



Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

Offices: Room 400 Finance Building, 613 North Street, Harrisburg
Mailing Address: P.O. Box 8737, Harrisburg, PA 17105-8737
Tel: (717) 783-1600 • Fax: (717) 787-5487 • Web: <http://lbfc.legis.state.pa.us>

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– Agenda –

Legislative Budget and Finance Committee Public hearing pertaining to Senate Resolution No. 20

8E-B Capitol East Wing
June 26, 2019 at 9:00 AM

- I. **Welcome by Senator Mensch**
- II. **Panel IV – Insurers**
 - Insurance Federation of Pennsylvania
 - Mr. Samuel R. Marshall | President
 - Questions from the Committee
- III. **Medical Colleges**
 - University of Pennsylvania
 - Dr. Patrick Brennan | Chief Medical Officer
 - Lake Erie College of Medicine
 - Mr. Michael Visnosky | Chairman
 - Penn State College of Medicine
 - Dr. Kevin P. Black | Interim Dean (effective July 1, 2019)
 - Questions from the Committee

“Providing members of the Pennsylvania General Assembly timely, accurate, and unbiased information, analysis, and performance evaluation to inform their policy decisions.”

The Insurance Federation of Pennsylvania, Inc.

www.ifpenn.org

June 26, 2019

To: The Honorable Members of the Legislative Budget and Finance Committee

From: Samuel R. Marshall, Jonathan C. Greer and Noah K. Karn

Re: Senate Resolution 20 – assessing the effects of the 2003 changes governing venue in medical professional liability actions

Thank you for this hearing as part of your study of the 2003 reforms to Pennsylvania's venue rules in medical malpractice actions.

Too often these issues are decided based on perception and rhetoric more than reality, and we respect that the role of this Committee is to get past that. That's the same function insurers try to provide – coverage that meets the needs of our policyholders and claimants, and priced based on facts and objective projections.

1. The impact of the 2003 venue changes – an accessible, fair, predictable and stable liability system

The general goal of a liability system – whether one is a plaintiff or defendant in a given claim, and whether one is providing or using a service or product that may lead to a claim – is that it be accessible, fair, predictable and stable.

That's the same goal we have as insurers: Insurance only works when covering risks and paying claims within that type of liability system. It attracts and retains the best of our industry, and it fosters responsible competition, lower rates, more innovative products and marketing, and better regulation – all of which addresses the primary objective of better coverage of our policyholders and claimants.

That's not hype or theory. You've seen it as a result of the medical malpractice reforms of 2002-2003, including the venue changes this Committee is evaluating. You've also seen it in other lines of coverage: The auto reforms of 1990 and the workers compensation reforms of 1993 and 1995 brought similar

predictability and stability to those liability systems, and insurers have responded with long-standing availability and affordability of coverage.

You've also seen what happens with an unpredictable and unstable liability system: Insurers tend to pull back, and rates go up and fiscal stability goes down as that instability encourages more claims and less predictability in settlements and verdicts.

The 2003 venue changes established a more predictable and stable system in which to resolve medical malpractice claims, nothing more and nothing less. They haven't limited access to the courts or imposed new requirements for the filing of malpractice claims; they simply put restrictions on the statutorily-recognized problem of venue shopping, making the filing of these claims based on where the malpractice occurred as opposed to the randomness and serendipity of attenuated and irrelevant connections.

2. The results of the current venue rules

The results of the overall reforms from 2002-2003 are self-evident: Malpractice filings quickly came down and have since flattened for the past decade-plus, and the same is true for verdicts. Insurance rates have followed the same trend, and new competitors have entered the market. In addition, the number of providers in Pennsylvania, as determined by the Mcare Fund for purposes of its annual assessments, has grown considerably since 2004, after being flat in the years of the most uncertainty in the medical malpractice area.

Segregating out the impact of the venue changes is a challenge. To that end, we and a number of other parties retained Milliman, a nationally recognized actuarial consulting firm, to report on the impact of the current venue rules and their possible rescission, with the specific purpose of distinguishing the venue reform from the other reforms. A copy of the report is attached; we've shared it with this Committee and with the Supreme Court's Civil Procedure Rules Committee, and we appreciate that the Committee has met with the Milliman team with follow-up questions.

The report is instructive on the value of the venue changes and the cost of its rescission as proposed to the Rules Committee:

- It projects the statewide impact of rescinding the venue reform will be an increase in malpractice costs of as much as 15% for physicians;
- It projects local and county impacts will be an increase in malpractice costs that range from 5% to as much as 45% in counties surrounding Philadelphia; and
- It projects that high-risk specialties could see additional increases in malpractice costs of as much as 17%.

The Milliman report emphasizes these are conservative estimates. Of particular import, it notes that health care provider consolidation has only grown since then. A number of hospitals in counties with fewer claims and lower severity are now affiliated with Philadelphia hospitals, which will mean claims in those once-local hospitals may now be brought in Philadelphia.

Going beyond the cost savings produced by the 2003 venue changes, we'd note a few other transformations in Pennsylvania's medical malpractice market. These aren't solely attributable to the venue changes, but that reform has played a large role:

- It is a far more vibrant market now than it was 15 years ago, with more and better insurers. The Insurance Department is best equipped to show that with numbers, but you've seen it as legislators: Providers are never shy with their complaints about insurance – but you haven't heard much about the cost or availability of malpractice insurance.
- That improvement is true across the state and across all types of providers, including those in high-risk specialties – a rising tide really can raise all boats. That has played a role in assuring medical care is more available across the Commonwealth, too – or at least in assuring that any lack of care isn't because of the cost or availability of malpractice coverage.
- There has also been an improvement in the voluntary market: The amount of coverage offered by the Joint Underwriting Authority, Pennsylvania's residual market mechanism, has greatly decreased. And insurers have

repeatedly urged the Insurance Department to increase the amount of coverage to be offered in the private market.

We recognize the 2003 venue changes should not be evaluated solely on savings in medical malpractice costs. As we noted at the outset, the goal of a liability system isn't just that it be predictable and stable, but that it also be accessible and fair.

As to the accessibility of the courts: These rules have taken effect, with well over a decade of consistent numbers, without complaints that they have denied plaintiffs access to the judicial system or imposed undue burdens on them. The trial bar is an able advocate for its clients, and it has considerable resources. If these venue rules were depriving its clients of access to the courts, it would have argued this with aggregate data, or at least verifiable anecdotes, long before now.

Notably, we haven't heard – in the 16 years of these venue rules – that those with malpractice claims have been limited to filing those claims in counties where taking discovery, attending hearings or going to trial would be uniquely difficult or expensive in terms of travel or availability of legal representation. Those might be valid reasons for considering a reform of the venue rules. But after sixteen years, those anecdotes or evidence have never emerged.

As to the fairness of the courts: We recognize there may be regional variations in the likelihood and amounts of verdicts and awards in our judicial system – that's what led to the problem of venue-shopping in the first place. If you really want to do away with regional variations, take the regional aspect out of our judicial system and establish a statewide medical malpractice court – something we've recommended in past sessions.

Absent a statewide court, there will be regional variations, so the issue is whether they unfairly come into play as a result of the 2003 venue changes. We've heard some contend that a given hospital may be a large employer in a rural area and therefore have an unfair advantage in a suit brought locally. We've never seen that substantiated, and hospitals are equally large employers in urban areas.

We also don't see how rescinding the 2003 changes would create a fairer liability system. It would merely return Pennsylvania to the venue rules that were expressly rejected by all three branches of government back then: Each branch

found the venue rules in place before 2003 to be unduly expansive and in need of change – in a word, unfair; and each branch agreed on the current venue rules to address that unfairness.

Granted, laws are meant to be stable, not stationary, and they can and should evolve to address changes or problems. That isn't what has been proposed here, though: Those complaining of the 2003 venue changes are proposing only a return to the old venue rules, not a new evolution of those 2003 changes.

It is tempting, when a reform has worked, to say the problem has been solved and the reform is no longer needed. Tempting but nonsensical. The 2003 venue changes aren't like training wheels on a child's bike, where they can be removed and the liability system remains reformed. To the contrary, rescinding them will inevitably bring back the problem of venue shopping the changes continue to address. We certainly haven't seen any evidence or explanation of why that wouldn't happen.

It is also tempting to say the 2003 venue changes were only part of a broader reform package, and these changes can be rescinded without losing the benefits of the other reforms. Maybe, maybe not. A package of reforms is just that – a package, where the savings and benefits of each reform work only or best when coupled with the other reforms. That is the case here, where the value of the venue changes is likely enhanced and enhances the value of the other 2003 reforms, as with the Court's Certificate of Merit requirement.

We appreciate this Committee is data-driven. We're happy to make available the experts at Milliman to explain their conclusions. We know your staff has met with them, and the Milliman report has been publicly available, so we welcome any inquiries.

In addition, we recommend the Committee look to other data sources. The Insurance Department is a good source. So might be the Annual Rate Surveys of the Medical Liability Monitor, which we understand go back 28 years, and the information on settlements and verdicts kept by the National Practitioners Data Base. To the extent we can help in obtaining that information, let us know.

We believe the 2003 venue changes have brought predictability and stability into the medical malpractice liability system, without sacrificing accessibility or fairness for patients and providers counting on that system. Others may disagree.

That's why your review is so important. It gives the Court the opportunity to consider a comprehensive record before making any decision on this. In the spirit of developing that record – a hallmark of any sound legal ruling from any court – we welcome the chance to answer any questions from the Committee and others, and to offer our insights on the comments and submissions of others.

Those who depend on a good malpractice liability system deserve nothing less.

Testimony of Patrick J. Brennan, MD
Senate Resolution 20
Legislative Budget and Finance Committee
June 26, 2019

Good afternoon, Chairman Mensch, Vice Chairman Brewster and members of the committee. My name is Patrick J. Brennan. I am the Chief Medical Officer and Senior Vice President of the University of Pennsylvania Health System as well as a professor of medicine at the Perelman School of Medicine at the University of Pennsylvania. I would like to thank Chairman Mensch and the committee for allowing me to provide testimony regarding the impact of venue for medical professional liability actions on access to medical care in the Commonwealth of Pennsylvania.

On behalf of the University of Pennsylvania Health System and the School of Medicine, I am here to express our strong opposition to the changes to the venue rules applicable to medical liability actions being proposed by the Pennsylvania Supreme Court Civil Procedural Rules Committee.

The proposed rule changes will have a deleterious effect on health care providers in Pennsylvania and ultimately the patients they serve. By permitting venue in counties with no real connection to the underlying cause of action, the proposed changes will facilitate the forum-shopping that contributed to the medical liability crisis which the legislature and the governor's office sought to address via the Medical Care Availability and Reduction of Error Act (MCARE Act) in March, 2002 and to which the Supreme Court responded in 2003 with the adoption of the venue rule currently governing medical malpractice actions and the certificate of merit rule.

The crisis led to liability insurers leaving the market, limiting their insurance offerings and experiencing significant downgrades in their credit ratings. As a result, there was a dramatic decrease in the availability in medical liability insurance and significant increases in the costs associated with professional liability coverage. As reported by the Pennsylvania Medical Society, the state's major medical malpractice insurers increased their premium rates between 80 and 147 percent between 1997 and 2001. This led some providers to retire prematurely or leave the Commonwealth and, in some instances, threatened the financial viability of hospitals and health systems. At Penn, medical students were acutely aware of the crisis and many opted to pursue their residency training out-of-state or not remain in the Commonwealth once their training was completed. I regularly interact with medical students at Penn in small group settings. I can tell you from first hand exposure that students of that era were aware of the liability crisis as they entered medical education and factored it into their choices of specialty training and the location of their residencies, avoiding higher risk specialties and the Philadelphia market. All of these factors jeopardized the availability of comprehensive and high quality health care across the Commonwealth and led the legislature and the Supreme Court to act in 2002 and 2003. It is not in the public's interest to plunge the health care industry in Pennsylvania into crisis once again.

As recognized by the legislature in the MCARE Act, changes in the health care provider system had unduly expanded the reach and scope of the existing venue rules and negatively impacted the training of new physicians and health care services as a whole. Since 2003, health care in Pennsylvania has experienced further consolidation with hospitals and providers throughout the state increasingly merging with or being acquired by health systems in major metropolitan centers.

This has enhanced training opportunities for new physicians as well as access to specialty care for more citizens of the Commonwealth. Given this interim development, the impact of reverting to pre-2003 venue rules in medical malpractice actions would have an even more profound impact than it did prior to the 2003 rule change.

Our Health System is illustrative in that regard with several facilities and numerous health care providers providing patient care in the counties surrounding Philadelphia, and in central Pennsylvania through our merger with Lancaster General Health. If the new venue rule is adopted, simply by virtue of Lancaster General Health being part of a Philadelphia-based health system, cases that involve care exclusively provided in Lancaster County could be brought in Philadelphia County. The impact of requiring an entity such as Lancaster General Health to litigate medical liability claims in Philadelphia cannot be overstated. It not only will dramatically impact the cost of insurance due to Philadelphia County's associated higher risk profile but also will be disruptive to patient care if physicians and other providers are unavailable while participating in proceedings in a distant venue.

The justifications put forward by the Supreme Court Civil Procedural Rules Committee simply do not warrant the adoption of the proposed rule changes and the associated impact on the health care industry. The fact that there has been a reduction in medical malpractice claims filings statewide, and in Philadelphia in particular, which has led to stabilization of the medical liability insurance market, suggests that the current venue rule has had the effect intended by the legislature. The fact that it is working is a reason to keep the rule in place, not eliminate it.

The Supreme Court Civil Procedural Rules Committee also expressed concern about fairness in affording special treatment to a particular class of defendants. Special venue rules reflect the determination of policy makers that in some instances specific parties and certain types of litigation warrant different treatment. In this instance, the legislature determined that there was sufficient basis for concern about the impact of the then-existing venue rule on the health care market that it included a provision creating an Interbranch Commission on Venue in the MCARE Act. The Commission which was comprised of representation from all three branches of government was charged to study the venue issue and make recommendations to the legislature and the Supreme Court. After completing its study, in August, 2002, the Commission recommended the venue rule which is currently in existence. It was overwhelmingly approved by the legislature and subsequently adopted by the Supreme Court.

The Committee's further contention that the rule change is warranted as fewer victims of medical negligence are being compensated appears to be based on unspecified reports, not data. A review of the data available on the claims payments made by the state MCARE Fund does not support this assertion. Indeed, the MCARE Fund claim statistics indicate that both the average number of cases closed with payment and the average case value have been relatively constant. Moreover, this contention is at odds with the insurance industry's experience which has been trending toward increased severity. To the extent the Committee was referencing statistics suggesting a decrease in the number of jury verdicts in favor of claimants, it is important to note that those statistics also indicate a decrease in the overall number of cases being tried to verdict and do not reflect the increasing number of cases resolved via pre-litigation resolution, mediation and other forms of alternative dispute resolution including high/low arbitrations and high/low trial arrangements. At

a minimum, the asserted impact of the current venue rule on claimants warrants analysis of actual data – not anecdotal reports.

We would like to thank the members of this committee for undertaking a comprehensive, fact-based analysis of this issue. We are confident that the study will bear out the concerns we have articulated. The proposed rule change threatens the continued availability and affordability of professional liability insurance, the training and retention of new physicians, and full access to quality health care for the residents of Pennsylvania.

I thank the committee for allowing me to testify today and for evaluating this important issue. I am happy to answer any questions the committee members may have.



LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE


Legislative Budget and Finance Committee
613 North Street
Room 400 Finance Building
Harrisburg, PA. 17105-8737

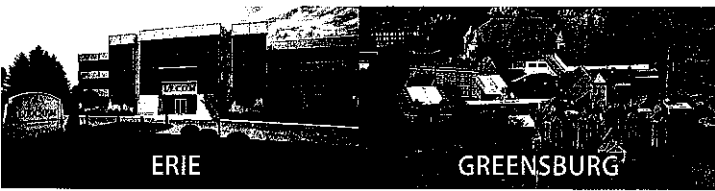
ATTN: CHRISTOPHER LATTA, Deputy Executive Director
Via email only: clatta@palbfc.us

RE: Remarks of Michael J. Visnosky, Esq. for the
Lake Erie College of Osteopathic Medicine

Dear Mr. Latta:

Please find enclosed the remarks which I will make before the Joint Committee on Tuesday, June 25, 2019. Thank you for the opportunity to address this important issue and its impact on the new doctors of Pennsylvania. I remain,

Sincerely,

Michael J. Visnosky, Esq.
Chairman of the Board Emeritus



LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE

STATEMENT OF THE LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE

for the
LEGISLATIVE BUDGET & FINANCE COMMITTEE
A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

Good morning Mr. Chairman and distinguished members of the Committee:

My name is Michael Visnosky and I am Chairman of the Board Emeritus of the Lake Erie College of Osteopathic Medicine which has been the largest medical school in the United States since 2011.

In May of 2019, the Lake Erie College of Osteopathic Medicine graduated 358 students from its Erie and Greensburg, Pennsylvania campuses. I am here to speak for them and LECOM's future new physicians. It is imperative for Pennsylvania to adopt and maintain rules and laws that encourage as many of those graduates to complete their graduate medical educations and establish their practices in Pennsylvania.

The Erie County Health Department in its 2018 Community Health Needs Assessment determined that there were 10 census tracts in the City of Erie and the North East Township area that were medically underserved areas.

The Union City/Corry area in Southeastern Erie County was designated as a primary care health professional shortage area. There were also 14 small townships designated as HPSAS. Considering that Erie County has 2 tertiary care centers, an acute care hospital and a critical access hospital, these are alarming statistics.

The demand for new doctors exists and is growing. The Association of American Medical Colleges 2018 study estimates that the United States physician shortage will be between 40,800 and 104,900 physicians by 2030. For Pennsylvania to attract the physicians it requires to serve its citizens it must be able to either retain or attract new doctors.

The student doctor graduating from LECOM in 2018 in Pennsylvania had an average of \$157,833 in student loans for medical school only for repayment. This represents a 10 to 30 year monthly payment obligation. This amount does not include any undergraduate debt. Many of these young doctors have families relying on them for financial support. Please remember that LECOM is the least expensive medical school in Pennsylvania at \$34,579 for tuition and fees in fiscal year 2019. That is at least \$15,000 per year less than any other Pennsylvania medical school. According to a recent US News Report it is the second least expensive private medical school in the country. When you add this debt to daily living expenses for necessities, the tuition repayment plan controls their economic futures.

Then, add a burdensome medical liability insurance premium to those expenses. According to the medical malpractice insurance rates filed with the Pennsylvania Department of Insurance, an emergency medicine doctor faces an average annual premium of \$38,049, a general surgeon pays an average premium of \$47,255, and an obstetrics and gynecology physician pays an average premium of \$67,498. Those premiums add a significant monthly or quarterly burden to a young physician's existing financial responsibilities. While these may be high risk practices, medical malpractice insurance is not inexpensive for a family practice physician with an average premium of \$13,371 or \$1,114 per month, or an internal medicine doctor with an average premium of \$13,705 or \$1,142 per month or a pediatrician with an average premium \$13,599 or \$1,133 per month. These monthly or quarterly expenses could wreck anyone's budget. These physicians are in demand, but have the same student loan debt as other medical students but are at the bottom of the earnings ladder.

I know that you, as a Committee, must consider the relationship of medical malpractice insurance premiums to retaining physicians in Pennsylvania, the easing the ability for valid medical malpractice victims to have an adequate recovery, and the social and economic costs of both. During this deliberation, remember that these new doctors will not necessarily be employed by group practices or hospital systems that will offer a fringe benefit of paying their two major expenses, namely: student loan debt and medical malpractice insurance premiums. If the employer does offer one or both of these perks, they will appear on the doctor's W-2 as taxable income. In fact, many hospital systems do not offer the payment of student loan debt as a fringe

benefit. And, don't forget, the physicians who choose to practice in rural areas of Pennsylvania whose incomes will not rise to the level of their urban brothers employed by a hospital system or a specialized medical practice.

The practice atmosphere for doctors should not subject them to any more obstacles that they already face, particularly, as new physicians. The venue rules adopted in 2002 and 2003 have served their purpose of confining the trial of alleged medical malpractice to the county in which it occurred, not Philadelphia or Pittsburgh. Pennsylvania already has high medical liability costs, even with the reform of 2002 and 2003 when compared to other states. I encourage policy makers not to retreat on the venue reforms and consider additional opportunities to reduce medical liability costs in Pennsylvania. More work must be done to reduce the cost of medical malpractice insurance. The venue rule should not be changed.

Thank you for this opportunity to address the committee on this important issue.



Kevin P. Black, M.D.
Interim Dean, Penn State College of Medicine (effective July 1, 2019)
Panel V – Medical Colleges
June 26, 2019
10:15 – 11:15 a.m.

Good morning Chairman Mensch, Vice Chairman Brewster and members of the Legislative Budget and Finance Committee (Committee). Thank you for the opportunity to appear before the Committee to offer my insights on the potential impact the proposed amendment to Pa.R.C.P. No. 1006 may have on medical colleges in the Commonwealth of Pennsylvania.

I would first like to thank Senator Lisa Baker for introducing Senate Resolution 2019-20, directing this Committee to conduct a study of the impact of venue shopping for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth and requesting that the Supreme Court delay action on the proposed amendment. Penn State Health and the Penn State College of Medicine commend Senator Baker for her efforts to ensure that the proposed rule be suspended to allow for the Legislative Budget and Finance Committee to conduct a full examination of its implications.

For the record, Penn State College of Medicine, Penn State Health and its affiliated hospitals and physician practices are opposed to the Pennsylvania Civil Rules Committee's proposed amendment and, as such, submitted formal comments in opposition to the proposed amendment on February 19, 2019, to the Civil Procedural Rules Committee of the Supreme Court of Pennsylvania under the signature of Dr. Craig Hillemeier, Sr. Vice President of Health Affairs for Penn State University, Dean of Penn State College of Medicine & CEO of Penn State Health.

I have been a faculty member and physician at the Penn State College of Medicine and Hershey Medical Center for 26 years, during which time I have practiced orthopaedic surgery (which I still do), taught medical students and orthopaedic surgery residents, and served as residency program director. For the past 16 years I have served as Chairman of the Department of Orthopaedics and Rehabilitation, and for the past 6 years as Vice Dean of our University Park Regional Medical Campus. I have been president of the Pennsylvania Orthopaedic Society and American Orthopaedic Association, the leadership society within the orthopaedic profession, largely comprised of leaders in academic medicine. On July 1, I will assume responsibility as Interim Dean of our College of Medicine.

Having practiced in Pennsylvania since 1993, I have experienced first-hand the impact of how a malpractice crisis impacts not only the care of our patients, but the educational experience of our medical students and residents. There is abundant peer review literature, some of which I will share with you now, which is supportive of what I have directly experienced. I will address this from two different but related domains. First, will we be able to attract and retain teaching physicians to our medical schools?

In 2003, one year AFTER the Medical Care Availability and Reduction of Error (MCARE) Act went into effect, and in response to Pennsylvania's medical malpractice crisis, researchers from the Harvard School of Public Health and Columbia Law School surveyed physician specialists from this state to obtain further information regarding the impact of the malpractice climate on physician plans to move their practices out of Pennsylvania, retire early, change practice patterns and understand access issues for patients. Strong majorities reported increased waiting times and driving distances for patients. 11% said they would retire or definitely move their practice out of state in the next two years, and another 29% said they were very or somewhat likely to move their practice out of state. In addition, 42% of specialists had reduced or eliminated high risk aspects of their practice. Do you want to run the risk of this happening when, in a 2016 report from the Association of American Medical Colleges, in which every combination of scenarios was modeled, a shortage of between 62k and 95k physicians is projected for our country?

Numerous investigations clearly indicate the association between the malpractice environment and the practice of defensive medicine. The latter includes the ordering of unnecessary tests, deviation from clinical practice guidelines, and avoidance of high risk patients. While each of these, by itself, is harmful to patient care, their practice in a teaching hospital will result in a generation of physicians that adopt similar unhealthy practice habits. In addition, the risk avoidance behavior of community physicians will result in referral of increased numbers of the most complex patients to teaching physicians at medical schools, contributing to stress and burnout which are already at unprecedented levels.

"Burnout", for which the rate is already twice as high among physicians relative to the overall population, will only be exacerbated by a return to the malpractice climate of 15-20 years ago. This will impact all aspects of a physician's professional and personal life. Not only is burnout associated causally with medical error, but it will also negatively impact the other core missions of medical schools and academic medical centers. In 2018 Medscape surveys rated Pennsylvania the 14th highest burnout rate among physicians nationally. Although admittedly multifactorial, Pennsylvania's malpractice climate, even now, is a likely contributing factor with the 4th highest malpractice award payout amount per capita.

The second domain relates to one of the core missions of a college of medicine: to improve the health and quality of life of our communities. One of the ways in which we do this is in training the next generation of physicians, with the hope that the most outstanding will remain to practice in our state. From 2002 to 2005, 16% of residents completing their training at Milton S. Hershey Medical Center remained in our state. Between 2006 and 2019, that number averaged 30%. These physicians are caring for many people in this room today, as well as your families and friends. I have no doubt, that elimination of venue shopping in 2002 contributed significantly to our ability to retain our best and brightest.

Thank you again for the opportunity to appear before the Committee and share my concerns with the deleterious impact the proposed rule change could potentially have on undergraduate and graduate medical education in this Commonwealth, ultimately impacting the overall healthcare delivery system. At this time I'd be pleased to answer any questions.



Testimony on Senate Resolution 20

Jessica K. Altman
Commissioner
Pennsylvania Insurance Department

Legislative Budget and Finance Committee

June 25, 2019

Chairman Mensch, Vice Chairman Brewster and Honorable Members of the Legislative Budget and Finance Committee (LBFC), I would like to, on behalf of the Pennsylvania Insurance Department, thank you for the opportunity to submit this testimony on Senate Resolution 20. Introduced by Senator Lisa Baker, this resolution directs the LBFC to conduct a study of the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in Pennsylvania.

Background

There has been a state operated patient compensation fund in the Commonwealth since 1975. However, Act 13 of 2002 created the Medical Care Availability and Reduction of Error (Mcare) Fund as a special fund within the Insurance Department. Since being under the auspices of the Insurance Department, the Mcare Fund has been a stable source of excess medical malpractice coverage for the physicians, hospitals and other health care providers that participate in the fund.

Health care providers practicing in Pennsylvania secure \$500,000 of coverage through the private insurance market or self-insurance. Mcare provides an excess layer of \$500,000. If the health care provider and insurer determine a medical malpractice lawsuit should be settled and the settlement amount will exceed \$500,000, the responsibility to negotiate a settlement is transferred to Mcare by a "tender" of coverage. The Mcare Fund works closely with all parties involved in the medical malpractice litigation to achieve the preferred disposition. Often the parties want the litigation settled, but there are also times when the outcome is going to trial. Even after trial, if the parties continue to want to explore settlement, Mcare helps facilitate their wishes.

Adjusting Claims

Regardless of whether the venue rule is changed, the Insurance Department will ensure that the Mcare Fund continues to provide the same high-quality claims adjustment services to the Commonwealth's healthcare providers and injured patients. Mcare employs experienced and focused claims examiners to adjust Pennsylvania catastrophic medical malpractice claims in all of Pennsylvania's 67 counties. Mcare informally acts as a liaison between the parties, and also offers a formal alternative dispute resolution program. The Insurance Department views Mcare's role as one of facilitating equitable resolution of claims, regardless of the litigation environment. A change in the venue rule will not alter this approach.

Collecting Assessments

The Insurance Department only permits the Mcare Fund to collect assessments from health care providers that are directly based on prior expenditures by the fund, as opposed to actuarial projections of future claims payments. This is because the Mcare Act requires Mcare to operate on a "pay as you go" basis. There is no provision for profit or the need to use actuarial projections that would include concerns about uncertainty of future losses. The statutory formula bases the assessment collected on what Mcare has paid the previous year in claims and operating expenses. If during an assessment year, claims payments and operating expenses do not exhaust the assessment collected, the remaining funds are used to reduce the amount of money to be collected the following year. Venue reform will not alter this process.

It can be expected that any adjustments to the amount collected due to venue reform would be incremental. This is because it typically takes almost two years from when the medical care in question was provided until the medical malpractice lawsuit is filed. Depending on a number of factors, payments to the plaintiff can take an additional 2-6 years. It is not unheard of that payments can even take 10 years or more from when the medical care is provided, especially if

a minor is involved. On average each 1% of assessment generates \$10 million in funds that Mcare uses to pay claims and operating expenses. For the last three years, the assessment rate has been 19%.

Conclusion

Regardless of any change in the venue rule, Mcare will continue to adjust the claims presented to it for disposition. It will continue to facilitate the parties' preference for how the litigation is resolved. The collection of assessments will still be done based on a statutory formula that requires no actuarial projections and on a "pay as you go basis".

Again, thank you for allowing me to submit this testimony to the committee. If you have any questions, please contact the Department's Legislative Director, Abdoul Barry, at (717) 783-2005.