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**Testimony Presented to the  
Illinois House of Representatives  
Committee on the Judiciary I- Civil Law Committee**

**Hearing on Medical Malpractice**

**February 23, 2005**

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**ILLINOIS HOUSE JUDICIARY COMMITTEE – TESTIMONY FEBRUARY 23, 2005**

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

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

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

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

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

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

- Changes in the frequency of claims including large losses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CHRPP Hospitals**

**Northwest Community Hospital – Arlington Heights, IL**  
**Victory Memorial Hospital – Waukegan, IL**  
**Norwegian American Hospital – Chicago, IL**  
**Swedish Covenant Hospital – Chicago, IL**  
**Holy Cross Hospital – Chicago, IL**  
**Elmhurst Memorial Hospital – Elmhurst, IL**  
**Sherman Health System – Elgin, IL**  
**Rush Copley Memorial Hospital – Aurora, IL**  
**LaRabida Children’s Hospital – Chicago, IL**  
**Rush Oak Park Hospital – Oak Park, IL**  
**Vista Health – Provena/St. Therese Medical Center – Waukegan, IL**  
**Gottlieb Memorial Hospital – Melrose Park, IL**  
**Rush North Shore Medical Center – Skokie, IL**  
**Centegra Health System**  
    **Memorial Medical Center – Woodstock, IL**  
    **Northern Illinois Medical Center – Woodstock, IL**  
**Thorek Hospital & Medical Center – Chicago, IL**