

them to be able see and feel what I had." Mr. Devitt accomplished his mission as millions of people in hundreds of American communities have visited the Moving Wall during its 20 years of existence.

The Moving Wall was built by Devitt, Norris Shears, Gerry Haver and other Vietnam veterans, and was displayed for the first time in Tyler, TX in October of 1984. Currently, there are two Moving Walls, which crisscross the country from April to November each year.

The 462-strong VFW Post 2164, commanded by Korean War veteran Sonny Carson, and the citizens of Wheaton, IL are to be commended for raising the \$26,000 required to bring the Wall to Wheaton. The Wall's presence in Wheaton was a particularly poignant event as the names of 14 of its sons are engraved upon the Wall's granite face, including a Medal of Honor recipient, James Howard Monroe.

The goal of bringing the Moving Wall to Wheaton was to help close old wounds, and to educate the community about the war in Vietnam and its profound effect on our Nation and our veterans. It is my pleasure to congratulate the members of VWF Post 2164 and the citizens of Wheaton for achieving that goal, and for helping the rest of us honor and remember those who made the ultimate sacrifice for our country.

MONEY FOLLOWS THE PERSON

Mr. SMITH. Madam President, my job as a Senator is to help protect and defend the freedoms of all Americans. Among the most basic freedoms are those we most often overlook: the freedom to choose where we live—for example, among family and friends and not among strangers—the freedom to walk down your neighborhood street, and not in a restricted courtyard; and the freedom to be an active member in your community.

All too often, these basic freedoms are denied to older Americans and Americans with disabilities. I have noticed an alarming trend in this country: we are unnecessarily isolating people with disabilities from their communities, friends, families, and loved ones by placing them in institutional care facilities.

Many of these Americans should not be in a nursing home or other institutional setting. Many Americans with disabilities could be better served—and better integrated into their communities—by allowing them to live in community-based homes.

However, recent data indicates that 70 percent of Medicaid dollars are spent on institutional care and only 30 percent are spent on community services for the disabled. Because Medicaid requires that States provide nursing home care for Americans with disabilities but does not require the same for community-based services, many individuals with disabilities and older Americans are forced to live in isolated settings.

In order to preserve the freedoms of our friends in the disabled community and their loved ones, we must do something to reverse this trend. I would therefore like to join my distinguished colleague from Iowa as a cosponsor of the Money Follows the Person Act of 2003. The Senator from Iowa and I first introduced the provisions of this act as an amendment to S. 1, the Medicare and Prescription Drug Improvement Act of 2003.

This bill would enact the President's 2004 Money Follows the Person Program to give people with disabilities the freedom to choose where they want to live. Under this legislation, Oregon's effort to help an individual move out of an institutional facility and into a community home would be 100 percent federally funded for 1 year. After that first year, the Federal Government would pay its usual rate. Under the provisions of this bill, States can take advantage of \$350 million annually for 5 years for a total of \$1.75 billion.

These dollars can help reintegrate countless older Americans and Americans with disabilities into a setting where they can be more active citizens. For instance, this bill is supported by the Oregon Chapter of Paralyzed Veterans because it helps honor and reintegrate those veterans whose disabilities resulted from noble and selfless service to this Nation.

Under the Americans with Disabilities Act and the Olmstead Supreme Court decision, we know that the needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act.

Americans everywhere realize the value of integrating Americans with disabilities into our communities. Needlessly isolating productive citizens from their communities, whether they are disabled or not, is unfair and unjust. It is time we work to reintegrate disabled Americans back into our communities.

I urge my colleagues on both sides of the aisle to support this important bill and to support the freedom of choice for Americans with disabilities.

LAOS

Mr. FEINGOLD. Madam President, I rise today to express my concern over recent events in Laos. As a member of the Subcommittee on East Asian and Pacific Affairs of the Senate Committee on Foreign Relations, I have consistently monitored the human rights situation in Laos and other East Asian nations. Recent news reports indicate that the human rights situation continues to deteriorate in Laos, specifically for the Hmong ethnic group.

As many of you may know, two European journalists and their translator, a Hmong-American pastor from Minnesota, were captured by the Lao government on June 4, 2003 and sentenced to 15 years of prison. After serious diplomatic negotiations between the gov-

ernments of Belgium, France, the United States and Laos, they were released from prison on Wednesday. While I am relieved that the Lao government has freed these people, I remain concerned about the continuous allegations of human rights violations by the Lao government. Amnesty International reports that Lao nationals who accompanied the journalists remain in detention without legal representation and are being tortured with sticks and bicycle chains, which I find horrifying. I also find troubling reports by the freed journalists regarding the "sham" trials they experienced.

In addition, Time magazine has recently released two articles that accuse the government of waging a war against the Hmong ethnic community within Laos. The articles state that the Lao government attacked a Hmong village in October, killing 216 people and has threatened to "eradicate" the population of Hmong. Time magazine also claims that "no political dissent has been allowed in [Laos for] 28 years, nor any right of assembly. Scores of political prisoners and youths have been detained for years in dark cells without trial; many have been tortured."

While I cannot confirm the specific allegations of the article, many of my Hmong constituents have raised similar concerns about the human rights conditions in Laos and the welfare of their families and friends who are living there. I strongly believe that the United States cannot ignore violations in Laos. I have consistently supported efforts to promote human rights and democracy in Laos, and in the 106th Congress, sponsored a resolution calling upon the Government of Laos to recognize and to respect the basic human rights of all its citizens, including ethnic and religious minorities.

Once again, I ask the Lao government to allow international humanitarian organizations to have access to areas in which Hmong and other ethnic minorities have resettled, to allow independent monitoring of prison conditions, and to release prisoners who have been arbitrarily arrested because of their political or religious beliefs. These violations must not continue.

THE WEISS REPORT

Mr. MCCONNELL. Madam President, during consideration of the motion to proceed to S. 11, I took exception to several findings included in the Weiss Report on Medical Malpractice Caps that I believed misinterpreted the data of the Medical Liability Monitor and the National Practitioner Data Bank. Following the vote on the motion to invoke cloture, I received a report supporting my conclusions from the Physicians Insurance Association of America as well as a statement from the Division of Practitioner Data Banks. I ask unanimous consent that these documents be printed in the RECORD.

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

THE WEISS RATINGS REPORT ON MEDICAL MALPRACTICE CAPS—PROPAGATING THE MYTH THAT NON-ECONOMIC DAMAGE CAPS DON'T WORK

On June 3, 2003, Weiss Ratings, Inc. published a report regarding the performance of the medical malpractice insurance industry entitled Medical Malpractice Caps The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage. The major recommendation of the report is that "Legislators should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs." Unfortunately, the Weiss report is ill conceived, and misleads the reader by falsely demonstrating that non-economic damage caps have not worked. Both of the data sources used by Weiss have gone on record disagreeing with the report's methodology, as described herein.

The conclusions drawn by Weiss are opposite of those previously published by reputable entities, such as the Congressional Budget Office, US Department of Health and Human Services, Joint Economic Committee of the United States Congress, Standard & Poors, American Academy of Actuaries, Tillinghast, and Milliman, USA, to name a few (see Appendix A). Unlike Weiss, all of these highly respected organizations have considerable experience and acceptance by government and industry for their knowledge and analytical product.

The purpose of this document is to evaluate Weiss' use of the data and analytical process. In short, Weiss misuses published industry data in an effort to demonstrate that non-economic damage caps enacted by several states have not been effective in reducing medical malpractice premiums in those states as compared to states without caps. Weiss underestimates the "average" claim costs for the two groups of states by employing inappropriate analytical technique to represent the burden on insurers. This is an error that is readily obvious to those who work with medical malpractice claims data, and it misleads the reader to an inappropriate conclusion.

WHAT DID WEISS DO WRONG?

Grouping the States

Weiss has grouped 19 states as having caps on non-economic damages, and 32 others (including the District of Columbia) as not having caps. Unfortunately, states with effective caps, such as California with a \$250 thousand cap, are considered the same as states having various levels of caps up to and including \$1 million. In fact, only 5 of the 19 states have a \$250 thousand dollar cap similar to that being proposed under current legislation. Eleven of the states have caps of \$500 thousand or greater. No attempt has been made to evaluate the effectiveness of caps at various levels, they have simply been lumped together. The American Academy of Actuaries has testified that caps are a key element of tort reform, and must be set at a level low enough, such as \$250,000, to have an effect. Any comparison chosen to demonstrate the effectiveness of non-economic damage caps should be sensitive to the level of caps in the various states and to their individual effectiveness.

In addition, as clearly shown on Appendix 1 of the Weiss report, more than half of the states enacting non-economic damage caps had not done so prior to the baseline date of 1991. Weiss compares premiums and claims costs for only two years, 1991 and 2002. The

caps enacted in 10 states were not in place in 1991, and thus, these states should not be included in the "cap states" category for this analysis. Two other states had only adopted their caps in 1990, and the beneficial effects of these laws may not have been recognized in the data by 1991 due to constitutional challenge and uncertainty about the ultimate effects of the caps.

Measuring the Premiums

Weiss uses the annual insurance rate surveys published by Medical Liability Monitor (MLM) for three medical specialties as the source of insurance premium data. He calculates median average premiums by state and then calculates a median premium for 1991 and 2002 for the two groups of states.

For example, Alabama had two insurers listed in the 2002 study, each with a premium for the three specialties. Weiss simply ranks the premiums from least to most, and then selects the middle value (or mean average of the two middle values when there is an even number of rates) as the median average value, as shown below.

MEDICAL LIABILITY MONITOR RATE SURVEY DATA ALABAMA

Insurer	Specialty	1991 rate	2002 rate
FPIC	Internal Med	N/A	\$6,043
ProAssurance	Internal Med	\$5,008	6,806
FPIC	Gen Surgery	N/A	19,286
ProAssurance	Gen Surgery	25,629	27,694
FPIC	OB/GYN	N/A	36,506
ProAssurance	OB/GYN	45,368	38,873
Median		25,629	23,490

¹ Calculated as the mean average of \$19,286 and \$27,694.

Alabama was selected for this discussion simply because it is alphabetically the first state. However, these data demonstrates many reasons why the use of the median is improper:

Data for different insurers are used for the two comparison years.

The median value is representative of only general surgery rates because general surgery rates are always higher than internal medicine and lower than OB/GYN.

Because two carriers are represented in 2002 and only one in 1991, the median value chosen by Weiss (the average of the two general surgery rates) is actually lower than the 1991 rate. However, the actual general surgery rates for the only carrier shown for both years increased—the opposite of Weiss' result.

The premiums shown are not adjusted for various discounts or surcharges, and do not reflect any dividends which may have been paid back to policyholders, thus reducing their total outlay. Medical malpractice insurers paid substantial dividends in the 1991 era, which had been largely reduced by 2002 due to industry losses.

Using the product of this calculation to represent insurance industry revenues is flawed for many additional reasons. First, there is no certainty that any of the table rates listed in MLM are actually charged. Carriers may have a premium filed in a given state (or in multiple territories in states), but may not write much business there. Weiss' analysis gives no weight to the actual amount of insurance sold by the various companies in any state, nor does it reflect discounts or surcharges which are routinely applied to standard premiums. In addition, many insurers pay policyholder dividends, which in effect reduce the annual premiums paid.

MLM has objected to Weiss' misuse of its data. In a July 7, 2003 email to Senate Majority Leader Frist, MLM Editor Barbara Dillard states "We believe it is misleading to use median annual premiums compiled with data from Medical Liability Monitor to dem-

onstrate the effect of non-economic damage limits on liability rates."

The Weiss analysis only includes premium data for three medical specialties, thus ignoring the experience for all of the rest. Even more glaring is the fact that the MLM data does not exist for seven of the capped states and five of the non-capped states for 1991. But, this did not stop Weiss from irresponsibly including these states in the analysis (see Weiss's Appendix 1 and 2).

An analysis using actual premiums as reported to the National Association of Insurance Commissioners (not medians) is helpful in evaluating differences between states having effective damage caps throughout the period of Weiss' analysis and those without. Such premiums include surcharges and discounts which may have been applied to standard rates.

The four states having a \$250,000 cap prior to 1991 (CA, CO, IN, KS) saw their total premiums increase by 28.0 percent between 1991 and 2001 (2002 data not available yet). States not having the \$250,000 non-economic damage cap experienced a collective 47.7 percent increase in premiums, over 70 percent greater. See Appendix B for details. This wide gap in premiums actually collected compares inversely to Weiss' faulty conclusion that annual premiums in states with caps increased by 48.2 percent as compared to 35.9 percent in states without caps.

Measuring Claim Costs

In order to evaluate the difference in claim costs between the two groups of states, Weiss analyzes median claim payments by state for 1991 and 2002 as reported to the National Practitioner Data Bank (NPDB). The NPDB provides the only readily available source of medical malpractice insurance indemnity payments by state. However, in order to use these data effectively, one must understand the nature of the claim payment values reported, and the shortcomings from that which might be normally expected (see Appendix C for a discussion of the NPDB claim payment data).

The use of the median claim payment value greatly compromises the accuracy of Weiss' analysis. While the median (or middle value of the claim payment distribution) might be an effective descriptor of what a plaintiff might receive as payment (before paying almost half to his/her lawyer), it cannot be used to measure the claim payment burden on insurers. The use of total claim payments reported by state shows a much larger differential result than Weiss' reported payout increase of 83.3 percent for capped states as compared to 127.9 percent for non-capped states.

The increase in total claim payments for the four states having a \$250,000 non-economic damage cap during the period of the Weiss analysis is 52.8 percent, compared to 100.1 percent for all other states—an 89.6 percent difference (See Appendix D). Thus the experience in the capped states is almost twice as good as that for states without effective non-economic damage caps prior to 1991. Using his faulty median calculation, Weiss would have us believe that the difference is only 53.5 percent (127.9/83.3).

The NPDB has gone on record opposing Mr. Weiss' methodology, saying that "Although the statistical median is usually the best measure of the 'average' malpractice payment received by claimants, it does not show the 'burden on insurers.' The 'burden on insurers' is the total amount of dollars paid, not the 'average' or median payment." (see Appendix E for NPDB statement).

Investment Performance

In addition to inappropriate analysis of premium and claims data, the Weiss report comments on the investment performance of

medical malpractice insurers. Being a long tail line of insurance, medical malpractice insurers routinely utilize the investment income generated by the premiums they collect and hold for the payment of claims in the future. It is no secret that bond yields have declined over the past decade, and are now at historically low levels.

In spite of the fact that medical malpractice insurers are 80 percent invested in bonds and have less than 10% invested in the stock market, Weiss still concludes that stock market losses are responsible for insurers' poor performance. While the fall in interest rates has reduced the interest income available to offset premiums, Weiss fails to mention that when rates go down, bond values go up, and insurers have been able to book capital gains to bolster their investment income.

The total return on investments for the industry has remained fairly stable, and does not explain why rates are rising. Rates are rising because of increasing claim costs.

CONCLUSION

The Weiss report recommends that "... 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 cost." This information exists, as reported herein and by many other reputable sources, and now is the time for the enactment of effective federal health care liability reform.

APPENDIX A—REPUTABLE SOURCES KNOW THAT MICRA'S CAP REINS IN PREMIUMS

Congressional Budget Office—"CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 5 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 percent to 30 percent below what they would be under current law."

[CBO Cost Estimate of H.R. 5, the HEALTH Act, March 10, 2003.]

U.S. Department of Health and Human Services—"States with limits of \$250,000 or \$350,000 on non-economic damages have average combined highest premium increases of 12-15 percent, compared to 44 percent in states without caps on non-economic damages."

[Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System, U.S. Department of Health and Human Services, July 24, 2002]

Joint Economic Committee of the United States Congress—"Tort reforms would reduce overall spending on healthcare, saving between \$67 and \$106 Billion over ten years."

[Florida Governor's Select Task Force on Healthcare Professional Liability Insurance (Report and recommendations submitted January 29, 2003)—"The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of

healthcare. The evidence before the Task Force indicates that a cap of \$250,000 per incident will lead to significantly lower malpractice premiums."

American Academy of Actuaries—"Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Since that date, California has continued to benefit from MICRA: Costs continue to drop as a percentage of the U.S. total, even as the percentage of physicians remains stable. Although other factors affect these . . . However, the California data show that premiums declined as losses declined . . . Although year-to-year fluctuations do occur, premiums have fallen in proportion to the decline in losses."

[Federal Budget Savings Through Medical Liability Reform, Physician Insurers Association of America]

Tillinghast-Towers Perrin—"We would expect that a \$250,000 cap on non-economic damages will produce some savings, perhaps in the 5 percent to 7 percent range for physicians. If the number of large malpractice claims is trending upward rapidly, a \$250,000 non-economic cap may also help to flatten out the rate of increase in the number of claims."

[Letter to Mr. Ray Cantor from James Hurley Tillinghast-Towers Perrin, January 7, 2003]

Milliman, USA—"California law prescribes a \$250,000 cap on non-economic damages and malpractice losses per physician are much lower than the countrywide average (i.e., about 50 percent of the countrywide average from 1991 to 2000). Thus, there appears to be clear evidence that a cap would be effective in reducing the cost of medical malpractice claims."

[Milliman USA, Florida Hospital Association, Medical Malpractice Analysis, November 7, 2002]

Standard & Poor's—"The U.S. medical malpractice industry in 2003 is likely to face a continued rise in loss severity, stemming from litigation, as it waits for meaningful tort reform. . . . If tort reform is unsuccessful, ultimately this would affect the ability of doctors to continue practicing, said Standard & Poor's credit analyst Alan Koerber. If severity trends continue to escalate in the absence of effective tort reform, we could arrive at a point where the whole industry structure is in peril. . . . In California—where the state has placed a cap on non-economic damages (punitive damages, or awards for pain and suffering) at \$250,000—insurance rates have not shown the sharp increases experienced in other states."

[Waiting for Tort Reform, U.S. Medical Malpractice Industry Battles Loss Severity Strain, Standard & Poor's Ratings Direct, June 6, 2003]

APPENDIX B

STATES WITH CAPS OF \$250,000 IN PLACE PRIOR TO 1991

State	91 Total premium	01 Total premium	% change
CA	\$529,056	\$644,598	21.8
CO	65,543	97,668	49.0
IN	34,174	58,693	71.7
KS	32,544	45,804	40.7
Total	661,317	846,763	28.0

STATES WITHOUT CAPS OF \$250,000 IN PLACE PRIOR TO 1991

State	91 Total premium	01 Total premium	% change
AK	\$13,731	\$13,226	-3.7

STATES WITHOUT CAPS OF \$250,000 IN PLACE PRIOR TO 1991—Continued

State	91 Total premium	01 Total premium	% change
AL	84,979	123,351	45.2
AZ	107,812	135,597	25.8
AR	23,135	39,727	71.7
CT	103,224	120,543	16.8
DE	20,068	17,215	-14.2
DC	37,612	30,893	-17.9
FL	241,421	604,014	150.2
GA	134,604	200,600	49.0
HI	16,066	30,092	87.3
ID	14,837	21,840	47.2
IL	289,811	399,142	37.7
IA	44,120	58,831	33.3
KY	58,212	81,826	40.6
LA	50,850	82,000	61.3
MD	107,893	155,433	44.1
MA	31,127	182,898	487.6
MI	169,347	177,045	4.5
MO	112,915	119,300	5.7
MT	16,613	17,348	4.4
ME	28,883	27,055	-6.3
MN	62,903	56,147	-10.7
MS	22,132	44,522	101.2
NE	17,972	22,359	24.4
NV	25,250	57,293	126.9
NH	10,253	19,296	88.2
NJ	241,892	290,103	19.9
NM	15,161	29,940	97.5
NY	699,493	888,290	27.0
NC	91,687	158,764	73.2
ND	12,764	12,887	1.0
OH	246,063	300,057	21.9
OK	59,666	63,526	6.5
OR	48,144	56,534	17.4
PA	228,266	335,491	47.0
RI	7,927	21,681	173.5
SC	8,542	23,587	176.1
SD	9,862	10,543	6.9
TN	118,135	250,361	111.9
TX	214,757	422,003	96.5
UT	24,858	37,152	49.5
VA	76,537	141,345	84.7
VT	12,593	6,891	-45.3
WA	104,323	134,009	28.5
WI	74,812	64,060	-14.4
WV	34,595	76,937	122.4
WY	8,118	10,594	30.5
Total	4,170,234	6,159,122	47.7
Total	8,340,468	12,318,244	47.7

Total premiums earned 1991-2001 PIAA. NAIC 2002 data not yet available.

APPENDIX C—GENERAL COMMENTS ABOUT NPDB PAYMENT VALUES

The National Practitioner Data Bank (NPDB) was designed to collect information on health care providers which would allow credentialing entities to identify individuals who had accumulated a "bad track record" and who may move to a new geographic location to start anew. While some of the data fields in the data base are useful, it was not designed as a medical malpractice research data base. The data are not well suited for measuring the actual payment values of verdicts or settlements in a malpractice case, as described below.

The Health Care Quality Improvement Act requires insurers to report the first indemnity payment (check written) made on behalf of any provider within 30 days of the date of payment. It is this value which appears in the numeric field in the NPDB data base, and which appears in the NPDB public use file. This payment value must be analyzed in light of the following:

A. The data reported to the NPDB is on a provider (doctor) basis, and represents payments made on behalf of only one provider. The Data Bank has no way of linking payments made on behalf of multiple individual providers to aggregate the total amount of the settlement or jury award. Thus, the total value of settlements or jury awards made for the plaintiff against multiple providers cannot be determined.

B. Insurers may make more than one indemnity payment on behalf of a provider. Only the first payment is required to be reported, and reporting entities are directed to explain any anticipated future payments in a non-machinable paragraph of description.

C. In cases involving continuing care (such as long term medication), the provider may

have been insured by more than one primary insurance carrier, each of which may have made a payment for any individual claim.

D. In cases where excess carriers or state-run compensation funds make an excess payment (usually amounts over \$1mil) in addition to the primary insurer payment, two reports are sent to the Data Bank, which then look like two smaller payments for two separate claims instead of one larger payment.

E. In many cases, insurers do not apportion payments made on behalf of multiple defendants, such as in a case where \$300,000 is paid on behalf of three doctors. In this instance, the Data Bank instructs the reporting entity to file a report for each doctor, each of which will have \$300,000 in the payment field. There is a separate field which should indicate that a payment was made on behalf of three practitioners. For these data records, the \$300,000 must be divided by 3 to get an accurate average payment amount for each of the three data records.

F. The Data Bank estimates that they are only getting 50% compliance with reporting entities. They have done quite a bit of work looking at insurers reports, and have uncovered little non-compliance. Thus, the problem may lie in self-insured plans, etc., if the non-compliance does in fact exist. In any event, the total amounts reported may not be complete.

APPENDIX D

STATES WITH CAPS OF \$250,000 IN PLACE PRIOR TO 1991

State	91 Total payment	02 Total payment	% change
CA	\$167,057,855	\$245,695,565	47.1
CO	12,766,034	47,346,789	270.9
IN	9,403,230	12,381,153	31.7
KS	24,557,394	21,153,550	-13.9
Total	213,784,513	326,577,057	52.8

STATES WITHOUT CAPS OF \$250,000 IN PLACE PRIOR TO 1991

State	91 Total payment	02 Total payment	% change
AK	\$2,976,192	5,036,632	69.2
AL	9,662,216	32,632,538	237.7
AZ	28,873,130	84,213,842	191.7
AR	7,567,795	24,988,884	230.2
HI	1,434,373	13,089,167	812.5
ID	3,300,506	6,903,966	109.2
CT	26,348,067	90,520,944	243.6
DE	6,658,001	29,206,312	338.7
DC	22,199,687	15,437,950	-30.5
FL	129,236,245	311,539,387	141.1
GA	40,712,086	116,301,797	185.7
IL	179,429,302	266,647,177	48.6
IA	15,868,786	28,037,027	76.7
KY	12,752,049	49,043,250	284.6
LA	23,507,975	46,669,001	98.5
MA	59,139,301	104,680,958	77.0
MD	30,065,789	85,903,788	185.7
ME	6,090,688	15,946,958	161.8
MI	85,142,892	92,333,909	8.4
MN	18,600,625	24,181,892	30.0
MO	65,472,456	61,868,283	-5.5
MS	7,400,134	39,598,854	435.1
MT	4,712,949	13,164,568	179.3
NE	7,440,991	17,447,940	134.5
ND	2,715,134	5,338,875	96.6
NM	11,594,337	10,997,782	-5.1
NV	11,616,548	38,994,264	235.7
NH	6,284,067	16,745,000	166.5
NJ	100,284,888	242,389,131	141.7
NY	328,102,491	640,812,015	95.3
NC	31,731,491	85,032,981	168.0
OH	80,370,391	150,743,405	87.6
OK	20,210,459	34,392,805	70.2
OR	18,050,981	34,278,386	89.9
PA	182,563,738	402,757,919	120.6
RI	12,274,927	13,684,082	11.5
SC	8,143,410	40,855,294	401.7
SD	1,207,251	3,406,750	182.2
TN	29,032,250	48,950,050	68.6
TX	167,034,605	252,306,549	51.1
UT	8,413,623	22,920,619	172.4
VA	21,037,767	66,040,922	213.9
VT	1,651,109	2,077,715	25.8
WA	21,775,473	77,739,921	257.0
WI	45,242,041	54,299,009	20.0
WV	26,823,084	40,899,280	52.5
WY	2,958,895	7,293,550	146.5
Total	1,930,735,003	3,863,314,696	100.1

NPPD total payouts by PIAA state 1991-2002.

APPENDIX E—STATEMENT OF THE DIVISION OF PRACTITIONER DATA BANKS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CONCERNING USE OF MEDIANS OF MALPRACTICE PAYMENTS REPORTED TO THE NATIONAL PRACTITIONER DATA BANK FOR ANALYSIS OF THE IMPACT OF CAPS ON MALPRACTICE PAYMENTS, JULY 2, 2003

The Weiss Ratings, Inc. report "Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage" mentions data from the National Practitioner Data Bank in its discussion of the relationship between caps on medical malpractice payments and medical malpractice insurance premiums. The report states on page 7:

Caps do reduce the burden on insurers—Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps for the period between 1991 and 2002, with the following results:

Payments reduced. In states without caps, the median payout for the entire 12-year period was \$116,297, ranging from \$75,000 on the low end to \$220,000 on the high end. In states with caps, the median was 15.7 percent lower, or \$98,079, ranging from \$50,000 to \$190,000. Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

Growth in payouts slowed substantially. The median payout in the 32 states without caps increased by 127.9 percent, from \$65,831 in 1991 to \$150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by 83.3 percent, from \$60,000 in 1991 to \$110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy medical mal claims.

Although the statistical median is usually the best measure of the "average" malpractice payment received by claimants, it does not show the "burden on insurers." The "burden on insurers" is the total amount of dollars paid, not the "average" or median payment.

Statistically, the median is the payment amount in the middle of a rank-ordered list of all payments. Thus in a set of 101 payments, 50 of which were for \$1,000, 1 of which was for \$25,000, 49 of which were for \$100,000, and 1 of which was for \$1,000,000, the median payment would be \$25,000. Arguing that the burden of payments on insurers is low because the median payment is \$25,000 is misleading. The total amount paid cannot be determined through use of the median. The burden on insurers would be better measured by examining the total of all payments by insurers.

ADDITIONAL STATEMENTS

U.S. INSTITUTE OF PEACE'S 2003 NATIONAL PEACE ESSAY CONTEST WINNER

• Mrs. FEINSTEIN. Madam President, on Wednesday, June 25, Granite Bay Student Kevin Kiley visited my office as part of the U.S. Institute of Peace's 2003 National Peace Essay Contest, NPEC, Awards Week in Washington.

Mr. Kiley had been selected by the Institute as the California State winner as well as the national award winner for his essay, "Kuwait and Kosovo:

The Harm Principle and Humanitarian War." The U.S. Institute of Peace has sponsored the essay contest annually since 1986 in the belief that expanding the study of peace, justice, freedom, and security is vital to civic education.

I am proud of Mr. Kiley's exemplary essay, commend his dedication to this studies, and congratulate his teachers at Granite Bay High School. This young man, who is thoughtful and mature beyond his years, will be a leader in his future endeavors in peace studies.

I would like to bring to my colleagues' attention a copy of Mr. Kiley's first place essay. I ask that it be printed in the RECORD.

The essay follows.

KUWAIT AND KOSOVO: THE HARM PRINCIPLE AND HUMANITARIAN WAR

War causes harm; of this there is no doubt. In determining the justification of war, the question hence becomes: when is it justified to cause harm? The only morally acceptable answer is that causing harm is justified if it prevents further harm. Thus, in general terms, the only justifiable reason to go to war is to minimize harm—if war is the lesser of two evils.

Underlying the issue of just and unjust war is the concept of sovereignty, for declaring war on a nation is a direct violation of its right to self-government. This adds another element to the harms calculation involved in justifying war. Even the United Nations accepts the view that sovereignty has inherent value, stating in a 1970 Declaration, "Every state has an inalienable right to choose its political, economic, social, and cultural system, without interference in any form by another state." Waging war against a sovereign nation constitutes a direct violation of this "inalienable right."

In determining what circumstances justify violating a nation's sovereignty, the laws governing the conduct of individuals provide a useful analogy. In On Liberty, John Stuart Mill establishes the Harm Principle, a criterion for when it is justified to violate an individual's sovereignty. Mill writes, "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others." Mill's aphorism can be taken a step further; it applies with equal force to sovereign nations. Just as an individual's freedom must be restricted if it harms other individuals, so too must a nation's freedom be restricted if it harms other nations. This principle, however, does not simply govern the relationship between two warring nations, for today's complex world is one of political interdependence. With the North Atlantic Treaty Organization, the United Nations, the Arab League, and other alliances, even those wars that are relatively limited in scope are becoming "world wars." Therefore, in applying the Harm Principle to the realm of nation states, any just war standard must specify what circumstances justify intervention by an international coalition. International intervention in Kuwait and Kosovo illustrate the success and failure of meeting just war criteria.

In 1990, Iraq sent shockwaves around the world by invading Kuwait, its small but wealthy neighbor. Within twelve hours of the invasion, "all of Kuwait . . . was under Iraqi control." Following Iraqi dictator Saddam Hussein's overwhelming victory, the resolve of U.S. President George Bush quickly became apparent; he immediately declared that the invasion "will not stand," that "no nation should rape, pillage, and brutalize its