the rapid removal of that product from the shelf.

So while I cannot support this proposal, there are, however, proposals which I could support because I do believe that rising premiums are creating a crisis all across this country in terms of access to care. Others have placed before this body a number of situations. Let me just repeat a few.

Obstetricians and gynecologists in Florida pay over $200,000 a year for malpractice insurance as opposed to $57,000 a year in California. And there is no more high-cost State than California. So OB/GYN premiums in Florida, $200,000; in California, because of MICRA, $57,000; surgeons in Michigan pay $110,000 for malpractice insurance. Twenty percent of the OBs and GYNs in West Virginia and Georgia have been forced out of their practice due to rising premiums.

Nine hundred doctors in Pennsylvania have left the State since 2001 to avoid annual premiums as high as $200,000. The Methodist Hospital in Philadelphia discontinued its prenatal program for low-income women because of high premium costs.

The neurosurgeons of Wheeling, WV, have left the area, and local trauma patients requiring neurosurgery need to be airlifted out of the State.

Not only are insurance premiums skyrocketing in some States, but insurers are leaving the market, and that is a very dangerous signal. There were 14 companies underwriting liability in Mississippi; today, there is but one willing to write new policies. Texas had 17 insurance carriers; today it has 4.

In California, we have nonprofits handling the insurance for California's doctors, and that is one reason the system works.

I have spent a number of months taking a good look at the California law to see what could be transferred to the national level. And I want to say, here and now, this Senator would support reasonable caps on noneconomic damages because I deeply believe they can lead to more stable premium rates.

At the time MICRA was enacted in 1975, the cost of health insurance in California was higher than any other market except New York City. In the 6 years before 1975, the number of malpractice suits filed per 100 physicians in California more than doubled.

MICRA has kept costs down. In 1975, California's doctors paid 20 percent of the gross costs of all malpractice insurance premiums in the country. Today, they pay 11 percent of the Nation's total malpractice insurance premiums. Clearly, costs have dropped in comparison with other States.

All over the United States, premiums have grown 505 percent in the past 25 years. California's premiums have grown 167 percent. In other words, premiums have grown three times slower in California than in other States. That alone shows that MICRA is working, regardless of what anyone might say.

Also, because of MICRA, patients get their money 23 percent faster than in States without caps on noneconomic damages. Bottom line: California's malpractice premiums today are one-third to one-half lower, on average, than those in Florida or New York.

Because the California law has proven successful at keeping premiums down—and I know there are those who do not want to believe it; they will say it is some other reason; but I believe it has—I used the law as a departure point for crafting a proposal which I believe is both just and fair and which I believe should stabilize and, over time, reduce premium costs.

I very much appreciate the efforts of Senator FRIST and Senator MCCONNELL in working with me to explore this option. I am not going to offer it on the floor today for one reason: Unfortunately, it would not have the necessary votes.

Specifically, my proposal would do the following: It would create a schedule for attorney's fees. It would create a strict statute of limitations, requiring that medical negligence claims be brought within 1 year from the discovery of an injury or within 3 years of the injury's occurrence. It would require a claimant to give a defendant 90 days' notice of his or her intent to file a lawsuit before a claim could actually be filed. It would allow defendants to pay damage awards in periodic installments. It would allow defendants to introduce evidence at trial to show that claimants have already been compensated for their injuries through workers compensation benefits, disability benefits, health insurance, or other payments—that is only fair—and it would permit the recovery of unlimited economic damages.

My proposal would differ from California's law in two key areas: One, noneconomic damages and, two, punitive damages. The California MICRA law has a $250,000 cap on noneconomic damages. In contrast, I would propose a $500,000 general cap on noneconomic damages. Today 15 States have caps of $500,000 or less for noneconomic damages. Twelve States have a cap of $500,000 or less on noneconomic damages, and that includes Alaska, Florida, Louisiana, Massachusetts, Michigan, Mississippi, Nevada, Oregon, Texas, Hawaii, North Dakota, and South Dakota. Three States have caps of $250,000-or-less and they include Montana, New Hampshire, and California. Thus, 15 States already have caps of $500,000 or lower.

In catastrophic cases, where a victim of malpractice was subject to severe disfigurement, severe disability, or death—in other words, a catastrophic exemption—the cap would be the greater of $2 million or 50,000 times the number of years of the life expectancy of the victim. This really takes into consideration terrible morbidity done to a young child whose life span might be 50 or 60 years more. Clearly, a cap of $250,000 or $500,000 is really not fair to that youngster. Therefore, the catastrophic exemption we would propose would provide the greater of $2 million or 50,000 times the number of years of life expectancy of the victim.

In addition, we would propose a less onerous punitive damages standard than California law. California law is very strict today with respect to a plaintiff's ability to prove punitives under the very high standard of fraud, oppression, or malice. In other words, if you can't prove fraud, oppression, or malice, you can't prove punitive damages. If a doctor is in the middle of surgery and walks out to go to his bank to make a deposit while the patient is under a general anesthetic, in my view, that doctor should have punitive damages brought against him because that clearly is not accepted medical procedure.

California's law is much stricter. You have to prove fraud, oppression, or malice. Under this law, I am not aware of a single case where a plaintiff has obtained punitive damages in California over the past 10 years. So at least in my view, for situations such as the one I just indicated, the California law is too strict in this regard.

Instead we would offer a four-part test where a plaintiff would have to show by clear and convincing evidence—and this was put together based on measures that have passed this Senate in the not too distant past—that

the defendant, one, intended to injure the claimant unrelated to the provision of health care; or two, understood that the claimant was substantially certain to suffer unnecessary injury and, in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; three, the defendant acted with a conscious flagrant disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid; or four, the defendant acted with a conscious flagrant disregard of acceptable medical practice in such circumstances.

Clearly, the doctor who walked out of a surgery and left a patient under a general anesthetic would fall under this fourth plank. It certainly is a flagrant disregard of acceptable medical practice which would be, you don't go to your bank in the middle of an operation to make a deposit when the patient is under a general anesthetic.

I firmly believe a variant of this type could lead to a compromise in the proposal in the Senate. Why didn't I go ahead with it? Much to my chagrin and, I think, surprise, both the American Medical Association and the California Medical Association rejected this proposal. The AMA contends that despite the fact 15 States have caps of $500,000 or less, they believe that a $500,000 cap is too high and it would not stabilize premiums.

The California Medical Association is opposed to it for a different reason. Although we leave State law in place, whether that State law is retroactively passed or prospectively passed, the CMA felt the State legislature might—I say ''might''—change the $250,000 cap to $500,000. So both of these associations have rejected that proposal which meant I wouldn't have a chance to get the necessary votes on either my side of the aisle or pick up a few votes on the other side of the aisle.

They refused to move from a cap of $250,000 for noneconomic damages in even catastrophic cases. To me this is wrong because a $250,000 cap in 1975, when the California law set this cap, adjusted for inflation was worth $839,000 in 2002. So last year a $250,000 cap, passed in 1975, would be worth $839,000, if passed today. If a figure of $250,000 was adequate in 1975, why couldn't a figure of $500,000, which is lower than the 1975 cap adjusted for inflation, be acceptable this year?

Now if a victim receives $250,000 today, this is equal to $40,000 in 1975. So when California led the Nation by passing the Medical Injury Compensation Reform Act and setting a cap for noneconomic damages of $250,000 in 1975, everybody should know that that is worth $40,000 today. In my book, that is unacceptable.

There are many specific instances of why it is unacceptable. Let me share one case. That is Linda McDougal. She is 46. She is a Navy veteran. She is an accountant, a mother. She was diagnosed with an aggressive form of cancer and underwent a double mastectomy. Two days later she was told that a mistake was made. She didn't have cancer and the amputation of both her breasts was not necessary.

A pathologist had mistakenly switched her test results with another woman who had cancer. Is this Congress willing to say there should be a cap of $250,000 on noneconomic damages for this kind of mistake? I think not.

A cap on noneconomic damages must take into account severe morbidity produced by a physician's mistake, such as amputating the wrong limb or transfusing a patient with the wrong type of blood.

Unfortunately, because of the opposition of both the American Medical Association and the California Medical Association, I am not proposing an amendment at this time. My purpose was to help physicians and patients, and I deeply believe that a $500,000 noneconomic damage cap, coupled with the catastrophic exception I outlined, would accomplish this, would accomplish it fairly, and would stabilize premiums over the long term.

I also suggest that State laws, where they exist, should prevail. So the California MICRA law, or any other State law, would prevail regardless of whether that State law was already enacted or retroactive.

So, bottom line, I could not get 60 votes for this proposal with the opposition of physicians. So the result may well be an alternative because I don't believe the House bill can pass in the Senate in its present form.

Let me say this. I have given this bill a great deal of thought. I really mean what I say—that I am prepared to support a reform bill. I am prepared to support a cap on noneconomic damages. But it has to be a cap that is realistic in view of today's time. It cannot be a cap that was passed 28 years ago that has an actual value of $40,000 today. So I am hopeful there will be another time and another place when a bill such as the one I have tried to outline might be found to be acceptable. In the interim, I will vote against S. 11. But, again, I stand ready to participate in a solution along the lines I have mentioned.

Mr. President, I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. CORNYN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CRAPO). Without objection, it is so ordered.

Mr. CORNYN. Mr. President, I wish to say a few words about the issue of medical liability reform, a matter that cries out for a remedy from the Congress because of its sheer scope and size.

When it comes to health care, I believe the proper role of the Government is to protect the freedom of all people to act in their own interests and in the interests of their health. I think it is appropriate that we make sure their decisions are not made by the Government but by themselves and their families. Patients and doctors, rather than lawyers and bureaucrats, should be trusted to decide what treatment is best for themselves and their patients.

I strongly believe that when people have good choices in a health care system built upon free market principles, it ultimately translates into high-quality care. One of the obstacles, though, to achieving access to that high-quality care is the current crisis involving medical liability litigation.

Today, America is experiencing a medical liability litigation crisis that is increasing the cost of health care, it is decreasing access to physicians and hospitals for many patients, and it is generally lowering the quality of care. As a matter of fact, we could hardly call our medical liability system a ''system'' because it is such a mess. In recent years, average jury awards have more than doubled, from more than $460,000 in 1996 to more than $1 million in the year 2000.

In the past year, medical liability insurance premiums in many States have increased by more than 20 percent, on average, and more than 75 percent for certain specialties. That is just in 1 year. Between 1991 and 2001, the number of medical malpractice payments of $1 million or more that were reported to the National Practitioners' Database increased from 298 to 806. The overall result is sky-high costs for liability insurance, increased costs for those who provide health treatment, and costs that have really created a crisis of enormous proportions, one that is threatening the quality of care, diminishing access to care, and exploding the cost of care.

According to studies at the Department of Health and Human Services, doctors across the country are closing their practices, they are limiting the types of patients they see, or they are leaving communities where they have long practiced because they cannot afford the rapidly increasing costs of medical liability insurance or, worse yet, insurance coverage is unavailable altogether.

Fear of liability suits—even frivolous litigation—also results in the practice of defensive medicine.

A recent survey, for example, conducted by an organization known as Common Good, revealed some disturbing trends: 79 percent of physicians admit that the fear of litigation has caused them to order more tests than they thought medically necessary, and 74 percent refer more patients to specialists than their best medical judgment would otherwise dictate. Half have recommended invasive procedures they do not consider on a medical basis to be necessary, but they have done it in an effort to protect themselves against the second-guessing that goes

along with the medical liability regime.

Defensive medicine increases risks for patients and it raises health care costs by as much as $126 billion per year. This is a crisis not just for the Nation's physicians, it is a danger to America's patients—in other words, every single one of us.

For example, pregnant women in Nevada, Mississippi, West Virginia, and Florida must drive hours just to find an obstetrician who can care for them, and many still cannot get the essential prenatal care they desperately need. The only level 1 trauma center in Las Vegas had to close temporarily last year because its surgeons could not afford medical liability insurance. Some physicians' annual premiums had increased from $40,000 to $200,000 in just a year.

In many States, physicians are retiring or moving their practices because they either cannot afford the liability insurance or simply cannot buy the liability insurance they need in order to protect what they have worked a lifetime to achieve.

In Mississippi, physicians are actually moving across the river to Louisiana to serve the same patients they would serve in Mississippi because they can no longer afford to practice in that State, and most cities in the State of Mississippi with populations under 20,000 no longer have any physician who will even deliver a baby.

There are many more examples from my State, the State of Texas. The city of Austin, for example, is suffering from a shortage of neurosurgeons caused by retirements and relocation to avoid liability coverage costs, a shortage so heavy that some patients have to travel more than 65 miles away to find treatment.

In 100 of the 254 counties in the State of Texas, there is no obstetrician; in other words, there is no medically trained specialist who will deliver a baby in 152 Texas counties. After 44 years, Spring Branch Medical Center near Houston has stopped delivering babies altogether due to the soaring malpractice insurance costs and the shrinking pool of physicians that will actually deliver babies.

According to the Texas Medical Association's physician survey last year, more than half of all Texas physicians, including those in the prime of their professional career, are considering early retirement because of the State's medical liability insurance crisis, and earlier this year the Fort Worth Star-Telegram reported about one story that illustrates the way this problem affects patients who need care the most. The story said:

> Last summer, a pregnant woman showed up at Dr. Lloyd Van Winkle's Castroville office in south Texas, less than 10 minutes from delivery. Her family doctor in Uvalde had recently stopped delivering babies, citing malpractice concerns, and the woman was trying to drive 80 miles to her San Antonio doctor and hospital. ''She made it as far as Castroville and decided she wasn't going to make it any further,'' Van Winkle said.

We all want to prevent disease and injury. When patients get sick, we all want to prevent medical errors, and when errors do happen, we can all agree that a patient should be compensated fairly. But if you can find some goal hidden somewhere within the current dysfunctional medical liability system, that goal would not be either the prevention of errors or the fair compensation for injury. Very clearly, the current medical liability crisis operates for the benefit of a few at the expense of the many.

Personal injury trial lawyers should not be able to drive good doctors out of medicine or to reduce patients' access to health care. This system undermines the ability of physicians to treat their patients without fear, and it destroys the trust and the important relationship between patients and their physicians, and it truly abandons the American patient—that is, every one of us—when we need the help the most.

I am proud to say that in my home State of Texas, the State government has stepped up in the legislative session just ended and passed some needed reforms in this and other areas. This year, despite overwhelming pressures from special interest groups, the State passed historic liability reform which makes it possible for doctors to practice in Texas without fear of unwarranted and frivolous lawsuits. The law puts caps on punitive damages while allowing for patients who are truly hurt to be fairly compensated. Judgments will be based on the amount of involvement in the act caused in the suit without consideration of who has the deepest pocket.

I must add, though, that even in my State of Texas, there will be a vote of the people on whether the Texas Constitution will be amended to provide a means to achieve this historic reform and much needed reform, and that vote remains to be given and taken. Yet there is still little recourse for patients in States without meaningful reform, and this is truly a nationwide crisis and not one that should be addressed by individual States, given the sheer magnitude of the crisis, its geographic expanse and, frankly, the amount of Federal taxpayers' dollars to go in to paying for the current dysfunctional system.

Our health care system is still burdened with frivolous lawsuits and outrageous jury awards. According to a Health and Human Services study, premiums in States without meaningful liability reform went up 39 percent in the year 2001 and an additional 51 percent in 2002. An out-of-control system in one State can have an effect on malpractice premiums in other States, even those States that have made some incremental step toward reform.

This is a national problem, and it demands a national solution. This legislation is comprehensive reform that will enact several critically needed components. For example, it caps noneconomic damages awarded in medical malpractice cases at $250,000. It will eliminate joint and several liability; in other words, the person at fault will pay for their percentage or their share of fault and no more. It will create a uniform statute of limitations; in other words, a period of time in which a lawsuit can be filed and pursued in court in a way that will preserve both the rights of the patient, as well as make sure that so much time does not pass that memories dim, records are destroyed, and the facts are difficult to discern.

It will reform the collateral source rule, another arcane rule of our legal system that says that even if someone has already been paid from one source they can still keep that information from the jury and seek to be paid yet again for the same loss.

Finally, it will create reasonable limits and court approval of attorney contingency fee awards. In many places, the amount of money that a lawyer will receive, and others will receive, in terms of costs of expert witnesses and the like routinely exceeds the amount of money that an injured patient will receive, somewhere on the order of out of every dollar that is awarded by a jury the injured patient only gets 40 cents. It is the lawyer and the bureaucracy in our litigation system that absorb the rest.

If this were truly about what is best for the patients, we would see reform. We would see it in the Senate. Unfortunately, this is about the 60 cents on the dollar that goes to people, other than the patient, who are obstructing true reform.

This legislation is a comprehensive reform and is modeled after the highly successful MICRA law in California, one that has been very successful both in making sure injured patients are fairly compensated while at the same time holding down the escalating costs of medical liability insurance in a way that allows most physicians to practice their chosen profession and which provides better access to good quality health care.

This act will help protect our critical care hospitals and provide needed relief for nursing homes and medical specialists. The cost of health care will be reduced as the need for high premiums for liability insurance will become a thing of the past.

We must remember that this crisis is not, in the end, about what is best for doctors, hospitals, insurance companies, or personal injury trial lawyers. What this bill is about is what is best for patients—in other words, what is best for the American people.

This crisis is threatening the quality of care, jeopardizing access to care, and escalating the costs of care. In my own State, one can travel to the gulf coast and Corpus Christi where emergency room physicians live in fear that they will be called to answer to a patient in a hospital emergency room, someone who they know they have never seen before and will never perhaps see again

after treating them in the emergency room, and for a patient visit that they will likely not get paid or will get paid only pennies on a dollar for their usual fee, but yet because of the medical liability crisis they will put at risk everything they have worked a lifetime to build and achieve for themselves and for their family. That is even when they can buy insurance.

The truth is, the costs of medical liability insurance have escalated so dramatically because of this crisis that many physicians cannot even buy adequate amounts of coverage. If they can, it is at such a cost that they figure why bother, why bother to practice, and so they simply leave.

I reiterate that in the end this is not about doctors, lawyers, hospitals, or insurance companies. This is about who gets access to quality health care, and in many parts of my State, and in many States across the Nation, access to health care is simply not there because of this crisis.

I believe we should end the liability lottery, where select patients and some trial lawyers receive astronomical awards, while others pay more—all of us really—for health care and many suffer access problems because of it. We should pass meaningful medical liability reform that includes real and lasting change and bring the lessons of Texas and other States that have done so to the Nation's Capital and the American people.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from South Carolina is recognized.

Mr. HOLLINGS. I thank the distinguished Presiding Officer.

My most respected colleague from Texas said it is not about doctors and it is not about insurance companies. I would have to dissent from that view from the standpoint of my experience over some 30 years dealing with this particular problem.

We started in the early 1970s with my good friend Victor Schwartz. Product liability was the style of the day, the crisis. The Little Leaguers could not play anymore at the playgrounds. Football was going to have to be abolished because they could not buy safe helmets. They were all being sued because of the helmets. We faced down the situation of so-called product liability and tort reform with the help of the National Legislative Association, the National Governors Association, and some others.

We went to Y2K. We would go to terrorism insurance. I resisted, being an old States righter. I have an unusually good insurance commissioner in South Carolina. In fact, we have low rates as a result of his administration. But from a studied view of this particular situation, the problem is, yes, the doctors and, yes, the insurance companies.

Why do I say that? Well, according to the Secretary of Health and Human Services, Mr. THOMPSON, there are 100,000 deaths a year in America as a result of medical malpractice. That is people killed. That is casualties. We had 58,000 people killed over 10 years, just about, in Vietnam.

Now, the doctors have to get ahold of themselves in the State of West Virginia, for example. There are some 40 doctors, I think it is, who account for some 25 percent, one-fourth, of the 2,300 malpractice claims.

Incidentally, they are moving down to South Carolina because I have talked to some of my doctor friends. There is no better friend of medicine than this Senator from South Carolina. I have worked with them closely over the many years I have been in the National Government, and as their Governor. We have a very disciplined, one might call it, medical practice in South Carolina. In fact, they have always told me, and again recently affirmed, that if we had the average licensed doctors of some of the other States we would immediately add 1,000 doctors. In other words, it is not easy to practice medicine in the State of South Carolina.

So we go immediately to the doctors disciplining themselves like the lawyers, and I can get example after example of us at the bar association disciplining the lawyers. Unfortunately, the doctors just recently returned now to that particular practice and they are beginning to see that they are having to pay for the whole thing. Otherwise, it is not tort reform; it is insurance reform.

The distinguished Senator from Texas mentioned California. I have heard, and it is true, that California has brought down the malpractice insurance rates for the doctors there. That was done with caps in the beginning, but it did not work—in 1975. And it wasn't until 1988 that they had Proposition 103, to institute insurance reform—not tort reform but insurance reform, where they had an immediate rollback of the rates of some 25 percent, regulation written by the insurance commission, and anyone who wanted to question any rate increase had a right before the commission to petition and be heard.

So, yes, there is a way to do it. But you will see, as I speak here this afternoon, it is not this tort reform. In fact, tort reform is being taken care of in the States. They are moving fast. They are already moving in the State of Illinois, as the distinguished Senator DURBIN has been pointing out, with respect to that, and other States have not waited.

The only trouble with the cap is that it has not brought down the rates. The cap States—I mentioned Illinois that has no cap. The rates are up there. But four of the first five—Florida, Michigan, Texas, West Virginia—these four of the five top States with the highest premiums have caps on damages.

So the proof of the pudding is in the eating. We have experienced this with caps. I have other examples to show. Time and again, the insurance executives say: Pass the caps, we are not going to lower the rates.

But the majority leader, the distinguished Senator from Tennessee, is one of the most eminent physicians. And I don't say that just speaking on the floor in a right fashion. He saved the life of a good friend of mine with a lung transplant back in Tennessee. She has been getting along extremely well as a result of the expertise, the touch, the sensitivity, the bedside manner of Dr. FRIST. So there is no question in this body that we have a very valued doctor friend as a Senator from Tennessee.

But Tennessee doesn't have that problem. Of course, there are no caps there. They are below the median in premiums, and they do not have damage caps. I am sure the distinguished doctor/Senator would long since have asked that his State move in that direction if that were the problem.

No, the problem is a political one. We have the doctors in town. It is almost like the computer crowd who came to town with Y2K, and the sky was going to fall—we had to immediately pass Y2K to make sure at the first of the century the world wouldn't end.

We have a similar situation now where we look for the needs of the campaign rather than the needs of the country. We call this bill, right in the middle of the energy bill, appropriations bill, and all the other important matters that we have, tort reform, medical malpractice, because the doctors are in town.

I guess instead of $2,000, those doctors could give $4,000 to political campaigns, so you might call this the $4,000 bill we will be voting on tomorrow morning, as to whether or not we should have cloture. I hope we do have cloture because we ought to nail this buzzard quickly and get rid of it.

You never hear anybody who has been represented as a result of medical malpractice complain about the fee. It is always the loser who complains about a plaintiff's fee. I never have found a plaintiff yet who complained about lawyers' fees.

That gets me right into lawyers because that is the pollster cancer we have in Government in Washington today. You get the pollsters—and they don't know. I never have found a pollster, incidentally, who ever served in government or public office. So they do not know the questions to ask, What about lawyers? Shouldn't we have tort reform? Of course, the Chamber of Commerce has us behaving like toadies for corporate America, doing everything they want because we want their money in order to run for office. So we only pay attention to the money needs and the campaign needs and not the needs of the country.

As far as tort reform is concerned, it is being taken care of at the State level. The big problem, of course, is the losses that have been, not from medical malpractice, incidentally, but from their investments.

Let's say a word about those lawyers because, after all, we just had the

Fourth of July. I saw a program about the forefathers. They were all mentioning the different ones who brought us this 227 years of freedom.

Is life so dear or peace so sweet as to be bought at the price of chains of liberty and freedom? I know not what course others may take, but as for me, give me liberty or give me death.

A lawyer said that.

I can see that 34-year-old Jefferson, with the quill in hand:

We hold these truths to be self-evident, that all men are created equal.

Equal justice under law, with the Declaration of Independence.

What is government itself, but the greatest of all reflections on human nature? If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: You must first enable the government to control the governed; and in the next place oblige it to control itself.

We are out of control: We have a $428 billion budget deficit, after talking about the surplus, surplus, and surpluses for 2 years. The public debt to the penny is $428 billion, and we have not finished the fiscal year.

Madison, the lawyer, the Emancipation Proclamation—Abraham Lincoln, the lawyer.

The only thing we have to fear is fear itself.

Franklin Delano Roosevelt, the lawyer.

You go right on down the line, giving meaning to equal justice under law.

Thurgood Marshall, the lawyer.

These were eminent lawyers and not jury fixers. We have 60,000 lawyers working on K Street. I am one of the 60,000 licensed to practice in the District of Columbia. There are 60,000, and 59,000 will never see the courtroom of law. They are supposed to fix the 535 of us lawmakers here in Government. They are salesmen. I delight in seeing them. They are a big help because we have to have the proceedings, and I listen to both sides and I make up my mind.

But they are, under the bill at hand that has been introduced, not limited in their fees. They sit there claiming frivolity. If you are a trial lawyer, you get the client who comes in. You have to perhaps get the doctor for him, get the medicine. Then if you get the case, get out on the highway, get some pictures and everything else like that, get the experts, draw up the pleadings. After the pleadings are drawn, make all the motions, the interrogatories, and discoveries. Still you haven't gotten a red cent. Time passes on, and what happens is you get to the trial and, after all the trial and the motions in the trial, you have to win all 12 jurors. And after the 12, you have to make the motions on appeal, you have to print up the briefs, you have to go and make the arguments before the appellate court. Then, if you finally win—if you finally win, yes, you get a good fee. But you probably spent a couple of years or more waiting around. And that is the practice of the trial bar.

I have been in it. I have also defended. And they are lazy. Man, they are lazy. I have seen them. They just absolutely sit there and let the runners and investigators do all the work, call that doctor and do this and do that, and then if it is inconvenient, they say: We have a witness who is sick, and we will move for a continuance—because, why? The clock runs. The clock runs, and they get, what, $450 an hour?

I remember when I passed the first textile bill here, a Senator on the other side of the aisle came and said: I know a lawyer downtown who has been paid $1 million to get that bill passed, and he didn't do anything. Here you are, a freshman Senator, and you passed it.

I said: Yes, and I passed it for free because I believe in it.

But you have big fees down here. The clock runs with this corporate crowd, just look at the bill. They say: Oh, no, no—they have no control over their fees. Just control the trial lawyers—with tort reform. You have the biggest myth on the courts we have ever experienced.

Let's go, since my time is limited, to the truth about malpractice premiums. According to the National Association of Insurance Commissioners:

Total profits as a percentage of premiums for 1999 [that is the most recent year for which data is available] are nearly twice as high in the medical malpractice line than the casualty and property insurance industry coverage. Recent price increases are merely an attempt by the insurance industry to maintain the extremely high level of profitability for malpractice coverage.

If that is all the profits, where are the losses? This is Enron. This is Kenny Boy. The Justice Department spent 2½ years and they can't get him. They have gotten everybody in the world. They have gotten WorldCom all the way through the courts up to the SEC and reaffirmed their bankruptcy plan, but you haven't heard any more about Kenny Boy.

Listen to what this says:

When terrorists slammed airplanes into the World Trade Center in 2001, the Donaldson Co. in Bloomington felt the blow almost immediately. The manufacturer's property insurance renewed just days later, with nasty surprises.

Our premium quadrupled from $500,000 to $2 million.

I ask unanimous consent to have this article from the Metro edition of the Star Tribune in Minneapolis printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Star Tribune, Mar. 9, 2003]

FEW SPARED AS INSURANCE RATES SOAR; CORPORATE, HOUSEHOLD BUDGETS FEEL SAME PAIN

(By Dee DePass)

When terrorists slammed airplanes into the World Trade Center in 2001, the Donaldson Co. in Bloomington felt the blow almost immediately. The manufacturer's property insurance renewed just days later, with nasty surprises.

''Our premium quadrupled from $500,000 to $2 million'' and suddenly excluded $150 million worth of terrorism coverage, said Marty Kohne, Donaldson's safety, environment and insurance manager.

After Enron imploded, Donaldson's cost to insure its directors and officers tripled to $300,000 a year.

''You get very frustrated because all these events affect you, but you have no control,'' Kohne said.

It's a common sentiment among insurance buyers of every kind, both corporate and consumer. Pushed by events as divergent as Enron's collapse, terrorism, natural disasters, and health care inflation, insurance costs are spiraling industrywide unlike anything seen in more than a decade. The insurance inflation is part of what's stifling corporate profits and eating into household budgets, and experts believe it could be at least another two years before prices stabilize.

Insurance executives contend they've had little choice but to make major adjustments in premiums. Paul Bridges, senior vice president of Marsh USA, the nation's largest insurance broker, explained the increases this way:

''We had an insurance industry that used to make all of its money off of investment returns on Wall Street. But with the death of the dot.bombs, those stopped,'' he said. ''Then, with recent losses, margins reversed and [insurers] weren't making money for stock holders.''

''We started ratcheting up prices partly on the backs of disasters'' last year, added Bridges, noting that premiums are still on the rise. Commercial policies ''started off rising 30, 40 and 50 percent and some even 100 percent.''

THERE'S NO ESCAPING

The burden is being felt at firms of all sizes.

Minneapolis CPA Barry Rogers runs his own firm with six employees. There have been no major illnesses among his workers, so he was shocked when his agent announced last year that his premiums were ''only going up 12 percent.''

''We had one person who had outpatient surgery done, and that was the extent of it,'' Rogers said of the firm's previous claims.

The firm's health care premiums jumped from $145 per worker to $163, with the co-pay from $15 per office visit to $25.

Rogers and his agent eventually worked out a plan to reduce the co-payment back to $ deductibles for hospitalization climbed from $300 to $500.

Statewide, commercial health insurance premiums rose 12 percent in 1999, 16 percent in 2001, according to the Minnesota Department of Health. Estimates are that rates will go up again around 12 percent this year.

Health care companies reported their costs rose 9, 13 and 10 percent in 1999, 2000 and 2001, respectively.

In many cases, the rising health care costs are being partly passed along by employers, effectively canceling out workers' cost-of-living raises. Workers are then finding that their personal insurance costs also take more money. Last year, homeowner premiums rose 10 percent nationwide. This year, homeowners' rates are expected to rise again.

''There's no doubt about it, '02 had lots of premium increases,'' said Kenneth Ciak, president of American Express Property Casualty, which collected $260 million in premiums last year.

CORPORATE COVERAGE

''Frankly, it's about time,'' Ciak said. ''On the personal lines side, we have not had a 9/11 catastrophe, but there are a fair number of storms that have occurred and the homeowners' product has just been underpriced. We have not made money for the last four or five years.''

While homeowners paid $37 million nationwide to protect their homes against storms, fire and other disasters in 2001, insurers reported losses and expenses equal to 114 percent of all home premiums collected last year.

Even corporate coverage, which for years was predictably and modestly priced, has exploded in cost, thanks to recent events. The accounting scandals at Enron, WorldCom and other companies have erased an change for reasonable directors and officers insurance or cheaply priced surety bonds.

The recent $1.4 billion settlement by investment banks with regulators over allegations of misleading stock recommendations also has increased the pricing pressures on such policies, as insurers brace for investor lawsuits alleging biased stock research. Directors and officers insurance protects companies if their executives are sued by shareholders or other plaintiffs.

A 2001 survey by Tillinghast-Towers Perrin found that insurance claims against executives averaged $5.7 million for each of its 2,037 corporate respondents that year, up 75 percent from 2000. Shareholder lawsuits alone leaped 178 percent to cost insurers $17 million on average in 2001.

PAYING FOR ENRON'S SINS

Companies that haven't been sued aren't escaping the fallout.

Apogee Enterprises of Minneapolis manufactures and installs exterior building glass. The company has 5,500 workers, 12 directors and no directors and officer claims in its history. Nevertheless, it is paying or Enron's sins.

''Last year we paid about $150,000 [in premiums]. Now we can expect it to go way up, maybe triple . . . even though [four underwriter groups] are very comfortable with Apogee and our governance,'' said Michael Clauer, Apogee's chief financial officer.

''That's the reality of Enron. If you want the coverage, you pay the price,'' Clauer added.

Marcy Korbel, a Marsh vice president of financial professional services, recently shared similar bad news with risk managers from General Mills Inc., 3M Co. and other firms.

Industrywide, directors and officers ''premiums average 50 to 300 percent increases and that's only if there are no claims,'' she said. ''We are seeing increases of more than 300 percent if there is claims activity and even more for companies with market caps over $1 billion.''

Policy prices have to reflect reality, said Bob Hartwig, senior economist for the Insurance Information Institute.

''The end of 2001 and all of 2002 were horrific years for this country in terms of corporate governance. We have had some of the worst scandals in the history of this country,'' Hartwig said.

PREMIUMS GOING UP

Enron alone hit 11 insurance companies for $350 million in director and officers claims. Enron's bankruptcy also cost the St. Paul Companies $10 million in surety bond losses and $12 million in unsecured debt the insurer held in the energy company. AIG has announced a $1.8 billion charge in part to deal with claims for both Enron and WorldCom.

All of this was on top of 9/11, which brought insurers $40 billion in losses.

The St. Paul Companies, which lost $941 million in 9/11 claims, hoisted commercial premiums 32 percent in 2001, and 27 percent last year to squeak back into the black after a dismal 2001. The company lost nearly $1 billion in 2001. It earned $290 million in 2002, about half the $567 million it earned in 2000.

St. Paul CEO Jay Fishman has said premium increases will continue this year.

At Apogee, the company's property premiums have risen 40 percent, while its general liability premiums doubled. To compensate, it has adopted higher property deductibles and is self-insuring for workers compensation claims.

''Not only did we assume more of claims but we also incurred even more costs because premiums keep going up. It's been a very challenging year for us,'' Clauer said.

On top of that, the company is still waiting for some projects to get going because of the lack of terrorism insurance, a product that is only beginning to be offered again now and is likely to add another cost equal to about 10 percent of the property's regular insurance costs.

''We still have projects on hold because of the developers' inability to get terrorism insurance,'' Clauer said.

SURGING PREMIUMS

After going through a long period of subdued prices in the '90s, premiums for business and homeowners insurance are rising fast, pushed by a confluence of events including terrorism, corporate crimes and natural disasters. Percentages for 2002 are estimated, percentages for 2003 are forecast.

Premium percent change from prior year—'90 4.5 percent; '02 14.0 percent; and '03 12.2 percent.

Mr. HOLLINGS. Mr. President, Enron alone hit 11 insurance companies for $350 million in director and officer claims. Enron's bankruptcy also cost St. Paul $10 million in surety bond losses and $12 million in unsecured debt insurers held in the energy company. AIG has announced a $1.8 billion charge in part to deal with claims for both Enron and WorldCom.

All of this was on top of 9/11 which cost insurers $40 billion in losses. Now, we find 9/11 and Enron. Kenny Boy is responsible for the losses. It is not medical malpractice. In fact, in all of the cases, only 1 out of 9, or 12 percent, of the cases actually go to court. Some 26 percent of that small percentage actually are tried. The verdicts are up instead of down. But now we find out from where they come.

I have another article in the final edition of the Gannett Corporation on Friday, January 3, 2003. I ask unanimous consent that it be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From USA Today, Jan. 3, 2003]

J.P. MORGAN, INSURANCE FIRMS SETTLE LEGAL DISPUTE

(By Edward Iwata)

Hoping to cut loose the Enron albatross, J.P. Morgan Chase early Thursday settled a legal dispute with 11 insurance firms that had accused the Wall Street bank of engaging in sham financial deals with the collapsed energy-trading firm.

Later in the day, J.P. Morgan Chase said it will take $1.3 billion in fourth-quarter charges to cover losses on its dealings with Enron and to create a $900 million reserve for related but unresolved legal claims.

J.P. Morgan Chase had sued the insurers last year, after the companies refused to cover $1.1 billion in losses on several failed energy trades in the late 1990s involving Enron and Mahonia, an offshore company associated with J.P. Morgan Chase.

The insurers—plus congressional investigators who have looked into Enron's ties with Wall Street banks—alleged that the deals between Enron and J.P. Morgan Chase were fake accounting transactions designed to hide debt and boost revenue.

Under the complex settlement submitted in court, the insurance companies could pay from $520 million to $660 million to J.P. Morgan Chase.

Neither side admitted wrongdoing, and both claimed a legal victory.

John Callagy, an attorney at Kelley Drye & Warren in New York who represents J.P. Morgan Chase, says the settlement bolsters the bank's contention that the Enron deals were legitimate. ''There was absolutely no evidence of fraud,'' he says.

Alan Levine, a lawyer at Kronish Lieb Weiner & Hellman in New York and the lead attorney for the insurers, says, ''We're very satisfied with the economics of the settlement.''

J.P. Morgan Chase's troubles relating to Enron haven't ended, though. The bank still faces the giant Enron bankruptcy case, a shareholders' class-action lawsuit against Enron and several Wall Street banks and federal investigations into the Enron scandal.

The insurers' settlement should have no legal impact on the other legal fights, says one attorney close to the cases. However, lawyers often use settlements as leverage in talks in related cases.

In the insurers' case, the settlement came early Thursday morning, near the end of a monthlong trial in New York before U.S. District Judge Jed Rakoff. The jury was ready to start its deliberations Thursday.

As part of the settlement, Travelers Property Casualty could pay up to $159 million; Chubb's Federal Insurance, $110 million; Lumbermens Mutual Casualty, $94 million; Allianz's Fireman's Fund, $93 million; St. Paul Fire & Marine Insurance, $80 million; CNA Financial's Continental Casualty and National Fire Insurance, $47 million; Safeco, $33 million; Hartford Financial Services, $25 million; and Liberty Mutual Insurance, $13 million.

Mr. HOLLINGS. Mr. President, it says:

Hoping to cut loose the Enron albatross, J.P. Morgan Chase early Thursday settled a legal dispute with 11 insurance firms that had accused the Wall Street bank of engaging in sham financial deals with the collapsed energy-trading firm.

As part of the settlement, Travelers Property Casualty could pay up to $159 million; Chubb's Federal Insurance, $110 million; Lumbermens Mutual Casualty, $94 million; Allianz's Firemen's Fund, $93 million; St. Paul Fire & Marine Insurance, $80 million; CNA Financial's Continental Casualty and National Fire Insurance, $47 million; Safeco, $33 million; Hartford Financial Services, $25 million; and Liberty Mutual Insurance, $13 million.

Let us talk about those losses. Where do we go?

I quote from an article dated June 30 in U.S. News and World Report.

The case of Samuel Desiderio, while tragic, seems to give perfect voice to the complaints of many doctors who see a legal system gone wild. As a 4-year-old, he suffered brain damage following surgery at a New York City

hospital. A state court jury awarded him a hefty $80 million for medical expenses and pain and suffering. In April, just two months ago, an appeals court approved boosting the award against his doctors and the hospital to an astonishing $140 million.

But as Joan Butsko's modest award suggests, caps may not be the answer. Insurance costs are up, but it's not clear that juries or the courts are the culprits, or even that the crisis is as dire as it's being portrayed. The statistics don't line up as neatly as doctors and insurers would have them, and left out of the argument is recognition that ordinary market forces may be at work instead.

For starters, there's no explosion of cases that might drive up legal costs. The number filed each year has remained fairly steady during the past decade, according to the National Center for State Courts. Further, most malpractice plaintiffs never even see a jury—two thirds of their cases are dropped or dismissed—and when they do, it often isn't a sympathetic one. Only a tiny sliver of cases filed—just 0.9 percent of some 5,500 cases surveyed for 2002—produce jury verdicts for patients claiming injury. And even the size of that small wedge is down by half since 2000, according to the Physicians Insurers Association of America, the trade group for malpractice insurers owned or operated by doctors, which account for about 60 percent of the market.

Within that wedge, the number of payments that doctors' insurers make following jury verdicts has held steady in recent years, at around 400 annually, according to a U.S. News review of hundreds of thousands of payments of all kinds reported to the federal National Practitioner Data Bank. These payments total about $143 million each year. Malpractice insurers are required by law to report their payouts to the system.

Doctors and insurers say that frequency of claims aside, the prime issue is the size of awards. Indeed, the size of insurer payments stemming from jury verdicts has been increasing in recent years, U.S. News has found; in 2002 it reached a median of $295,000. But, that's far below the median jury award of $1 million the AMA and others often cite. Even assuming two defendants per case—a number insurers say is typical—plus other adjustments, the median payment remains hundreds of thousands of dollars short of the $1 million figure.

But it's not clear that verdicts are really the whip behind settlements. Over time, the size of a typical settlement payment has grown somewhat faster than a typical jury verdict payment. And while the sum from jury awards has remained stable over the past decade, the total of payouts from settlements has soared, especially recently, when doctors say the crisis has emerged.

Mr. President, that is what punitive damages do. They really set the pace.

Dickie Scruggs and Ron Motley, the trial lawyers in the tobacco case, did more to cure people of cancer or prevent people from getting cancer than Dr. Koop and Dr. Kessler.

I have been in the vanguard since Warren Magnuson had me have cancer hearings all the way back in 1967 and 1968. And over the years, we have tried everything in the world to stop people from smoking.

If my time is up, I ask unanimous consent for 10 additional minutes, Mr. President.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. HOLLINGS. I thank the distinguished Presiding Officer.

People talk about those two lawyers and say, ''Look at all the fees they got.'' I say look at all the good they did. Over the many years, we have had the American Cancer Society, we have had fundraisers, we have had cancer institutes, we have had all kinds of research and everything else like that, but how do you stop people from smoking? When they got that 360-some-billion-dollar settlement with the Government, the Attorney General, the medical community, and everybody concerned, and the State attorneys general, that failed to pass the Senate, so it was taken up, and I think it was $232 billion that the States settled for. That money is being paid out. In many States they have programs to teach youngsters to avoid smoking. I go to the heart of the Pee Dee in South Carolina where they grow tobacco, and you will see a big sign on the courthouse that says: ''No smoking.''

Now, that really got me. Those two lawyers really deserve every dime they get out of the legal fees. They had been bringing cases upon cases upon cases, and I think their average victory was some 4 in 100 cases.

They just lost another case down in Charleston last year. Of course, there have been ridiculous verdicts, like in Florida, where the punitive damages is somewhere around $27 million, but had been $145 billion. Well, that was a six-man jury and a judge who did not know what they were doing. That was just a seven-man conspiracy. I agree, it was wild and unjustified.

My point is, these trial lawyers are really doing a wonderful service. I can go to the class actions, I can go to the asbestos cases. The onslaught has got to be stopped here on this so-called tort reform because it is totally political. It is totally campaign funds. It is totally the election next year and not the needs of the country.

Mr. President, that is what is going on, and colleagues have to wake up and realize we have a President who runs off to Africa, who has not settled Afghanistan, who does not know where he is in Iraq. All he knows is the election is next year, in November. So there we are. We are being put upon with not the needs of the country but, frankly, with the needs of the campaign.

I have an article here dated September 7 of last year from the New York Times. I ask unanimous consent to have that article printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Sept. 7, 2002]

INSURERS SCALE BACK CORPORATE LIABILITY POLICIES

(By Jonathan D. Glater and Joseph B. Treaster)

Shellshocked by corporate scandals and fearful of the hefty payments they will have to make to settle shareholder lawsuits, the big commercial insurance companies are cutting back sharply on liability coverage for American corporations, their directors and senior executives.

The cutbacks are taking the form of higher deductibles and lower limits on overall coverage. But the insurance companies are also demanding that corporations pay part of any court settlements or jury awards out of their own pockets. As a result, corporations in telecommunications, energy, financial services and pharmaceuticals—where the risk of being sued is thought to be highest—could face payments of up to half of the cost of any settlement.

The three leaders in this line of coverage—the American International Group, the Chubb Group and Hartford Financial Services—have already begun requiring some customers to share the expense of settlements.

The cutbacks effectively limit the size of policies insurance companies will sell to any one company, said Andrew Marcell, who is in charge of insurance for directors and corporate officers at Guy Carpenter, a New York reinsurance broker and a unit of the Marsh & McLennan Companies.

''Companies that until recently were willing to provide $50 million in coverage are now offering $25 million, and companies that offered $25 million are now providing $10 million to $15 million,'' Mr. Marcell said.

Enron had $350 million in this kind of coverage and some corporations had been buying up to $1 billion worth. But now, Mr. Marcell said, ''$250 million in coverage is pretty hard to come by.''

The sharing of the burden of settlements may also leave directors' and officers' personal assets exposed, lawyers said.

''This is very bad news for directors and officers,'' said Michael Young, a partner at the law firm of Willkie Farr & Gallagher in New York who often represents directors and officers. ''The insurance industry is sending out the word that for outside directors, insurance that provides 100 percent protection is going to be increasingly difficult to get and companies are going to have to pay through the nose for it.''

John Keogh, a unit president of the American International Group, said that some corporations could avoid sharing the costs of lawsuits with insurance companies and get full coverage up to limits of their policies by paying higher premiums. But David H. McElroy, who is in charge of this kind of insurance at Hartford Financial Services, said the riskiest clients could not get full coverage at any price.

The insurers say they are merely acting in self-defense as they watch corporate giant after corporate giant collapse as they come under fire for deceptive accounting and management abuses that have drained companies like WorldCom, Global Crossing and Tyco of hundreds of millions in corporate money.

As share prices of these companies have plunged, shareholders have turned to lawsuits in an attempt to recover at least some of their losses.

Combining the expected costs from some of the latest lawsuits, which are still in their early stages, and scores of others that have been working their way through the courts over the last few years, insurers estimate that they will have to pay out $7.5 billion this year on liability policies for directors and officers—but they collected only $4.5 billion in premiums.

''The expected claims paid out are going to be multiples of the premiums that have been collected,'' said Mr. Keogh of A.I.G. He would not comment on specific numbers. Some insurers said that they expected the actual losses to be lower, but that the industry would still lose money this year. Quietly, several insurers have also begun trying to cancel certain policies, arguing that corporate fraud makes them void—a nightmare for executives.

The cutback in liability coverage and increases in premiums are hitting corporations

hard. Bruce S. Zaccanti, an insurance consultant at Ernst & Young, said a nationwide real estate management company he had been advising paid $3 million for $100 million in coverage last year. This year, the company's premium jumped to $4.5 million for $70 million in coverage. On top of that, he said, the deductible has jumped to $15 million from $5 million.

By forcing the companies to share the cost of settlements, the insurers also hope to prod them to fight harder to keep those costs down. When all the costs have been covered, the insurers said, the corporations are often eager to settle quickly—rather than work for a smaller settlement.

''There is no doubt in our minds that insureds' settlement behavior has been less reluctant than maybe it once was when there was an economic alignment,'' said Tony Galban, vice president and manager of directors and officers liability insurance underwriting at Chubb Specialty, a subsidiary of Chubb & Son.

In recent years, the average size of settlements in securities lawsuits has increased drastically, rising to $16 million in 2001, according to the Securities Class Action Clearinghouse, an organization at Stanford University that tracks securities litigation. Before 1995, when a law was passed making it tougher to bring securities fraud claims, the average settlement was less than half that amount.

The possibility that individual directors and officers could be forced to dip into their own wealth may make it harder to recruit executives to serve on corporate boards, said Brooks Chamberlain, head of the global insurance practice at Korn/Ferry International, an executive search firm. Fearful of personal liability, more and more recruits are conducting their own due diligence on prospective employers, he said.

Smaller companies, companies with financial problems, companies in certain industries perceived to have a higher incidence of fraud, and companies with fewer hard assets but sizable market capitalizations will have more trouble, Mr. Chamberlain said.

According to Mr. Young of Willkie Farr & Gallagher, directors want some assurance that somebody else will be able to pay any settlement or damage award.

''What if the company goes into bankruptcy? Then who covers?'' he asked rhetorically. ''Or what if the company's just not wealthy enough?

The changes have already had the odd effect of leading to the creation of a new type of policy that will protect only independent directors. A.I.G. will sell the policies that cannot be canceled even in the case of management fraud, Mr. Keogh said.

But Gregory M. Schmidt, general counsel at the LIN TV Corporation, an owner of television stations in several states, wondered whether companies might choose not to take on the additional cost of these policies and instead promise to cover any settlement costs owed by the directors. ''The question is whether that's going to be satisfactory'' to the directors and officers, he said.

LIN's policies are not up for renewal until March, he said, but executives at the company are monitoring changes the insurers are announcing.

''We're worried,'' he added.

Mr. HOLLINGS. We really are in trouble. I have in my own State the widow of a physician who worked at a hospital in Columbia, where her husband died after surgery. They had to sue as a result of his death.

How can we, the Congress, solve this problem? Let the doctors discipline the doctors. They are going to have to do it on the one hand. And let's have insurance reform. Yes, the Durbin-Graham approach is salutary in that it does away with the fixing of rates. That ought to be done away with. But the only way to really get at the problem itself is what they did in California with proposition 103 that passed in 1988 and that is to regulate the rates themselves.

You can get the information only then from the insurance companies, and I have tried my best as a member of the Commerce Committee, subject to insurance jurisdiction, to try to again and again, year in and year out. And the insurance companies won't tell you anything because they say they are State regulated and we have no jurisdiction whatsoever over them. If there is one thing that is engaged in interstate commerce, it is insurance.

Let's don't just go with terrorism insurance, and just tax credits to pay the premiums, and patchwork little Band-Aids on this problem. Let's get to the real heart of the problem. The insurance companies lost money. They lost it on Kenny Boy. And now the officers and directors of these corporations are being sued, and the rates have gone up with respect to corporate bad practice. The only way to get at it is insurance reform itself.

We are just acting like a dog chasing its tail when we go on about tort reform, and the lawyer's fees, and joint and severable liability, and product liability. If they are real problems, every State has a legislature and they are subject to that jurisdiction. They can do it. But as far as insurance goes, I have worked with them. I have seen them, after 50 years of governmental service at every level. I had to clean up my own insurance department as Governor of South Carolina. I know it intimately.

I can tell you that we have an insurance reform bill, and I want to work with my colleagues on this, for this is how to take care of the medical malpractice increase in premiums.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Ohio is recognized.

Mr. VOINOVICH. Mr. President, I rise today in strong support of S. 11, the Patients First Act, of which I am an original cosponsor. Throughout my career in public service, health care has been one of my top legislative priorities. We all want access to quality, affordable health care. And when the quality is not there, when people die or are truly sick due to negligence or other medical error, they should be compensated. But when healthy plaintiffs file meaningless lawsuits to coerce settlements or to shake the money tree to get as much as they can get, there's a snowball effect and all of us pay the price.

For the system to work, we must strike a delicate balance between the rights of aggrieved parties to bring lawsuits and the rights of society to be protected against frivolous lawsuits and outrageous judgments that are disproportionate to compensating the injured and made at the expense of society as a whole.

I have been concerned about this issue since my days as Governor of Ohio. I wish we had the outpouring of support for medical liability reform 6 years ago that I see now. In 1996, I essentially had to pull teeth in the Ohio Legislature to pass my tort reform bill. I signed it into law in October 1996. Three years later, the Ohio Supreme Court ruled it unconstitutional, and if that law had withstood the Supreme Court's scrutiny, Ohioans wouldn't be facing the medical access problems they are facing today: doctors leaving their practice, patients unable to receive the care they need and costs of health insurance going through the roof.

During my time in the Senate, I have continued my work to alleviate the medical liability crisis. To this end, I worked with the American Tort Reform Association to produce a study that captured the impact of this crisis on Ohio's economy in order to share these findings with my constituents and colleagues. Guess what we found? In Ohio, the litigation crisis costs every Ohioan $636 per year, and every Ohio family of four $2,544 per year. These are alarming numbers! In these economic times, families can not afford to pay $2,500 for the lawsuit abuse of a few individuals.

It is not just the individuals but the lawyers who bear some of the responsibility. I recently received my yellow and white pages. Look what I found on the front and back covers, advertisements for personal injuries. This is the yellow pages of the Cleveland phonebook and the white pages, advertisements on the front cover and on the back cover. One of them says: Medical malpractice. It talks about wrongful death, quadriplegic/paraplegic. They have pictures, birth injuries, nursing home negligence, Erb's palsy, cerebral palsy, heart attacks/late treatment, cancer late diagnosis, emergency room negligence.

It goes on to say, ''Our firm will advance expenses for our clients in most cases,'' and ''Clients do not have to repay expenses unless there is a successful outcome.'' This kind of stuff is in the yellow pages and on television every night.

When I got out of law school, solicitation was a violation of the canons of professional ethics of lawyers. That has all changed today. I think unfortunately so.

Next to the economy and jobs—the most important issue facing our country today is health care. In fact, it is a major part of what is wrong with the economy. We have too many uninsured, employers face spiraling costs, and those who have insurance face soaring premiums every year. The impact on

businesses is great. It affects their ability to offer health insurance to employees. Too many times, they pass on the added costs to their employees, whose family budgets are often already stretched razor thin. And then there are those who lose their jobs and can't afford COBRA, assuming their company is still in business and COBRA is available.

This issue is a personal one for me. My daughter-in-law, who is expecting her fourth child, recently learned from her obstetrician that after her delivery, she is no longer going to deliver any more babies. Her doctor is in a four-physician group, all of them obstetricians. They have never had any lawsuits against them, yet their insurance premiums have skyrocketed from $81,000 three years ago to over $381,000 today. That's $75,000 per person over a period of 3 years. How can physicians be expected to afford rate hikes like these? And how many babies do they have to deliver in order to pay for medical insurance. Think of somebody getting out of medical school that is an OB/GYN and being told: Before you open the door, you will have to pay a premium of $75,000 to $80,000 to practice medicine.

This crisis is out of control, and when you listen to the statistics, you will be astounded:

From 1994 to 2000, the median award for medical negligence in childbirth cases, $2.05 million, was the highest for all types of medical malpractice cases analyzed.

The median medical liability award jumped 43% in one year, from $700,000 in 1999 to $1 million in 2000; it has doubled since 1995.

Medical liability reform could produce $12.1 billion to $19.5 billion in annual savings for the Federal Government and increase the number of Americans with health insurance by up to 3.9 million people.

There are some who say the Federal Government doesn't have a dog in the fight. We certainly have, when medical liability reform could produce $12.1 billion to $19.5 billion in annual savings and increase the number of Americans covered by insurance.

Seventy-six percent of physicians in Ohio, surveyed by the Ohio State Medical Association, said rising professional liability premiums have impacted their willingness to perform high-risk procedures.

Over half said they are considering early retirement as a result of rising costs.

There has also been an immense jump in million-dollar verdicts. In 1995–97, a little over 36 percent of cases resulted in an award of $1 million or more. By 1998–99, the rate of million dollar awards reached 43 percent. By 2000–01, it was at 54 percent, with one quarter of all awards exceeding $2.7 million. It is going up like a rocketship.

These numbers are shocking, and they continue to grow. We feel this crisis very strongly in Ohio. Medical Liability Monitor ranked Ohio among the top five states for premium increases in 2002. OHIC Insurance Co., among the largest medical liability insurers in the State, reports that average premiums for Ohio doctors have doubled over the last 3 years. But don't listen only to the statistics. Let's talk about doctors—human beings who have practices and patients:

Dr. Perm Jawa, a Cleveland urologist, says that soaring liability premiums leave him in perpetual fear of career-ending lawsuits. ''I shy away from major cases now. Sometimes you know what the best thing is but you don't want to be doing it because there are potential complications with it,'' Jawa said. ''You're not as aggressive as you should be.''

In Columbus, Dr. David Stockwell has seen coverage for his two-physician OB–GYN practice climb to over $100,000 a year. And he expected his premiums to rise 20 to 25 percent in May.

Dr. Robert Norman, a geriatrician in Cuyahoga Falls, saw his annual medical liability premium jump $5,700 to $34,000 last year. He had been warned that it could reach $100,000 this year if he continued treating patients in nursing homes. But in May he received an unexpected ultimatum from his insurer and every other carrier he queried: agree to stop seeing nursing home patients or lose liability coverage altogether. As a result, 150 of Dr. Norman's patients had to find a new doctor.

Dr. Stephen Cochran lost his hospital privileges at Akron General Medical Center when his insurer's financial stability rating was downgraded recently. He is seeking another insurer, but meanwhile, he says, ''We receive daily phone calls from the patients: 'Why aren't you here? Why aren't you seeing me? I want my doctor.' '' He says. ''It's been very stressful to a lot of the patients, particularly the geriatric patients . . . This [the malpractice crisis] has probably changed the nature of our practice more than anything that has happened in the last 10 to 20 years.''

After practicing for 15 years—their entire careers—in Cleveland, Dr. Christopher Magiera and his wife, surgeon Patricia Galloway, decided to leave Ohio to seek refuge from overwhelming liability premiums. Their insurance agent warned them that both would soon be paying $100,000 in annual premiums, up from $30,000 this year. Magiera and his wife decided to ''get out before the situation became hopeless,'' he said. They resettled in Wisconsin. Good for Wisconsin.

This is disgraceful. This crisis is forcing doctors to close their doors and greatly affecting patient access to care.

I want to commend the physicians' grassroots efforts—they are really starting to get attention for this issue. On May 3, 2003, I spoke in my home State of Ohio at the annual conference of the Ohio State Medical Association. I also participated in a physicians rally last October in Columbus, OH which was sponsored by the Ohio State Medical Association. I was impressed with all of the speakers, in particular, Dr. Evangeline Andarsio, an OB–GYN from Dayton, who described the changes in the profession and the effect of the litigation cloud:

> The professional liability crisis is creating a barrier to patients' access to good medical care, especially pregnant women. . . . a paradigm shift needs to occur in our society. Our laws must change to begin to reflect this paradigm shift.

After speaking at this rally, I received a letter from a young doctor, telling me that he was leaving Ohio because he couldn't afford his medical liability insurance premiums. Dr. Cly had received a notice from his insurance carrier that his premiums would be increased by $20,000–30,000. This, plus the $20,000 increase from last year, forced him to make the difficult decision of uprooting his family and his practice to another State. Dr. Cly was unable to make the insurance premiums and still take care of his student loan obligations and his family. Even though he has never had a malpractice claim or judgment against him during his residency training or his private practice years, his rates continued to skyrocket to the point where he could no longer afford them. His move to Fort Wayne, IN, will save him $50,000 per year in liability insurance.

In his letter to me, which I would like to submit for the record, Dr. Cly writes:

> I represent young physicians in Ohio. Most young physicians I speak with are all considering relocating to a place where the ability to practice medicine is better and the liability situation is more stable. I do not want to leave. I have developed close relationships with many patients, families, nurses, physicians, and staff here in Dayton, Ohio. I always planned to retire here and raise my children here. It saddens me greatly to have to make this decision. I feel as if I am giving up and ''throwing in the towel'' by leaving, but I believe my decision is the right one for my family.

I ask unanimous consent that this entire letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MAY 16, 2003.

Hon. GEORGE V. VOINOVICH,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR VOINOVICH: Thank you for you listening to the challenges Ohio physicians are facing regarding the medical malpractice insurance premiums. As you may recall, I was the young physician from Dayton, Ohio who spoke with you after your speech to the Ohio State Medical Association May 3, 2003, while you were walking to another meeting. I work alongside Dr. Evangeline Andarsio at Miami Valley Hospital.

I too, am an obstetrician/gynecologist here in Dayton, Ohio. I have been in Dayton since 1988 when I attended the University of Dayton. I later went to Wright State University School of Medicine in 1992. After graduating from medical school, I did my residency training at Miami Valley Hospital from 1996

until 2000. I have been in private practice for the past 3 years.

In order to attend college and medical school I had to take out educational loans and work during those years. As a result, I have accumulated $150,000 in student loans. With the decreasing reimbursement and increasing medical liability insurance premiums I am not able make much effort in paying off my student loans. In addition, I am married with a set of 5 year old boy and girl twins. I haven't been able to afford to save for their future college educations yet, nor have I been able to put away much money in a retirement plan for me and my wife.

Unfortunately, the liability insurance rates are being unfairly and significantly increased once again this July by our carrier, OHIC. I am expecting another $20,000–30,000 increase from the $20,000 increase last year. Currently, prior to the July increase, I am paying $55,000 for my insurance premium. It is important to know that I have never had a malpractice claim or judgment during my residency training or private practice years.

I no longer afford to stay in Dayton or Ohio to practice medicine. I am leaving the state, in July, 2003, and I will be moving to Fort Wayne, Indiana to practice medicine. I will save approximately $50,000 per year in liability insurance alone. In addition, the managed care penetrations is much less and the reimbursement is better. These factors will allow me to begin eliminating my debt and saving for my family's future.

I represent young physicians in Ohio. Most young physicians I speak with are all considering relocating to a place where the ability to practice medicine is better and the liability situation is more stable. I do not want to leave. I have developed close relationships with many patients, families, nurses, physicians, and staff here in Dayton, Ohio. I always planned to retire here and raise my children here. It saddens me greatly to have to make this decision. I feel as if I am giving up and ''throwing in the towel'' by leaving, but I believe my decision is the right one for my family.

I am extremely thankful of your willingness to help physicians with this crisis. I am genuinely concerned about the future of medicine for our patients. If these issues aren't corrected soon, many patients will suffer due to the lack of access to care.

If I can be of any assistance please contact me. My home phone is 937–376–0705. My cell phone is 937–657–5094. My 24 hr pager is 937–636–3263. My office numbers, until June 27, 2003, are listed above. My email is geoffcly@msn.com.

Sincere Thanks,

GEOFFREY CLY, MD.

Mr. VOINOVICH. For those of my colleagues who think medical liability reform is a State issue, I ask them to read this letter and see how the medical liability crisis transcends State lines—particularly my friends from the neighboring State of West Virginia. Our Ohio physicians who practice along the border are feeling the effects of their proximity to West Virginia and its favorable plaintiff's verdicts. They are feeling these effects in their increasing insurance premiums.

This is a nationwide crisis. And it's not only doctors crossing State borders to find better insurance rates—it's patients as well. Citizens living along the thousands of miles of State borders very often obtain their medical care across that line. Federal action is appropriate and critically necessary. Even more so because this crisis affects Federal health care programs, including Medicare and Medicaid, and costs the Federal Government billions of dollars every year.

In fact, the cost of this crisis to the economy is quite staggering. With over 41 million Americans without health insurance, including an estimated 1.25 million Ohioans at some time in 2001, we have to look at a new system—because this crisis is not only bad for doctors and patients, it also affects our competitiveness in the global marketplace. Many of our company's insurance costs have skyrocketed because of medical lawsuit abuse costs that their competitors just do not have.

The Nation's medical schools and students feel the effects of the medical liability crisis. According to the National Resident Matching Program, a private, nonprofit corporation, the number of American medical students applying to general surgery residency programs declined by 30 percent from 1992 to 2002. If this trend continues, less than 5 percent of medical school graduates will choose a career in surgery by 2005, and only 75 percent of general surgery residency positions will be filled by graduates of medical schools in the United States.

Thank God we have foreign doctors who have come to the United States of America. In Ohio, one out of six doctors is an Asian Indian.

And, in its 2003 biennial survey of medical residents in their final year of training, the firm of Merritt, Hawkins & Associates, MHA, noticed a disturbing trend. When asked if they would study medicine or select another field if they had their education to begin again, one quarter of all residents surveyed indicated they would select another field—this compared with only 5 percent in 2001. It is sweeping across the country and everybody is getting hit. It is going to have a disastrous effect—it already is—and we have to do something about it. When asked to identify what factors caused them a significant level of concern, sixty-two percent of residents indicated that malpractice is a significant area—compared to just 15 percent of residents surveyed 2 years ago.

Specific medical specialties feel the crisis more than others. A September 25, 2002 report by the American Association of Neurological Surgeons, Congress of Neurological Surgeons, and Council of State Neurological Societies, entitled ''Neurosurgery in a State of Crisis'' found that professional liability costs among Ohio neurosurgeons have skyrocketed since 2000. For a $5 to $7 million coverage policy, in 2000, a physician would have paid $75,000. By 2002, this number had jumped to $168,000.

Not only in Ohio, but across the nation, between 2000 and 2002, the average premium increase was 63 percent. As a result, of those neurosurgeons polled: 14 percent said they plan to, or are considering moving; 25 percent said they either plan to, or are considering, retiring; 34 percent said they already do, or are considering, restricting their practices.

In my hometown of Cleveland, OH, at one of our hospitals, the neurosurgeons just left. There was no one there to take care of emergency patients, although just recently because of something the Cleveland Clinic did, they agreed to step in, but there were four neurosurgeons serving about 15 hospitals, and they just decided they were getting out. Who is going to pick that up for them? What is going to happen to those patients?

Patients cannot get emergency medical treatment because fewer neurosurgeons are covering ERs, and trauma hospitals are shutting their doors and diverting patients with serious head and spinal cord injuries to other locations.

Patients cannot find a neurosurgeon close to home because neurosurgeons are moving to States where insurance costs are relatively stable.

Further exacerbating this problem is the high retirement rate. According to the American Board of Neurological Surgery, in 2001 alone, over 300 neurosurgeons retired. This is 10 percent of our Nation's neurosurgical workforce. And for the first time in over a decade, there are now fewer than 3,000 board certified neurosurgeons practicing in the U.S.

Earlier this year, I participated in a press conference with my distinguished colleague from Pennsylvania, Senator SANTORUM, and my distinguished colleague from Nevada, Senator ENSIGN. During this conference, I met a doctor from Florida who had rushed his son to the hospital with his head hemorrhaging, only to find that there were no pediatric neurosurgeons there. He asked if a regular neurosurgeon could help, but they could not because pediatric neurosurgeons require special liability insurance. Due to the exorbitant costs of insurance for pediatric neurosurgeons, only seven were practicing in the State of Florida and the nearest one was 150 miles away. Fortunately, the boy survived, but this type of scenario does not need to happen.

I was recently speaking with some doctors in Cleveland who told me that the nephrologists practicing there will not even look at a baby facing kidney problems, because adding pediatric work to their existing practices will cause their premiums to skyrocket.

The effects of the medical liability crisis can also be felt by the obstetrics-gynecologists community. In fact, obstetrics-gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for OB-GYNs have increased dramatically: the median premium increased 167 percent between 1982 and 1998. The median rate rose 7 percent in 2000, 12.5 percent in 2001, and 15.3 percent in 2002 with increases as high as 69 percent, according to a survey by Medical Liability Monitor, a newsletter covering the liability insurance industry.

According to Physicians Insurance Association of America, OB-GYNs were first among 28 specialty groups in the number of claims filed against them in 2000. OB-GYNs were the highest of all specialty groups in the average cost of defending against a claim in 2000, at a cost of $34,308. In the 1990s, they were first—along with family physicians-general practitioners—in the percentage of claims against them closed with a payout of 36 percent. They were second, after neurologists, in the average claim payment made during that period.

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence.

That is something we should point out. It does not reflect an increased rate in negligence.

In fact, OB-GYNS win most of the claims filed against them. A 1999 American College of Obstetrics and Gynecology survey of its membership found that over one-half of claims against OB-GYNS were dropped by plaintiffs' attorneys, dismissed or settled without a payment. Of cases that did proceed, OB-GYNS won seven out of ten times. Enormous resources are spent to deal with these claims, only 10 percent of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients. In 2000, the average cost to defend a claim against an OB-GYN was the highest of all physician specialties: $35,000.

According to an ACOG survey of its members, the typical OB-GYN is 47 years old, has been in practice for over 15 years, and can expect to be sued 2.53 times over his or her career. Over one-fourth of ACOG fellows have even been sued for care provided during their residency. In 1999, 76.5 percent of ACOG fellows reported they had been sued at least once so far in their career. The average claim takes over 4 years to resolve.

Practicing medicine and having lawsuits hanging over your head, and only 10 percent are well taken, can you imagine, Mr. President, how it is to practice medicine under those conditions?

How does all of this affect patients' access to care?

As premiums increase, women's access to general health care—including regular screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, and other serious health risks—will decrease. OB/GYNs are disappearing.

It leads to more uninsured women. Last year, 11.7 million women of childbearing age were uninsured. Without medical liability reform, a greater number of women ages 19 to 44 will move into the ranks of the uninsured.

The legislation we are debating today gets us on our way to enacting meaningful medical liability reform.

There are going to be a lot of excuses. We are going to hear from some colleagues as to why this is not a good thing, and they are going to get into specific caps and so forth.

The fact is, this legislation provides a commonsense approach to our litigation problems that will help keep consumers from bearing the cost of costly and unnecessary litigation, while making sure those with legitimate grievances have recourse to the courts.

That is what we want to do. We want to make sure those who are legitimately harmed have recourse to the courts and are compensated.

The bill sets sensible limits on noneconomic damages to help restrain medical liability premium increases, while ensuring unlimited economic compensation for patients injured by negligence.

In other words, there is no cap on economic compensation. All of those issues that can be documented, you can be reimbursed for. It limits attorney's fees so the money awarded in the court goes to the injured parties, who are the people who really need it. It mandates that relevant medical experts testify in malpractice trials, as opposed to highly paid ''expert witnesses'' who are often used to influence juries and foster abuses in the legal system. It also allows physicians to pay any large judgments against them over a period of time in order to avoid bankruptcy, and requires all parties to participate in alternative dispute resolution proceedings, such as mediation or arbitration, before going to court.

It is a sensible way of handling a problem in our country and, at the same time, looking at the societal costs that are being paid today by all Americans.

Providing this commonsense approach to our medical liability premiums is a win-win situation. Patients would not have to give away large portions of their judgments to their attorneys, truly injured parties can recover 100 percent of their economic damages, punitive damages are reserved for those cases that are truly justified, doctors and hospitals will not be held liable for harms they did not cause, and physicians can focus on doing what they do best: practicing medicine and providing health care.

I end with the words of Dr. Andarsio, whom I quoted earlier:

> Help us to maintain an ability to have a practice that offers patients excellent access to care—to continue one of the most important relationships in our lives—the doctor-patient relationship—thus maintaining individualized and compassionate care.

In my own particular case—and it may be why I am probably more fired up about this than some people in the Senate—when I was about 2 years old, I contracted osteomyelitis.

It is a disease in the marrow of the bone. There was a lot of controversy among a couple of doctors on how I should be treated for that osteomyelitis. There was one physician who had the courage to try some new things. His name was Dr. Holloway. Dr. Holloway saved my life. I will not ever forget going to his funeral.

There are a lot of other people around this country like GEORGE VOINOVICH who are in need of access to orthopedic surgeons and other types of medical care. I want them to have the same opportunity I had, to have a life. That is what this is about.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCONNELL. Mr. President, I also understand we are under an agreement that we go back and forth. It could be that a Democratic speaker might have been next. Therefore, I ask unanimous consent that I be allowed to go ahead and speak since I am in the Chamber and prepared to speak.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCONNELL. Mr. President, I have heard colleagues on the other side of the aisle extol the virtues of the Weiss report to justify opposing limits on noneconomic damages. Some of our colleagues on the other side of the aisle seem to view this report as the end all and be all of reports on the effect of damage caps.

This Weiss report makes the rather bold and somewhat astonishing assertion that States with caps on damages actually have higher premiums than States without caps on damages. I never heard of such a conclusion. Indeed, it flies in the face of common sense, common experience, and the expertise of actuaries and insurance commissioners.

As one can imagine, I was intrigued by this report and wanted to learn more about it. Upon reviewing the report, it reminded me of the saying by Mark Twain, or Will Rogers, who said: There are lies, there are damn lies, and then there are statistics.

I am wondering how Weiss calculated the median premiums found in his report. No one can seem to figure that out because the report never really explains how the median premium was established.

The Weiss report uses data over a decade-long period. We are talking about the cost of something, in this case insurance coverage, over a substantial amount of time. Inflation is a pretty basic statistical variable for which one should account. Does the Weiss report take inflation into account in reaching its conclusion regarding caps? It looks as if the Weiss report knows that to do a proper analysis one should take inflation into account. After all, it does so in analyzing insurance company payoffs.

For some inexplicable reason the Weiss report fails to do so in its analysis of the increase in insurance company premiums. There is no indication Weiss took inflation into account, despite the fact it does so in making a similar calculation for insurance company payoffs in other parts of the report. If I didn't know better, I would say such a glaring and telling omission was part of an effort to arrive at a predetermined conclusion.

The publication from which the Weiss report obtained its data is something called the Medical Liability Monitor. It is one of the best sources for medical malpractice premium information. Many legitimate reports use the data found in this publication to help explain the crisis. The most recent comprehensive rate survey in the Medical Liability Monitor, dated October 2002, had a headline that reads ''2002 rate survey finds malpractice premiums are soaring. Hard market wallops physicians. Average rate increase more than double those in 2001.''

It seems to me the methods the Weiss report uses are not only wrong but, in fact, misleading. The Weiss report is so seriously flawed, according to the Medical Liability Monitor, the experts who collect the data that Weiss manipulated, actually had to print the following disclaimer in a June 2003 issue to ensure this report was not used to mislead the public.

Let me read the most salient parts.

The Weiss ratings analysis of medical malpractice caps cites Medical Liability Monitor as the source of data Weiss uses to calculate average and median premiums for physicians during the last 12 years.

While we are an independent news publication and take no position on tort reform or other proposals to improve the medical liability climate, we feel it necessary to comment on the use of our statistics because some readers have expressed concern.

The medians and averages in the Weiss report are not the numbers we report in our annual rates surveys. Weiss may have taken our numbers—the amounts and increases of premiums paid by doctors State by State—and used them to arrive at their statistics, but it is impossible from their report to say definitely how our numbers have been used.

It is our view that it is impossible to calculate a valid ''average'' premium for physicians or for physicians in a particular State or territory, and we state that clearly in the executive summary of our rate survey.

But the editor of the Medical Liability Monitor goes further, advising the leaders it is misleading to use median annual premiums compiled from data from the Medical Liability Monitor to demonstrate the effect of noneconomic damage limits on medical liability rates. This is exactly what Weiss does. The report uses median annual premiums compiled with data from the Medical Liability Monitor to try to demonstrate the effect of noneconomic damage limits on liability rates. Not only is this wrong, it down right misleads the public.

I would be the first to confess I am not an expert on the subject but according to many experts, including the PIAA, it is impossible to calculate a valid and useful median premium using the numbers found in the Medical Liability Monitor for many reasons. One of the obvious reasons is a median is not a weighted average. Thus, the Weiss methodology, as far as we can tell, actually inflates the insurance carrier's premium increase by not weighing premiums according to market share. This is critically important because the highest rate probably has the lowest market share.

In fact, the Medical Liability Monitor does not report how many doctors have a particular premium, so a helpful weighted average is impossible to calculate based upon that data as the authors of the Weiss report will tell you.

In short, according to the very experts upon whom the Weiss report relies, the conclusion of the Weiss report on the effective economic damages are wrong, misleading, and should be avoided.

I think it is better to look at some legitimate studies. While folks should question the Weiss study, we can generally trust CBO. So let's look at some highlights from CBO.

Reading from pertinent parts, States with limits of $250,000 or $350,000 on noneconomic damages have an average combined highest premium increase of 15 percent compared to 44 percent to States without caps on noneconomic damages. In California, where the State has placed a cap on noneconomic damages, punitive damages, or rewards for pain and suffering at a quarter of a million, insurance rates have not shown the sharp increase experienced in other States.

Looking at my next chart which has been used by a number of proponents of the underlying legislation, it is very clear that major cities in States which have adopted some kind of caps on noneconomic damages are experiencing lower malpractice insurance rates for physicians. California and Colorado, where there are sensible restraints on noneconomic damages, whether you look at a specialty of internal medicine or general surgery or obstetrics, there is a dramatic difference between the rates in California and in Colorado compared to States such as New York, Nevada, Illinois, and Florida where there are no such caps.

The most dramatic example, I suppose, is in the area of obstetrics where in California the annual premium is $54,000; in Colorado, $30,000; compare these figures to a premium for obstetrics in Florida, which is $200,000 a year, Illinois is $100,000 a year, Nevada is $107,000 a year, and New York is just under $90,000 a year. These are actual 2002 premium survey data looking at selected specialties in States where there are caps versus States where there are no caps.

I repeat, once again, this legislation does not deny the victim a full recovery for all economic damages, plus on top of that, a quarter of a million dollars for pain and suffering, plus on top of that, punitive damages at twice the amount of economic damages or a quarter of a million, whichever is greater.

This is a bill that does provide for victims. In addition to that, it provides some reasonable restraint on lawyer's fees, which of course also benefit the victim because the dollars the lawyers don't get, the victims do.

We can have many legitimate arguments. I know my colleagues on the other side of the aisle seem to be terribly concerned about States' rights as it applies to this issue. I think that is certainly a reasonable argument to make. But it seems to me it borders on nonsensical to argue that caps on noneconomic damages have not had an impact on premiums, because clearly they have. The facts speak for themselves. All you have to do is look at the premiums for these specialists in States where there are caps on noneconomic damages and compare them to premiums in States where there are not. Clearly it makes an enormous difference.

Taking a look at California again, their underlying legislation, which is commonly referred to as MICRA, is the model for the bill which we hope to be able to proceed to. California has had very stable rates over the years going back to 1976 when MICRA was adopted, going right up to the present. If you look at the rest of the United States, California has had a 182 percent increase in medical malpractice liability insurance premiums over this quarter of a century period, but if you compare that to the rest of the country, there has been a 573 percent increase. Any way you look at it, the California law obviously has had a positive impact on making it possible for physicians to afford their liability insurance and therefore continue to offer health services for their people.

That takes us back to where I started yesterday. A year ago when the underlying bill was offered as an amendment, or a portion of it was offered as an amendment, we had a number of States in crisis. Today we have more States in crisis. Wyoming just yesterday changed from a state with problem signs to a state in crisis. Also, in the year since we last debated this issue, my own State of Kentucky, which was a State with problems a year ago, is now a State in crisis. We have to add both states to the red State list.

Connecticut. A year ago Connecticut was a State in trouble. Today, it is a State with a genuine crisis. So it will have to be added to the crisis State list today.

North Carolina. A year ago North Carolina was a State with problem signs. Today it is a State that is in crisis over this issue.

Arkansas. One year ago when we were considering legislation similar to this, Arkansas was a State with problems. Today, Arkansas is a State in crisis.

Missouri. A year ago, Missouri was in trouble. But today it is in crisis.

Finally, Illinois would have to be added today as a State in crisis.

So let's take a look at the map, where we stand today. As I can count them, there are only six States in America that are currently OK according to the AMA; that is, physicians are not avoiding choosing certain specialties or retiring early or closing their shops over the cost of their medical malpractice premiums. We now have 19 red States. Red States are States in crisis. I think we had 11 this time a year ago. Now we are up to 19. Then the rest of America is yellow. That is, States with problem signs. At the rate we are going, many of these yellow States will become red States in the coming months if we do not act to deal with this truly national problem.

I think the argument of States' rights occasionally makes sense, but this is a national issue, affecting health care for all Americans. This is really largely about the patients. Some people have described this as sort of a titanic struggle with doctors and insurance companies on one side and lawyers on the other. Frankly, I am not particularly interested in that struggle. I am sure it exists in a number of different ways. The real issue is whether or not patients are going to be cared for, whether or not there is going to be a medical professional within reasonable proximity of patients in order to deliver a service all Americans are entitled to. That is no longer the case in a significant part of our country.

In my State in eastern Kentucky we have had a number of horrendous occurrences as a direct result of medical professionals not being available because they went out of business. They simply could not afford to pay their medical malpractice insurance premiums and still be in business. So this is a national crisis.

Let me just say in closing, we are debating a motion to proceed. Reasonable people can differ about how to do something about this crisis, but I don't think there are many Senators coming out here, saying this is not a crisis. It is a crisis. Even those who are opposing the motion to proceed, I would expect most of them think we have a major problem here. One of the advantages of voting for the motion to proceed is to get us onto the bill so amendments can be considered. I would not even rule out the possibility that by the time we came to final passage of this legislation, it might look quite different. I might not like that, but I am not sure where the votes are unless we get onto the bill and have a chance to consider amendments and options to deal with this measure about the national health care crisis.

Two weeks ago we added a prescription drugs benefit to a reformation of Medicare. The House has acted. A conference will unfold in the coming weeks and we will on a bipartisan basis deal with one of the major health care issues confronting senior citizens, that is how to afford prescription drugs and whether or not they are going to have choices under the Medicare program.

Now we need to turn our attention to another major health care crisis, and that is the unavailability of health care in major portions of the country simply because physicians can no longer afford to pay their medical liability insurance premiums and still provide health care for patients. That is why we call this the Patients First Act of 2003.

I hope tomorrow, late morning, when we have the vote on cloture on the motion to proceed, that cloture will be invoked, that we will move on to this legislation, consider the various suggestions that have been made by Senators on both sides of the aisle as to how we ought to deal with this crisis. But let's act. Let's act. Let's make an effort to tackle one of America's great health care problems of the 21st century.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, I ask unanimous consent that I be allowed to address the underlying bill for no more than 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Mr. President, I will not object, but I would like to amend that to be recognized after the Senator from Nebraska.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, rapid increases in the cost of medical liability insurance are forcing many physicians to stop performing high-risk procedures, limiting the kind of patients they will see, moving to another State where the liability climate is more favorable, or, simply, they take the option of early retirement. When this occurs, who wins? Who benefits? No one. Everyone loses.

Twenty-six States, including my State of Nebraska, have instituted some sort of cap on noneconomic damages. However, some States have had their caps overturned by the courts and other States are barred by their State constitutions from enacting a cap. Medical liability and access to quality health care are national problems. Medical liability reform is needed to help preserve the ability of health care providers to obtain affordable malpractice insurance so we can remain in practice and deal with the health care needs of America. At the same time, we must ensure that victims of medical malpractice continue to have access to the courts and jury awards.

This is not an either/or issue. S. 11, the Patients first Act of 2003, is a responsible solution. It is a balanced approach to maintaining access to quality care while preserving the rights of both patients and providers.

S. 11 does not cap actual damages. S. 11 caps non-economic damages but defers to current or future state caps. It limits punitive damages to two times actual damages, or $250,000, whichever is greater, but does not preempt existing state caps. It does not preempt State law with respect to compensatory or punitive damages, regardless of the limit.

S. 11 limits attorney contingency fees so that awards go to victims, not to trial lawyers.

No provisions in the House-passed bill or in S. 11 would limit awards for actual damages.

This legislation is important to ensuring access to quality health care for our citizens, and retaining our healthcare workforce.

As an example of what providers face and the impact on patients, consider the fact that annual medical liability insurance premiums for OB-GYNS range from a low of $12,000 a year in Nebraska, to a high of $208,000 in certain areas of Dade and Broward Counties in Florida. Women in rural areas have historically been particularly hard hit by the loss of obstetric providers.

Practicing obstetrics is already economically marginal in rural areas due to sparse population, low insurance reimbursement for pregnancy services and growing managed care constraints. An increase in liability insurance rates will force rural physicians to stop delivering babies.

This is happening now. With fewer obstetric providers, women's access to early prenatal care will be reduced.

This is happening now.

Greater availability of prenatal care over the last several decades has resulted in this country's lowest infant mortality rates ever.

Providers' ability to maintain this standard will be threatened because the cost of insurance places a major additional strain on our maternal health care system.

Dr. Daniel Rosenquist, family practitioner in Columbus, NE who has been in practice 16 years, has delivered babies across Nebraska. However, if Nebraska's medical liability cap is overturned, he may have to give up that part of his practice. In the months before the cap was finally upheld, Dr. Rosenquist had to tell his patients that he wasn't sure if he would be able to continue seeing them.

Dr. Rosenquist is not alone. The Harris Interactive for Common Good Poll of April 11, 2002 states that 432 percent of physicians said they have considered leaving the medical profession because of changes brought about by the threat of malpractice liability.

Because of a liability cap, Nebraska is able to recruit physicians into rural areas by keeping medical malpractice insurance premiums at the fifth lowest in the Nation. It is important to note that even with a cap in place, medical liability premiums in Nebraska rose 36 percent in 2002.

Dr. Christopher Kent, one of four neurosurgeons in Lincoln, NE, who has come to view Nebraska as a great place

to practice medicine, initially came to Nebraska to practice because of its reasonable medical liability structure.

If Nebraska's cap were to be overturned, he says he would have to leave the State, probably within a year. One of his partners would also leave Nebraska and another would retire. This is equivalent to losing 75 percent of the neurosurgeons in Lincoln, and 15 percent of the neurosurgeons statewide. Dr. Kent and his colleagues have already begun restricting their practice, and worry that they will have to restrict care further if the cap is overturned.

According to a study by the Department of Health and Human Services' Agency for Healthcare Research and Quality, States that have enacted limits on non-economic damages in medical lawsuits have about 12 percent more physicians per capita than states without such caps.

Medical liability reform is about quality of care and access to care.

Caps on non-economic damages help keep premiums down, and keep doctors in practice all over our State. S. 11 will provide security to States like Nebraska facing the uncertainty of legal challenges to existing caps, and will result in a faster, fairer, simpler medical liability system that protects both patients and doctors.

The economic benefits of medical lability reform are substantial.

CBO estimates that if legislation such as S. 11 is signed into law, Medicare, Medicaid and the Federal Employees Health Benefits Programs would save $14.9 billion in Federal spending over the next 10 years.

State and local governments would save about $8.5 billion. State spending for Medicaid would decrease by $2.5 billion over that period—again putting that money where we need it the most, where health care is most urgent.

The Joint Economic Committee in a May, 2003 report, estimates an additional $16.7 billion will be saved over 10 years due to reductions in the practice of defensive medicine. According to a July 2002 Health and Human Services report, States with reasonable caps on noneconomic damages saw premium increases of 12 to 15 percent in 2002 compared to 44 percent in States without caps on noneconomic damages.

Dr. Daniel Kessler, a professor at the Stanford Business School, and Dr. Mark McClellan, a former Stanford University economist who is currently FDA Commissioner, in a February 2000 study, looked at spending cuts after tort reform, beyond claim payouts and insurer expenses.

They concluded that States adopting direct reforms exhibited reductions in hospital expenditures of 5 percent to 9 percent, but this did not result in higher patient mortality rates or an increase in serious medical complications.

If these savings were generalized to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms, in addition to that sense of confidence that would be increased across America because these dollars would be focused in areas that need the health care the most—productive uses for $50 billion.

I am proud to be an original cosponsor of this responsible legislation, S. 11, the Patients First Act of 2003. I urge my colleagues to give it serious consideration and support S. 11.

Thank you and I yield the floor.

The PRESIDING OFFICER (Mrs. DOLE). The Senator from Illinois.

Mr. DURBIN. Madam President, I thank my colleagues on the other side of the aisle and on the other side of this issue for coming to the floor because I hope the tone we have set in this debate indicates that regardless of which side of the aisle you are on, regardless of which side of the bill you are on, we understand that we are facing a national challenge.

There is entirely too much medical malpractice in our country today. The best doctors concede that. However, the insurance that is being charged to even good doctors is too unreasonable in many areas, depending on the specialty and where they choose to live. Frankly, there are a lot of people who will suffer if we don't do something about that. Obviously, the doctors themselves who have dedicated their lives to the medical profession want to see some solution to this. I do as well. But the patients who are served by them are also looking for us to do something constructive and positive to make certain that quality health care is available across America.

I don't personally believe S. 11 is up to that challenge. I am not even certain it is a step in the right direction. There has been lengthy debate about whether or not putting a limitation on the amount that can be awarded to a person who has been a victim of medical malpractice is going to bring down malpractice insurance premiums.

This bill, S. 11, suggests that rather than giving that decision to a jury—whether it is in Rhode Island or Illinois or Nebraska—that decision on how much an injured patient should receive will be made by a jury of 100 U.S. Senators. We will pass a bill that says: Regardless of what has happened to you, what happens to your family as a result of medical negligence and medical malpractice, you will be unable to recover anything more than $250,000 for your pain and suffering. Oh, yes, they will pay the medical bills. And if you have lost wages, those will be paid, too. But when it comes to pain and suffering, regardless of whether you are 6 years old, 60, or 96, there will be a limitation of $250,000 which can come your way.

Now, $250,000 in the abstract sounds like a large sum of money—until you sit down and consider the cases, the actual people who have been affected by medical malpractice.

In a few moments, I am going to talk about a number of them, some of whom I met for the first time today. When you hear their stories, I hope those who are following the debate will step back for a second and say: Wait a minute—as I have—is this right for the Senate, for those of us elected from 50 States across the Nation, to decide in each and every case what the maximum recovery will be for medical malpractice injuries? I think the answer is clearly no. That is why I am encouraging my colleagues to vote against the cloture motion, which is a motion which tries to bring this bill before the Senate.

What I believe—and others, I think, share this belief—is that we have a national challenge and a problem when it comes to medical malpractice. But it is a problem that will not be resolved until we deal with it responsibly and completely, until we look at all the facets of the problem.

This bill says it comes down to one thing: Injured victims of medical malpractice are recovering too much money for their injuries. If we can limit the amount of money they recover, then the system is going to be so much better.

I think that oversimplifies it. In fact, I think it really is an abuse of the situation rather than an effort to rectify it. That is why I am opposing it.

We had testimony a few weeks ago from the Bush administration, a doctor from the Department of Health and Human Services, saying that medical malpractice in America has reached epidemic proportions—epidemic proportions. There are those who estimate that as many as 100,000 Americans lose their lives each year because of medical malpractice—not because they are destined to die because of God's choice but, rather, because someone has made a very serious and fatal mistake in their medical treatment—100,000 a year.

We also have studies that have come out from Harvard University that suggest that only 1 out of every 50 cases of medical malpractice ends up in a lawyer's office with a claim against a doctor or hospital—1 out of 50. So I say to those who support this bill, if you do not look at the underlying incidence of medical malpractice in this country, simply limiting the amount that an injured person can recover is no guarantee you will not face an avalanche of cases coming at you for medical malpractice. We have to go to the underlying issues in how to deal with it.

It is interesting to me, as well, how many elements are being overlooked during the course of this debate. All the debate on the floor has been about doctors: States that do not have doctors, communities that do not have obstetricians to deliver babies, red maps brought before us to show State after State where doctors are facing problems.

But read this bill. This bill isn't just about doctors. This bill is about protecting HMOs, managed care insurance companies, pharmaceutical companies, medical device companies, and nursing

homes. So in all of this debate about the sad situations many doctors do face in America, no one has come to the floor to justify why, within this bill, there is protection for these special interests: HMOs, managed care insurance companies, which many times make decisions which can be as lethal and fatal as any decision made by any doctor.

I think most Americans know of what I am speaking. When an HMO that you are a part of or a managed care insurance company that your family is a part of makes a decision as to whether or not they will pay for a diagnostic test, a laboratory procedure, your hospitalization, or a surgery, when they decide how many days you can stay in the hospital, they are, in fact, dictating medical care in the name of profitability. They want to make more money. They would like to keep you out of the hospital as much as possible, reduce your costs as much as possible, and they make medical decisions.

It is interesting that today a report came out. It is a report that was published by Health Affairs, and those who prepared it are people from the American Medical Association based in Chicago: Matthew Wynia, Jonathan VanGeest, Deborah Cummins, and Ira Wilson. This report is entitled ''Do Physicians Not Offer Useful Services Because Of Coverage Restrictions?''

They surveyed doctors across America and asked them the question: How often have you decided not to offer a useful service to a patient because of health plan rules?

I have talked to doctors who have told me many times that is happening more often than they would like to admit.

Let me show you a chart which tells you what they found in asking doctors across America that question. They were asked this question: How often have you, as a doctor, decided not to offer a useful service to a patient because of health plan rules, insurance rules? In this case, ''very often,'' 2 percent; ''often,'' 6 percent; ''sometimes,'' 23 percent; ''rarely,'' 27 percent. Even if you take the ''very often,'' ''often,'' and ''sometimes,'' you have 31 percent of the cases. Almost a third of the time doctors are saying they are making decisions not to provide a useful service to a patient because the health insurance company tells them they will not pay for it and they cannot do it.

Now, that isn't part of this debate. No one has brought into this conversation the question as to whether or not HMOs, in the way they are treating doctors, are having some impact on medical malpractice and injuries to patients. No. What we are doing for HMOs is not holding them accountable but, rather, saying we are going to give them even more privileges under law. We are going to insulate them from the liability of these bad decisions. So the insurance companies, particularly the HMOs, are running rampant across the Senate when it comes to malpractice instead of being held accountable, as they should be, for their restrictions on good doctors making sound medical decisions.

This is another question asked of these doctors in this Health Affairs study that came out today: If ''sometimes'' or ''more often'' you decide not to offer a useful service because the insurance company tells you you can't, are you doing so more often, less often, or about as often as you were 5 years ago? Most of them say unchanged: 55 percent. But 35 percent say ''more often.''

So you have doctors who are increasingly finding insurance companies making decisions on what you, your mother and father, your wife or husband or child is going to receive in terms of medical care. Is that the answer to this issue, that we are going to say that HMOs will make these decisions, and when they are wrong, and people are injured, and these poor people then turn to a court and ask for some compensation for their injury, they will be limited not only in what they can recover from the doctor or the hospital but even the HMO insurance company? That is what this bill says. That is what this bill is designed to do: to insulate from liability even HMO insurance companies which are responsible for more and more doctors making medical decisions which they believe, based on their training and experience, are not the right decisions for their patients. I do not think that is fair. I do not think it treats people as they should be treated.

Let me mention a couple other items. We have a nursing shortage in America. It worries me. I am reaching an age when I am thinking about the day when I want to punch a button at a hospital or some other place to call a nurse and hope that someone shows up. But the likelihood that is going to occur is diminishing because we have a nursing shortage, and it is a serious shortage.

As America's population ages, we need more nurses to take care of us in convalescent homes and nursing homes and hospitals and other places. Sadly, those nurses are not as plentiful as they once were.

Let me tell you about a report from the Journal of the American Medical Association that relates to the issue of malpractice and the shortage of nurses. This is a report from October of 2002 from the Journal of the American Medical Association. They published the results of a study that, for the first time, showed that the number of patients who die in the hospital increases when nurses are assigned to care for too many patients. An estimated 20,000 people die each year in hospitals from medical mistakes attributed to nurses caring for more patients than they can handle.

This accounts for 20 percent of the nearly 100,000 deaths annually from medical mistakes. While a link between nurse staffing and quality of care seems like common sense, many hospitals downplayed the link until the study was published.

This is a troubling report as well. I read from a book entitled ''The Wall of Silence,'' written by Rosemary Gibson and Janardan Singh. This is a quote from the book:

> Experienced nurses as well as newly-minted nurses are leaving patient care at the bedside at a time when other job opportunities exist. Their knowledge and skills are valued in pharmaceutical companies, managed care organizations and information technology firms. How many are leaving? It is hard to say precisely. The Federal Government's Bureau of Health Professions issued a report showing that about 50,000 fewer nurses were using their licenses in 2000, as compared with 1996.

As our population ages, as the demand for nurses increases, the number of nurses in America diminishes. We have seen that when there are fewer nurses in a hospital, there is more likelihood of medical mistakes, medical malpractice, and medical injuries. Has that even been mentioned in the course of this debate? Has anyone talked about the HMOs and their impact on medical practice? Has anyone talked about the shortage of nurses and the fact that it is leading to more medical mistakes, leading to more lawsuits filed against doctors and hospitals. Instead what we have had in this debate is a strict debate, limited to the question of how much injured parties can recover once they face medical malpractice, once the injuries have occurred.

I would like to introduce in the debate now some real-life stories about people who have been victims of medical malpractice. As I mentioned earlier, some of them were kind enough to join Senator LINDSEY GRAHAM and myself earlier this morning when we held a press conference and introduced our version of a bill which we think is a more reasonable approach to dealing with the medical malpractice challenge we face in America.

The first person is Colin Gourley. Colin is on your left as you view this picture here in the striped shirt. This is his twin brother Connor. Nine-year-old Colin Gourley, from the State of Nebraska, suffered a terrible complication at birth as a result of a doctor's negligence. Colin has cerebral palsy. He cannot walk. He could not speak until he was 5 years old. He has irregular brain waves and the amount of time he has spent in a wheelchair has affected his bone growth. He has had five different surgeries, and he needs to sleep in a cast every night to prevent further orthopedic problems. His twin brother Connor survived birth without any injury.

A jury ruled that Colin was a victim of medical negligence. They decided that because of that medical negligence the Gourley family was entitled to receive $5.6 million. That was what was needed to compensate him for his medical care and for the lifetime of suffering and problems which

he will face. Last month, the Nebraska Supreme Court upheld a Nebraska law that severely cut this jury verdict to about one-fourth of the award. As a result, Colin will have to rely on the State of Nebraska and the Federal Government for assistance for the rest of his life.

The jury understood what the case was worth. The jury got to meet Colin, his brother, his two sisters, and mom and dad. The jury heard what happened that led to this terrible medical malpractice, and the jury decided in fairness that he and his family were entitled to $5.6 million. Yet the law came in and said: I am sorry. We have to limit you—a law similar to the one we are considering in the Senate this evening, a law which will say no jury in Nebraska nor Illinois nor North Carolina is going to make that decision. This decision will be made by a jury of 100 United States Senators, and we will decide, in the case of Colin, that no matter what his life may be, whether it is 5, 10, 20, 50, or 80 years, the maximum amount we will pay for his pain and suffering is $250,000.

What may have sounded like a large amount of money at the beginning of this conversation, as we understand as we consider each and every case, becomes an amount which is hardly adequate to take care of what Colin is going to face, as well as his family.

Let me introduce you now to Kim Jones. This is a picture taken before Kim's medical malpractice. As you can see, she is a lovely, proud mother from King County, WA. She was 30 years old and she remains severely brain damaged and in a comatose state today after undergoing routine tubal ligation surgery following childbirth at the Washington State Medical Center. After the operation, the hospital staff failed to notice that Kim had stopped breathing since her vital monitors had been improperly removed. Though successfully resuscitated, Kim suffered multiple seizures and was given seizure control medication that actually worsened her condition. She was later taken by helicopter to another medical facility.

Today Kim is unable to control her bodily functions. She has no discernable mental function and is being cared for at a convalescent center. Kim's father filed a lawsuit against the hospital and the anesthesiologist. The case is still pending.

Kim is standing there at a better time before the medical injury with her daughter. Now she is in a nursing home or convalescent home for the rest of her natural life. What is it worth? After the medical bills are paid, after her lost income is paid, what is it worth to her, to her daughter, to her parents? According to this bill, we know exactly what it is worth. It is worth no more than $250,000 for the pain and suffering she will endure for the rest of her life.

Now let me introduce you to a young lady who made quite an impact on us this morning. She told her terrible story. This is Sherry Keller from Conyers, GA. Sherry is shown in her wheelchair. That is where she was today when she came to speak to us. She stood up and said: I am from Conyers, GA, and I am a registered Republican. I want to make that clear.

I said: We have Republicans and Democrats and Independents. Then she told her story.

Sherry Keller received a complete hysterectomy. Her surgeon relied upon staples rather than sutures to hold her incision closed. Upon having the staples removed, Sherry's incision began to bleed. The surgeon began cleansing the wound. Unfortunately, the incision opened. I won't go into the graphic details. But the doctor in that situation—this happened at the doctor's office—apparently panicked and left her alone in the room for 35 minutes when the doctor went to call a wound specialist. She left her lying on an examination table. The doctor continued to see other patients while the specialist was on the way and left Sherry in that examining room for 35 minutes. Sherry went into shock from loss of blood, lost consciousness, and fell off the exam table. There was no one with her. Her head hit the counter as she fell. She came to but in the process damaged her spinal cord and rendered her an incomplete quadriplegic. She dragged herself out in that condition into the hallway to get the attention of a nurse or doctor to come to her aid. The doctor called for an ambulance but gave directions that she should be transported only. She, the doctor, left instructions that a doctor would go to the emergency room to dress the wound later.

Sherry was then left in the emergency room for 2½ hours waiting for a doctor to treat her wound. As a result of that fall in the office, Sherry will never walk again. As she was not employed outside the home, she has no lost income for her injury. Her damages were virtually all medical bills and pain and suffering. Here she is, a woman, some 35 years of age, who faces a lifetime in a wheelchair now because of malpractice.

This law we are considering would pay her medical bills but say that the total amount of compensation for her for the pain and suffering she and her family will go through is limited to $250,000. Some Senators as jurors have decided that in her case $250,000 is adequate, thank you.

I think a jury has a right to consider that case. A jury has a right to consider whether that doctor is guilty of malpractice and whether this woman and her family are entitled to more than $250,000. The fact that she was at home raising her children, because of this bill, will be used against her. She has no job where she earns a paycheck, but she has a real job as far as America is concerned; she was raising her family.

And now look at this situation. This bill will actually penalize her for being a stay-at-home mother with her family. For a Senate that is supposed to be dedicated to family values, it is hard to understand how Sherry's case tells that story.

The next person I would like you to meet is Evelyn Babb of Tyler, TX. This case is similar to many you may have read about. She is a bright, happy-looking person in this picture. She needed arthroscopic surgery on her right knee for a torn lateral meniscus. Her doctor marked her right knee to be operated on with an X. However, the hospital staff negligently prepared her left knee for surgery. Without verifying whether the staff had properly prepared the patient, the doctor proceeded to operate on the knee which the staff had prepared. He began performing the partial lateral meniscectomy before he realized he was operating on the wrong knee. The staff then prepared the other knee, and the doctor performed the operation as previously planned.

Due to the unnecessary surgery on the one knee, Mrs. Babb's recovery was considerably longer and more painful than it would have been. She has severe pain and swelling in her left knee and a lingering infection. She continues to suffer from pain, has difficulty walking, and has a markedly decreased range of motion in her knee.

As an elderly woman of 75, Mrs. Babb will suffer no loss of income, however, and there will be few, if any, additional medical expenses because there is nothing that could be done to improve her condition. Virtually all of the damages she could recover for this obvious malpractice would relate to the pain and suffering she would endure. This bill has decided how much her case is worth: no more than $250,000, period.

When you look at that situation, a person who is retired, with no active income, and with limited medical bills, but a serious medical outcome, it is an indication of the unfairness of this underlying bill.

This case I will tell you about now involves Heather Lewinsky from Pittsburgh, PA. Seventeen-year-old Heather Lewinsky's face remains scarred for life after a Pittsburgh plastic surgeon performed radical surgery to correct a skin disorder near the left corner of her mouth when she was 8 years old.

The doctor claimed to have done this procedure on children many times before when, in fact, neither he nor any doctor in the United States had ever done the surgery to treat a condition such as Heather's. Following the operation, Heather was left with horrific facial scarring and a terrible stroke-like tugging at the corner of her mouth.

The doctor attempted to fix the problem with two additional surgeries, which made it even worse, forcing her to undergo 10 more operations with other doctors between the third and tenth grades.

The pain, swelling, and recuperation with each procedure were excruciating. Heather and her family filed a lawsuit

against the doctor who only paid a small fraction of the jury verdict because he had insufficient insurance coverage.

This is an indication of a young lady who is scarred for the rest of her life. What is permanent disfigurement worth if it is the result of medical malpractice? A point will be reached when no more surgeries will be indicated; they won't add much to her improvement. She may not have lost wages, but she is scarred for life. As far as this bill is concerned, permanent disfigurement because of medical malpractice is worth $250,000, not one penny more.

The last case I want to talk to you about is a case that involves Alan Cronin of California. In the year 2000, Alan Cronin, then 42 years old, went into the hospital for a routine hernia surgery. Alan was married with three children at the time—two of them still at home. He goes in for a routine hernia surgery. After the surgery, two doctors failed to diagnose an acute infection following the routine hernia repair. The doctors treated him as though he had the flu rather than inspecting the surgery site. He became septic and suffered toxic shock. Once the doctors finally opened the surgery site, the pus and sepsis were so overwhelming that they told Alan's family that he had a 98-percent chance of dying. Gangrene had set in and all of Alan's limbs were amputated. When he awoke from his coma, he no longer had arms or legs.

Alan was a customer service representative for a medical equipment manufacturer. Workers' compensation paid for all of his medical bills, including future expenses. He also had a private disability policy that was used as an offset against future economic damages.

In speaking with Alan about the cap on noneconomic damages, he says that there are so many things that you don't think of as necessities, and $250,000 could not begin to cover those expenses. Alan, 42 years old, has had the amputation of his arms and legs from medical malpractice. How much is the suffering and pain that he will endure in the next 30, 40 years of his life worth? We know in the Senate. It is worth $250,000 and not one penny more.

Incidentally, there is another provision in the bill. Because Alan had the foresight to work for a company that provided him with health insurance that covered some of his medical bills after the medical malpractice, and because he also had a private disability policy that will help him with some of his expenses as he tries to struggle through rehabilitation and rebuilding his life, that information, according to the bill, should be brought up in the trial. As a former trial lawyer, I can tell you it is being brought out so as to encourage the jury to diminish any award they are going to give to Alan Cronin. Because he had the foresight to pay for health insurance and a private disability policy, he would be penalized in a court of law by the disclosure of this insurance and this disability policy.

That isn't done today in any court in America, but it would be done under this bill. S. 11 has decided that is a fair way to deal with medical malpractice. I think most Americans would disagree. What they believe is, if you put a cap or limit on the recovery of a person who is a victim of medical malpractice, the malpractice insurance premiums may come down. They hope if they come down, the threat to the lifestyle and future careers of doctors is going to be diminished. Yet when you look at the studies—the Weiss study, for example—you find the opposite is true.

States with limitations on what can be recovered in court had a higher percentage increase in malpractice premiums between 1991 to 2001 than States without caps. So not only is this proposal in S. 11 fundamentally unfair, it is totally ineffective. What we are doing is seeing, frankly, this battle between the White House and the people who are gearing up for some Presidential campaign and the American trial lawyers. That is what this is about. It is not about malpractice premiums, bringing them down. It is not about the incidence of malpractice and reducing it. Frankly, it is about a political battle which should be secondary to the more important issues before us.

S. 11, as it has been brought to us today, is a bill against which I have led the fight. I am sorry I have to do it in one respect, but I am proud to do it in another. I am sorry because this should not be the bill we are considering. We ought to be coming before the American people with a bill that addresses this problem in its entirety and in a fair way. We ought to bring into this conversation medical providers across America. We should sit down and have an honest and open conversation about how to reduce medical injuries and medical errors. That would be good for everyone. I am sure doctors could tell us ways to do that.

Let me give you an example of what we have tried to do in the past. We decided at one point that we would create a national registry to try to find out how often we have these incidents of problems. With that national data bank, we would say to hospitals that before you hire a doctor on your staff, you can check to see whether he has had his license suspended or has been sued successfully for malpractice. In the 1980s, we established that—my colleague, Ron Wyden from Oregon, was then a Congressman who proposed the legislation. He thought if this data bank were present, we could find the limited number of doctors who are most responsible for malpractice and make certain that they either change their ways or get out of the practice of medicine. It was certainly a good idea.

Sadly, there haven't been many people who have used it. Consider this fact:

> The data bank is an effective information tool only if hospitals and other health organizations actually report adverse actions involving a health care professional. Federal law requires this information to be reported. But hospitals are not complying. Since the data bank was established, more than 60 percent of hospitals have never reported any adverse action [against a doctor that occurred on the premises.] It was expected that hospitals would report more than 1,000 disciplinary actions every month, yet fewer than 1,000 are reported in a year.

Managed care organizations, which are protected by this bill from liability—the HMOs and managed care organizations which, again, receive preferred treatment by the Senate under this bill—are not doing much better.

> From September 1, 1990, to September 30, 1999, [the managed care organizations in America] reported only 715 adverse events to the data bank. Eighty-four percent of them have never reported any adverse action. The investigative arm of the Federal Department of Health and Human Services, the Office of the Inspector General, notes that ''with close to 100 million individuals enrolled in [managed care organizations and HMOs] and hundreds of thousands of physicians and dentists associated with them, fewer than a thousand adverse action reports over nearly a decade of service, for all practical purposes, are reported.

So the efforts we put in place to track medical malpractice, to try to weed out the bad actors, to try to take the doctors away who perform some of these acts of malpractice have been in vain.

Hospitals, HMOs, managed care organizations, have refused to report the bad actors. Yet our answer on how to deal with that situation is S. 11. We are going to limit the amount of money victims can recover. Is this totally upside down?

Should we not start with the premise that we want to limit the amount of malpractice itself and medical error in America and then follow through to the next and obvious question: When doctors are going to buy insurance, how can we help them secure reasonably priced malpractice insurance policies? That, of course, would mean bringing in the malpractice insurance companies and reinsurance companies.

Incidentally, there is one thing I said yesterday that we are going to look into. It was my understanding from reports we received that there were five reinsurance companies available to U.S. insurers. A call today to the Illinois State Medical Society said they work with 9 or 10. I want to make sure the record is corrected and reflects the fact that at least we are trying to come to the right number of reinsurance companies. Regardless of whether it is 5 or 50, the reinsurance companies have to be part of this conversation as to how we are going to reduce the cost of malpractice insurance for doctors and hospitals across America.

The third point, and equally important, and I speak to this one as a

former trial lawyer myself, is that the legal profession has to be part of this conversation. We have to say those lawyers who would consider filing a frivolous lawsuit are going to face severe penalties. They will have to pay compensation of cost and fees associated with those cases, and if, in fact, they are found to have done it repeatedly, we can prohibit them from that field of practice completely.

I add, based on my personal experience, it would take an absolute fool as a lawyer to entertain a medical malpractice case that really did not have a chance of success and that could be considered frivolous. Those cases in my State of Illinois are extremely expensive. You start with a certification by a doctor that you actually have a justifiable cause of action before you file your complaint. An important consideration in taking these cases up is whether or not you can move them forward to recover for the plaintiff who is injured. If you do not think you have a chance, you have to tell that sad news to the client who sits in your office, and I have done that.

Frankly, you have to honestly tell many people who are seriously injured: I do not think you have a case on which you can recover.

We have to bring together, if we are serious about medical malpractice, the doctors who can speak for their profession, nurses who can help us understand how we can bring more medical professionals to the job to reduce the likelihood of medical injuries, HMO insurance companies that have to be told they can no longer dictate sound medical practice, where doctors are told what they have to do regardless of whether they think it is right professionally. We have to bring in the insurance companies to make certain the rates they charge are reasonable, and lawyers have to be brought in as well so they are involved in responsible conduct which is focused more than anything else on recovery for the patient or claimant involved. That is what this is about.

The idea that by limiting recovery for the victims we have talked about here is going to solve the problem just will not work.

Let me use this chart as an illustration as well. Here are two States in the Midwest: One I am very familiar with, my State of Illinois, and a neighboring State, Michigan. They are comparable States in makeup of the population in rural areas and urban areas. They are big States by most standards.

Michigan has caps and limitations on how much a person can recover in court. Illinois does not. Here we take a look at the professional liability insurance that is being paid in these two States as of October of last year. We will see in the State of Michigan, OB/GYNs on average are paying more than in the State of Illinois that does not have caps. With surgery, it is the same story. With internal medicine, it is the same story. Michigan, with caps, has higher medical malpractice insurance rates than the State of Illinois without caps.

The belief that in passing this bill and establishing caps across America we are going to bring down malpractice insurance premiums I do not think is a reasonable conclusion, which is borne by the evidence presented here, and this comes from an analysis of the medical liability monitor data, the same monitor data used by both sides of the debate.

I understand the Senator from Utah is here and would like to speak. I close at this point by saying what I said at the outset, and I repeat today, I value very much the medical profession. They have meant so much to me and my family. I have entrusted the care of my greatest treasures on Earth—my wife and children—to great doctors, and I thank God they were there when we needed them.

I want them to continue in practice. I want them to feel good about what they do for a living. I do not want them looking over the shoulders at lawyers who are filing frivolous lawsuits. I do not want them facing 35-percent increases in malpractice premiums they cannot cope with, that they cannot pass on to patients, that force them to make decisions that, frankly, are not in the best interest of good medicine.

Today, during the course of our press conference with these victims of medical malpractice, one of the staff in the back of the room fainted. When he fainted, we stopped everything and somebody said: Call a doctor. How many times have we heard that said? We say it because we all know in those dire emergency situations and in everyday situations, we need the medical profession.

I said at the outset of this debate, and I repeat, I stand ready to sit down with anyone in good faith who wants to deal with the medical malpractice crisis facing America. Let us deal with this in its entirety and in an honest fashion. Let us ask everyone to make a sacrifice—the doctors, the lawyers, and the insurance companies—and then I think we can come up with a bill that is worthy of the Senate.

For us to deliberately limit the amount of money available to these victims with tragic stories, which I have brought to the Senate today, is fundamentally unfair. It is as unfair to those victims as those malpractice premiums are unfair to many of the doctors who are paying them today.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I rise to speak about the medical liability and medical crisis threatening our great Nation. Over the years, I have pressed for legislation to protect our health care delivery system from the ravages of an out-of-control medical liability system.

Many times we have come close to enacting legislation, and a giant opportunity stands before us today. I hope we do not let it slip through our fingers once more.

I remember as a young lawyer in the early days of my practice in Pittsburgh, PA, the law basically was, if you met the standard of practice in the community, there was no case because everybody knew that medical science is not an exact science. Once they adopted the doctrine of informed consent in its various forms, it meant that every case goes to the jury, regardless; every case that has a bad result, even though the doctor did everything in his or her power to effectuate a decent result. And we have had this medical liability catastrophe upon our hands ever since.

I can remember as a defense lawyer, my advice to some doctors was that they needed to do everything they possibly could to make sure there was absolutely no way they overlooked anything with regard to any person's complaint. If a person came in to them with a common cold, they could no longer say: Take two aspirin every 6 hours, drink all the liquids you can, and in 7 days you will be better. Or: Don't do anything and in 7 days you will be better. No, they have to give vascular and respiratory examinations, blood tests, et cetera. As a result, what used to be a $5 bill in those days, or at most $15 or $20, is far more today. Of course, I believe unnecessary defensive medicine such as that has driven our country to its knees from a medical liability standpoint.

Today, defensive medicine increases health care costs by $60 to $108 billion per year according to the Department of Health and Human Services report of last year.

As I have noted previously, out-of-control medical liability litigation is needlessly increasing the cost and decreasing the quality of health care for every American. It is preventing patients from accessing high-quality health care or, in some cases, any care at all because doctors are being driven out of practice.

I was pleased that President Bush announced his desire to address medical liability legislation reform last summer when he spoke of the need for reform in his State of the Union Address and when he called on us to pass meaningful medical liability reform legislation in this Congress. I am pleased that our majority leader, Dr. FRIST, has brought the Patients First Act forward to be debated today.

Our colleagues, Senator ENSIGN from Nevada, who introduced this bill, and Senator MCCONNELL from Kentucky, deserve special recognition and thanks for their work on this bill as well.

Of course, this was not the first time we have addressed this issue. As many of us will recall, we passed medical litigation relief language with the Commonsense Product Liability and Legal Reform Act in 1995. Unfortunately, it was stripped from that bill in conference.

I am sorely disappointed that in the ensuing 8 years we have not addressed this problem. As a result, the problem has continued to fester like an infection that will not heal. Worse yet, this infection is spreading to all parts of our country.

This map which has been utilized throughout this debate, and I think properly so, with data supplied by the American Medical Association, shows the States that currently are experiencing a medical liability crisis and those that are showing signs of a developing crisis. The 19 red States are crisis States. Nineteen of the 50 States are crisis States. The 26 yellow States are showing problem signs. Only 5 States are currently OK. The red ones are in crisis. The yellow ones are about to be in crisis. The white States are currently OK generally because they have passed medical liability litigation reform legislation like S. 11.

To contrast this for my colleagues, I must note that on a map with last year's data, only 12 States were in crisis. In March, it was up to 18. Now it is 19. The problem is growing and it reaches from coast to coast.

There are very unfortunate consequences to this crisis—doctors forced to quit practicing, trauma centers closing, babies being born by the roadside, and, yes, people dying. These are all due to out-of-control litigation and soaring medical liability insurance premiums.

The crisis is particularly acute in the farming and ranching communities of rural America where obstetricians and family practitioners, some of whom have been delivering babies for 25 years, are quitting their obstetrical practice. As a result, there is an increased shortage of obstetricians in the rural west, including in my home State of Utah.

Studies by both the Utah Medical Association and the Utah chapter of the American College of Obstetricians and Gynecologists underscore the problem. According to the Utah Medical Association:

> 50.5 percent of family practitioners in Utah have already given up obstetrical services or never practiced obstetrics. Of the remaining 49.5 percent who still deliver babies, 32.7 percent say they plan to stop providing OB services within the next decade. Most plan to stop within the next five years.

The Utah study examined the causes of the crisis also:

> Professional liability concerns were given as the chief contributing factor in the decision to discontinue obstetrical services. Such concerns include the cost of liability insurance premiums, the hassles and costs involved in defending against obstetrical lawsuits and a general fear of being sued in today's litigious environment.

Although many blame out-of-control litigation, others believe that the downturn in the economy caused the crisis. In an attempt to identify the cause, in February Senator GREGG and I held a joint hearing of the HELP and Judiciary Committees. We heard from a lawyer who believes the downturn in the economy and problems with State insurance regulations are responsible. But, in addition, we heard from the Texas State insurance commissioner and from the president of Physician Insurance Association of America, representing provider-owned or operated insurance companies that provide insurance for the majority of American doctors.

One reason they do is not because the insurance companies are so awful. It is because the insurance companies will not handle this type of coverage any more. The reason they will not is because of the exposures they are facing. So they have turned now to provider-owner and operated insurance companies.

These gentlemen face this crisis and its consequences every day. Their data and their studies, as well as those from the Department of Health and Human Services, show that increasingly frequent frivolous lawsuits and skyrocketing awards are responsible for rapidly rising premiums.

Have the recent downturns in the economy and the stock market affected medical liability premiums? Possibly. But this does not appear to be a major cause of the current crisis.

Look at this chart. This is a chart showing how insurance companies that offer medical liability coverage allocate their assets. As this chart shows, between 1997 and the year 2001, insurance companies invested conservatively, primarily in bonds—that is corporate in red, Government in green, which is the middle line, and municipal bonds in purple. A minority of funds, only about 10 percent, happens to be invested in equities, which is shown in the yellow.

This conservative investment strategy minimizes the effect that changes in the stock market have on insurance premiums. In fact, there is good evidence that increasing medical liability awards are responsible for increasing premium costs.

This pie chart with data from the Physicians Insurance Association of America shows the outcome of medical liability cases. The area in the orange, almost 68 percent of the pie, represents medical liability cases that were dropped or dismissed. In other words, a vast majority of cases are frivolous to begin with. In those cases, the plaintiff received no award because no harm was found. Yet these frivolous lawsuits cost money, an average of at least $25,000 per case, and those costs increase the costs of medical liability insurance.

This next chart shows the growth in median—that is the blue line and the average in red—medical liability claim payments between 1989 and the year 2001. Prior to 1995, median and average claim payments increased readily, as we can see. But the rate of growth for both increased dramatically after 1995.

Finally, this next chart shows the growth in million dollar ''mega verdicts'' claim payments equal to or greater than $1 million between 1985 and 2001.

In 1985, less than 1 percent of all awards exceeded $1 million. In 2001, over 8 percent of awards were $1 million or higher. The data is very clear. A high percentage of medical liability claims are frivolous. Average and median claim payments are increasing rapidly and the percentage of mega awards, those greater than $1 million, increased dramatically as shown on this particular chart.

It seems clear to me that out-of-control medical liability litigation is driving the increase in premiums, not the economy and not a problem with the insurance industry which some would try to make it. It is not just the doctors but all Americans who are paying the price. This is a national problem and one that requires a national solution.

In my letter of March 12 to Budget Committee Chairman NICKLES and Ranking Democrat CONRAD, I emphasized the important implications of medical liability litigation on the Federal budget. In that letter, I wrote:

> The Federal Government pays directly for health care for members of the armed forces, veterans, and patients served in the Indian Health Service. The Federal Government provides reimbursement for the Medicare and Medicaid programs. According to the Department of Health and Human Services' March 3, 2003, report . . . the Federal Government spends $33.7 billion–$56.2 billion per year for malpractice coverage and the costs of defensive medicine.

That is $33.7 billion to $56.2 billion a year just for malpractice coverage in these areas of Federal Government medicine.

That report states:

> reasonable limits on noneconomic damages would reduce the amount of taxpayers' money the Federal Government spends by $28.1 billion to $50.6 billion per year.

Now I continued to write:

> In my view, Federal legislation that would decrease costly frivolous medical liability lawsuits and limit awards for noneconomic damages is necessary, not only to ensure patient access to health care, but to curb increasing Federal health care costs. Because of the substantial and important budgetary implications, particularly to the Medicare and Medicaid Programs, we request that the budget resolution include language calling for medical liability legislation reform.

I am pleased to report the budget resolution we passed in the Senate recognized the tremendous impact of medical liability costs. The budget resolution included $11.3 billion in savings over 10 years as a result of medical liability reform based on CBO calculation. The Medicare Program alone would save $7.9 billion while Medicaid would save $2.9 billion. The remaining savings would occur in the Federal Employees Health Benefits Program and the Department of Defense.

What if we had that money to help with the poor? It would certainly do a lot of good, more good than is being done by spending it on medical liability.

But it is not only the Federal Government that is affected. Medical liability litigation directly and dramatically increases health care costs for all Americans.

What is more, skyrocketing medical litigation costs increase health care costs indirectly by changing the way doctors practice medicine. In an effort to avoid frivolous suits, doctors often feel compelled to perform diagnostic tests that are costly and unnecessary. This defensive medicine is wasteful. Unfortunately, for doctors, it has become a necessity.

I hate to admit it, but I am partly responsible for that myself because, knowing that many doctors are going to be sued unnecessarily and improperly, I advised them to do what they can to protect themselves. Consequently, this defensive medicine is leading to a lot of unnecessary defensive medicine. And they have to do it or they face unnecessary litigation.

According to a recent Harris poll, fear of being sued has led 79 percent of doctors to order more tests than are medically needed; 74 percent refer patients to specialists more often than necessary; 51 percent recommend invasive procedures that they thought were unnecessary; 41 percent prescribe more medications, including antibiotics, that they did not think were necessary.

Defensive medicine increases health care costs. But the real problem inherent in the current medical liability system and the resulting process of defensive medicine is that it also puts Americans at risk. Every test and every treatment poses a risk to the patient. Every unnecessary test, procedure, potentially puts a patient in harm's way.

According to the Harris poll, 76 percent of the physicians are concerned that malpractice litigation has hurt their ability to provide quality care for their patients.

That brings us to the main question. What can we do to address this crisis today? The answer is, plenty. There are excellent examples of what works. The March 2003 Department of Health and Human Services report describes how reasonable reforms in some States have reduced health care costs and improved access to, and the quality of, care. According to this report, over the last 2 years the States with limits of $250,000 or $300,000 on noneconomic damages premiums have increased an average of 18 percent compared to 45 percent in States without such limits.

In 1975, California enacted the Medical Injury Compensation Reform Act, MICRA. Again, I will refer to this chart. This graph shows that MICRA slowed the rate of increase in medical liability premiums dramatically, and it did so without affecting negatively the quality of health care received by the State's residents.

The red on the chart is States that have gone up 573 percent from 1976 to the year 2000. In California they have increased by only 182 percent. As a result of MICRA, California has saved billions of dollars in health care costs, and Federal taxpayers have saved billions of dollars in the Medicare and Medicaid Programs.

The March 2003 report goes on to state:

> A leading study estimates that reasonable limits on non-economic damages such as California has had in effect for 25 years, can reduce health care costs by 5–9% without ''substantial effects on mortality or medical complications.'' With national health care expenditures currently estimated to be $1.4 trillion if this reform were adopted nationally, it would save $70-$126 billion in health care costs per year.

Now, in our joint HELP and Judiciary Committee hearings in February, we heard from those who believe insurance reform is a cure for this crisis. These individuals believe the Federal Government rather than the States should regulate insurance. Those who advocate Federal insurance regulation apparently believe the States and the State insurance commissioners are not able to accomplish this alone. They suggest that insurance companies are colluding to increase premiums. In all honesty, some of them are getting out of the business because of the risks and exposure they face.

There has been little, if any, evidence during or after our hearing to support these allegations. In fact, we heard that the State insurance commissioners monitor and regulate insurance business practices very closely. The State laws are based on the National Association of Insurance Commissioners model rating laws that include the following language:

> No insurer or advisory organization shall attempt to monopolize or combine or conspire with any other person to monopolize an insurance market or engage in a boycott . . . of an insurance market.

And:

> No insurer . . . shall make any arrangements with any other insurer . . . which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance.

Moreover, insurance companies are precluded from increasing premiums to make up for past losses. It seems to me insurance reforms that some have proposed not only miss the mark badly, they would do nothing to address the cause of the crisis and would prevent State insurance commissioners from performing their jobs.

I have to say I came away from the hearing convinced, and I remain convinced, that out-of-control medical litigation is the major cause of the crisis and we have to do something to stop it. The current medical litigation system represents and resembles a lottery more than a justice system. This system harms patients in many ways. All Americans deserve the access to care, the cost savings, and the legal protections that States such as California provide their residents. This problem has reached crisis proportions, and it is high time we end it.

The task before us is to design a system that protects both the patient and the provider. S. 11, the Patient First Act of 2003, which I am proud to cosponsor, includes provisions that have been shown to work that are fair to all concerned. So S. 11 would encourage speedy resolution of claims by providing a reasonable statute of limitations. The bill provides for unlimited awards for economic damages, and it limits awards for noneconomic damages to $250,000.

Moreover, S. 11 does not preempt State limits on awards for damages, noneconomic or otherwise, even if the State limits are higher than those imposed by S. 11. The Patient First Act limits attorney's fees, thereby reducing the costs of medical liability litigation and channeling award money to where it belongs, the injured patient.

Normally I am against that, limiting the attorney fees, but in this particular case we have to do something. Women are going to be without obstetricians. Many people are going to be without surgeons and many will be without specialists. Young people are not going to go into the profession. Young outstanding geniuses who would make great doctors do not want to go into the profession.

In addition, S. 11 provides for evidence of collateral source payments to be introduced in any health care lawsuit. Juries would be made aware of existing health insurance or other sources that compensate individuals for injuries. No longer would Americans compensate an individual twice for the same injury.

While there is much to commend S. 11, one provision we should consider adding is the carefully crafted catastrophic exception to the limit on awards for noneconomic damages. A carefully worded catastrophic exception can provide that individuals who have particularly severe injuries as a result of extremely egregious acts of negligence receive an award for noneconomic damages that would be greater than the limit. Nine States have included such a provision in their statutes.

Having said that, I must say that S. 11 is a very good bill and I believe that it will accomplish our primary goal of ensuring that Americans have access to health care.

What I like most about the ''Patients First Act'' is that it is true to its name.

The bill puts the patient first.

Not the doctor.

Certainly not the lawyer.

You see, it is the patient who is threatened the most by the medical liability litigation crisis.

It is the patient who eventually pays for the increased health care costs and it is the patient that suffers most when he or she cannot access needed care.

The medical liability litigation crisis threatens the economic health of our country and the personal health of every American. It is like a festering

wound, spreading like an infection throughout the country. It is time that we cured this infection by treating it with a proven remedy. S. 11, the Patients First Act of 2003 is the proven remedy Americans need and deserve. I urge my colleagues to join me in supporting this very important legislation.

Madam President, I began these remarks by stating that, as someone who had experience in this field, I have witnessed an unfortunate transition; a transition from the days when the standard of practice in the community was the rule in most communities, which seemed to me to be a fair rule, to a rule of the doctrine of informed consent, which means the doctor has to so inform the patient that the patient knows all of the risks involved. Well, the patient would have to go to medical school to know all of the risks and it would take so much of the doctor's time to advise a patient of those risks that none of us could afford it.

There are always risks in surgery and there are always risks in a number of clinical procedures. Consequently, because no doctor can ever really meet those standards, every one of those cases go to trial. In this country, jurors don't realize by giving outrageous awards that are not justified in these medical liability cases, they are basically spreading that cost to everybody in society.

If we do not act, babies will not be delivered with the utmost care in the future. Americans will not have access to trauma care. Americans will not have access to the top surgeons.

And if we do not act, unnecessary and costly defensive medicine will continue. I have to say, I have witnessed the increased use of costly CAT scans and MRIs in cases where patients could very easily have been treated at a very low cost in comparison. You can go right on down the line in almost everything else. It is getting so that young people in this country cannot afford to have children because it costs so much, and it is all driven by this medical liability situation. I think that is pathetic. I think it is pathetic for anybody to stand on the floor and say this is not a problem of tremendous concern and, literally, say that it is the insurer's fault.

That just is not the case. In all honesty, it doesn't take a rocket scientist to figure out what the problem is. I hate to say it, being a lawyer and having been a trial lawyer. The problem is caused by many in our profession who are bringing these frivolous suits. I have to tell you that I have seen lawyers bring frivolous medical liability suits for one reason and that is because it costs between $50,000 and $100,000 to defend those suits. Many of these insurance companies, rather than take the risk of a runaway jury or a forum shopping situation, even within in a state, will pay the defense costs to get out of the case even though the case has no merit.

Settling 20 of these frivolous cases per year, makes a pretty good living for an attorney, just forcing the insurance companies to pay defense costs because the insurance company doesn't want to take the risk of a runaway jury verdict in a runaway community.

I think what jurors need to know is that in many respects, by allowing outrageous verdicts in some of these cases where there has been no negligence, they are basically running this system right into the ground. That is what has happened.

As I say, I would have a catastrophic provision in this bill if I could, that basically would take care of particularly egregious, gross negligence type cases. There are reasons for bringing litigation from time to time. There are good reasons to weed out those doctors who should not be in the operating room, those doctors who really are incompetent, those doctors who do not do what is right.

But those are the exceptions, not the rule. We are finding that far too many good doctors are leaving the profession because they cannot stand this intolerable situation anymore. The country cannot stand it, either.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, this legislation, S. 11, is not a serious attempt to address a significant problem being faced by physicians in some States. It is the product of a party caucus rather than a bipartisan deliberation of a Senate committee. It was designed to score political points, not to achieve a bipartisan consensus which is needed to enact major legislation. For that reason, it does not deserve to be taken seriously by the Senate.

We must reject the simplistic and ineffective responses proposed by those who contend that the only way to help doctors is to further hurt seriously injured patients.

Unfortunately, as we saw in the Patients' Bill of Rights debate, the Bush administration and congressional Republicans are again advocating a policy which will benefit neither doctors nor patients, only insurance companies. Caps on compensatory damages and other extreme tort reforms are not only unfair to the victims of malpractice, they do not result in a reduction of malpractice insurance premiums. Not only does this legislation fail to do what it claims but it would do many things that its authors are attempting to conceal.

In reality, this legislation is designed to shield the entire health care industry from basic accountability for the care it provides. While those across the aisle like to talk about doctors, the real beneficiaries will be the insurance companies and large health care corporations. This amendment would enrich them at the expense of the most seriously injured patients, men and women and children whose entire lives have been devastated by medical neglect and corporate abuse.

This proposal would shield HMOs that refuse to provide needed care, drug companies whose medicine has toxic side effects, and manufacturers of defective medical equipment.

In the last 2 years, the entire Nation has been focused on the need for greater corporate accountability. This legislation does just the reverse. It would drastically limit the financial responsibility of the entire health care industry to compensate injured patients for the harm that they have suffered. When will the Republican Party start worrying about the injured patients and stop trying to shield big business from the consequences of its wrongdoing? Less accountability will never lead to better health care.

According to professor Sara Rosenbaum, a nationally respected expert on health care law at the George Washington University School of Public Health:

> This measure is so vast in scope that it reaches every conceivable health care claim against every health care corporation or manufacturer of health care products . . . In this sense the measure extends far beyond its popular billing as one related to the crisis facing physicians and other medical professionals in individual practice.

In testimony on the companion bill to S. 11 before the House Commerce Committee, she stated that the bill was written so broadly that it would shield health care companies from claims as varied as billing fraud, providing tainted blood to patients, fixing the prices of drugs, deliberately overcharging Medicare or Medicaid for health services, making defective implants and violating nursing home safety rules. This legislation is attempting to use the sympathetic family doctor as a Trojan horse concealing an enormous array of special legal privileges for every corporation which makes a health care product, provides a health care service, or insures the payment of a medical bill. Every provision of this bill is carefully designed to take existing rights away from those who have been harmed by medical neglect and corporate greed.

This legislation would deprive seriously injured patients of the right to recover fair compensation for their injuries by placing arbitrary caps on compensation for noneconomic loss in all of these cases. These caps only serve to hurt those patients who have suffered the most severe, life-altering injuries and who have proven their cases in court.

They are the paralyzed, the brain-injured, and the blinded. They are the ones who have lost limbs, organs, reproductive capacity, and in some cases even years of life. These are life-altering conditions which deprive a person of the ability to engage in many of the normal activities of day to day living. It would be terribly wrong to take their rights away. The Bush administration talks about deterring frivolous cases, but caps by their nature apply only to the most serious cases which have been proven in court.

A person with a severe injury is not made whole merely by receiving reimbursement for medical bills and lost wages. Noneconomic damages compensate victims for the very real, though not easily quantifiable, loss in quality of life that results from a serious, permanent injury. It is absurd to suggest that $250,000 is fair compensation for a person paralyzed for life.

Caps are totally arbitrary. They do not adjust the amount of the compensation ceiling with either the seriousness of the injury, or with the length of years that the victim must endure the resulting disability. Someone with a less serious injury can be fully compensated without reaching the cap. However, a patient with severe, permanent injuries is prevented by the cap from receiving full compensation for their more serious injuries. Is it fair to apply the same limit on compensation to a person who is confined to a wheelchair for life that is applied to someone with a temporary leg injury?

Caps discriminate against younger victims. A young person with a severe injury such as paralysis must endure it for many more years than an older person with the same injury. Yet that young person is prohibited from receiving greater compensation for the many more years he will be disabled. Is that fair?

Caps on noneconomic damages discriminate against women, children, minorities, and low-income workers. These groups do not receive large economic damages attributable to lost earning capacity. Women who are homeowners and caregivers for their families sustain no lost wages when they are injured, so they only receive minimal economic damages. Noneconomic damages are particularly important to these vulnerable populations.

In addition to imposing caps, this legislation would place other major restrictions on seriously injured patients seeking to recover fair compensation. At every stage of the judicial process, it would change long-established judicial rules to disadvantage patients and shield defendants from the consequences of their actions.

It would abolish joint and several liability noneconomic damages. This means the most seriously injured people may never receive all of the compensation that the court has awarded to them. Under the amendment, health care providers whose misconduct contributed to the patient's injuries will be able to escape responsibility for paying full compensation to that patient.

The bias in the legislation could not be clearer. It would preempt State laws that allow fair trdatment for injured patients, but would allow State laws to be enacted which contained greater restrictions on patients' rights than the proposed federal law. This one-way preemption contained in Section 11(b) shows how result-oriented the legislation really is. It is not about fairness or balance. It is about protecting defendants.

The amendment preempts State statutes of limitation, cutting back the time allowed by many States for a patient to file suit against the health care provider who injured him. Under the legislation, the statute of limitations can expire before the injured patient even knows that it was malpractice which caused his or her injury.

It places severe limitations on when an injured patient can receive punitive damages, and how much punitive damages the victim can recover. Under the bill, punitive damages can only be awarded if the defendant acted ''with malicious intent to injure'' or ''deliberately failed to avoid unnecessary injury.''

This is far more restrictive than current law. It prohibits punitive damages for ''reckless'' and ''wanton'' misconduct, which the overwhelming majority of States allow. In the very small number of cases where punitive damages would still be allowed, it would cap them at twice the amount of economic damages, no matter how egregious the defendant's conduct and no matter how large its assets.

It imposes unprecedented limits on the amount of the contingent fee which a client and his or her attorney can agree to. This will make it more difficult for injured patients to retain the attorney of their choice in cases that involve complex legal issues. It can have the effect of denying them their day in court. Again the provision is one-sided, because it places no limit on how much the health care provider can spend defending the case.

If we were to arbitrarily restrict the rights of seriously inured patients as the sponsors of this legislation propose, what benefits would result? Certainly less accountability for health care providers will never improve the quality of health care. It will not even result in less costly care. The cost of medical malpractice premiums constitutes less than two-thirds of 1 percent—66 percent—of the Nation's health care expenditures each year. For example, in 2001, health care costs totaled $1.42 trillion, while the total cost of all medical malpractice insurance premiums was $7.3 billion. Malpractice premiums are not the cause of the high rate of medical inflation.

This chart clearly reflects that we spend $1.42 trillion a year in total personal health care expenditures. It is a very large amount per individual. If we are ever able to get the cost of health care per individual down to a reasonable amount there would be real savings. But that isn't what this is about. This is about $7.3 billion, and that amounts to just one-half of 1 percent of all medical costs. Medical malpractice premiums do not contribute to the overall rise. We ought to address the cost of health care. That isn't what this bill is about.

Over the last 15 years, medical costs increased by 113 percent. The total amount spent on medical malpractice insurance rose just 52 percent over that period, less than half the rate of inflation for health care services. The increase is rising at virtually one-half of what other health care services are rising.

The White House and other supporters of caps have argued that restricting an injured patient's right to recover fair compensation will reduce malpractice premiums. But there is scant evidence to support their claim. In fact, there is substantial evidence to refute it.

In the past year, there have been dramatic increases in the cost of medical malpractice insurance in States that already have damage caps and other restrictive tort reforms on the statute books, as well as in States that do not. No substantial increase in the number or size of malpractice judgments has suddenly occurred which would justify the enormous increase in premiums which many doctors are being forced to pay.

Comprehensive national studies show that the medical malpractice premiums are not significantly lower on average in States that have enacted damage caps and other restrictions on patient rights than in States without these restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when ''tort reform'' is enacted.

Let's look at the facts. Approximately half of the States have a cap on medical malpractice damages. Most have had those statutes for a substantial number of years. The other half of the States do not have a cap on malpractice damages. The best evidence of whether such caps affect the cost of malpractice insurance is to compare the rates in those two groups of States.

Based on data from the Medical Liability Monitor on all 50 States, the average liability premium in 2002 for doctors practicing in States without caps on malpractice damages was $31,926, virtually the same as the average premium for doctors practicing in States with caps, which was $30,521.

There are many reasons why insurance rates vary substantially from State to State. This data demonstrates that it is not a State's tort reform laws which determine the rates. Caps do not make a significant difference in the malpractice premiums which doctors pay. This is borne out by a comparison of premium levels for a range of medical specialties.

The average liability premium in 2002 for doctors practicing internal medicine was less—2.8 percent—for doctors in States without caps on malpractice damages—$9,552—than in States with caps on damages—$9,820. Internists actually pay more for malpractice insurance in the States that have caps.

The average liability premium in 2002 for general surgeons was almost identical for doctors in States without caps—$33,016—than States with caps—$33,157. Surgeons are paying the same regardless of the State's tort laws.

The average liability premium for OB/GYN physicians in 2002 in States without caps—$53,163—exceeded the rate for doctors in States with caps—$48,586—by less than 10 percent, a relatively small difference.

Shown on this chart are the figures for: internal medicine, general surgery, OB/GYN, and the physicians in States without caps on damages and the physicians in States with caps on damages. A fair reading of that would indicate there is virtually little that would reflect itself in lower malpractice insurance rates for those States with caps.

This evidence clearly demonstrates that capping malpractice damages does not benefit the doctors it purports to help. Their rates remain virtually the same. It only helps the insurance companies earn even bigger profits. As Business Week Magazine concluded after reviewing the data ''the statistical case for caps is flimsy.'' That is from their March 3, 2003 issue.

Since malpractice premiums are not significantly effected by the imposition of caps on recovery, it stands to reason that the availability of physicians does not differ between States that have caps and States that do not. AMA data shows that there are 233 physicians per 100,000 residents in States that do not have medical malpractice caps and 223 physicians per 100,000 residents in States with caps. Looking at the particularly high cost speciality of obstetrics and gynecology, States without caps have 29 OB/GYNs per 100,000 women while States with caps have 27.4 OB/GYNs per 100,000 women. Clearly there is no correlation.

If a Federal cap on noneconomic compensatory damages were to pass, it would sacrifice fair compensation for injured patients in a vain attempt to reduce medical malpractice premiums. Doctors will not get the relief they are seeking. Only the insurance companies, which created the recent market instability, will benefit.

A National Association of Insurance Commissioners study shows that in 2000, total insurance industry profits as a percentage of premiums for medical malpractice insurance was nearly twice as high—13.6 percent—as overall casualty and property insurance profits—7.9 percent. Do we understand that now? This is the National Association of Insurance Commissioners. Their study showed, in the year 2000, that the insurance industry profits as a percentage of premiums for medical malpractice insurance was twice as high as casualty and property insurance profits. The profits from the premiums for medical malpractice insurance were twice as high. This is the National Association of Insurance Commissioners study.

In fact, malpractice was a very lucrative line of insurance for the industry throughout the 1990s. Recent premium increases have been an attempt to maintain the high profit margins despite sharply declining investment earnings. That is what is at the root cause here.

Insurance industry practices are responsible for the sudden, dramatic premium increases which have occurred in some States in the past 2 years. The explanation for these premium spikes can be found not in legislative halls or in courtrooms, but in the boardrooms of the insurance companies themselves.

There have been substantial increases in the last 2 years in a number of insurance lines, not just medical malpractice. Insurers make much of their money from investment income. Interest earned on premium dollars is particularly important in medical malpractice insurance because there is a much longer period of time between receipt of the premium and payment of the claim than in most lines of casualty insurance.

The industry creates a ''malpractice crisis'' whenever its investments do poorly. The combination of a sharp decline in the equity markets and record low interest rates in the last 2 years is the reason for the sharp increase in medical malpractice insurance premiums. What we are witnessing is not new. The industry has engaged in this pattern of behavior repeatedly over the last 30 years. When ''tort reform laws'' are enacted, the insurance companies pocket the resulting savings to bolster their profits.

Last month, Weiss Ratings, Inc., a nationally recognized financial analyst, conducted an in-depth examination of the impact of capping damages in medical malpractice cases. This is a nationally recognized financial analyst. Their conclusions sharply contradict the assumptions on which this legislation is based. Weiss found capping damages does reduce the amount of money that malpractice insurance companies pay out to injured patients. However, those savings are not—those savings are not—passed on to doctors in lower premiums. That is the conclusion.

This is what the Weiss report, issued on June 3 of this year, states:

> Since the insurers in the states with caps reaped the benefit of lower medical malpractice payouts, one would expect that they would reduce the premiums they charged doctors.

At the very minimum, they should have been able to slow down the premium increases. Surprisingly, the data show they did precisely the opposite. Between 1991 and 2002, the Weiss analysis shows that premiums rose by substantially more in the States with damage caps than in the States without caps. The 12-year increase in the median annual premium was 48.2 percent in the States that had the caps, and only 35.9 percent in the States that had no caps. In the words of the report:

> On average, doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps. . . . In short, the results clearly invalidate the expectations of caps proponents.

There it is. Those States with the caps, 48.2 percent median premium increase; States without caps, 35.9 percent. That is from the study by Weiss Rating, Inc. It is not a study that is made up by those of us who are expressing opposition.

Doctors, especially those in high-risk specialties, whose malpractice premiums have increased dramatically over the past 2 years, do deserve premium relief. That relief will only come as a result of tougher regulation on the insurance industry.

When insurance companies lose money on their investments, they should not be able to recover those losses from the doctors they insure. Unfortunately, that is what is happening.

Doctors and patients are both victims of the insurance industry. Excess profits from the boom years should be used to keep premiums stable when investment earnings drop. However, the insurance industry will never do that voluntarily. Only by recognizing the real problem can we begin to structure an effective solution that will bring an end to unreasonably high medical practice premiums.

I conclude with a quotation from the analysis of medical malpractice premiums by Weiss Ratings, Inc. Weiss Ratings, as I said, is not speaking from the perspective of a trial lawyer or a patient advocate, but as a hard-nosed financial analyst that has studied the facts of malpractice insurance ratings. Here are their recommendations to us based on those facts:

> First, legislators must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers plus a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

Mr. DURBIN. Will the Senator yield for a question?

Mr. KENNEDY. I also reference a really excellent article in U.S. News and World Report from June 30 that shows on a chart what has been happening with premiums going from $2.9 billion to $4.9 billion and, on the other hand, points out insurers' payments after the jury verdict was $147 billion in 1993 and in the year 2001, $172 billion—so basically a fairly flat line across almost a 10-year period, a dramatic increase in the premiums and virtually flat in terms of the payments.

I am glad to yield.

Mr. DURBIN. If the Senator from Massachusetts would yield for a question, I would ask him, since he has been our leader in the Senate on the issue of a Patients' Bill of Rights to ensure that patients across America have their rights against HMOs and managed care companies—I ask the Senator from Massachusetts, is he aware

that despite the copious debate on the floor about the crisis facing physicians across America, S. 11 provides a limitation on liability not just for doctors and hospitals but also for HMO insurance companies, managed care organizations, pharmaceutical companies, and manufacturers of medical devices?

Mr. KENNEDY. The Senator is exactly right. It is not only limited to those groups the Senator has cited, but there is a strong belief that it would also apply protection for billing fraud, tainted blood to patients, fixing of prices of drugs, deliberately overcharging Medicare and Medicaid for health services, as well as making defective implants, and violating nursing home safety standards.

We don't hear much from those who are supporting this about why all of these various groups need this kind of protection. It is a catch all, not dealing with what was stated by many of those who were speaking in favor. This is a catch all for anything to do in any way, under any pretense, with the health care industry.

Mr. DURBIN. May I ask the Senator from Massachusetts another question through the Chair. There is a section in this bill I would like to call to his attention, section 13. I would like to read it to the Senator and ask him to respond, since he has been the sponsor of a Patients' Bill of Rights, so that once and for all HMOs and managed care companies will be held responsible and accountable for medical decisions they make that injure patients. I ask the Senator if he would respond and tell the Senate on the record what it means to include in S. 11 a section 13, with the following language—sense of Congress:

> It is the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

I ask the Senator from Massachusetts, does this sense of Congress language guarantee that those who are harmed by health insurers who make bad decisions about diagnostic procedures, stays in the hospital, necessary surgery—is this language some refuge and comfort for them that finally now they will have their day in court and now, with this sense of Congress, they can hold these health insurance companies accountable?

Mr. KENNEDY. It really insults the intelligence of the average family, and the average family is far too bright and smart not to understand what this says and what it does not. As implicated in the Senator's question, this is a sense of the Senate of something we should be doing by legislation which we have attempted to do with the Patients' Bill of Rights.

This sense of the Senate is meaningless. It isn't even worth the paper it is written on, because of all the other provisions included in the legislation which the Senator has spoken to so effectively during the course of the debate.

This is sort of a catch all, a ''make them feel good,'' section, for some to be able to say: Look, they have language in here that it is the sense we all feel this way. But, of course, it says this in a piece of legislation which will effectively undermine the protections for working families, for their parents, and for their children.

We have many things that can be done to provide help to some of those who have the particular specialties which need attention, but the idea that you have these two lines of a sense of the Senate to effectively say: We have done all of these bad things, and we have put them in law, but we want a sense of the Senate to make you feel good and show that we are actually protecting the average family in this country—as the Senator well knows, it isn't worth the paper it is printed on.

Mr. DURBIN. If I may ask one last question of the Senator?

Mr. KENNEDY. If I may just add, as the Senator remembers—I hope the American people do—we had weeks of debate on the floor on the Patients' Bill of Rights. As the Senator remembers, what underlined that whole debate was that we ought to put the well-being and the health care interests of the patients of this country ahead of the bottom line of the HMOs. This was a debate in which the American people really participated. It was sidetracked because the administration refused to allow States to make the ultimate decision about compensation for individuals. That was in the final compromise which this administration refused.

So for all those who want to talk about States rights issues on this and the States know best—all those who make that argument—they somehow miss the importance of the real protections for people.

Mr. DURBIN. My last question to the Senator: If this sense of the Congress is not worth the paper it is written on, as the Senator has said, is it fair to conclude that since the HMOs and managed care companies prevailed before when the Senator from Massachusetts offered his Patients' Bill of Rights to protect individuals from insurance companies making medical decisions, is it fair to conclude that if S. 11 were enacted as written, limiting the liability of these HMO and insurance companies, these companies would win again, that we would reward them again for bad conduct, despite the sense of the Senate, sense of Congress, section 13 of this bill?

Mr. KENNEDY. I think what you could say is that this is the anti-Bill of Rights for the American consumer because it goes in just the opposite way. Rather than guaranteeing protections, it undermines whatever protections are out there. This is a battle we have been fighting over and over again in recent years, making sure the most basic protections for our consumers and families in the health care area are not undermined.

As the Senator has pointed out, this is going in the opposite direction.

Mr. DURBIN. I thank the Senator.

Mr. KENNEDY. I thank the Senator.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Nevada.

Mr. ENSIGN. Mr. President, I wish to respond to a few of the items just laid out in the Senate and try to point out what I think are glaring inaccuracies.

First of all, the Weiss report we have heard so much about from the last two speakers uses numbers from the Medical Liability Monitor. The Medical Liability Monitor just provides the numbers. They are not a group that is pro tort reform or anti tort reform. This is what the editor, Barbara Dillard, says about the numbers that the other side of the aisle is using to somehow skew what the premiums are doing in those States that have enacted tort reform. Let me read some of the most salient parts:

> The Weiss ratings analysis of medical malpractice caps cites the Medical Liability Monitor as the source of data Weiss uses to calculate ''average'' and ''medium'' premiums for physicians during the last 12 years. While we are an independent news publication and take no position on tort reform, or other proposals to improve the medical liability climate, we feel it is necessary to comment on the use of our statistics because some readers have expressed concern. The median and averages in the Weiss report are not the numbers we report in our annual rate surveys. Weiss may have taken our numbers, the amounts and increases of premiums paid by doctors State by State, and used them to arrive at their statistics. But it is not possible from the report to say definitely how our numbers have been used. It is our view that it is impossible to calculate a valid ''average'' premium for physicians, or for physicians in a particular State or territory, and we state that clearly in the executive summary of our rate survey.

But the editor of the Medical Liability Monitor goes further. She advised the leader's office that:

> It is misleading to use median premiums compiled with data from the Medical Liability Monitor to demonstrate the effect of noneconomic damage limits on liability rates.

This is exactly what Weiss does. That is the report they have been quoting here. The report uses median annual premiums compiled with data from the Medical Liability Monitor to try to demonstrate the effect of noneconomic damage limits on liability rates. Not only is this wrong, it downright misleads the public.

Let me refer to some of the other issues they were talking about. Half of the States have enacted medical liability reform. My State did that a year ago. It has caps. If you look at my State, as far as the numbers, it would look like it hasn't worked. It takes a minimum of probably 8, 10, 12, or 15 years to go through the courts to find out whether the caps are going to be upheld. If the insurance companies are unsure whether the caps are going to be upheld or not, there is no predictability there because they can reach way back—once it is held unconstitutional, they can go back and try those cases and get those awards.

That is why in California it took so long—from 1975 until the mid-1980s—to

find out whether the law was going to work. Colorado and California have now had their laws in place long enough to stabilize rates. Let's look at those two States, in major cities, compared to other cities around the country.

Here are Los Angeles and Denver. We will start with the general surgery. It is almost $37,000 in Los Angeles for the medical liability premiums for the year; that is for a general surgeon. In Denver, it is around $34,500. New York is about $51,000. Las Vegas was $70,000. It is a lot higher this year in Las Vegas. In Chicago, it is $68,000. In Miami, it is $174,000. The cities in the gray on the chart are States without medical liability reform. The two in the white have had medical liability reform in place long enough for them to have predictability.

This whole debate isn't about hurting patients; it is about helping them to have access to quality care. In my State, we had a level I trauma center close for 10 days because of a crisis, where the specialists who were treating patients there could not afford the medical liability insurance anymore. So they had to say: We cannot come in there and practice because we cannot afford the insurance. The Governor of our State, within a week, called a special session of the legislature. They enacted, in a bipartisan way, caps. Unfortunately, like a lot of the caps in the country—and they use a lot of these statistics—they are similar to the caps in my State where they have loopholes that you can drive a truck through, which makes the legislation pretty much, as far as a court of law is concerned, ineffective. That is why there is a move in my State to close those huge loopholes down to where just the most serious cases actually have unlimited pain and suffering type of awards.

In our State, the way they reopened the level I trauma center in that special session of the legislature—not only did they enact a $350,000 cap for the general population but for the level I trauma center they put it under the State. Guess what. Our State has $50,000 caps total—economic, pain and suffering, medical, the whole thing. That is the only way they could get the level I trauma center back open. Why did they do it? They knew there was a crisis. People had died, and more would die if they didn't reopen the trauma center.

Well, how bad does it have to get in the U.S. for us to say there is a crisis? When will the other side realize how bad the situation is in America? We are losing specialists. People are leaving the practice of medicine—especially those specialties and subspecialties in which we already have a shortage in many areas; and new people are not going into these areas because they see the writing on the wall. They see it is going to be too expensive for them to go out and practice.

I have a good friend from Las Vegas, Dr. Spoon. We were talking a couple months ago. One of his favorite things to do in his practice—he is an obstetrician—is to deliver babies, especially those high-risk pregnancies. He got so much enjoyment from bringing them to the point where they were successful. His insurance company made him stop performing high-risk deliveries, and they also cut him down from 250 or 300 deliveries a year, and he can deliver no more than 125 babies a year.

Southern Nevada is the fastest growing metropolitan area in the country. Yet we are losing OB/GYNs and new ones are not coming in. So what happens in that area is women are having serious trouble locating OB/GYNs to deliver their babies.

I want to try to talk a little bit about the bill and what it really does do and try to clear up some of these issues. First, to go back to premiums. It was said that in places such as California premiums and caps on economic damages—caps on pain and suffering don't work. According to the CBO, they do work. H.R. 5, which is virtually identical to the bill we have today, would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. Premiums for medical malpractice insurance ultimately would be an average of 25 to 30 percent below what they would be under current law.

The Congressional Budget Office is nonpartisan, and everybody is supposed to respect the numbers they put out around here. They certainly don't have any pro or con as far as tort reform is concerned. There are others such as the U.S. Department of Health and Human Services that say States with limits of $250,000 or $350,000 on noneconomic damages have average combined highest premium increases of 12 to 15 percent—that is average combined highest premium increases—compared to 44 percent in States without caps on noneconomic damages.

The Joint Economic Committee of the Congress says that tort reform will reduce overall spending on health care savings by between $67 billion and $106 billion over the next 10 years.

I wish to talk a little bit about what kinds of economic damages. That has been criticized. We don't cap economic damages. What can you get in economic damages under this bill? You can get all lost wages and benefits. Lost earning capacity. They say it hurts children. You get a child who gets hurt because of malpractice and you can calculate what that child would have had over the next 60, 70 years.

Mr. DURBIN. Will the Senator yield for a question?

Mr. ENSIGN. They may not have the education to know what their total potential was but it is 60 or 70 years' worth of earnings they can get in economic damages. That can be significant. I will freely admit it is not what Barry Bonds would get if he got hurt, or LaBron James, the new basketball player. They would obviously get a lot more money because they have the potential of making so much more money. But this child would still get a significant amount.

Let me go through these points, and then I will yield for a question.

All medical expenses would be covered under this bill: long-term care, assisted living devices, child care, household services, lost time, special medical damages, value of care, counsel, advice, aid, comfort, counsel for children, parents, and spouses. All of those are possible under economic damages in this bill.

The final point I wish to make is this: Does this capping hurt patients? We just have to look at Colorado and California and ask: Are there people out there being hurt? I submit there are a lot more people being hurt and going to be hurt in States such as Nevada where the doctors are leaving, where the doctor will not be in that emergency room or will not be able to deliver a baby, especially in those high-risk pregnancies.

This one case in Florida is a very good example. I actually met this gentleman. He is a physician himself. He was not performing duties as a physician at this time, he was a parent of an injured child. His name is Dr. Frank Shwarin. His 4-year-old child in Naples, FL, fell and hit his head on the side of the swimming pool. This was in July of 2002. The father is named Frank and Craig is the son. He rushed him to the nearest hospital only to find that none of the neurosurgeons on call would treat patients under 18 years of age. Why? Because they could not get medical liability coverage to treat, even in an emergency situation, a pediatric neurosurgery case. They had to medevac his son a couple hours away. Fortunately, because the father is a doctor, he was able to keep his son alive during that time.

A woman testified before the Senate that when the level I trauma center crisis happened in my State, her father died when that trauma center was closed because he had to be sent to another emergency room, and an emergency room is not a trauma center. They do not have the kind of expertise to treat severe trauma. As a result, her father died.

We cannot guarantee he would not have died in the trauma center, but we can guarantee he would have had the best possible care and the best chance of living. That is what I believe this debate has come down to: The system is out of balance now. It is not working. To correct this imbalance, we have to start reining in some of these frivolous, outrageous jury awards.

I yield for a question.

Mr. DURBIN. Mr. President, I thank the sponsor of the legislation for coming to the Chamber. I want to give him an opportunity to complete his statement, and perhaps at the end of that statement, if he and I can engage in dialog or debate, that would be fair. I do

not want to interrupt his train of thought during his presentation.

Mr. ENSIGN. That would be fine. I have a couple other issues to go through. There are a few other cases I would like to bring to the attention of our colleagues.

First, because we need to put a real face on this issue—we need to put a face on the patients, and I think it is legitimate to put a face on the other way. I think it is legitimate to put a face on somebody who has had a claim of malpractice and actually had malpractice committed against them, and it is also fair to put faces on those people who now are having trouble finding the kind of health care they need.

This is a balancing act, there is no question about it. There is no perfect answer to this situation. I wish there were. The fact is, the current system is driving health care providers out of the practice of medicine, hospitals are closing down, and we need to correct the situation so that when we seek health care in an emergency situation or in a nonemergency situation, we will have the kind of care we need.

A friend of mine in Las Vegas has Parkinson's disease and goes down to Loma Linda—I told this story earlier today—to see his subspecialist in neurology to treat this disease. He had some fairly radical surgery where they actually separate parts of the brain. He has had very good success with it. He had a specialist talked into moving his practice to Las Vegas shortly before the medical malpractice crisis hit in Las Vegas. Once that hit the news, the guy said: Sorry, I live in California where we have caps. I cannot go to Las Vegas and pay $250,000 a year for my practice for medical liability coverage. I cannot afford to do it. Why would I do that when I have a good practice here, we have caps, and it is working well in California?

He wanted to move to Las Vegas. He was ready to go with his family. He liked the quality of life in Las Vegas. He did not go simply because he cannot afford to take that kind of economic hit. So people in Las Vegas have to drive down there.

Most of the time those are not emergency cases, but for those cases that are an emergency, it is just a shame.

People say this is a State issue. I would counter that this is the United States of America, and we are supposed to be able to live where we want to live, and now we are saying to people: No, you cannot go there because of medical liability premiums, you cannot afford to open up your practice because of medical liability premiums. People should be able to find the kind of health care they need wherever in the United States and live the quality of life and obtain the best health care they can possibly get based on what is available in the area. I do not think outrageous premiums should be the limiting factor.

Let me close with this point, Mr. President. Earlier there was debate about punitive damages and that we are protecting big companies. Under this bill, we do protect companies that make medical devices if they have followed FDA regulations. In other words, the manufacturer would not be liable for punitive damages if it satisfied FDA's rigorous approval process and if the harm to the patient did not result from the company's violation of an FDA regulation. If they played by the rules that the Government set down, we protect them in this bill from noneconomic—we do not protect them from economic or from medical expenses. But if they violate the FDA rules, then they are not protected. I think that is fairly reasonable. That is why we think this bill is a reasonable compromise, is a reasonable approach to solving what I believe is an out-of-control system.

I will be happy to yield for questions.

Mr. DURBIN. Mr. President, I thank the sponsor of the legislation. I would like to ask him this question. Virtually every example the Senator has given, every compelling example he has given for this legislation involves doctors paying malpractice premiums. Yet as he has written this legislation, it goes far beyond providing limitation of liability for doctors. It includes limitation of liability for HMOs, managed care, pharmaceutical companies, medical device manufacturers, and nursing homes.

Can the Senator from Nevada explain to me why he has not come before us and argued on behalf of HMOs and why their exposure to liability for wrongdoing is a source of concern and leads to, he thinks, the need for legislation?

Mr. ENSIGN. Mr. President, we know we live in a litigious society. We are sue happy today. Everything is somebody else's fault, and we immediately go to court. Because of the nature of our courts, it is easier to settle. When we settle, it drives up the cost for all of us. A lot of the cases never make it because it is too expensive to take the case all the way to court.

A lot of companies especially are self-insured for certain amounts of money. It is easier for them to calculate the cost of going to court, and what happens in the long run is that all of us pay for that in higher premiums. When we have higher premiums, it is pretty simple. We end up with a situation where employers cannot afford it. A lot of small employers especially are dropping their health insurance coverage and we are ending up with 41 million uninsured in this country and a big part of that is the cost, not only of the premiums to doctors but just the whole cost of defensive medicine that we have to practice today because of the fear of being sued.

Mr. DURBIN. So if the Senator from Nevada will yield for another question, through the Chair, is the Senator from Nevada going to bring for us then more evidence, as he has when it comes to doctors, as to the insurance crisis facing drug companies in America, which as I understand are the most profitable corporations in America with an average annual return of 18 percent on capital, about 6 times the rate of return of the Fortune 500? Is he going to tell us about the liability exposure of HMOs that really necessitate this protection which he is building into his proposed law, S. 11? Is he going to tell us about the medical device corporations that have made faulty products which are causing problems across America and how their exposure and liability necessitate this need to limit their accountability and cap the recovery of innocent people who are victims of their misconduct?

Mr. ENSIGN. If the Senator would vote for us to go forward with the bill tomorrow when we have a cloture vote, we will have a lot of time to debate this. We can amend it and go forward with this debate. So I hope he will join us in voting for cloture because I do have a lot of evidence to justify the various provisions in the bill.

The bottom line is we all know that today it costs around $900 million to bring a single new drug to the market. I am not here to defend the pharmaceutical companies or any other company.

Mr. DURBIN. That is what the bill of the Senator does.

Mr. ENSIGN. No. What I am here to say is we have a problem with our health care system today and we need to fix it. If we can go forward with this bill, if there are amendments the Senator thinks can improve this bill, let's at least move to it so that we can amend it, put the amendments forward, and have a healthy debate. We can take a week, or whatever it takes, to do that so that we can go forward and try to fix some of the glaring problems. If the Senator thinks there are some problems with the bill, let's bring forth amendments and try to fix it.

Mr. DURBIN. If the Senator will yield for another question, I am curious. What the Senator has just suggested is a good basis for establishing what we might even call a Senate committee where we could have Members of the Senate come together, consider evidence, and offer amendments before the bill comes to the floor. If I am not mistaken, the Senate bill already provides for committees. Why is it that this bill, of such consequence, should not go through a Senate committee system so that the very aspects that we have just discussed can be openly debated and amended and come up with a work product that might be of real value to this country?

Mr. ENSIGN. I say to my friend and colleague that it is obvious why. We could not get a bill to the floor. The Senator knows that and everybody here knows that. It is just like last year when the Senator was in the majority, there were at least two bills that I remember, the Energy bill, as, well as the prescription drug bill, that were brought to the floor that were not brought through committee. They were

brought directly to the floor by the majority leader at the time. It is not a common procedure, but it is a procedure that has to be done every once in a while to bring up important legislation that cannot go through committee and my colleagues know cannot get through committee.

The way the Senate works is so different than the House, and the Senator knows that. We both served in the House of Representatives. The House of Representatives does almost all their work in the committee. We can do a lot of our work on the floor and produce a pretty darn good product by bringing it to the floor, amending the bill on the floor, and that is what I think we should do.

Mr. DURBIN. If I could ask the Senator from Nevada, the sponsor of this legislation, another question, he has spoken about his own home State of Nevada and the problems they have faced. In the last 2 days, there has been a lot of discussion on the Senate floor about the medical malpractice crisis in this country that involves an increasing incidence of medical malpractice. In fact, the Bush administration says it has reached epidemic proportions.

I ask the Senator from Nevada, what in his bill, S. 11, would deal with the problem in his home State of Nevada, reported by Business Week on March 3 of this year, in which they reported that in his home State of Nevada, which adopted a $350,000 cap on recovery last year, it was discovered that two doctors in his State were responsible for $14 million of the $22 million in claims awarded in Nevada in 1 year? What in this legislation would make certain that those doctors, guilty of malpractice, would be held accountable for their wrongdoing and would be removed from practice if, in fact, they are not meeting the standards of professional conduct?

Mr. ENSIGN. Mr. President, I say to my colleague that it is a great point. I practiced veterinary medicine and I understand how professional boards work. I understand that with professional boards there is a self-policing that is assumed. It is supposed to happen with lawyers. It is supposed to happen with accountants. It is supposed to happen with veterinarians. It is supposed to happen with physicians. The big problem today with professional boards is they are afraid to do something with somebody's license because if they do, they can be held personally liable. That happens time and time again.

All of the professional boards go through this; that as badly as they would love to jerk somebody's license, unless it is so clear and the evidence is so outrageous of what they have done to deserve their license being jerked, it just does not happen. Frankly, it should happen more. There are incompetent doctors. There are incompetent lawyers. There are incompetent veterinarians. More of them should have their license jerked in that case, and I wish they were empowered a little more and maybe protected a little more to do that.

Mr. SESSIONS. Will the Senator from Nevada yield for a question?

Mr. ENSIGN. I am happy to yield for a question.

Mr. SESSIONS. I say to Dr. Ensign, we appreciate his leadership on this matter and know that he is a professional himself, and he is familiar with these liability issues. The Senator talked about two doctors in Nevada being responsible for $14 million of the $22 million in punitive damages. I guess what I want to ask the Senator is that in this way we operate with punitive damages, is not the real truth that when two doctors get hit with big verdicts that the premiums from all the innocent doctors in Nevada go up? It is not just the bad doctor who pays—it is supposed to punish him—but the insurance company pays it, does it not, and then they pay for that by raising the premiums on everybody else?

Mr. ENSIGN. The Senator from Alabama brings up a very true point, but also the Senator from Illinois is correct in that we do need to do a better job of policing the physicians. They need to do a much better job of that. That is why I brought up the point of the boards. The point is, though, if we vote for cloture tomorrow, maybe we can work this out. Maybe we can come up with something that could be addressed, or at least give suggestive language to the States to be able to work this out. It is so clear that if we can invoke cloture—for the general public, that means that we can proceed to the bill. The vote tomorrow is just whether we can proceed to the bill. All of this is just pre-debate on whether we are going to proceed to a bill that is so critical to the future health care in this country.

Mr. SESSIONS. The Senator is exactly correct. I certainly agree, as a Federal prosecutor—and I prosecuted some physicians and other professionals in the medical business for bad behavior, but the odd thing about the way our tort system works, people think the doctor who gets sued is being punished, but really the doctor has insurance which he is required to have in order to practice in a hospital—virtually everybody has to have some, no matter how much it costs—and they do not end up being punished. Every physician in the community is punished, are they not? Is that not an odd thing that we are dealing with in current law?

Mr. ENSIGN. I do not know if the Senator can see this chart—maybe we can have that chart turned just slightly so the Senator from Alabama can see it, but it brings up the exact point. The States that have capped noneconomic damages in the white, California and Colorado, represented by Los Angeles and Denver, in those States let's go down to the OB/GYNs, $54,000 in Los Angeles for the annual premiums for the medical liability insurance, $30,000 in Denver. Go over to New York; it is almost $90,000; in Las Vegas, $108,000. I guarantee that number in Las Vegas is old because friends of mine who are OB/GYNs say they are paying anywhere from $130,000 to $150,000 a year. Chicago, $102,000 and Miami is over $200,000 a year. The cities in gray, representing the states in gray, have no tort reform that has been on the books. Nevada has it but it has not been on the books long enough. It will take 6, 8, 10 years. Los Angeles and Denver have had their laws on the books long enough to work.

Because they have enacted what we want to do today, we see these premiums.

I yield the floor.

The PRESIDING OFFICER (Mr. TALENT.) The Senator from Alabama.

Mr. SESSIONS. I will share my thoughts. I believe this bill is a good way to go about at the present time dealing with what is a health care crisis in America—the surging costs of insurance and liability. I wish we were not in the Senate having to deal with it. I have some great friends in the tort business, good lawyers, and they have learned over the years how to utilize the system to maximize verdicts and maximize recoveries. They have been successful.

Things have gotten out of sync. They need to be brought into sync. We can do it a number of different ways. We can do it State by State. The truth is over half of the medical care in hospitals in America today, and a very large percentage of what doctors do every day, is paid for by the Federal Government in Medicaid. It is our tax money. We are paying it. Part of the need they have for higher pay and higher reimbursement rates is because of the malpractice insurance they must pay.

Caps on damages have worked. Last week I was in the small town of Russellville in Alabama where I practiced law for a year or so. It is pretty far off the beaten path. A bright young doctor gave me a couple of ideas about reforming medical care unrelated to this issue. He told me he had come from California. His premiums in Alabama were substantially higher, and growing each year, than his colleagues he left in California. He did not expect that. We have little or no caps. We have some caps in Alabama, but not the kind in California.

I talked to a physician friend of mine, a wonderful person I go to church with, Dr. Conrad Pierce, former president of the OB/GYN Association. And he talked about the $100,000 liability premiums that OBs pay. He said, Jeff, you can get by in a city if you are delivering a couple hundred babies a year, but if you deliver 50 or 100 babies, this is $1,000 per delivery. It represents your health care premium. That is a big deal.

Mr. ENSIGN. If the Senator will yield, is the Senator aware that, for instance, in Las Vegas, they are limiting

the number of babies they are allowed to deliver to 125. What your friend was talking about is right, they used to deliver 250 to 300. Now they limit how many they can deliver.

Mr. SESSIONS. That is the result we are dealing with. All kinds of factors are occurring that are impacting adversely health care as a result of the premiums.

As my friend pointed out, in some rural areas you only deliver 50 or 60. It is not precisely how many babies delivered by a doctor that determines the premiums paid. You pay a basic premium if you deliver any at all. So the low numbers drive out physicians in rural areas who do not deliver that many babies.

It is a big deal. We have seen medical malpractice insurance jump by 81 percent over the past 2 years alone. It has driven people out of business.

The Physicians Insurance Association of America shows a fourfold increase from the period of 1991 to 2002 in the percentage of jury awards that exceed $1 million. We have a fourfold increase in the percentage of jury awards that exceed $1 million. Some say the reason these premiums have gone up is because insurance reserves are not producing the returns they used to produce. I don't think it is disputed that we have a substantial increase in the large verdicts around the country. That does drive the market.

In West Virginia, Charleston Area Medical Center lost its Level I Trauma Center status, leaving West Virginia University Ruby Memorial Hospital as the only Level I Trauma Center in the State. The inability of this facility to find neurosurgeons and orthopedists created a situation in which critically injured patients had to be medevac'ed out of the State.

Open the newspaper and you will read of similar crises in Pennsylvania, Nevada, Mississippi, and other areas. Rural areas are hit hardest by the increasing costs. This places additional burdens on those who can least afford it.

In my home State, I was in the town of Atmore, not too far from where I grew up. The Atmore Community Hospital was forced to close its obstetrics unit because it could not afford the 282 percent increase in malpractice insurance from $23,000 to $88,000. When you deliver a limited number of children, $88,000 is a substantial cost against you. Now expectant mothers must travel either to the hospital in Brewton, 30 miles away, or to Mobile or Pensacola, FL, an hour away, eliminating availability of health care.

Another rising crisis in my State has been brought to my attention involving the nursing home industry. It was a stunning statistic. At the request of the American Health Care Association, Aon Risk Consultants conducted an actuarial analysis that found there was a substantial increase in premiums, an extraordinary increase from 1995 to 2002 for nursing homes, meaning that the cost for settling and defending malpractice claims increased from $320 a bed in a nursing home to $4,410 per bed, over a tenfold increase in the insurance premiums paid. This was first brought to my attention by an individual I know in my hometown of Mobile who shared those numbers with me. It is consistent with his personal experience. I was shocked. We are looking at $4,000 per-bed cost annually for liability insurance per nursing home bed. That is very significant.

I hope as we go forward we can move beyond obstruction and a filibuster to be able to offer amendments, if people think they can make it better, that we can do things that would be realistic and effective. I think we can do that. This bill has a good core right now. I intend to support it and I intend to vote for it and I intend to vote to move it up for debate.

The odd thing about malpractice in America today and the lawsuits that get filed are, as I suggested to my able friend from Nevada, Senator ENSIGN, we think we are punishing doctors who make a mistake and we sue them for punitive damages. This historically was not a big part of litigation in America, but in the last 20 or 30 years punitive damages have become a staple in litigation. If a doctor makes a mistake, they sue him for the mistake, they sue him for the compensation, damages, pain and suffering of the patient, and they invariably add it was done recklessly, wantonly, or without due regard of care and that he is, therefore, responsible for punitive damages. Those punitive damages are added on to it as a punishment to that doctor. But already the doctor in the basic recovery is above the deductible he had on his insurance policy. He has already paid that out of his pocket. So whether it is $1 million or $10 million or $500,000 in punitive damages, that is paid for by the insurance system that we set up. And who pays into that insurance system? All the doctors in the community.

I absolutely agree with Senator ENSIGN that we need tighter controls on physicians by the medical associations, just as I believe—and have believed for a long time—we need tighter controls by the legal professional community, of which I have been a part. We do not do enough there.

But, regardless of that, you are still going to have negligence. You are still going to have these kinds of recoveries. If not capped, they continue to shift the payment from the person who did wrong to the innocent doctors and physicians out there who will all see their premiums increase substantially.

I have visited hospitals in my State on a regular basis. I visited probably 30 hospitals in the last 3 or 4 years. I ask them about how their liability insurance premiums are doing. They tell me they tripled in the last several years, invariably—more than double consistently, they tell me, over the last 3 or 4 years. Each one is somewhat different but the premiums have gone up at an extraordinary rate.

I think this Congress, faced with a demand for improving health care and health care delivery to more people, and at the same time trying to do so with contained cost, ought to look at one aspect of the medical system that produces little or no benefit and that is the amount of money paid out through this system.

Yes, I do believe that lawsuits make some physicians more careful. I do think it has led to the altering of practices for better health care. I do not believe all lawsuits are bad. I do not believe all recoveries are bad. I think it is good sometimes if physicians get hit and popped and sent a message. I think the embarrassment of the lawsuit itself has a substantial impact on this physician and other physicians in the community. But whether the recovery is $500,000 in punitive damages, $250,000 or $2 million is not the point. That physician is not really going to be paying it. The other physicians in the community will be paying it.

I think we will get the same impact in terms of improving health care if we allow lawsuits to go forward but we don't allow them to turn into jackpot justice where one patient, one victim, one injured patient who sues gets $10 million and another one gets $500,000 or zero for virtually the same circumstance. Too often that has happened. This is not a systematic way we are dealing with malpractice in America. And who is paying for it? John Q. Citizen, the Federal Government, in terms of Medicare and Medicaid moneys we send out.

I think we can do better. I think this bill is a step in the right direction. My friend from Illinois is a skilled lawyer. There is no doubt in my mind his remarks on this bill will represent the best comments that can be made in opposition to it. But overall I think it is a net plus. It is the right step to take. We are going to need to do something about these costs. I do not believe the benefits in improved health care are anything like the costs that are being incurred by physicians. They do not consider the amount of care being denied American citizens as a result of physicians choosing another course.

Finally, I read in the newspaper about Dr. Sumpter Blackman from Camden, AL, a small town I grew up in of not much more than 1,000 people with a small hospital with about 20-some-odd beds. Dr. Blackman is the main physician there.

It was reported that he may have to give up his practice; that he could not get insurance. One of the companies had changed and he was not able to get other insurance. The rates were extraordinarily high. He was wondering whether or not he should stay in the business.

I could say to the Members of this Senate, with no doubt, if you took a poll of the people in Camden, AL, and the environs and asked who was the

most important person in that community to them, Dr. Sumpter Blackman would win that hands down.

He was my mother's physician. He takes care of people there. He knows them. He is an excellent physician. He is talking about retiring early as a result of lawsuits. I think this has gone beyond just talk and debate and big insurance companies and rich companies and poor victims and doctors. I think it is a health care issue. We cannot afford to lose people such as Dr. Sumpter Blackman from the medical profession. He has saved the lives of thousands in his long career there in Camden, AL, and there are a lot more like him. They are thinking maybe this business just isn't worth it; I put aside some money and maybe I will just go off somewhere and do something else and not have to worry about this and worry about getting insurance.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I thank the Senator from Alabama for his kind words. He and I disagree on many issues but respect one another very much. I am sure there will be an issue somewhere along the way on which we agree. We are both waiting, and after 6 or 7 years the day may come. We will announce it.

Mr. SESSIONS. If the Senator will yield, I think we do agree we need to work to improve our legal system to make it the best we possibly can. How do we do that? Sometimes we disagree but I respect the Senator from Illinois and his skill.

Mr. DURBIN. I consider that a rhetorical question but I respect the Senator from Alabama.

Let me say there was a statement made earlier by the sponsor of this legislation that tells the whole story. When he came to illustrate the savings in malpractice premiums from States with caps and States without caps, he said to us, I think the CONGRESSIONAL RECORD will reflect what I am about to say is accurate, that the reason he only chose Los Angeles and Denver to illustrate that States with caps lower malpractice premiums was because it takes a long period of time for the caps to be reflected in the premiums charged to doctors. In his words, he said 8 to 12 to 15 years before premiums come down.

I think perhaps he may be right. Perhaps he may not be right. Over a period of 8 to 15 years it is hard to measure what is going to have an impact on malpractice premiums. It could be the investment success of the insurance company as much as a cap or any other thing. But it tells an important part of the story. If we are facing a medical malpractice insurance crisis today in America, what is being proposed, limiting the recovery of medical malpractice victims, putting a cap on the amount of money they can take home from a lawsuit, is, in fact, not going to provide relief to doctors or hospitals facing these high premiums today. In fact, it may be 8, 10, 12, or 15 years, according to Senator ENSIGN, the sponsor of this legislation. I think that should give pause to every Senator who believes they can vote for this legislation, see it enacted, go home to doctors in their community and say we have met our obligation. I do not think that is a fact.

There is another side of the story here that is worth at least pointing to. When I asked the Senator from Nevada why he included more than just doctors in this bill, more than just hospitals in this bill, why did he go on to include health care organizations such as insurance companies, HMOs, managed care organizations, why did he include pharmaceutical companies, medical device manufacturers, nursing homes, why are all of them being brought into the debate if our concern is whether or not there will be enough doctors around to deliver babies, he basically said we are trying to reduce the cost to the health care system. I assume if you limited recovery to zero dollars, you could reduce it even more. This bill limits it to $250,000 in noneconomic losses. He gave an illustration of the fact that economic losses include lost wages. Then he went on to say that if a child were injured and would be unable to be employed, for example for the rest of his life, they would have to try to make some calculation as to the lost wages.

I might remind my friend from Nevada that his bill requires objective verifiable losses. How do you calculate that for a 6-year-old boy, such as the one I talked about yesterday, who will literally have no work life, no work experience the rest of his life on Earth? How do you calculate that in objective verifiable ways, as to his future lost wages?

The importance of that, of course, is that is only one of two things he can be compensated for—medical losses as well as loss of income. So the calculation is very difficult under the exact language of the bill written by the Senator from Nevada.

I take exception to a comment made during the course of this debate by my friend from Alabama. He has made this comment before. He referred to what he called ''jackpot justice.'' He referred to verdicts that really are of little or no benefit, as he said, to society.

I suggest to him that we have statistics. Virtually both sides inundated the record with statistics. But these come from the National Association of Insurance Commissioners. Here is what they tell us.

The number of new medical malpractice claims declined by 4 percent between 1995 and 2000. During that 5-year period of time, new medical malpractice claims declined by 4 percent.

If we were talking about a proliferation of claims or lawsuits, the record suggests it is not the number. But, of course, some will argue how much is being awarded to those that are being filed. I would concede that the general awards have gone up. It reflects a number of things. It reflects inflation in medical care, and the cost of medical care. Everybody knows that is a fact. The cost of prescription drugs, the cost of doctors' care, and the costs of hospitals have all gone up. That is reflected when a verdict or an award is given to someone who has been injured. You would expect under normal circumstances for a person who is aggrieved or injured by medical malpractice on a year-to-year basis to see that award going up, understandably so. But how about the big awards, ones over $1 million?

According to Business Week, and their March 3, 2003, issue, which I quoted earlier—Business Week is hardly a liberal publication—in 2001 there were only 895 out of 16,676 payouts exceeding $1 million, about 1 percent. That is up from 506 in 1996.

In a 5-year period of time, the number of awards over $1 million went from 506 to 895.

From the debate on the floor you would conclude that the number was much larger.

I take exception especially to a reference to these awards and settlements in larger numbers as ''jackpot justice.''

I will not bring out the photographs. But earlier I mentioned some of the people who have been victims of medical malpractice.

Heather Lewinsky of Pittsburgh, PA, a 17-year-old who has gone through a series of plastic surgeries and will be deformed and scarred for the rest of her life by medical malpractice—would a verdict in her case be a jackpot? I don't think so.

Evelyn Babb, a 75-year-old woman from Tyler, TX, went in for a simple knee surgery and the surgeon operated on the wrong knee. As a result, this 75-year-old lady lost her mobility and will be suffering with pain for the rest of her natural life. Would a verdict in her case be ''jackpot justice''?

Sherry Keller from Conyers, GA, a graphic case which I talked about earlier, a lady who went into her doctor's office after a hysterectomy and had a terrible situation where her womb was reopened because of bleeding and she went into shock—the doctor left her alone in the room, she fell off the examination table striking her head as she fell to the floor, eventually leading to a situation of being a quadriplegic. If she received an award, this mother and homemaker, of $500,000, has she hit the jackpot?

I don't think so.

Colin Gouley from Nebraska came with his family to see us today. This little 9-year-old boy, whose life has been compromised dramatically, will have a difficult time doing things we pray that every child can do, such as read, write, engage in conversation, walk, and run. He will never have that chance. A jury in Nebraska thought that his damages from malpractice committed against him was worth

more than $5 million. So did Colin Gouley hit the jackpot with a $5 million verdict if he has a lifetime of being in a wheelchair because of medical malpractice? Is this ''jackpot justice''?

Kim Jones, 30 years old, went in for a simple tubal ligation and ended up in a comatose state in a nursing home for the rest of her life. Is an award in her case a jackpot? Did she hit it big if they gave her enough money for someone to care for her the rest of her life? Frankly, she will never be able to care for her daughter again.

Or Alan Cronin, 42 years of age, who went into a hospital in California for a routine hernia surgery and ended up with an infection so serious that it lead to gangrene in all of his limbs and amputation of both arms and legs—Alan Cronin, would he be the winner of a jackpot if those who were responsible for his losing his arms and his legs had to pay and compensate him not only for his medical bills and lost wages but also for his pain and suffering?

That is the part of the calculation which those who bring the bill to the floor have not spoken of. They talked about the challenges facing doctors. We conceded that. In some areas of the country, malpractice insurance is too high. Don't overlook what this bill does. It closes the door and removes the jury from the decision about fair compensation for people who have been injured through no fault of their own.

That is why I think those who are pushing this bill will probably be unsuccessful tomorrow. People on this side of the aisle, and Republicans as well, believe this bill, S. 11, goes too far. This is excessive. This is not setting out to simply solve the problem. This is setting out to make a political point—that we are going to go after those who would be so bold as to file a lawsuit.

In the pages of this bill, you will see a limitation on what attorneys can be paid if they represent one of these clients or one of these patients I have mentioned—people who have lost their limbs, people who are no longer able to function as normal human beings. If they go to hire a lawyer to represent them in a case of malpractice, this law will restrict how much their lawyer can be paid.

If you believe in justice, wouldn't you also argue that those who defend the doctors and defend the hospitals should have their attorney's fees limited as well? Wouldn't that be fair? Isn't that justice with a blindfold? No. The blindfold is raised on one side. It is a wink and a nod to the defense industry representing the doctors and the hospitals. But when it comes to these poor people with limited economic resources fighting for compensation for injuries that are no fault of their own, this bill limits the amount of money that can be paid to those lawyers.

I will tell you that without the contingency fee system, most of these poor people I have described today will never ever have their day in court. No attorney will be able to represent them.

Do you recall not too many months ago that sad story in North Carolina, I believe at a major university, where there was supposed to be a heart-lung transplant and they mistakenly brought the wrong blood and tissue type organs to be transplanted and a mistake was made? It was clearly not the mistake of the family or the little girl who was involved. Discovering this error, they tried to implant an additional set of organs—heart and lung—to save her after this serious mistake was made.

I can tell you that this little girl, who sadly died because of that malpractice, would have recovered little or nothing for that wrongful death under this legislation.

Where do you point to in terms of lost wages for a little girl who died during the course of the surgery? Where is the pain and suffering in a wrongful death lawsuit? Yet that is what it comes down to.

Those sponsors of this bill are prepared to close the courthouse door and say that for her family, they do not have the opportunity to get a lawyer because the contingency fee is limited, and once they have that lawyer there is little or nothing they can recover despite clear evidence of medical malpractice.

That isn't fair. It isn't American. It isn't just. We are talking about rewarding people who have been seriously and egregiously injured.

I hope my colleagues will join me tomorrow in voting against the motion for cloture. We should not proceed to this bill. This bill should proceed to a committee. It should go to a committee for a long period of study of compromise, of amendment, of a good-faith effort on both sides involving the medical profession, and the insurance industry which gets a windfall from this bill, as they do virtually every bill that comes through here, as well as the legal profession; and a bill that will end up in a resolution of the problems facing our doctors and medical providers whom we value very much, but I don't believe they would stand behind such a product that is so fundamentally unfair.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

A TRIBUTE TO ROZ WYMAN

• Mrs. FEINSTEIN. Mr. President, 50 years ago today a young and dynamic woman was elected as a member of the Los Angeles City Council. She was just 22 years old, making her the youngest council member in the city's history.

The fact that such a record has been held for so long is in itself remarkable. But then again, we are talking about a truly remarkable woman, Rosalind Wyman.

For many years now, Roz has worked tirelessly, for her family and friends, for the city she loves, for the State of California, for the Democratic Party, and for women everywhere.

There is a wonderful photo of Roz when she was only 2 years old, smiling up at a portrait of Franklin Roosevelt. Her mother, Sarah, was a precinct captain for FDR's first Presidential campaign, running the operation out of the family's drugstore on 9th Street and Western Avenue in Los Angeles.

Roz's father, Oscar, worried that such a partisan stance would cost them customers, but Sarah believed that electing Roosevelt was much more important.

Small wonder, then, that Roz developed a deep and abiding passion for political activism and the Democratic Party. Her first campaign was working on behalf of Congresswoman Helen Gahagan Douglas, in her ill-fated 1950 Senate race against Richard Nixon, when he unfairly portrayed her as ''the Pink Lady.''

Then, 2 years later, Roz made history by becoming the youngest person ever elected to the L.A. City Council, and only its second woman member. She went on to serve in that body for the next 12 years, on the finance and budget committees, and eventually becoming president pro-tempore.

As another woman who entered California politics in the 1950s, I can assure you that it was quite a different world back then. It was still very much a male club. In both Los Angeles and San Francisco, one was hard-pressed to find a women's bathroom anywhere near the chambers.

Something else Roz inherited from her mother was a love for baseball. In fact, there is nowhere that Roz Wyman would rather be than at Dodger Stadium, at the home plate corner of the Dodger dugout, where she has had her seats for over 40 years now.

It is no exaggeration to say that the Dodgers would not have come to Los Angeles without the vision, fortitude, and sheer determination of Roz Wyman. Just ask Tommy Lasorda, who said: ''What this lady did for baseball in this city, they should erect a monument to her.''

Today, it is hard to believe how polarizing the effort was to bring the Dodgers from Brooklyn in the late 1950s. Yet Roz, believing that a professional sports team was just what L.A.