COMMONWEALTH OF PENNSYLVANIA

A JOINT COMMITTEE OF THE
PENNSYLVANIA GENERAL ASSEMBLY

LEGISLATIVE BUDGET AND FINANCE COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

CAPITOL EAST WING
ROOM 8E-B

TUESDAY, JUNE 25, 2019
9:03 A.M.

PRESENTATION ON SR 20 (SENATOR BAKER)
PROPOSED CHANGE OF VENUE RULE
FOR MEDICAL MALPRACTICE CLAIMS

BEFORE:
HONORABLE ROBERT B. MENSCH, CHAIRMAN
HONORABLE JAMES R. BREWSTER, VICE CHAIRMAN
HONORABLE STEPHEN E. BARRAR
HONORABLE H. SCOTT CONKLIN
HONORABLE MARGO L. DAVIDSON
HONORABLE CRIS DUSH
HONORABLE KRISTIN PHILLIPS-HILL

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Debra B. Miller
dbmreporting@msn.com

ALSO IN ATTENDANCE:
HONORABLE LISA BAKER

COMMITTEE STAFF PRESENT:
PATRICIA BERGER
EXECUTIVE DIRECTOR

I N D E X

TESTIFIERS

* * *

SUBMITTED WRITTEN TESTIMONY

* * *

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P R O C E E D I N G S

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CHAIRMAN MENSCH: I'll call the meeting of the Legislative Budget and Finance Committee to order.

Members, those of you who are here, thank you for joining, and I hope you can weather the day with me. I will do my very best to stick to the schedule.

So let me say good morning. We're here today to accept testimony as requested by Senate Resolution 2019-20 concerning the impact of venue for medical professional liability actions on access to medical care and maintenance of health-care systems in the Commonwealth.

Pat, please call the roll.

(Roll call was taken.)

CHAIRMAN MENSCH: All right. Thank you, Pat.

Since this is a session day, many of our Members have other commitments. They will be in and out, and that is just the way business is done on a busy third last day of the budget season. So thank you all for being here.

For those of you who are not familiar with the topic, let me briefly describe the background as it is presented in Senate Resolution 20.

In 2003, a Pennsylvania Medical Society report found that practitioners were leaving this State or retiring early due to availability and affordability issues when obtaining medical liability coverage. In addition, the report stated that new practitioners were choosing to practice elsewhere when faced with the same conditions.

The General Assembly passed Act 13 of 2002, known as the Medical Care Availability and Reduction of Error Act, also known as Mcare. Section 514(b) of Act 13 established the Interbranch Commission on Venue for actions related to medical professional liability consisting of representatives of the Executive, judicial, and legislative branches of State Government.

The Commission was charged with reviewing and analyzing the issue of venue as it related to medical professional liability actions filed in this Commonwealth and reporting its findings and recommendations for legislative action or promulgation of court rules on venue to the General Assembly and the Pennsylvania Supreme Court.

The Commission issued its report on August 8, 2002, with a majority of its members recommending that venue be limited in medical professional liability actions to a county where a cause of action arose or where a transaction or occurrence took place out of which the cause of action arose.

Act 13, among other actions, reduced the amount of liability insurance carried by health-care professionals from 1.2 million to $1 million, changed the collateral-source rule, and reduced verdicts to present value.

The General Assembly passed Act 127 of 2002, which provided in part that a medical professional liability action may be brought against a health-care provider for a medical professional liability claim only in the county in which the cause of action arose.

On January 27, 2003, the Pennsylvania Supreme Court modified its Rules of Civil Procedure, similarly restricting venue in a medical professional liability action to the county in which the cause of action arose.

The court also required a certificate of merit from a licensed professional that the action brought was a breach of professional standard of care.

On December 22nd of 2018, the Civil Procedural Rules Committee published notice in the Pennsylvania Bulletin that it intends to propose to the Pennsylvania Supreme Court a change to the venue rule, eliminating the provision for venue in medical malpractice liability actions, as that provision no longer seems warranted.

On February 8, 2019, the Senate adopted Senate Resolution 20, directing the Legislative Budget and

Finance Committee to conduct its study and requesting that the Pennsylvania Supreme Court delay action on the proposed amendment to the rule until the LBFC report is released. The Pennsylvania Supreme Court has agreed to delay consideration of amendments to the rule until the LBFC report is completed.

I want to thank all the stakeholders who are taking time to present testimony to us today, as well as tomorrow. Although having this type of a hearing is unusual for the LBFC, the rest of our work under Senate Resolution 20 will follow the approach our staff normally takes in conducting its work.

Welcome to all of you, and I look forward to your testimony.

Mcare also submitted written testimony to our staff, and it is included in our Members' materials.

I would like to recognize the presence of Representative Davidson. Thank you for joining us.

And I'm turning the mic to Senator Brewster for any comments.

VICE CHAIRMAN BREWSTER: Thank you, Mr. Chairman.

Just briefly, I also want to thank the stakeholders for coming today and providing your testimony. I'm anxious to hear your viewpoints on this very important issue. So in the interests of time, we'll move on.

CHAIRMAN MENSCH: All right. I would like to recognize now Senator Baker, the prime sponsor of Senate Resolution 20, who is with us.

Senator Baker, would you like to make some comments?

SENATOR BAKER: Good morning, everyone.

Thank you, Senator Mensch. And to members of the Commission and to your professional staff, I just want to thank you for your attention and commitment to what I consider a very vital project for the Commission. We also want to thank the Supreme Court for making a decision to delay action on the rule.

The analysis that we have asked the Legislative Budget and Finance Committee I believe has urgency, gravity, and certainly some means of controversy attached to it.

There was substantial alarm inside and outside the Legislature when a proposed rule suddenly materialized that would have undone what was so carefully crafted -- protections for venue shopping that Senator Mensch outlined -- and could have been finalized without any source of public hearings. So this latest round of debate about the issues reminds us that there probably will never be full consensus on what constitutes true fairness in the outcome of medical malpractice.

Some have suggested that the review that you are undertaking should have encompassed issues beyond what are contained in Senate Resolution 20. My request was very carefully crafted to deal with the issues raised only in the draft by the Civil Procedural Rules Committee. So you will note, they were very specific.

There can be fairness in the matter in which information and statistics are gathered and interpreted by the Commission. You will be not lacking in statistics. I'm sure, Pat, as we have spoken, to the contrary, I think you're going to be awash in statistics. But we need reliable representation of the cases filed, the outcomes of judgments and settlements, physician population and distribution, provider performance, patient safety, and insurance affordability.

So the politics of decisionmaking will then come back our way to decide whether this is a matter of legislative action or adoption of a civil procedural rule. So I believe the hearings that you will be conducting, the testimony you will be taking, and the input you will receive will be very crucial as we continue to look at this issue. So I appreciate your attention and look forward to further deliberation and the outcome of your study.

So, Senator Mensch, thank you very much. I apologize, I am conducting hearings of the Senate Judiciary

Committee this morning and can't stay for all of it, but we will continue to monitor, my staff and I, and I greatly appreciate what you're doing.

I think it is unusual for you to be conducting hearings, but I think it's vital that we have on the record the information that will be presented today.

Thank you so much.

CHAIRMAN MENSCH: Thank you, Senator Baker, for your good work on this.

Members, each panel is going to have 30 minutes to present their testimony, and then we, the Members, will have an additional 30 minutes to ask questions.

I think it's important that we try to stay within that time frame today, particularly given, as I said, it's the third last day before the budget.

PANEL I:

PATIENT SAFETY

CHAIRMAN MENSCH: Our first presenter today is Ms. Regina Hoffman. She is the Executive Director of the Patient Safety Authority. So obviously our first panel is about the patient's safety.

So if you would stand, please, and be sworn. Raise your right hand:

Do you swear to tell the truth and the whole truth and nothing but the truth?

MS. HOFFMAN: I do.

CHAIRMAN MENSCH: Thank you. Please offer your testimony.

MS. HOFFMAN: Good morning, and thank you for the invitation to be here this morning.

So I can promise you I will save you some time, because my testimony will not take---

CHAIRMAN MENSCH: If you could turn your microphone on. Make sure the green button is pushed.

MS. HOFFMAN: It's on. Is that better?

CHAIRMAN MENSCH: Okay. There you go.

MS. HOFFMAN: I think I need to be closer.

So first of all, thank you for having me this morning. Good morning. I promise you my testimony will not be 30 minutes, so I will gain you some time. It should be about 15, and we'll have plenty of time for questions.

So I did have some slides that I presented to you. So it's in a packet, and the first thing that I wanted to note is that the Patient Safety Authority in the issue of venue neither supports nor opposes a change in venue for medical malpractice cases in Pennsylvania. We are here today because we are interested in providing the Committee with facts associated with the data that we

collect and to provide an opportunity for you to ask questions about that data, what it means, what perhaps it doesn't mean.

So as you know, pursuant to Act 13 of 2002, Pennsylvania acute-care facilities are mandated to report patient safety events. By acute-care facilities, I mean hospitals, ambulatory surgery centers, abortion facilities, and birthing centers. Additionally, in 2007, nursing homes were added to that list for health-care associated infection reporting only. So reporting for acute-care facilities began back in June of 2004. So when you see our data, what we have included is 2005 through 2018, because it's a full year.

So facilities, health-care facilities, are required to report both incidents and serious events to the Patient Safety Authority. Both of those type of events have very specific definitions outlined in Mcare.

An "incident" is an event, an occurrence, or a situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health-care services to the patient.

A "serious event," per the Mcare definition, is an event, occurrence, or situation involving the clinical

care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health-care services to the patient, and I'll give you some examples to help you better understand.

Another term that I'll use in the presentation is "high-harm event." This is not defined in Mcare. It's a term that we use internally when we do our analysis. And these are a subcategory of the serious events that resulted in permanent harm to a patient, immediate threat to their life, or death.

And at the bottom you'll see I have a note. None of these definitions include the term "medical error." So in Pennsylvania when Mcare was issued -- that was before I worked for the Patient Safety Authority -- I have to applaud the Legislators and everyone that was involved in that, because they had the foresight to know that there would be events that happen that are important to improve patient safety even when an error doesn't happen. So this database is not a database of medical errors, which I think many people confuse the terms; it's a database of events that happen, sometimes related to an error and sometimes not.

For example, I do not have any allergies to medications that I'm aware of. I have never had an

allergic reaction. If I'm admitted to a hospital and my physician prescribes maybe an antibiotic or some other medication and I have an allergic reaction to that medication that requires maybe IV Benadryl, or I need to be admitted to the Intensive Care Unit, I may need ventilator support if I have had an anaphylactic reaction, a very severe reaction, no one did anything wrong in that case.

I didn't know I had an allergy. My physician didn't know I had an allergy, the nurses. No one knew that I would have an allergy to this medication. That's a reportable event in Pennsylvania because it's unanticipated, not because someone did something wrong.

You can contrast that with, I came into the hospital. I told the admitting nurse I'm allergic to penicillin. Maybe he or she noted that on my chart. Maybe it got mixed up, and somewhere along the way, I get penicillin and I have an allergic reaction. Still reportable in Pennsylvania, but here's where maybe, obviously, that could have been prevented. An error occurred somewhere along the way in the communication, because I shared with them I had this allergy, people knew I had the allergy, and I received the medication anyway.

So hopefully that clarifies a little bit of what our database includes.

When you think of "incident" and "serious event," 97 percent of the events in our database are incidents. These are events that, if you read the definition, may have not injured the patient. Serious events are events where an injury occurs and that person needs additional medical care.

For example, I'm taking care of a patient who falls. That patient falls. They have a very, like a minor abrasion to their arm. I'm their nurse. I clean it. Maybe I put a Band-Aid on it. Pretty much first-aid care. That's an incident.

My same patient falls and they fracture their arm or they fracture their hip. That now maybe requires surgical intervention and other medical care. That becomes a serious event.

That's a very high-level way of trying to categorize those two: when you think that something happens that requires, that either there was no injury at all or it required first aid versus it was a more serious injury requiring additional health-care services to the patient.

On the next slide, if you look, it's a timeline of our events from 2005 through 2018, and this is also in our annual report. Most of you should have received a copy of this. If you didn't, I only had a limited number.

They're online.

So if you look at the total number of reports -- that's that dark line that you see -- that started back in 2005 around, it looks like about 160,000, 170,000 events reported and, through 2018, reached just near 300,000 events.

If you look at that line that it's more of like an orangish-brown color, those are our high-harm events. Again, those are those events that either cause permanent harm to a patient, it was a life-threatening, you know, an immediate threat to life, or the patient died.

And the numbers on the right side of the graph correspond with that brown line. So if you look back in 2005 and you follow over, it looks like it's between about 700 and 800 of those events reported in that year, and then if you look at 2018, a little over 300 reported.

On the next slide, you'll see our reports by Harm Score. So every report that comes in to our database by the facilities is scored by a Harm Score, from an "A," and that means something that it was just an unsafe condition. Someone found a floor wet that wasn't supposed to be wet that a patient could have slipped on.

Our "B" categories, those are events that happened that were near misses. It didn't reach the patient either by chance or because someone intervened.

So I am a nurse by background. In this case, I am going to pass medications to my patients, and Representative Conklin, you're my patient today. I'm pulling your medications out of the drawer, and I pull the wrong one, but I notice it. You know, when I check my medications against what you're supposed to get, I say, oh my gosh, I pulled the wrong one. I put it back. That's a near miss. It didn't reach you. It could have, but I caught it. So those are our "B" categories. Those are near misses.

And those are important. We want to know about those, and hospitals and health-care facilities want to know about those, because when you capture those, you can look at, why was that medication in the wrong drawer to begin with? Because the next nurse coming along could pull that same wrong medication, maybe not notice it, and administer it to you. So when we see those near misses, we want to look at the processes of what broke down behind them. There was still a breakdown in the process, and can we fix it before harm reaches a patient the next time.

If you move across the graph, our "C" category, these are events from here on out that now they have reached the patient. So this event happens; I pulled the wrong medication. It was Tylenol. You were supposed to get Advil. I gave you the Tylenol in error. Nothing

happened. You were fine. There was no -- you didn't have a problem with the Tylenol. We didn't have to give you any additional health-care services. So these were events that reached the patient but didn't really cause you any harm.

We still need to know about them. You as a patient still need to know about them, but no harm became of them.

This is also, I suspect many of you may have children, grandchildren, nieces, nephews. If you remember back to the age when they were, you know, between 1 and 3 or 4 and they were starting to walk and toddle around, they fell a lot. I have several -- I mean, this is what kids do. They bump their heads. They fall. This is a pediatric patient that is maybe 2 ½, 3 years old that was in the playroom. You know, they're in the hospital long term, and they're toddling around and they fall. They're fine. The nurse checks them. The physician checks them. They're not hurt, but they still fell. It still gets reported. It's in that "C" category.

Our "D" category events, these are events that, again, reach the patient, and there was either a very minor injury, so that same little boy that fell as he was toddling around gets a scrape on his arm. You know, we clean it. We put a Band-Aid on it. Or these are events where I just -- maybe we need to watch you a little bit

closer to make sure that you're not injured. So we have an elderly patient that falls and we know that maybe they did, they bumped their head. We want to watch that patient very closely to make sure that there's no neurological changes going on.

So this is a "D." So it reached the patient. A very minor injury, or we need to watch them closer. We need to monitor them. Maybe we need to do an X-ray to make sure that there's not a more significant injury that happened. Those are all incidents up to "D."

Once you move over to category "E," these are our serious events. If you look at category "E," so now you have an event that happened that there was actually temporary harm that occurred and that patient needed some sort of additional health-care services. Perhaps it was a new medication they needed because of the event that happened. They needed to be monitored at a higher level. Maybe they were moved to an Intensive Care Unit for higher level monitoring.

"F," also temporary harm, but now you also have prolonged or an initial hospitalization. So maybe I was a patient in the outpatient center. I was coming in for a CT scan. I fell while I was there, and now they had to admit me to the hospital because I fell. So that's a category "F."

As you move across to "G," these are events that caused permanent harm, so irreversible harm to a patient.

"H," these are our life-threatening events. That's that anaphylactic reaction and they needed to put a tube down my throat to help me breathe and put me on a ventilator until I made it past that event and stabilized.

And "I" is our patient deaths.

So what this graph shows is the breakdown for 2018, all of the events that were received in our database and what the level of harm was for each of those.

These are the numbers that a lot of people, you know, the public sees. Some Members, you know, of the Legislature, you see, and without knowing the story behind them, I don't know that everyone really understands what they mean. And event reporting and patient safety is very complex. It's not always a black-and-white issue or decision that gets made.

So my last slide, what I listed were some facts that we know and then an opinion, my opinion, at the end.

So we know, it's a fact, that if you look at the total number of reports from 2005 to 2018, they went up. You can clearly see that. They went up significantly in that time frame.

We know that the number of high-harm reports has decreased since 2005. You can see a nice steady trend

down.

We know that Pennsylvania has the largest database of its kind in the nation. This is because our Legislature had that foresight back in 2002-2003 to say, we're not just going to report harm in Pennsylvania, we're not just going to report medical errors; we want to know what's happening across the industry. We want to know about these events that maybe weren't errors but we could still learn from them to make care better the next time. So that was very important.

Other States, when I meet with or represent people like me from other States that have agencies similar to ours or other for-profit or nonprofit entities, they look to Pennsylvania. They look at our data. They look at this database, not as, oh my gosh, what the heck is happening in Pennsylvania. They say, wow, your facilities are really on top of this. They're reporting what they're finding, and that's indicative of a good culture in your organizations.

Another fact: There is limitations to our data. We know, I know, that not everything is in there. Yes, we have legislated. There is legislation that says we must report this, but there's a lot of factors that do play in.

So even with mandatory reporting requirements, not all events are captured or submitted. One, you're

relying on people to report things, so you're relying on that nurse that, you know, pulls the wrong medication, almost gave it to his patient, but didn't. Someone, he or she, has to stop what they're doing at the end and file that report. It has to be captured somewhere. So we know that even though we have the largest database in the country, we're still not getting 100 percent of events. So our numbers do not represent all patient safety events in the State.

They also don't represent events that occur outside of those health-care settings that are required to report to us, such as long-term care other than infections, home health agencies, physician practices, other outpatient services. Those areas are -- events that happen in those areas are not captured in this data.

We also know that low numbers of reports does not mean that care is safer, and that seems counterintuitive. You say, well, if the reports are going down or you have low numbers, you must be, those facilities that have low numbers must be safer. Maybe, but they very well may not be.

And in fact when we look at facilities across the State, you know, we look at how many events people are reporting and compare it to their peer group. Well, the folks we target when we're looking at pure numbers,

aggregate numbers, are the ones that aren't reporting a lot.

And in fact what we do when that happens, we have a group of patient safety liaisons. These are professional expert people in patient safety that cover our entire State. Each acute-care facility is assigned one of these people. They are consultants that go out and help them to work through patient safety problems.

So when they see a facility in their region is, you know, they haven't reported a serious event in a year, that seems pretty odd that you wouldn't have one thing that happened. Or if your incident numbers are really much lower than your peer group, we look at that as potentially a red flag that maybe those folks aren't reporting as much as they should. Those are the ones that we target.

We have whole toolkits for our staff and patient safety officers in those facilities to say, here are things to look at to increase your reporting. That's what we want them to do. When Mcare was enacted and we started collecting all these events, we expected, and I'm kind of going down into my opinion, but we expected over time that those events would increase.

Last year alone, our staff educated 11,000 health-care providers in Pennsylvania, and that's indicative of, you know, most years. We educate a lot of

people on a lot of patient safety topics, including what's reportable in Pennsylvania.

We have a lot of people that move to this State. We have nurses, physicians. You know, they still come and go. We're very different in Pennsylvania, so that education is ongoing. So we expect over time those numbers to go up.

Another fact: While we know that the number of reports has increased, and this is what we're getting at, we can't conclude that the total number of actual events that happened to patients increased. You can't conclude, because in 2005 we had 150,000 and in 2018 we had 300,000 events. Those are reports. That's why we go out. That's what we preach. That's what we educate people on, on what they have to report. It doesn't mean that you have two or three times as many actual events happening. What it means is that people are recognizing them and they're doing what they're supposed to do.

On the flip side of that, you know, we have that nice trend down on high-harm events. That is also, those are reports. We would like to believe that those numbers are actually coming down, but remember, we don't capture, we know we don't capture everything. So it's encouraging, but we can't conclude, based on that, that just because the reports are coming down that the actual events are coming

down, because they're not validated against anything else. There's not another data source that you can compare and say, well, Hospital A, here's this data source and they had a hundred serious events but they only reported five. Nothing like that exists. So we are truly, we are dependent upon the facilities having a positive culture that supports reporting and us getting the information.

Our opinion is that seeing that inverse relationship, when you look at the total number of events going up over time and those high-harm events coming down, we look at that as a positive signal for the people in Pennsylvania. Because when you have events that didn't reach patients or didn't cause harm to patients and people, those are the ones that are going up exponentially, and people are capturing them. And if hospitals and providers are putting processes in place to try to fix things before that really bad event happens, you would expect those really bad events, those high-harm events, to go down in relation to those near misses or those very low-harm events going up. So that's what we have expected to see over time.

We still have a long way to go in Pennsylvania, so I don't want to paint a rosy picture and say that things, you know, over the last 15, 20 years are fixed. They're not. Hospitals, their partners, you know,

insurance companies, folks like, you know, the CMS, Medicare, organizations like HAP, we work with very closely on collaborative work to help hospitals improve. Improvements are being made. We know that we still have work to do, and that's why we're all here.

I would like to stop talking at this point and answer questions, because that's a very -- I mean, it's high level when you look at our data. When you're getting, you know, 300,000 events that come in in a year, there's a lot of information that we gain from that, and having that robust reporting is what allows us to then analyze the data, make sense of it, and then be able to put programs together to educate staff out in hospitals, to be able to put performance improvement projects together with our partners to help things get better.

Thank you.

CHAIRMAN MENSCH: Ms. Hoffman, thank you for your testimony.

MS. HOFFMAN: Yes.

CHAIRMAN MENSCH: We'll start with Representative Dush.

REPRESENTATIVE DUSH: Thank you.

And I used to work as a crime prevention specialist, and I tried to actually get increases in reports for just this reason. And I think one of the

things that I would like to see taken away is the people who might be hesitant or who aren't reporting.

This inverse relationship, when you see the number of reports going up, I think it does benefit the industry, because then they can see the problems, identify them, and then take corrective action.

Your data is actually kind of proof of that concept in that the more reporting we have -- what is it? It looks like about a 50-percent or more reduction in the number of serious incidents even though the reports have gone up by upwards of 100,000.

So I want to commend you on it, and whatever you can do to try and pass on that it is actually beneficial to increase the amount of reporting, right? And I'm encouraged by what I'm seeing with your statistics here.

Thank you.

MS. HOFFMAN: Thank you.

CHAIRMAN MENSCH: Senator Brewster.

VICE CHAIRMAN BREWSTER: Thank you, Mr. Chairman.

A couple of questions.

You mentioned a number of times that you weren't comfortable that there wasn't a hundred percent reporting. What is the consequence of not reporting, if any?

MS. HOFFMAN: There are consequences to not reporting, and I don't want---

VICE CHAIRMAN BREWSTER: Legal consequences.

MS. HOFFMAN: There are regulatory consequences for not reporting in the State of Pennsylvania.

The Patient Safety Authority was set up independent of the regulatory function. So our team, we receive the data. We analyze it. We go out and we provide consultation, education, have very good working relationships with the hospitals and providers in Pennsylvania.

The other piece of that is the Department, our Pennsylvania Department of Health, which, you know, they are the regulators. So I don't want to testify for them, but they are responsible for making sure facilities comply with the act.

So when they go into a facility and there -- I was a patient safety officer in a hospital before I worked for the Patient Safety Authority. So my experience, my personal experience was when we had the Department of Health, when the survey team would come in, they would say to me, you know, Regina, I want to see for the last year, show me a list of your serious events; show me that you're reporting your incidents, and I would provide them. And as they went through the survey and they were looking at patients' charts or interviewing staff, if they came across something that they thought was a serious event, then they

would compare that to my list and see, did we report it?

So the penalties associated with that, you know, they would be, if someone was not in compliance, they would be cited for not being in compliance with the law, and then we'd need to submit a corrective action plan to the Department. And I know that there is an option for the Department to fine facilities for not reporting as well, but I couldn't speak to how often that happens or such.

VICE CHAIRMAN BREWSTER: Does the Auditor General get involved with audits of the facilities, do you know?

MS. HOFFMAN: Excuse me. Can you repeat that?

VICE CHAIRMAN BREWSTER: The Auditor General, does he get involved with audits of facilities?

MS. HOFFMAN: I'm not aware that the Auditor General does or does not.

VICE CHAIRMAN BREWSTER: This next question is, do patients make reports to you?

MS. HOFFMAN: Patients, there is -- patients do not make reports directly to us. Patients, each hospital is expected in other regulations to have mechanisms for patients to be able to report any type of complaint to them, whether it was patient safety, customer service, care, et cetera. But there's not a mechanism for patients to provide actual reports to us.

We include patient perspectives in our work. You know, we have patient representatives on our board. We work with a patient council that helps advise us in our work. But as far as if something happens to a person, they don't report it directly to us. They can report it to the Department of Health.

VICE CHAIRMAN BREWSTER: Okay.

And the last question, when there's litigation, is the Authority subpoenaed to give information on the data they have collected on a facility?

MS. HOFFMAN: We are not, because that data that is collected by hospitals, under the act, what comes to us and what is prepared to be in compliance with the act is protected information, so we are not called to testify.

VICE CHAIRMAN BREWSTER: Okay. Thank you for your testimony, Ms. Hoffman.

Thank you, Mr. Chairman.

CHAIRMAN MENSCH: Representative Conklin.

REPRESENTATIVE CONKLIN: Thank you, Regina.

Did I understand you correctly, when you get information, do you get information from everything from a personal-care home to a hospital?

MS. HOFFMAN: No.

REPRESENTATIVE CONKLIN: Okay.

MS. HOFFMAN: We receive information from

long-term care facilities. Not personal-care homes, just licensed nursing homes---

REPRESENTATIVE CONKLIN: Okay.

MS. HOFFMAN: ---specifically on health-care associated infections. So no other type of patient safety event in nursing homes.

Hospitals, ambulatory surgery centers, birthing centers, and abortion facilities report all of their patient safety events into our database.

REPRESENTATIVE CONKLIN: Is there any correlation between what would be -- so you would get information from, and most of them are closed now, the county nursing homes and those type of facilities?

MS. HOFFMAN: Can you repeat that?

REPRESENTATIVE CONKLIN: Do you still, with the information you would receive---

MS. HOFFMAN: Mm-hmm.

REPRESENTATIVE CONKLIN: ---would it be from like the county nursing homes -- there aren't a lot of them left now -- but to the private-care homes to the hospitals then?

MS. HOFFMAN: Yes.

REPRESENTATIVE CONKLIN: Is there any correlation between the number of reports between what would be a government-run facility to a privately run? When you see incidents coming in, is there any -- are they about the

same or do you find that there may be more reporting in one type of facility versus another?

MS. HOFFMAN: I have not studied -- we have not studied that in the long-term care facilities to see if there's a discrepancy or difference in that data, so I can't answer that.

REPRESENTATIVE CONKLIN: Oh, that's okay. Thank you.

CHAIRMAN MENSCH: Representative Davidson.

REPRESENTATIVE DAVIDSON: In your long-term care reporting, you said the only types of incidents had to do with infectious disease?

MS. HOFFMAN: With health-care acquired infections. So if I come, if I'm admitted to a nursing home and I do not have any infections when I get there but I get an infection while I'm a resident in that long-term care facility, that infection is reported to us.

REPRESENTATIVE DAVIDSON: Would that include bedsores that can develop into sepsis at stage 4 and 5?

MS. HOFFMAN: It would only include bedsores if that bedsore became infected. So in that case, I mean, if it was sepsis -- but what would be reported to us would be the sepsis.

So bedsores without an infection we don't see in our data. If it becomes infected while the resident is in

the nursing home, that would be reported.

REPRESENTATIVE DAVIDSON: Okay.

And are you seeing a lot of reports regarding that, or is that something that you found to be underreported or are you seeing a lot of reports in that regard?

MS. HOFFMAN: We see -- I'm going to refer to our annual report here for just a second. I mean, we definitely see reports in that regard. I would say, you know, we have less years with the nursing homes.

Anecdotally, there's still room for improvement. I am not convinced that there is any one group of facilities in Pennsylvania that are reporting, you know, everything that they need to be. There is still room to improve those reports.

So yes, we are seeing them, and there is a breakdown in our annual report which talks about the different types of infections that we see in long-term care facilities.

REPRESENTATIVE DAVIDSON: All right. Thank you.

MS. HOFFMAN: In fact, I will send it to you after, the page that it's on.

REPRESENTATIVE DAVIDSON: I would appreciate that. Thank you.

MS. HOFFMAN: Thank you.

CHAIRMAN MENSCH: Questions or comments from other Members?

If you can bear with me, I have a couple of quick questions.

MS. HOFFMAN: Sure.

CHAIRMAN MENSCH: First, the change in the venue rule in 2003, has it had a positive, a negative, or no impact, in your opinion, on the access to medical care in Pennsylvania?

MS. HOFFMAN: I would -- I did not have any information that we collect or study that would support or not support that.

CHAIRMAN MENSCH: Thank you.

MS. HOFFMAN: So you're asking for an opinion that I don't have data to back up---

CHAIRMAN MENSCH: I appreciate that.

MS. HOFFMAN: ---and it would just be a personal opinion.

CHAIRMAN MENSCH: I truly appreciate that. Thank you.

What, in your opinion, would happen if the Supreme Court ruled and changed the venue rule?

MS. HOFFMAN: I do not anticipate that that would change reporting to the Patient Safety Authority and the

events that get reported. I don't believe that that would have a direct, immediate impact.

CHAIRMAN MENSCH: All right. Thank you.

MS. HOFFMAN: But I can't -- other than looking at my reporting, I don't want to speculate.

CHAIRMAN MENSCH: Okay.

Does your organization collect data from VA hospitals?

MS. HOFFMAN: We do not.

CHAIRMAN MENSCH: Fraternal hospitals like Masonic or other fraternal-provided facilities?

MS. HOFFMAN: If they are privately -- so the VA, no. If it's a privately owned facility that is licensed in the State of Pennsylvania, we would receive reports from them.

CHAIRMAN MENSCH: You would. Okay. All right.

All right. Thank you.

Other questions or comments from Members?

Ms. Hoffman, thank you very much.

MS. HOFFMAN: Thank you.

CHAIRMAN MENSCH: I understand you have a very busy day as well, so---

MS. HOFFMAN: I do. Thank you.

CHAIRMAN MENSCH: Good luck.

All right.

PANEL II:

PROVIDERS

CHAIRMAN MENSCH: Our second panel will represent providers. Will the representatives from The Hospital and Healthsystem Association of Pennsylvania and the Pennsylvania Medical Society please come forward.

Thank you for joining us. I believe we have from The Hospital and Healthsystem Association Mr. Warren Kampf; from the Pennsylvania Medical Society, Dr. Danae Powers and Mr. Peter Hoffman.

Thank you for joining us today. If you would all please rise and raise your right hand:

Do you swear to tell the truth, the whole truth, and nothing but the truth?

(Testifiers responded "I do.")

CHAIRMAN MENSCH: Thank you. Please have a seat.

And you can begin your testimony. I'm sure you have a prearranged order, so begin when you're ready.

I guess you don't have a prearranged.

MR. KAMPF: We'll go with your list, Senator, if that's okay.

CHAIRMAN MENSCH: That works for me, Warren.

MR. KAMPF: Senators and Representatives, I'm here, Warren Kampf. I'm the Senior Vice President for Advocacy and External Affairs for The Hospital and Healthsystem Association of Pennsylvania, otherwise known as HAP. As you may know, HAP advocates for approximately 240 of our member organizations across the Commonwealth, as well as for the patients and communities they serve.

HAP appreciates the opportunity to provide comments to the Legislative Budget and Finance Committee to assist in the preparation of a report evaluating the proposed changes to the Pennsylvania Supreme Court's Rules of Civil Procedure that would repeal medical professional liability venue reforms adopted during 2002.

Pennsylvania physicians and hospitals, and most importantly, health-care consumers, would be adversely affected by such a rule. By allowing venue selection in counties with little relation to the underlying cause of action, the trial bar could shop for verdict-friendly venues in which to file their suits.

This would again lead to higher premiums for medical liability insurance, make Pennsylvania less attractive to physicians considering practicing in the State, increase medical costs, and adversely impact access to care for consumers. The proposal is not in the public interest.

During my testimony today, I will provide general background about this issue and explain why the Supreme Court should not implement the proposed rule change.

As a result of the passage of the Medical Care Availability and Reduction of Error, Mcare, Act, both the Legislature and the Supreme Court adopted reforms that reduced the number of and total dollar amount of malpractice claims brought in Pennsylvania, especially in Philadelphia and Allegheny Counties. This was accomplished, to some degree, by limiting venue for medical liability actions to the county "in which the cause of action arose." Previously, expansive venue rules allowed medical liability plaintiffs to sue defendants almost anywhere they did business, even if the alleged malpractice occurred elsewhere.

Even with these reforms, however, Pennsylvania remains, based on 2017 data, the third highest cost State for insurance premiums on a per capita basis.

The Civil Procedural Rules Committee of the Supreme Court proposed late last year an amendment to the rules that limits venue in medical professional liability actions to the county in which the cause of action arose.

While HAP believes that patients injured during medical negligence should be compensated, HAP does not

believe that a rule change is justified based on the explanation and limited data provided by the Rules Committee around the proposed rule.

The proposal does not acknowledge the changes to the health-care system between 2003 and today, which could amplify the negative impact of a rule change, nor the obvious financial consequences of such a change.

Changes to the health-care delivery system that have taken place since the early 2000s include hospital consolidations, workforce shortages, improvements to medical liability insurance availability, and escalating cost pressures.

First, mergers and consolidations:

Since 2000, the number of hospitals affiliated with health systems has risen by 88 percent. Because many hospitals that had been independent prior to the current venue policy are now affiliated with health systems, lawyers would have access to a much wider footprint of the State when shopping for plaintiff-friendly venues. For example, one Pennsylvania health system operates facilities now within 18 of our counties.

Worsening provider shortages:

Based upon State-level projections of physician supply and demand performed by the U.S. Department of Health and Human Services' Health Resources and Services

Administration, Pennsylvania will face a deficit of approximately 1,000 primary-care physicians by 2025, or about 10 percent less than the estimated demand of more than 10,000 primary-care physicians needed to serve Pennsylvania's population.

Rural areas are particularly vulnerable to losing providers given the disproportionate burden they face around statewide physician shortages. And I should say that these shortages are not simply limited to physicians. There are other licensed health-care professionals -- nurses come to mind -- where shortages exist in Pennsylvania.

Medical liability insurance costs and availability:

The impact of increased medical liability costs could cause closure of critical units like obstetrics, which can inhibit adequate access to care. For example, between 1999 and 2000, median medical liability awards increased nearly 43 percent, and the average award for neurologically impaired infants, which was 1 million nationally during 2003, reached in one case in Philadelphia $100 million.

Not surprisingly, between 1999 and 2005, Pennsylvania saw a 17-percent decrease in obstetrics units. After the venue rules changed, the number of staffed

obstetric beds began to increase, expanding access once more. The increasing burden of the cost of medical liability insurance diverts critical resources from being reinvested into infrastructure and innovation.

A recent report by Milliman, which I believe was appended to another testifier's written testimony, was prepared to evaluate the impact of the proposed change to the venue rule. This report shows that the current average statewide medical professional liability costs and insurance rates for physicians in Pennsylvania will likely increase by 15 percent.

Many individual counties will likely see increases in the physician medical professional liability costs and rates of 5 percent, while counties surrounding Philadelphia will likely see larger increases of 45 percent.

High-risk physician specialties, such as obstetrics and gynecology and general surgery, will likely experience additional cost and rate increases of 14 percent above and beyond the increases stated above. So in counties surrounding Philadelphia, instead of a projected 45-percent increase, you could see a 60-percent increase.

Notably, the report explained that these projected increases are likely understated, as the analysis

did not account for several additional items that could increase these costs and rates, including the impact of health-care provider consolidation, uncertainty in pricing, and an increased incentive to bring smaller borderline claims.

Simply put, any physician, other licensed professional, or health system that can be sued in Philadelphia or other high-cost jurisdictions will need to be insured as if they practiced all the time in Philadelphia.

Fiscal insecurity of today's hospitals, especially in rural areas:

An analysis of the Pennsylvania Health Care Cost Containment Council financial data indicates that during 2018, more than a third, almost 40 percent of Pennsylvania's hospitals, reported negative operating margins. In other words, almost 40 percent of our hospital buildings in Pennsylvania are operating in the red. Among the Commonwealth's rural hospitals, more than half, more than 50 percent, reported negative operating margins.

Keep in mind that while many of our hospitals are doing well, providing excellent care, and in possession of state-of-the-art health-care infrastructure, Medicaid only reimburses at 80 cents on the dollar of hospital costs, and Medicare reimburses at slightly below cost.

Hospitals, in addition, still provide three-quarters of a billion dollars in uncompensated care to the State's uninsured and those who cannot pay high deductibles. So that three-quarters of a billion is in addition to the 80 cents on the dollar or the cost reimbursement dollar for dollar by Medicare.

In other words, the uncompensated care is for the uninsured or for those who cannot pay high deductibles. They are not refused at the door, but their care is provided without a dollar of reimbursement, except what this General Assembly chooses to help us with to supplement that.

To offset higher medical liability coverage costs, hospitals will need to divert money from a wide range of operating and infrastructure needs, which may have a chilling effect on health-care innovations.

The health-care ecosystem in hospitals is complex, it is costly, and in many locations, it is fragile. A venue change driven by lawyers on behalf of complainants may upend that ecosystem in ways that truly affect access to care.

And if I could pause here for just a minute, after the venue change went into effect in 2002, it is true that the overall dollar total recoveries across the State went down. I saw approximations of about $150 million,

which means that the venue rule is working. I'll get to that in a second.

But if you went back to those days, you would insert, just by that rough calculation, an additional cost of $150 million into the system. And that number, that $150 million, based on a 2002 recovery total of 500 million, which today, in 2019 dollars, is probably 700 million or a billion. So just that back of the napkin, in my eyes, means we're talking about something on the order of $500 million more in costs to the health-care system.

We were recently made aware of some arguments that suggest that since hospitals more and more frequently employ physicians, there is no risk of physicians limiting practice or leaving the State because all costs will be borne by hospitals.

As I stated just a minute ago, many, many hospitals manage the costs they have today at a seemingly insurmountable burden with government payers reimbursing below actual costs. Adding massive liability insurance increases, whether imposed by a separate carrier, insurance carrier, or through self-insurance, would only make that situation far more serious.

Further, just as hospitals have increasingly joined or become health systems themselves, a number of

physician practices have sought to grow and conduct business in multiple counties, which means that the venue change proposed will impact their financial prospects separately and distinctly from that of a hospital.

Available data does not support the conclusion that the current venue rule should be rescinded. The reduction of court filings of medical malpractice actions demonstrates that the tort reform measures enacted by the Legislature and the Supreme Court are working.

Specifically during 2002, the percentage of medical liability cases filed in Philadelphia represented 44 percent of all filings throughout the Commonwealth. Of those reaching jury verdicts in Philadelphia during the period of 1999 to 2001, 41 percent yielded plantiffs financial awards, a rate that is more than double the national average of 20 percent, and half of such verdicts exceeded a million dollars.

By 2003, after enacting venue rule reform, filings in Philadelphia fell substantially, and during 2017, Philadelphia's cases accounted for 28 percent of the 1,449 filings statewide.

Under the 2002 venue rule, however, patients can still bring medical liability suits, but such cases now must be tried in the jurisdiction where the alleged liability occurred. This 2002 reform did not deprive a

claimant of the ability to access the courts to right a wrong. It only restricted where that case could be brought.

In fact, filings increased in many counties because of the change in the venue rule. That means that it worked. And I should pause here and simply say that while filings fell, that is different from the fall in recoveries.

The reason for or a solid reason for the fall in overall dollar recoveries is that venue change to places where recoveries were in fact lower, that does not mean that filings which went down, the number of filings that went down, is because of the venue reform. It is more likely that that is because of the other reforms like certificate of merit, which would have made a frivolous claim expensive. You had to hire a doctor in order to get a report that the claim you were about to make as a lawyer, and that costs money. So that is an explanation why filings went down. But overall recoveries going down shows that the venue reform worked and is a very important reason for why the insurance market stabilized, because those massive increases did not have to continue.

There is no evidence suggesting that individuals obtaining care in any Pennsylvania county lack access to the courts, nor is there evidence that counties where

malpractice actions are currently being litigated are not rendering fair results.

Moreover, and there was some discussion of this obviously with the Patient Safety Authority's testimony, which was excellent, but let me point out that that testimony, what I heard was Regina said that "medical error" is nowhere in the definition of any of the reporting requirements to the Safety Authority. So using the overall report numbers is misleading when trying to figure out whether there is uncompensated medical malpractice somewhere in the Commonwealth. The Patient Safety Authority does not examine or base reporting on medical error, which is the basis of medical malpractice cases.

Logic and fairness dictate that venue rules remain in medical liability matters:

There are logical and ethical arguments for the current rule. Where negligence is alleged to occur, where witnesses are located, where health-care professionals and the patient may reside, this is the place that ought to be where the trial occurs.

Further, our State faced a medical liability insurance crisis of epic proportions only 16 years ago. Reforms, including this one, enacted at that time should not be repealed simply because the crisis has abated and

the reforms were successful. Such a move flies in the face of logic.

Keep in mind, we still have the third highest medical liability insurance rates in the country.

Conversely, trying a case in a distant jurisdiction which has no obvious connection to the matter is illogical and unfair. For one, it encourages forum shopping, the practice of picking the friendliest jurisdiction to large recoveries.

On this point, some may argue the doctrine of forum non conveniens, or inconvenient forum, will eliminate the threat or temptation of forum shopping. This is not correct. All such disputes -- this is where you file a motion saying, I'm in the wrong forum. I should not be here. It's inconvenient -- those will need to be argued, they will need to be briefed, they will need to be fully litigated, and that in and of itself will drive up costs in the absence of having a bright-line rule.

Furthermore, anyone who has handled such a dispute knows it is a high burden for the person trying to prove a forum is inconvenient to get that forum changed to some other county. Perhaps a health system in Allegheny County where the alleged act occurred could not be brought into court in Philadelphia, could prove it was inconvenient, but there are cases in the law books holding

that even hundreds of miles are not an inconvenience, let alone 50 or a hundred miles.

Finally, the proposal, if adopted, would represent a departure from the past practice of building consensus on rule changes that could have a significant public policy impact.

The Interbranch Commission on Venue, created under Act 13, was comprised of appointments from the legislative, the Executive, and the judicial branches of this government. A majority of the members of the Commission recommended that medical liability cases only be filed in the county in which the cause of action arises. The Pennsylvania Supreme Court adopted the Commission's recommendation, as did the General Assembly through Act 127 of 2002.

In short, the current venue policy was effectively built by three separate branches of government, while the current proposal to reverse that policy is a unilateral move that sets a dangerous precedent, one that may undermine future opportunities for interbranch collaboration.

For all these reasons, HAP believes that the Supreme Court should not implement the proposed rule change. It is also worth noting that HAP has been joined by more than 20 health-care provider and advocacy groups

in opposing this change, and I attached that joint comment letter to my testimony for this Committee's review.

HAP appreciates the opportunity to provide these comments to you, and we hope that the information we provided will assist you as you draft your report.

Thank you, Mr. Chairman.

CHAIRMAN MENSCH: Thank you, Mr. Kampf.

Let us continue with the Pennsylvania Medical Society, please.

DR. POWERS: Great. Good morning.

CHAIRMAN MENSCH: Good morning.

DR. POWERS: Good morning, Chairman Mensch, Vice Chairman Brewster, and Members of the Legislative Budget and Finance Committee.

I am Dr. Danae Powers, President of the Pennsylvania Medical Society, a physician organization that represents more than 23,000 members. I appreciate the opportunity to provide a physician's perspective on the proposed venue rule change and to be the voice for Pennsylvania physicians.

The Pennsylvania Medical Society would like to extend our sincere thanks to Senate Judiciary Chair Lisa Baker and her Senate cosponsors for introducing and advocating for Senate Resolution 20.

By way of background, I'm a board-certified anesthesiologist serving rural Pennsylvania counties around State College. I completed my medical degree from Albany Medical College through a combined biomedical program with Rensselaer Polytechnic. I have worked for the University of Pittsburgh Medical Center transplant team, as well as their School of Medicine. I have worked at Emory University Hospital in Atlanta and Allegheny General Hospital in Pittsburgh directing research and teaching.

Because of this resolution, we have been afforded the opportunity to explain the potentially harmful impacts of this proposed change. What may seem like a procedural change will in fact impact the physician workforce and the 12.8 million Pennsylvania patients that we care for every day.

We sincerely believe that patients who have suffered loss deserve their opportunity to be heard in court. And regardless of our perspective in this discussion, I know this to be true: We are all committed to protecting and promoting the health of Pennsylvania citizens and ensuring fairness in the judicial system.

The Pennsylvania Medical Society strongly opposes the proposal presented by the Civil Procedural Rules Committee. The proposal presented by the Committee threatens three distinct but interrelated issues: forum

shopping in metropolitan markets across the Commonwealth; the stability of liability premiums for physicians to practice in the State; and perhaps most importantly, the impact on patients and their access to quality care.

First for forum shopping:

The venue rule, which went into effect in 2003, was designed to address forum shopping, the proclivity of plaintiffs' attorneys to file medical professional liability actions in high-verdict counties such as Philadelphia, even when there was no sensible connection between the county and the care received by the plaintiff.

Philadelphia is regularly used as an example of the potential abuse of venue:

- Between 2000 and 2002, Philadelphia County averaged 1200 medical malpractice filings, which as we said earlier was 44 percent of the cases filed statewide.
- After the venue restrictions were put into place, the number of filings in Philadelphia fell to 29 percent of the cases filed statewide.
- Since courts prohibited forum shopping in 2003, there has been a two-thirds decline in medical liability cases filed in Philadelphia

County.

Let me explain the effects of this venue shopping.

One of my colleagues explained that at a time early in his career, in the early 2000s, he was involved in a lawsuit. He had only seen the patient as a referral, had done nothing wrong, had no direct, long-term involvement in the patient's care, but because a lawsuit was filed, he was, of course, named in the suit.

The action was filed in Philadelphia where the physician wasn't even from. His attorney and insurance carrier recommended settling the claim based on nothing except the fear of the Philadelphia court system and the fact that litigating the case in Philadelphia was going to be more costly than settling it would be.

As I stated earlier, we sincerely believe that patients who have suffered loss deserve their opportunity to be heard in a courtroom. Physicians and other health-care providers likewise deserve the opportunity to be able to defend themselves without a demonstrated bias from some jurisdictions.

Returning to a rule that permits medical professional liability suits in the county where the defendant regularly does business will mean that a

physician will be required to defend a case possibly hundreds of miles away from where he or she works, robbing other patients of the care they would have been able to provide.

Thankfully, the certificate of merit and possibly other reforms have had positive effects. The number of cases filed and physicians sued declined, while at the same time, both the plaintiff and the defendant were given a fair opportunity to be heard in their local community by local juries and local judges.

In terms of liability premiums, the proposed changes could also usher the return of skyrocketing medical liability premiums for physicians that we say and I lived through and we felt in the late 1990s and 2000s. Even with the current reforms in place, medical liability insurance costs in Pennsylvania still rank among the highest in the nation.

We train many, many physicians in this State, and as I travel to other States in my capacity as President, I meet some of them, and one of the reasons they leave is our still current liability climate and the expenses. So we're providing excellent doctors to other States. I prefer they stayed here.

The proposed rule would increase the cost for the professional liability insurance carriers in this State,

and a domino effect could occur:

- Medical liability carriers may voluntarily or involuntarily move out of the Pennsylvania market. Insurance carriers could become selective in who they choose to underwrite. All Pennsylvania physicians will be impacted as the number of carriers has the potential to decrease, making it increasingly difficult to find liability coverage in our State.
- Since professional liability insurance is required to practice, physicians could be left with three options: seek other practice alternatives, retire, or leave the State altogether, which Pennsylvania had started to see in the early 2000s.

I have been told that there is a feeling that this proposed change shouldn't bother physicians because most physicians are employed and, therefore, don't pay for their own medical liability insurance. Although it is true that more physicians are employed than in previous years, there are still significant numbers of physicians who continue to operate independently and do pay their own insurance and other costs.

These physicians often practice in medically underserved areas. Along with paying their own insurance, they are also employers supporting the local economy and community, and increases in their expenses means that they must find areas to cut in other business operations, as all businesses do when they face increasing costs with no increase in revenue.

The statement that physicians don't pay their own medical liability expenses also overlooks the fact that someone still does pay them. Whether it's a health-care system or another entity, the ultimate cost will still be passed along to the consumer -- in most cases, the patient -- either in higher out-of-pocket expenses, higher insurance premiums, or both.

And thirdly, the impact on patients and their ability to access quality care, particularly in rural areas:

Most importantly, this proposed venue rule change could threaten patient access to quality physician care, particularly in rural areas:

- Forty-eight of sixty-seven counties in Pennsylvania, home to more than 25 percent of the State's residents, are designated as rural.

- Twenty-two percent of Pennsylvania's citizens live in areas with health-care provider shortages.

The rural access-to-care problem links directly to and is exacerbated by the medical professional liability insurance issue.

In 2016 Pennsylvania Rural Health Association's report points out that affordable medical professional liability insurance is a major factor for physicians when contemplating where they will practice. And although greatly improved from the early 2000s, Pennsylvania's liability climate continues to be a challenge, discouraging physicians from choosing to remain in practice in Pennsylvania.

The difficulty of getting health-care providers to locate in rural communities is well documented. If the current venue rule is changed, we will risk losing those providers who already live and work there, as well as discouraging others from choosing to locate there.

Under the current rule, if sued for an alleged medical error, physicians who choose to practice in a rural area can expect to defend in his or her rural county, submitting to the liability and compensation judgments of the citizens of that county.

If the venue reform is rolled back, however, it is more likely than not that the plaintiff will seek to sue in Philadelphia or some other jurisdiction with a record of high plaintiff success or verdicts. This means that the physician is away from their practice for a longer period of time, reducing patient visits during the legal proceedings and impacting the patient's ability to see their physician in a timely manner.

In addition to time away from patients, the rural physician will face a higher likelihood of plaintiff verdicts, a higher verdict or settlement amount, and a resulting higher malpractice insurance rate and Mcare assessment.

In closing, I know that the liability crisis of the late nineties and early 2000s brought this Commonwealth's medical community to its knees as high-risk specialists like neurosurgeons curtailed complex surgeries, OB/GYNs stopped delivering babies, and the ability to recruit physicians to practice in our Commonwealth all but dried up. Vulnerable populations like older Pennsylvanians, newborns, expectant mothers, and trauma patients suffered while personal-injury lawyers pocketed millions in contingency fees.

The current venue rule, which stipulates that medical liability claims must be filed in the county where

the alleged medical error occurred, helped stabilize our liability climate back in 2003. And despite this, oddly enough, the Committee proposes to undo the very reform that was part of what helped create stability by pointing to significant reduction in medical professional liability actions over the past 15 years. To the contrary, a reversal of the venue rule will only serve as a catalyst for a resurgence in forum shopping for verdict counties like Philadelphia.

We must learn from history or we are doomed to repeat it. The result of the proposed venue rule change by the Civil Procedural Rules Committee will create a domino effect of negative implications for the professional liability insurance market, physicians, other health-care providers, and most importantly, access to quality care for all Pennsylvanians.

Thank you again for the opportunity to share with you our concerns regarding the proposed venue rule change.

CHAIRMAN MENSCH: Doctor, thank you for your testimony.

Mr. Hoffman, any additional comments?

MR. HOFFMAN: I'll try to keep it very, very brief. I know we're over time.

CHAIRMAN MENSCH: Please.

MR. HOFFMAN: I'm glad for the opportunity to be here to talk to this group.

I have a perspective which may be a little different than some. I started working with the Pennsylvania Senate Select Committee on Malpractice in 1984. One of the things we looked at was venue.

I served on the Rules Committee for 6 years. I was one that helped to draft Act 195 and Act 13 and was on Governor Rendell's Select Committee.

In 2001, I was asked by Chief Justice Cappy to work with him and Judge Wettick and Gerry McHugh, a very accomplished Philadelphia lawyer who is now on the Eastern District bench, to discuss two issues: certificate of merit and venue. The certificate of merit and venue emanated from the General Assembly; it was their concept, and Chief Justice Cappy thought it was important enough to review.

Some have said there was no crisis. It was manufactured. That is belied by what the General Assembly did. It's belied by the Pew Trust study, Governor Rendell's committee. And, folks, I lived through it. Insurance premiums had skyrocketed, doctors had left, and it was a real problem.

Is Philadelphia a verdict plaintiff-friendly forum? It sure is, and my colleagues have already talked

about it. And if it weren't a plaintiff verdict-friendly, why would the plaintiffs' bar be fighting so hard over the venue rule? I think the question answers itself.

Verdicts in Philadelphia for plaintiffs are twice as likely as anywhere else in this State. The size of the verdicts are more than twice as high throughout the State. They are amongst the highest in the United States, but that's the tip of the iceberg.

Ninety percent of civil cases get settled. So we hear about the verdicts; I know about the settlements. We, the defense lawyers -- and I have been one for over 40 years -- seldom try big cases in Philadelphia. Why? There was a verdict there, I guess 4 or 5 years ago, for $100 million. There's a fear of swimming in the water in Philadelphia County because of the size of the verdicts and the likelihood of a plaintiff's verdict.

Doctors left Philadelphia. Cooper Hospital across the bridge in Camden is the beneficiary of a number of great docs who left southeastern Pennsylvania. I'm interested in obstetrics and maternity and women's health, as I'm sure everybody else is. Pennsylvania Hospital, which ran one of the greatest residency programs in OB, had no residents at that time because people didn't want to come to Pennsylvania.

In Philadelphia, the biggest city in the State

population-wise, if you go to City Hall and you go south of City Hall into South Philadelphia, there are no hospitals that deliver babies. How many obstetricians who are independent do you believe practice in Philadelphia County? Zero. They don't. If they're there, they're working for the systems.

You could go north and you'd have Einstein and Temple. You could go west and you'd have Penn, and you could go east and have Jefferson. Or just around the corner, you would have Drexel and Pennsylvania Hospital. But the biggest portion of the population of Philadelphia is Northeast Philadelphia, and there's not a hospital there that has a maternity service, an OB service. They're all closed down, and they're closed down and we know why they're closed down and we know when they closed down.

The number of cases that went down in Philadelphia County, what happened right before the rules went into effect? There was a tsunami of cases that were filed right before the effective date of the rules. So did the cases drop in Philly? Sure they did, because they were blown up out of proportion before the rule went.

Now, are there cases still being filed in Philadelphia? Yes. Are they filed in southeastern Pennsylvania? Yes. Montgomery County, Bucks County, Delaware County, they're up; Philadelphia's numbers are

down. Why? Because of the venue rule. Are cases throughout the State down? Yes. Why? I believe because of the certificate of merit, which was, I thought, a great rule.

Are victims being compensated in Pennsylvania outside of Philadelphia County? Yes. My friend, Tim Lawn, who is going to talk to you in a little bit, got a $20 million verdict in Delaware County. There was a $20 million verdict in Chester County, Montgomery County. Last week, there was an $11 million verdict in Bucks County. There have been big verdicts in Clearfield County.

There is a friend who is here who had a plaintiff's verdict of $6 million in Schuylkill County. You can get justice if you're a plaintiff throughout Pennsylvania. Are the odds as good as Philadelphia? No, but you still can get justice.

So let's talk about common sense. Let's talk about Lancaster County, which is now part of the Penn System.

So a patient goes to Lancaster, lives in Lancaster, gets care in Lancaster County by a Lancaster County physician. Under the changed rule, that case would be brought where? You know where it would be brought. It would be brought in Philadelphia County because of the relationship between Lancaster General and Penn. All of

the care was there. The plaintiff is there. The witnesses are there. Doctors might have to close down their practice for a week or 2 weeks. What are we doing to patient care, because the case would then be brought in Philadelphia County. And I'm not going to say why, but you can figure out why.

That's why I think that in terms of common sense, forget the statistics. We all know what the numbers are. We can interpret them as we wish. But in terms of common sense, fairness, justice, and victim compensation, and most importantly, patient access, the change doesn't -- it creates a problem, it doesn't solve a problem.

If it ain't broke, don't try to fix it, and the situation ain't broke. And it ain't broke because of two things: the certificate of merit, the venue rule, and other things in Act 13. Why then would you scrap an important part, which is the venue rule?

I think what happens -- I won't give you my opinion. You already know what it is, and it's not important.

I want to mention something about insurance premiums.

Doctors who practice in systems that have self-insured programs, that only means that they have access to insurance. They don't have to deal with an

insurance company that may not insure them. So they'll have access to the premium, but the premium will be the premium. And we know that Mcare pays out a third of its money every year to Philadelphia lawyers for Philadelphia cases. So those doctors will be charged a premium. It may come up on their maybe taxable income to them, it may come out of their overhead, but it's still a cost, and it still goes to the bottom line.

And Warren has talked about, you know, the mission, and he has talked about, you know, a hospital has to be able to do what? To meet its mission, and it's operating on razor-thin margins. They have to be able to meet the margin. And cost is a key part of everything, and most importantly, patient access to quality care.

I have talked too long, and I thank you for the time.

CHAIRMAN MENSCH: Thank you, sir.

We'll open it to the Committee for questions or comments, and we'll start with Senator Phillips-Hill.

SENATOR PHILLIPS-HILL: Thank you, Mr. Chairman.

Thank you very much for your testimony. I think that we all want to ensure that Pennsylvanians have access to quality, affordable medical care.

Technology is constantly evolving and changing. We can do things today that we couldn't have dreamed of

20, 30, 40 years ago. So it would be really helpful if you could help me understand the changes in the practice of medicine that have been designed to reduce medical error or implemented to reduce the potential for medical malpractice since the passage of the medical malpractice and venue reforms back in 2002 and 2003.

DR. POWERS: By that, do you mean what the act did or what the profession of medicine and physicians are doing as we move forward?

SENATOR PHILLIPS-HILL: Well, I mean, obviously the act created changes.

DR. POWERS: Sure.

SENATOR PHILLIPS-HILL: But technology is constantly evolving and changing, and so I am certain that there have to be technology changes that have improved the quality of care as well as---

DR. POWERS: Absolutely.

SENATOR PHILLIPS-HILL: ---helped to reduce things that would lead to medical malpractice.

DR. POWERS: Yeah. There's a lot that has been done.

First of all, we have the innovation that has come with the electronic systems that are available, the data monitoring that we have, the communication systems that have really been beefed up. We are on the forefront

of a telemedicine revolution now. We have much broader databases where the information is being fed in. We have a much quicker ability to disseminate information, so that if something is discovered or understood to be of medical importance, that information gets out way faster now than it did 10 or 20 years ago.

I have been personally involved in situations that, while not quite telemedicine, if we have had concerns about something that was going on, we were instantly able to reach out to a colleague or an expert at Sloan Kettering or California and get that information involved.

And in addition, technology is improving. Drugs are being invented and discovered. Diseases are being delineated. What is happening with genetic understanding is allowing us to look, for instance, to genetically type patients to determine who might be at greater risk of having a negative or adverse reaction to a medication or a procedure. So we're being able to get more granular in how well we can understand what the patient may or may not experience.

There's a lot going on, and I think the future is very bright. I mean, there's a constant drive to continue improving our ability to keep patients safe.

MR. HOFFMAN: Could I chime in for a sec? And I'll keep it short.

DR. POWERS: I'll shut up. No; go ahead.

MR. HOFFMAN: No, no, no.

Dr. Powers, you know, she's got the gravitas. I'm just sort of down the street.

But Dr. Powers has said it, EMR, electronic medical records, which we didn't used to have and which have revolutionized everything. So a doctor, let's say at the University of Pennsylvania downtown, can access the records of his patient who was seen at Radnor and vice versa and can get the lab reports and the radiology reports in an instant.

Jefferson, Penn, they're all part of the system. So if I'm a doc at Jefferson, I can access Peter Hoffman's records from Penn if it's important. You couldn't do this 10 years ago. So you have got the flow of information. You have got communication.

We have robotic surgery which we didn't have before. You can get in and out of the hospital a lot faster. The Gamma Knife. The---

DR. POWERS: Designer drugs.

MR. HOFFMAN: Yeah; designer drugs.

DR. POWERS: I mean, you can go for your chemo now and get your tumor type tested, genetically analyzed, and they can pick the chemo that would be best for you.

MR. HOFFMAN: If you're even going to get chemo.

DR. POWERS: If you're going to even get chemo. You might get the immunologic therapy now, the oncologic viruses that they're using to immunize patients so their own immune system comes out.

I was talking the other day with a patient. Diseases that used to be considered fatal, certain of the leukemias, the lymphomas, melanoma, they're now curable, not to mention HIV. I mean, there's a lot of exciting stuff happening.

MR. HOFFMAN: But it comes at a cost -- big cost.

DR. POWERS: Yeah.

SENATOR PHILLIPS-HILL: Well, it is a great time to be sick, right? I mean, if you have to be sick---

DR. POWERS: I would advise against illness in general.

SENATOR PHILLIPS-HILL: Always.

DR. POWERS: Yeah.

SENATOR PHILLIPS-HILL: But if you do become sick, yeah, I mean, things have gotten so much better.

I guess those changes, I mean, we're doing a much better job of collecting the data. I know that we have had certain issues that have arisen in York County where I represent where that communication with other hospitals, other, you know, places of treatment, helped save lives, and that was a good thing.

So are these things -- they're tangible. Are they being documented? Do we have the statistics to show these improvements?

DR. POWERS: I think we do, but what is also happening is sicker and sicker patients are living. I mean, I have a perspective going back many decades in medicine, so things that used to be considered, go home and make your plans, or, I'm sorry, nothing could be done, are now we intervene. Our expectation is survival, our improvement of quality of life. So at the same time that the technology is advancing and the services we are offering are expanding, we're capturing sicker and sicker patients that we no longer, for want of a better term, feel helpless with.

So, I mean, there's a lot of moving parts in that question. I'm sorry if I don't quite understand what you are trying to get at, but.

SENATOR PHILLIPS-HILL: I mean, I think what I'm really trying to get at is, you know, can we identify data or statistics that could support that these changes have improved the quality of medical care while at the same time reducing---

DR. POWERS: Yeah. Well---

SENATOR PHILLIPS-HILL: ---the rate of malpractice filings?

DR. POWERS: Okay. I'll say in anesthesia, loss of an airway. When we anesthetize a patient, one of our concerns is making sure that the airway, which is getting oxygen to your heart and your blood, is always maintained. We do have statistics showing that with modern means of what we call securing the airway, we now have fiber-optic instruments we can use to get into airways. We have monitors that instantly can record whether or not we're getting carbon dioxide. So all that technology has driven down absolutely the risk of loss of airway.

And not to mention, I mean, we have video laryngoscopes now, where actually you don't even look at the patient while you're doing the airway; you're looking at screens and everything is being monitored on the screen.

So yes, things like loss of airway are dramatically diminishing in anesthesia. At the same time, we're dealing with much more complex airways, because people, frankly, are getting bigger. I mean, I have had patients with BMIs of 60 and 70. That's difficult to secure the airway, but it's safer now than it was 20 years ago, yes.

SENATOR PHILLIPS-HILL: Thank you.

DR. POWERS: Yes.

MR. KAMPF: Senator, just on the subject of technology and telehealth, although I'm new to the hospital

system, I have certainly practiced law for a while. There have been some discussions internally that happened among our member organizations about partnerships that they formed around telehealth and whether a change in the venue rule might have an impact on that. It's obviously an area of the law that I doubt has had much, you know, judicial opinions.

But if a rural hospital in, you know, a state-of-the-art, top-notch facility somewhere have a telehealth arrangement, is that doing business in the plaintiff-friendly jurisdiction?

SENATOR PHILLIPS-HILL: Thank you for bringing that to our attention, because certainly as we move forward from a technology perspective and from an affordable health-care perspective, telemedicine is very important. So thank you very much.

Thank you, Mr. Chairman.

CHAIRMAN MENSCH: Thank you, Senator.

Representative Dush.

REPRESENTATIVE DUSH: Thank you, Chairman.

One of the things I want us to definitely focus on is, the reason we were here back in 2000 was because of the impact on the communities with the venue shopping.

Personally, I moved up from Delaware in '95 and in '97 lost one general practitioner, a year and a half

later lost another one. One went out of State altogether, the other one went into a health-care system, and it was because of this, the insurance premiums and that sort of thing.

And one of the things that stood out, and when we were doing the Policy Committee hearing on this, Dr. Powers, if you could speak to, up until we really started having this huge impact by the venue shopping, it was generally an older physician, when he was looking to sell his practice and get a retirement out of that, he would bring on a younger physician, have him working with him, establish that kind of relationship with the patients.

Can you address some of your experience and the experience the other physicians had who were experiencing at that time and how that impacted the community?

DR. POWERS: Yeah.

I came back to practice in Pennsylvania in 1992, and by 1999 and 2000, I had actually had colleagues leave. I mean, some of the best surgeons I knew had actually left the State. Other surgeons we were having trouble recruiting. It has gotten better, but I have to say that Pennsylvania is still seen as a liability-unfriendly State.

I have a statistic here that says we are still ranked number four in the nation for claims and liability experience, and when you talk to young doctors, they are

aware of that. So not only should we not be moving in the direction of making it worse again, I think we still have things we have to do to try to improve the malpractice climate in Pennsylvania.

But yes, physicians were not able to recruit for their practice, which led them to close their practice earlier because they burnt out earlier. Doctors who were in independent practice did look to sell and merge their practices, and often that was not something that worked well for them because it was a culture change that they might not have been looking for otherwise.

I'm not saying that the employed situation is in any way, shape, or form unacceptable and not appropriate for many physicians, but there were physicians who, for liability reasons, joined larger groups or went into the employment status only because of the liability crisis.

And I am still in touch today with doctors who have left the State, and I can tell you, I have had them call me up and say, get out of there; come to South Carolina; it's a whole lot better. I mean, I get calls like that.

But I think we have a lot to offer in Pennsylvania, and I think we can still make the improvements we need to make and keep some of the great students and residents that we're training in some of the

finest medical schools in the world, keep them in our State.

REPRESENTATIVE DUSH: Thank you.

We have actually got a new internship program up at Penn Highlands---

DR. POWERS: Right.

REPRESENTATIVE DUSH: ---that is focusing on getting the doctors to stay in rural Pennsylvania.

DR. POWERS: Right.

REPRESENTATIVE DUSH: But if this goes into effect, I'm very concerned for that. Warren had touched on the fact that there are so many hospitals that are on the negative side of the ledger.

And Peter, if you could address something, being a defense investigator prior. I know that when these multimillion-dollar verdicts, these hospitals that are operating in the red or the physicians that are operating right there on the borderline, you get these huge verdicts, and the insurance companies' premiums are going to go up for that physician. And it's going to take so many more patients and so many more cases in order to actually get those people back into the black, and if you could address some of that impact.

MR. HOFFMAN: Sure.

First of all, the $100 million verdict seldom is

what it gets settled for. But that's what hits the newspaper, that's what scares the docs, that's what scares the insurance companies, and that's what influences juries. That's what they see. That's what they know. So that happens.

Now, most hospitals, most hospitals -- let's just talk about hospitals, not docs. Docs have mandatory insurance of a million dollars, 500 primary, 500 Mcare. Almost none of them have excess insurance. So hospitals, and let's talk about southeastern Pennsylvania that I'm most familiar with.

The hospitals, in order to have excess insurance, I'll use a term called the attachment point. If you had your own homeowner's policy and you had a PLUP, an excess policy, it would attach after your primary policy. The way it works with the hospitals, after the primary policy of 500, the excess or the Mcare policy of 500 -- a million -- they don't have excess insurance. Why not? Because the cost to get the excess insurance between the million-dollar point and let's say 11 or 15 or $20 million is not cost effective at all. So they are uninsured, and I'll call it for the buffer or the uninsured zone.

Now, that's a decision they make. Now, that's a decision they make. So if there's a verdict or a settlement above a million dollars and before 20, that

comes out of operating, and that's what hurts the ability to practice then.

You know, some plaintiffs say, well, they get it out of the linen closet. Well, it ain't out of the linen closet; it's out of operating, and, you know, it hurts.

Now, do the hospitals make a decision not to have the excess? Sure. And the reason they don't have the excess is because the excess insurance is basically dollar for dollar. You want to have 11 million dollars' worth of excess, you're going to have to pay $11 million. That's how it works. Because the actuaries who look at this, and insurance companies really aren't in the business of losing money. We know that. They're in the business of taking a premium and then figuring out how not to pay the excess claims, but I don't want to talk about Sam Marshall before he gets here, so.

But it's a problem, and it's a huge problem. And, you know, back in the 2000s, there were no insurance companies, commercial insurance companies in Pennsylvania. They left. We had five liquidations in a year.

So the insurance market was kaput. It was kaput in '76. It got kaput then, and now it's different. And it has changed because of the RRGs and other things, and it's basically the hospitals that have done that, you know?

It's a very fragile, Representative, it's a very fragile situation.

So that's why when you say, well, why did the hospital settle that brain-damaged infant, cerebral-palsy case in Philadelphia County? Because the odds were against them in trying the case. And it's a risk-benefit analysis, and the risk exceeds the benefit. You settle the case and you pay the piper, and you may have to pay the piper out of your operating account. But that's the cost of doing business in Philadelphia and in this State.

MR. KAMPF: Could I just add to that, Senator?

CHAIRMAN MENSCH: Please, be brief. We're running really tight on time, Warren.

MR. KAMPF: Okay.

And just for the Committee, so Mcare was supposed to go out of existence, that range between 500,000 had a million, if there was insurance capacity, meaning there were carriers or whatnot capable of writing for that space. And as of yet, that has not taken place, and those costs for Mcare are borne by assessment on the health-care community.

And the other thing is, there was a reference to RRG, risk retention groups. Hospitals do make decisions above a million dollars, and sometimes between zero and 500,000, which is their money. There is self-insurance in

all manner of sectors in our economy regardless, not just in the hospital space. But often the hospital space is forced to make that decision, because going to a carrier and trying to get a premium is impossible or incredibly costly.

CHAIRMAN MENSCH: All right. Thank you.

Representative Conklin.

REPRESENTATIVE CONKLIN: Thank you, Senator. I'll try the speed round.

Just real fast, Mr. Hoffman. You said about there was relocation to New Jersey from Philadelphia. Can you tell me what the venue rules are in New Jersey?

MR. HOFFMAN: I don't know, but you don't get sued in Philadelphia if the carrier you rendered was the Cooper Hospital in Camden. And I'll tell you the names of these orthopedic surgeons that left. I mean---

REPRESENTATIVE CONKLIN: No, I was just curious if you knew.

MR. HOFFMAN: That's why they left.

REPRESENTATIVE CONKLIN: I'm trying the speed round. You know, I apologize. And I'm sure if you're in New Jersey, you don't get sued in Pennsylvania at all in any county, but.

MR. HOFFMAN: You can try, but it generally doesn't work.

REPRESENTATIVE CONKLIN: Just, and this one is just a curiosity question.

A young individual that worked for me for many years just finished their doctorate degree, and they're going to another State. And I asked them, I said, can you tell me why you're going to another State? And their answer was quite simple: When I researched, the average physician in Pennsylvania makes in the 160s; where I'm going to makes in the 270s, and Pennsylvania is one of the least paying States for a physician. And they made it very clear to me that their reason as a physician for leaving our State wasn't anything more than a financial reason, because they can make more money elsewhere.

And again, this isn't to hit you on anything. I have had this argument about our professors in universities and others, that we're losing them because of better pay. Do you think this could be a factor as well? I know it is in this case, but do you think this could be a factor as well for Pennsylvania, that we're having trouble only because they have better opportunities elsewhere?

Just anyone.

DR. POWERS: Well, yeah. I mean, students are coming out in debt, and Pennsylvania has -- there is multiple reasons why our reimbursements or the net that a physician makes is less than they can make in other States.

So we do have a reimbursement climate that could be improved, but we do have an expense side that could also be improved. And we are the fourth highest malpractice State in the country.

And these kids are paying attention, particularly if they're coming out with debt. I mean, I know people -- I talked to a young resident who was over 300,000 in debt between college and medical school. That person is not going to go to rural anywhere and take care of uninsured patients. It's not going to happen because they're 30-something years old and they can't even buy a house.

So, yeah, we have a lot we have to look at. But everything that makes it worse should be avoided.

REPRESENTATIVE CONKLIN: Thank you. That was my point. We really need to work with these young people.

MR. HOFFMAN: One of the things we did -- I studied it awhile back -- the reimbursement from the big insurance companies for let's say delivering a baby, they give the same amount whether it's a vaginal or whether it's a section. Does that make sense? No. They include the prenatal care and the postnatal care, and the number was $1500. Let's say it's $2,000, and let's say the premium for an obstetrician is over $100,000. Well, if you did the arithmetic, how many babies would you have to deliver before you made your overhead? It's a disaster.

And reimbursement we're not going to talk about today, but that's part of the problem.

MR. KAMPF: Representative Conklin, just a couple of stats on that.

I think the premium, a typical premium for OB/GYN in Philadelphia annually is $102,000. Elsewhere, it's still 50,000. A neurosurgeon in Philadelphia, $160,000 just for the premium, but neurosurgeons elsewhere in Pennsylvania, a $70,000 premium. So that's a cost that is built in to every practice of medicine, whether it's a hospital or a private practice.

REPRESENTATIVE CONKLIN: Which goes to the reason I brought that up, is that when you look at the cost of going to school and the cost of insurance, if you can make $100,000 more a year, that's one of the things I think we have to look at, not only in your field but other fields as well, to keep Pennsylvania competitive.

Thank you.

CHAIRMAN MENSCH: Thank you, Representative.

Senator Brewster.

VICE CHAIRMAN BREWSTER: Thank you, Mr. Chairman.

I'm just going to make a few observations, and I wouldn't want anybody to read into the fact that it's an opinion. But thank you for your testimony. Just a couple of points.

Mr. Kampf, you mentioned that there has been a 40-percent increase in insurance premiums and what have you due to a reduction since the venue had changed in 2002. I would make the argument slightly that the reason claims are down is because of what the previous speaker said: There are fewer reports. So one could also draw the conclusion that the hospitals and doctors are doing a better job and there aren't as many claims being reported. That's what the first speaker said, if I read the data.

I just wanted to bring that up, because while I understand that attorneys can go do what they want to do, sometimes there are a few that may take advantage of that system.

I live in Allegheny County, and we fancy ourselves, as evidenced by yesterday's agreement between UPMC and Highmark, that we arguably have the best health care in the world in Allegheny County. I don't see people fleeing. And as Representative Conklin mentioned, the ones that do leave leave because of opportunities to make more money somewhere else where there may not be as many doctors.

Again, I'm going to keep emphasizing, I'm not denying the fact, that somebody may be taking advantage of the system somewhere. But, you know, if what you say is true, the premiums, as a former mayor I can tell you that

insurance premiums, health-care costs, have caused some of my communities to go into Act 47.

So nothing from 2002 until now, if the venue situation was better, has helped us on the back end. For example, if I have a $10 million budget in a community and $3 million goes towards health care, I'm out of business. Thousands of people don't have a police department, a fire department, everything else, because of health-care premiums. I don't hear of any insurance companies going out of business.

I do know, and I want to say this, I will defend our hospitals, and I can only speak to western Pennsylvania. Some pay taxes and some do not. They have billions -- not millions, billions -- in fund balances. So I'm having a hard time understanding whether there's some unscrupulous lawsuits that shouldn't happen, which I get, I still have hospitals that are pretty well off. They're building new hospitals, okay? And we fancy ourselves and we say to the public, we have the greatest and the best facilities, technology, and doctors in the world where I live.

So I'm having a hard time putting together the facts here. I have got what appears to be some evidence of, you mentioned Philadelphia. At the risk of losing my friends in Philadelphia, I'm not going to comment. You

said it. I guess that's happening. That's probably not a good thing. I would agree. But why am I not seeing reductions? With all the technology, all the things you can do medically, all the new hospitals being built in our area, all the doctors that we say are the greatest, why am I still seeing high premiums to companies, to municipalities? They're not going down in accordance with what you're saying.

And it doesn't have anything to do, in my opinion, with the lawsuits, because, and I have insurance folks in the audience who are my friends, too, they're not going out of business. They're making money. The hospitals are making money. Some are marginal, okay? But it's hard to tell the average person -- I represent 250,000 people -- who know that 25 percent of their income goes to health care.

MR. HOFFMAN: Senator, you hit the nail on the head, but there's two different types of insurance. The liability insurance that the hospital is paying or that you as the mayor was paying for the fire engines and the trucks and the policemen and all that liability, that's one thing, and that's what we're talking about here with premiums.

The health insurance that we all have to pay or our employer pays or you have to pay we will all agree is off-the-chart high. We could get into why that is, but

we're not going to do it today, and that is for any company. Health insurance is the biggest cost of their overhead. It didn't used to be, but it is now.

VICE CHAIRMAN BREWSTER: Well, Counselor, I would agree with you. My point is, and I'm not trying to move the blame around, but shouldn't you be having that conversation with the insurance carriers? They're not going out of business. They're making money.

MR. HOFFMAN: I have tried to have those conversations with the Blues and others.

VICE CHAIRMAN BREWSTER: Well, I mean, I don't want to get into everyone's business here, but I like to see the profit margins. I worked at a bank for 30 years, so I know a little bit about that, okay? And all I'm saying is, the venue issue may be an issue, but I don't think it's all the issue. Everybody is complicit in this problem.

We heard that the reporting is down because doctors and hospitals are doing a better job. I believe Ms. Hoffman when she said that, okay? And I also believe that there is probably some folks out there doing some things with the system and it's probably inappropriate.

As my colleague, Senator Hill, said, technology has come in and we should see prices going down if we can do things faster and better. I would submit to you that

the public, the general public, John Q. Worker out there, is paying for every piece of improved technology that you come up with, which saves lives, but they're paying for it. Every insurance company that's making money and not going out of business, they're paying for it. And so it's just a different perspective is what I'm trying to say to you.

And I would say that everybody in this room, whether you're an insurance person, an attorney, a doctor, or a Legislator, we're all complicit that health care, along with pensions, are two of the most significant issues in the lives of every American. I don't care if you're a millionaire or you're working for $10 an hour, okay?

And my concern is that when we make these changes, or if we make them, that we should challenge each entity to get engaged here. Nobody wants to give up a buck. And you're right; if I'm a doctor and I can go -- hey, listen, Doctor, I understand your point. You want to make money. You come to Allegheny, the fourth or fifth largest State in the Union, why wouldn't we have more complaints? Why wouldn't we have more cases? We have more people. I mean, we have a huge -- we're the fifth largest State in the country, so you're going to see bigger numbers.

DR. POWERS: Well, that was per capita.

VICE CHAIRMAN BREWSTER: Okay.

DR. POWERS: So it was adjusted for population.

VICE CHAIRMAN BREWSTER: You didn't qualify that, but I get it.

DR. POWERS: Yeah; I'm sorry.

VICE CHAIRMAN BREWSTER: But if an attorney can go -- or I'm sorry. If a doctor can go into a community where there's a shortage, then that doctor has a captive audience, because health care is emotional and serious.

And so, you know, we trust our doctors. We don't understand what they do and how they do it. And when something goes bad, there is a process in this country where you can take advantage of the legal system.

And I'm not suggesting that we do any changes; I'm just giving a perspective of the average person, if you brought 200,000 people in this room, they're going to have the same opinion I have. They're going to blame everybody, okay?

So I just want to make -- I wanted to bring those points up, because it sounds like we're doing better, and I don't want to belabor the point. I'm sorry, Director. It sounds like the hospitals and the doctors are doing a better job, so there are fewer complaints.

As my colleague said, technology, and you have confirmed, technology in the medical field has helped create less problems, in my opinion, but the costs are

still going up. So somewhere along the line -- and we haven't mentioned the providers of the equipment, the folks that sell the tools that do the operations. They're involved in this. Huge -- I know folks who are in the business. They're making huge amounts of money to sell the equipment. I'm saying equipment, but the tools that our doctors use in operations. So there's an awful lot of different entities, I think, that are involved in this issue.

But I wanted to just thank you for your testimony. I don't disagree with what you said. All I'm saying is, I think there are other components that add to the problem. So thank you.

MR. KAMPF: Senator, may I?

Just thinking of this proposed rule change for a minute, though, and I get what you're saying and you made lots of accurate statements. But this rule would promote getting those buildings, those hospitals that rely almost exclusively in the far-flung or the rural areas on Medicare and Medicaid, to be subject to suit in the places where those costs are very high.

So while I'm not, I'm not discounting what you're saying, I would like the Committee to focus on the fact that this rule, where we literally have 50 percent of our rural hospitals, "rural" as defined by CMS, operating in

the red, relying heavily on Medicaid and Medicare, which do not reimburse that cost.

This particular rule has an effect that takes us in the wrong direction, not the other items you mentioned. And I just -- okay.

DR. POWERS: I'm also going to say, you brought up some absolutely excellent points, and generally what's going on in health care is that it's very murky. Very few people understand how it's put together. And the individuals with incentive to game the system unfortunately are far more sophisticated at manipulating policy and outcome than the people who are doing what they like because they like it, and I'm hoping that over time, some of that starts getting exposed and unwound.

But in the particular issue just of the venue rule, even with everything else going on in medicine, it will drive up costs and it will lower our ability to recruit physicians, just even in the mess that is the current health-care system.

But I would love to dialogue, if you're curious, and tell you what we physicians think is going on in the health-care system, and the physicians are not happy. We may be watching our incomes go up or down, but right now the biggest issue, one of the biggest issues facing physicians in this country is something we call burnout.

We now have twice the national rate of suicide. And doctors are not happy, not related to what's going on with the money but the mess that our health-care system is in, and believe me, it is a mess.

VICE CHAIRMAN BREWSTER: Well, Doctor, I would agree with that.

So thank you for your testimony. And my boss, Senator Mensch, just left, and I have to continue the program here or he'll give me a hard time. So thank you very much for your testimony.

PANEL III:

ATTORNEYS

VICE CHAIRMAN BREWSTER: And we're going to ask the next panel to come up.

I'm going to ask our Director to introduce the panel and swear them in.

EXECUTIVE DIRECTOR BERGER: Okay. Our third panel represents attorneys. Would representatives from the Pennsylvania Association for Justice and the Pennsylvania Bar Association please come forward.

Please introduce yourselves for the record.

MR. LAWN: I'm Tim Lawn.

MS. BENZIE: Lisa Benzie.

MS. KRAVITZ: Kathy Kravitz.

MR. PURCHASE: I'm Eric Purchase.

EXECUTIVE DIRECTOR BERGER: And please stand to be sworn in. Raise your right hand:

Do you swear to tell the truth, the whole truth, and nothing but the truth?

(Testifiers responded "I do.")

EXECUTIVE DIRECTOR BERGER: You may begin your testimony.

VICE CHAIRMAN BREWSTER: Thanks, Pat.

MR. LAWN: Thank you, and good morning.

Medical error is presently the third leading cause of death in the United States, according to a study done by the Johns Hopkins University School of Medicine. It causes more than 250,000 deaths annually in the United States. I have seen more recent reports suggesting it may be as high as 400,000.

Twenty years ago, in 1999, the Institute of Medicine estimated the number of deaths annually in the United States attributable to medical negligence to be 98,000. And importantly, in 1999, the Institute of Medicine said that those totals need to be reduced by 50 percent over the next 5 years.

Well, that didn't happen. It didn't come close to happening. And in fact the Hopkins School of Medicine report says presently, approximately 1 out of every 10 deaths in the United States is attributable to medical negligence, so we have gone in the wrong direction.

Shortly after, the Institute of Medicine was calling for measures to cut in half the 98,000 deaths a year from medical negligence. In Pennsylvania, we embarked on a series of measures to address a so-called malpractice insurance crisis, and out of those measures came the Mcare Act that we have been talking about as well as rule changes from the Supreme Court, including the venue rule which we're here to talk about.

So what ended up cut by 50 percent was not the number of patient deaths from medical error but rather the number of lawsuits seeking to hold health-care providers accountable for those deaths.

My name is Tim Lawn, and I represent victims of medical neglect. I also spent the first 7 years of my career defending physicians in malpractice cases.

While not as old as Mr. Hoffman, I have been in practice for 30 years. I have lived through the Mcare Act, the so-called malpractice insurance crisis and the run up to it, and I appreciate the opportunity to discuss with you all today the issue of malpractice venue. Frankly, I would

like to discuss all of the changes that the Mcare Act and the rule changes brought about, but today we're limited to venue.

And I will caution, while Ms. Benzie will discuss the venue rule more specifically than I will, I will caution that you cannot just look at one of the changes that happened at that time and quantify, at least honestly quantify, the effect that it has had.

We do know from the statistics that lawsuits are down by 50 percent, and we do know that medical errors continue to climb, and as the Hopkins study tells us, medical deaths related to medical errors continue to climb. The cumulative effect of all those rule changes have essentially denied access to justice for many of our citizens.

Accountability is what is needed if you really want to improve patient safety and reduce errors. It is civil accountability that improves safety in the workplace, civil accountability that made safer the automobiles we drive in, the airplanes we fly in, the cribs our children sleep in, and a whole host of other products and places.

Unfortunately, corporations simply do not respond unless or until a jury tells them to, and sadly, it appears that health-care corporations are no different.

Take, for example, Medicare never events. Around

2006, Medicare came out with a list of never events that should not happen, and they told hospitals and health-care providers, we're not going to pay you for a surgery you perform on the wrong body part. We're not going to pay you for surgery to retrieve an object left in the patient in a prior surgery. We are not going to pay you to treat hospital-acquired infections.

Medicine had known for over 150 years that poor handwashing was causing infections in postoperative patients, and steps were not being taken, despite regulations requiring the reporting of infections, until Medicare stepped in and said, we are not going to pay you for that. Holding these health-care providers financially responsible is what all of a sudden incorporated simple and basic handwashing policies, sanitizers in rooms, and other steps designed to prevent those never events.

Look at the airline industry. We have always held the airline industry accountable. Last year, two Boeing jets fell out of the sky overseas, killing a little over 700 people. The response was, ground all of those Boeing jets until we figure out why that happened and make it safer. The response wasn't, oh, let's limit the rights of the victims of those tragedies.

Respectfully, the Mcare Act has not reduced medical errors. It has reduced the amount of insurance

available to a catastrophically injured victim. It has given one class of corporate defendant the ability to select the venue where a lawsuit can be filed against them. It has made lawsuits against health-care practitioners more expensive to prosecute and reduced the damages the patient can recover if they are successful in their verdict. It has virtually eliminated malpractice suits being brought on behalf of senior citizens. It has reduced that accountability I talked about earlier.

As I said, I was a defense attorney, defending physicians insured by Physicians Insurance Company back in those days. And I'm not sure who on the panel still remembers Physicians Insurance Company or the practices they engaged in that saw them left with no reserve to pay claims, or PHICO or PIE of Ohio. That's what led up to the malpractice crisis of the late nineties.

And Mcare's goal in 2002, its stated goal was to reduce and eliminate medical errors and promote patient safety, and respectfully, that has not happened. But I will tell you, it is impossible to separate out the one rule that made the difference. It was a multifactorial approach. We know the lawsuits are way down because of many issues, and it's impossible to identify the economic impact of the venue rule. And I would suggest that any study purporting to do so is biased and funded by one side

in this argument. But returning the venue rule to the same rule that applies to every other citizen and corporation in this Commonwealth is a necessary first step to improving accountability.

Malpractice victims aren't asking you for any special exceptions. We're not asking you to do anything for them. We're asking you to return the rule to the same rule it is for every other citizen in this Commonwealth. If you ask any 10th grade civics class, do you believe that the rules of court are applied equally to all who stand before the court, hopefully they would all say, absolutely, because Lady Justice is blind. Well, that blindfold was taken off for one particular class of parties.

Medical malpractice victims are your neighbors. They're your relatives. They are the kids playing on your street. For me, it was my best man at age 29 who died, leaving a 2-year-old son and a wife 4 ½ months pregnant. It was my 40-year-old first cousin, a police officer injured in the line of duty, sent home from a hospital, dying in front of his wife 15 hours later. Thankfully, his four grade-school-age children were still asleep. They come from all walks of life.

There was a little girl paralyzed from an improper delivery, the daughter of a former Member of this body. These folks don't have a lobby. They don't have a

PAC. They don't have a spokesperson or a PR firm or an association to speak for them. What they have is you all, because they are your constituents. They have entrusted you to come out here and protect them and protect their rights, and eliminating this special exception for venue I suggest is the first step needed to do that.

Thank you very much.

MS. BENZIE: Thank you.

Good morning. I'm going to talk a little bit about the actual venue rule as it exists for every other person, company, corporation in the Commonwealth, and then how it exists for medical corporations, what the difference is and what the change that you are asked to study here would mean for the people of Pennsylvania.

You have heard from a lot of other people here today, and the one consistent thing that you have heard from the Patient Safety Authority, that you have heard from the folks who represent hospitals, who represent and defend hospitals and doctors, and from a physician herself is that it is very hard to separate out venue from every other reform that was enacted around the same time. And I'm going to tell you, I think that's pretty impossible. But we were summoned here today because this study focuses on venue, and that's what I'm going to talk about.

I would ask you to keep in mind all of those other reforms that were implemented at the same time and their likely rule with the statistics that you do need to take a look at that have been provided in a multitude of studies that I believe have been given to you by a number of different groups.

When you look at those statistics, I don't want you to ignore the statistics. I want you to look at who did the study. I want you to look at who paid for the study. I want you to look at the poll that they used to come up with their statistics. And when you apply that to venue, you're going to determine that you can't draw a line between any of that information and venue alone. You need to look at a lot of other factors, like certificate of merit; like the fact that insurance has gone from 1.2 million down to $1 million of collectability along with those reforms; like the fact that the collateral source rule has been eliminated for victims of medical malpractice, like this venue rule.

The other things that I heard were, let's look at reimbursement. And I have heard from the Patient Safety Authority, I think it was pointed out, that there aren't many teeth that they have. They can't really hold people accountable. Maybe we need to take a look there. There could be some improvements with reporting.

So you have got a lot of things to look at, but venue is, where can a lawsuit be filed, and that's what I understand we're here to talk about today. Venue is actually determined by the company, the person, or the corporation who opts to do business in a particular county.

For example, a hospital that wants to build here in Dauphin County has submitted itself to the venue of Dauphin County. If they also want to build an office across the river in Cumberland County, then they are subject to the venue of Cumberland County. The defendants in malpractice cases who are hospital corporations decide what counties they want to submit themselves to the rules of and the venue of by opening doors there, by building buildings there, by renting space, by employing people in those counties. They select the counties. If they select three counties, then they should be able to be sued in any of the counties that they chose to do business in.

If you don't want to be sued in a particular county, don't do business there. That's how the venue rule works for every other professional, for every other person in the Commonwealth of Pennsylvania. That's not how it works for medical corporations.

But it's one-sided. I have heard the term "venue shopping": We don't want to permit venue shopping. I'm going to tell you that you do. You actually permitted,

when this rule changed back in 2003, the defendants to pick the venue where lawsuits can be brought, and you have done that because what happens is, small rural towns now that have a hospital can bring in a surgeon from Philadelphia, from Pittsburgh, from any other place, and if they operate in that small rural county, they pick the venue where they can be sued. The plaintiff doesn't have any other option under this current venue rule. They shopped, we created a rule, and that's what we have been living with.

It's inherently unfair and it's unjust. That same doctor that performs the surgery in Warren County, that same hospital that employs that doctor and brought him in there, what do they do if they have a billing dispute with that patient over that exact procedure? They can sue that patient in any county that they want, that they do business in. They reverse forum shop. It's inherently unfair.

There wasn't a need then and there isn't a need now if we're looking solely at venue.

What we have also seen and what Tim has pointed out are medical errors. We can look at the reports from the Patient Safety Authority, and we should, and we should look at how they term them, and we should look at the incidents which are near misses; by the way, not lawsuits. A near miss isn't a lawsuit. You have to have harm. And

so that 97 percent of reports, those aren't the lawsuits that are being filed. You have to have harm. You have got to have negligence, and you have to draw a line between that act or omission and specific definable harm. That has always been the law. That wasn't changed.

The special treatment that we have given to medical corporations is inherently unfair for the reasons that I stated, but let's look at the injured person. Let's look at the person who has surgery, that has their rights limited.

Behind every lawsuit is a person. It's somebody who got hurt. In my lifetime, it was my father. My father was a victim of medical malpractice when I was 10 years old. He was the breadwinner of the family. He was a coal miner in small-town, rural Pennsylvania. That's where I was born and raised. I now live here in central Pennsylvania.

I was the youngest of eight kids, and I saw the impact that that had on my family and on the small town. I saw the system fail time and time again for my family. We're talking about people.

I heard a lot about the cost of insurance going up. I actually heard insurers aren't in the business to lose money, and that's true, and you need to think about that. You need to take a look at the studies that talk

about, why was there a crisis to begin with? You need to look at the polling that was done then and the formation of risk retention groups and the failed investments and the Pennsylvania Department of Insurance report that talks about the increase in premiums. Take a look at all of the data you have. Look at those statistics. But please don't forget that we're talking about people. We're talking about injured people. We are talking about the third leading cause of death behind cancer and heart disease.

The doctor said burnout is facing the medical profession, and I believe her. I believe her because I hear it and I see it and the people that come to me who are hurt at the hands of medical corporations. You have got to look at how times have changed, and we need to be able to hold these medical corporations accountable for how they have changed the practice of medicine and turned it into the business of medicine.

Doctors are mandated to see patient after patient. My own family doctor that I had for 15 years left to go to concierge practice so that he could practice medicine once again on his own terms. So venue alone doesn't give us a lot of guidance on what we need to do with the overall system. You can't link it to increased premiums. You can't link it certainly to safer practices. What you can do is just simply look at the rule. Look at

it in its inherent unfairness. Look at it on the whole with every other type of professional and person and see that the scale is already tipped for people who are hurt.

Tim mentioned to you that you're the people that can advocate for injured persons. My role is limited to the civil system that I'm in. Those people who are injured are your constituents. They're your family members. They're your friends. It was my father. The reason that we are now seeing verdicts in some of the smaller counties is because medical errors -- errors, not the incidents or the near misses -- are the third leading cause of death, and it has gotten to the point where everyone is touched by medical malpractice.

And when you look at these smaller counties, the verdicts are rare, because oftentimes the hospitals, the medical corporations, are mega employers, and they touch everyone in that county. People make a living. You go to pick a jury and you're looking at people, you know, in Johnstown with Conemaugh written all over their shirts. You're looking at people with UPMC. You're looking at people with Penn Med. It's challenging, and there was no good reason to change the rule and create a special class for one group of people.

So I ask you, when you look at the venue rule and whether or not in this study we should put injured people

on the same terms as everyone else, that you come up with the conclusion that we should go back to it. We should go back to the way that it was, because there was never any good reason to change it.

You weren't given a good reason then and you're not given a reason now how venue alone, which is what we're studying, has changed anything from 2002 to the present time.

Thank you.

MS. KRAVITZ: Good afternoon.

My name is Kathy Kravitz, and I'm a partner with Barley Snyder's Lancaster office and Chair of its Health Law Group. I'm closing in on 30 years defending health-care providers throughout central Pennsylvania.

And I want to make one thing clear. We keep hearing the refrain "health-care corporations." Corporations, buildings, do not care for people. It's other people caring for people, and I think we need to remember that. It's the nurse who is pulling a double or working a night shift giving the patient the medication, doing her best to assess their vital signs and everything they need to be checking on throughout the night. It's the doctor on call or the surgical tech and OR nurse who gets called in on a Saturday to come help with a procedure in a small community.

These are people, and I have represented these people in their depositions, countless depositions, throughout the years, many whom cry through their depositions because there's an attorney there accusing them and certainly making them feel like they killed a small child or caused a lifetime of misery to a newborn. It's worth taking this issue from their perspective as well.

Now, I would like to start by taking you back to the year 2000. That year, measles was declared eradicated. Why then -- and it was declared eradicated thanks to a very, very effective program of vaccination. So why then have we seen double the cases of measles this year than what we saw, in the first half of this year than what we saw all of last year?

Now, before you say, Mrs. Kravitz, you're in the wrong hearing, let's look at the answer. The answer is that somebody decided that notwithstanding the existence of an effective, highly effective remedy, that we were just going to stop vaccinating some of our children, and everyone suffered because of it.

It defies logic to consider doing away with a tried and true prophylactic measure when the problems that it was designed to address are still there. And a number of the problems in the health-care delivery system have been addressed today, some of which are not directly

related to the venue issue.

But when I hear somebody using medical errors and the incidents of medical errors as an excuse to take the venue rule back to what it was, it sounds an awful lot like, well, you know, they deserve it. They deserve to be sued in Philadelphia County where you get three times the value of a case that you get in Lancaster. Let's punish those health-care providers. That's what it sounds like. And I will tell you, my experience is, that's what it would feel like.

Now, given the relative stability of the insurance market in the present time, it would be easy to forget what it was like 15, 20 years ago when OB/GYNs saw their insurance premiums increase by more than 100 percent between 2000 and 2002, and orthopedists had insurance premiums, some of the highest in the country. And a glut of cases filed in Philadelphia County overburdened that county and forced providers to litigate in foreign venues.

There has been some discussion of the numerous health-care providers who went belly up in those instances. Let's not forget the people, the doctors who were insured by those providers, believing that they had healthy insurers. And when those insurers went belly up, they left uninsured claims or underfunded claims and health-care providers, physicians, and hospitals with gaps in their

coverage, and that exposed them to individual, potential individual liability. That scenario was not good for anyone, including the claimants, and that's what we're looking at going back to should we walk backwards and take away an effective remedial measure.

Now, in order to survive, many hospitals, and in order to provide a broader range of better services and more advanced services, many hospitals of all sizes, smaller rural hospitals and hospitals that are not particularly small community hospitals, have integrated with larger health systems that may be based in Philadelphia or Pittsburgh or other larger cities. But it's these arrangements that are essential to the ability to deliver these miracles of modern medicine that we were talking about earlier to a more rural area. Those areas might not have access to X kind of surgeon or X kind of medicine or this study and this particular drug if there was no affiliation.

So when you say, well, if you don't want to be subject to liability in this county, don't do business there, well, first of all, you have to remember that when Penn Medicine affiliates with Lancaster General, it's not so much, you know, it's not Penn Medicine subjecting themselves to Lancaster County venue that's the issue. It's now Lancaster County is subject to Philadelphia venue.

But saying that, don't do business in those counties if you don't want to be sued there, is like saying, hey, don't bring the people of those rural counties, those superlative, excellent services that they can access through your system, keep it all to yourself in Philadelphia, because that's what you're encouraging. That's what you're encouraging.

I have heard the argument that the hospitals in their integration and the purchasing of other systems, they're doing it just for the money, and there are sometimes some economic advantages to integration. That is the idea, to do more for less. But when a health system embraces a small community hospital that may have been struggling, I don't think that's particularly a big cash cow for anyone involved. And revocation of the venue rule may very well squelch any efforts to save those kinds of community hospitals that sometimes their only option has been to make an affiliation with a larger system like UPMC or Penn Medicine or Geisinger or Penn State.

Frankly, no health-care provider, no doctor, no nurse, no nurse practitioner, should be punished because they have joined an effort to provide better service to their community.

Another argument that has been proffered in support of revoking the preventative measures suggest that

plaintiffs are going uncompensated. I have heard that filings are down, so plaintiffs must be going uncompensated because the reports to the fund are up. There's no objective data that plaintiffs are going uncompensated. And in fact there's still a lot of lawyers, a lot of plaintiffs' lawyers, and a lot of Philadelphia plaintiffs' lawyers come to Lancaster. A lot of Philadelphia lawyers come to Franklin County where I practice a great deal. They travel, and they don't do so because they think they're going to be short shrifted.

And a plaintiff can still go to a lawyer, and a lawyer can still evaluate a case, and if the case still has merit, then that case can still be filed, and that case could still be prosecuted, and that case could still be litigated, and that case can still be settled.

The venue rule was meant to reduce the number of cases brought in Philadelphia County inappropriately, and that's why you saw a reduction in those cases and an increase in other cases.

There was a 270-percent increase in the cases filed in Lancaster County over the last -- since the venue rule was changed. There was a nearly 400-percent change in Philadelphia's neighboring county of Montgomery, a 400-percent increase in claims filed, because now they couldn't drag those Montgomery County doctors into

Philadelphia. And actually, Bedford, Bucks, Crawford, Greene, Indiana, Lancaster, Lawrence, Luzerne, Montgomery, Washington, and Wayne Counties all experienced increases in the number of claims filed since the venue rule was changed.

In addition, although loopholes, what my practice tells me are loopholes in the application of the certificate of merit rules, have in recent years detracted from their effectiveness, that aspect of the Mcare Act has also certainly reduced the number of claims by weeding out the ones that a plaintiff attorney looks at and says, it's not worth the money of just getting an expert to say, yeah, there's really a case here, whereby that case, regardless of whether anyone had said it has any merit, except the plaintiff attorney, would've been filed.

The contention that plaintiffs are not being compensated as evidenced by the lack of verdicts in some other more conservative counties also ignores the fact that many more claims are being resolved through settlements than in litigation through the courts.

We heard Mr. Hoffman say that 90 percent of claims are resolved. If a county like Lancaster has had years where we have had 30-some claims filed but no cases tried, do you think that those cases just sat there and nothing happened?

According to the Mcare Fund's 2018 report, 1700 claims have been through ADR of some type or another since the venue rule, or since the Mcare Act was enacted.

The fund and its primary insurers in fund-level cases have paid out 777 million to medical malpractice plaintiffs in 2018. Somebody got that money. Some plaintiffs were compensated with that money, and that doesn't even include claims that didn't reach the primary level. So there are numerous other claims that are settled without the fund. And that number, that 777 million, is a 30-percent increase in claim payouts over the last 5 years.

While there are many arguments that affected these numbers, it's difficult to argue that plaintiffs are going uncompensated in the face of these statistics. Indeed, one prominent Philadelphia firm with excellent lawyers that I have litigated against has famously advertised recovering $400 million in one year for their clients. Now, they don't do that because they think people are going, well, is that all? They're not doing it because they feel, they're not making that claim because they feel that either they or their clients have been shortchanged by the system.

Finally, Ms. Benzie has pointed out, appropriately, that there have been verdicts popping up. My home county of Lancaster has seen a number of verdicts

of late. We are, I think, actually in line with the national average of about 20 percent of cases, medical malpractice cases, that are tried since 2004 have been plaintiff verdicts. We've had some seven-figure verdicts. And, you know, that's obviously not something that I like to advertise, but it's a fact of life. You can win cases in Lancaster County, and more importantly, you can resolve them fairly according to community norms as well.

The forum non conveniens rule has been mentioned. That is not really an option. It is just like having a case within a case, because you have to do discovery, depositions, get affidavits. It's an incredibly burdensome way to open up a case just to get it back to the venue where it should be. Medical malpractice litigation is already costly enough for all involved at many levels to add that to the burden.

It has been suggested that it's appropriate to bring cases in Philadelphia County, and I have heard this said, because the Philadelphia County juries "get it right." And obviously that's an affront to the jurors of other counties who give their time and swear or affirm, if you're in Lancaster County, to tell the truth and exercise their duties properly.

The fact that one county may be more conservative than another is not a reason to subject everyone to venue

in Philadelphia County and herd all the cases there.

Another common refrain, which we've heard already in just the past few minutes, is, why should medical malpractice cases be treated differently than any other cases? Well, I think it goes without saying that health care is a lot different than any other product.

A health-care system is not a McDonald's franchise. It's not an airline. It's not a multinational corporation like the ones that are subject to venue where they do business. Health care is provided by individuals, first of all, and even in the context of a hospital that is integrated, hospitals maintain their autonomy with separate governing boards, separate medical staffs, separate licenses.

CHAIRMAN MENSCH: Could we get to the point, please? I appreciate the narrative, but it seems to be a lot of hyperbole.

MS. KRAVITZ: Okay.

CHAIRMAN MENSCH: Can we get to the point---

MS. KRAVITZ: Okay.

CHAIRMAN MENSCH: ---so that we can move the hearing forward?

MS. KRAVITZ: Sure. Sure. Sure.

Well, I'll just, the only other point I would like to make is that there is precedent for tweaking a

general rule to accommodate an important community need.

For example, the Mental Health Procedures Act has a qualified immunity that it provides health-care providers, and if you look at the findings of fact or the statements of the Legislature, in that legislation they were opining or they were noting and they enacted that rule in part because they felt it was very important to ensure access to behavioral health care, to ensure that the patients who really needed care could get it, and I think the same really could be seen as applying in this instance.

I will close there, and I thank the Committee for their time. And I'm the only defense attorney here, but you have heard a great deal about our position from other providers today. And I apologize for any redundancies and hope that you'll take that all under due consideration. I appreciate the time.

CHAIRMAN MENSCH: Thank you.

MR. PURCHASE: Good morning.

I'm Eric Purchase. I'm from Erie, Pennsylvania, and I represent injured people in northwestern Pennsylvania.

THE CHAIRMAN: Okay.

MR. PURCHASE: I want to start with just some fundamentals that may have gotten lost in the mix.

Pennsylvania's courts, they are inherently fair, all of them. Our judges are knowledgeable. They are evenhanded. Our juries come to the courthouse with no stake in the outcome of the case that they are about to decide. And so venue as a decision far more often than not is about convenience, convenience of the parties and efficiency of the system.

But our rules, Pennsylvania rules, have always allowed for choice of venue where the cause of action arose; where the defendant resides; if a defendant is a business, where the defendant has chosen to do business, and those rules are the same in our Federal system and the vast majority of American States. They have always been thus, and why? Well, because sometimes juries do come with an interest in the outcome. We don't always know when or why that's going to happen, but we know it does.

Sometimes there are defendants of particular cases who have such an overwhelming influence in an area that jurors see themselves, correctly or not, as having an interest. For a time, it was mining, or sometimes it was railroads. It's hospitals now in small counties, hospitals who are sometimes the only health-care provider in a county, sometimes the largest employer. Sometimes they are supporting additional jobs. The American Heart Association says that each hospital job supports two additional jobs in

the community.

And people in those communities are told, as you heard today, that their health care is tenuous, that if things don't go well for the hospitals in their communities, those hospitals and those health-care providers may leave or may reduce the care that they provide. And so jurors in some of these small counties walk into that courtroom and they're not necessarily impartial. They cannot help but consider how their decision today affects the delivery of service tomorrow.

That matters, because that's not justice anymore. It's not about a particular outcome in a case; it's about evenhanded judges and impartial juries, and we don't have impartial juries. How do I know that? Well, aside from personal experience, I can tell you we have got good information from health-care providers that health-care providers are winning 80 to 90 percent of the cases that they themselves would regard as weak cases. They're winning 70 percent of the cases that they regard as a toss-up. It could go either way. And they're winning 50 percent of the cases that they regard as strong cases for the plaintiff.

It's not evenhanded. If you look across Pennsylvania, there are counties in Pennsylvania with 100 percent defense verdict rates over 18 years, bunches

more 90-plus percent, suggesting very strongly that you don't have a good chance as a plaintiff of getting justice.

We heard it from someone today who I think perhaps unintentionally said, can you get justice as a plaintiff in Pennsylvania? Yes. Are the odds as good as they are in Philly? No. It's a remarkable thing that we have got better odds of getting justice in one community than another, and it oughtn't be that way.

I'm from Erie. By the way, this notion that Philadelphia is inherently better for plaintiffs or unfairly better for plaintiffs is misguided. Defendants win 65 percent of the time there.

Now, I'm from Erie. As a practical matter, am I filing in Philadelphia? I am not filing in Philadelphia. My clients are not going to Philadelphia. We're filing in northwestern Pennsylvania where defendants win 80-plus percent of the time. We're not trying to get a particular outcome; we're trying to get a trial in front of a jury that is impartial, that doesn't already have a vested interest in the outcome.

I'm going to leave it at that.

CHAIRMAN MENSCH: Thank you very much.

I'll open it to questions from Members.

Yes; Representative Conklin.

REPRESENTATIVE CONKLIN: I'll try the speed round again.

To start with my colleagues who sit next to me on the Floor, Representatives Harkins and Merski say hello to you.

MR. PURCHASE: Good; good. Tell them I said hi.

REPRESENTATIVE CONKLIN: They're following my directions right now while I sit here.

Just very, very quickly. When you take a client, what do you consider? Is it just to sue for money, or do you actually go in-depth before you take a client on when you're looking at a malpractice suit? I mean---

MR. PURCHASE: So that's a great question, and I won't speak for everybody, but I'll say there's a couple of things.

For me at least, my decisionmaking goes in at least two parts, because first, there's the determination: Do I want to investigate this? Do I want to invest the time and resources necessary just to make a determination about whether the case can be pursued, because I usually don't know when the client walks in the door. I have got a lot of work to do to figure that out.

The next step after you've done your investigation is whether you pursue it, whether you make a claim, whether you're willing to pursue it in litigation.

And what do you consider in making those decisions? Economics are a part of it, because there is substantial expense associated with investigating and litigating. We know with certainty if there is litigation, it is likely to be defended tooth and nail to the very last moment. So no matter how good your case is, you know there's going to be a substantial investment that you have to make just to get to a potential for resolution.

But there are other noneconomic factors. There's the importance of the case to the community and to the client. I mean, we're fortunate that we are busy in my office. We don't have to take every case. We're trying to do the right thing for the people whom we serve.

REPRESENTATIVE CONKLIN: Just a quick follow-up.

We were told that basically 18 years ago you couldn't get malpractice insurance. If we go back, if this change is made, will we once again face those days to where a doctor will not be able to get malpractice insurance again?

MR. PURCHASE: Well -- yeah; go ahead, Tim.

MR. LAWN: No. Certainly there's no way we can just specify the venue rule and say that's going to affect these cases. I mean, first and foremost is the certificate of merit. There are not frivolous cases. That term gets thrown around a lot, but every medical malpractice case

filed has had an expert, board certified in the medical specialty that you are challenging the care provided by, sign off on it, review all the records and sign off on the case. So if there is multiple defendants, there are multiple experts before you can even put it in suit.

So venue rule itself is not just, is not the only thing. There's a multifactorial approach that has reduced the number of lawsuits.

And again, I touched on it a little bit, but what led up to that malpractice crisis was really severe mismanagement, frankly, to put it politely, some would suggest even more than that, on behalf of a handful of malpractice insurance carriers that threw the whole system out of whack. And all of a sudden these folks were left and these doctors were paying their hard-earned dollars for these premiums that these companies were squandering and did not have the reserves. They were investing it heavily when the market was doing well and they were living large, and they did not have the reserves set aside to fund these claims.

And unlike what was said earlier, the physicians weren't left bare when those companies got placed into solvency, the victims were, because no physician was ever held liable for any gap in coverage from a policy that went insolvent.

There is case law and law that says that the policyholder gets the benefit of that, and you cannot go after the policyholder for a gap because an insurance company went insolvent. So when that crisis hit, it was the victims of malpractice who lost even more insurance coverage, and verdicts weren't being paid, settlements weren't being paid because of that insolvency.

So proper management of the malpractice system, I think if you read the 2018 Mcare Fund report, there is more carriers than ever insuring folks in Pennsylvania, more primary carriers than ever. But the venue rule alone will not have a deleterious effect on the malpractice insurance market.

REPRESENTATIVE CONKLIN: Thank you. You're so good, you answered my question on what to prevent the frivolous lawsuits.

And just one last question, if I can?

CHAIRMAN MENSCH: Yes.

REPRESENTATIVE CONKLIN: Just quickly.

I have heard about the City of Brotherly Love today, you know, the place of the Liberty Bell, our first Congress, our first House Legislature, Ben Franklin's house, everything. What is the difference percentage-wise, the winning percentage -- do you know, because I don't know -- between the county of Philadelphia versus the rest of

the State? Is it that much higher, the winning percentage rate, than the rest of the State?

MR. LAWN: I don't believe it's that much higher. I think the last statistics from 2017 where plaintiffs prevailed in I think 70 -- I mean, the defense prevailed in 70 percent in Philadelphia County, 69, 70 percent of the verdicts in Philadelphia County. Some of the other counties, yeah. We've heard some counties have never had a plaintiff's verdict.

I don't know what to attribute that. I know when I was a defense attorney, I was about 2 years out of law school, and one of my very first trials ever was defending a physician out in one of the suburban counties, and he asked me to get this particular surgeon expert on board for the case. He trained under him, and I talked to that surgeon. He reviewed the file and said, I can't defend this; he's a good guy, but this was clear malpractice.

I went and asked the second surgeon. He said the same thing: I can't defend this. And this was the two experts this particular doctor thought of and asked me to consult.

We ended up with a third expert, because the insurance company is not going to settle out in these counties. The third expert, I'm about 3 years out of

law school, a defense verdict in about 45 minutes.

So like Mr. Purchase was saying, I don't know why it is in some other counties the jurors come in with this kind of concept that you really have the burden of proof is so much higher. It's almost like a criminal "beyond a reasonable doubt" burden, which is improper, but it's a fact. It's there.

And Philadelphia County is a fair county. It's a large county. It's a very diverse population of citizens being called for jury duty, which is not a bad thing. And I think that's why the statistics, it's not the panacea that everyone on the other side wants you to believe, but that's why I think the statistics are a little bit better for plaintiffs in Philadelphia County than some of the surrounding counties.

REPRESENTATIVE CONKLIN: Thank you.

CHAIRMAN MENSCH: Senator Phillips-Hill.

SENATOR PHILLIPS-HILL: Thank you.

I love to make data-based decisions. I dug into AOPC's data, copiously went through it. But I have someplace I need to be at noon, so hopefully I can be even more succinct than my good friend, the good gentleman from Centre County.

So, Mr. Lawn, if a plaintiff sustains an alleged injury due to medical malpractice and his or her attorney

is able to obtain a certificate of merit from an appropriate medical professional, would they be denied the ability to bring a suit?

MR. LAWN: They still may be, depending on all the other factors that you need to consider; for instance, if it's a senior citizen who is no longer working. I mean, in a lot of these -- you hear about these verdicts -- they are mostly almost uniformly driven by the economics, the cost of future medical care, these kinds of things.

But yeah, there's a lot of cases where there is clear malpractice and there's clear injury, but would it be worth it to that family or that victim and the attorney to invest the money and 5, 6 years of their time in some of these smaller counties.

SENATOR PHILLIPS-HILL: But it would not be due to venue, an issue of venue; it would be due to merits of the case.

MR. LAWN: Well, I'm saying venue would play into that. If it's a case that you knew you could get on trial in 2 ½ years in Philadelphia County---

SENATOR PHILLIPS-HILL: And why -- oh, okay. Because Philadelphia County is different than everybody else.

MR. LAWN: Well, part of their case management system. I'm not saying, it's not just hunting for jury

verdicts, but the case management system is very important.

I represented a 36-year-old woman who was left blind and cognitively impaired from medical negligence in January of 2013 in York County, a housewife with three children. I filed the suit in June of 2013. We didn't get a jury, a trial date, until August of 2018. It took over 5 years. They lost their house in the meanwhile. She was earning a little bit more than her husband, both hardworking folks.

And so there's a lot of factors. It's not just, yeah, it's a valid case; we'll file suit. There are other factors which play into it which sometimes interfere with the ability to get justice, even though you have a righteous case.

SENATOR PHILLIPS-HILL: Thank you.

Ms. Benzie, you testified that the impact of venue cannot be separated from the other changes. So my question to you, if that is the case, wouldn't that support maintaining the current system? Because, you know, I'm not an attorney, but my understanding is that the burden of demonstrating a need for change should be on the proponent of that change.

MS. BENZIE: Well, there wasn't a need when it was put in place as part of this package, and I'm saying we should go back. When you examine the rule, and we chose to

start here with venue, because that's the one that is before us, and yes, it is part of that entire package, but let's look at just venue in and of itself and the inherent unfairness in what it does to people who are hurt through no fault of their own, people who go in for medical care.

We have to look at from the time it was implemented the change in the business of medicine, and I call it that because it has changed tremendously and it has become more unfair. So the venue rule alone, if you're looking at that, it's not the equal scales of justice. They're tipped, and only one side gets to take advantage of the venue rule and the other side is told where they can file their lawsuit.

It's inherently unfair, and I don't see the harm in putting people back to equal footing. Let's start there, and then let's take a look at everything else that we talked about here today.

CHAIRMAN MENSCH: Thank you, Senator.

Thank you all for your kind attention to the issue today. These hearings always remind me or these committee meetings always remind me of Agatha Christie's book "And Then There Was One." You know, we keep losing bodies along the way. But there are so many things going on in the Capitol today. I apologize that we're in and out, and I myself had to be in and out.

In closing let me say, you know, the Legislative Budget and Finance Committee, I view it very often as a research, operations research function within the government, and because of that, we need to deal with a lot of data. We look for data. We look for quantitative information.

While we have had a great deal of emotional commentary today, we're still scratching our heads a little bit and saying, where is all the quantification? So I leave not only you four but anyone who has testified here today, we are going to be continuing to search for specifics, because we need to separate venue from the rest of the argument if we're going to render a reasonable decision in the way of a report.

So it's incumbent on all of us to try and get to a point where we can get this conclusive, quantitative information. What you have offered, there's no argument with it. I mean, it's -- but it's more anecdotal. It's your personal experiences, and we need to convert that into something that we can go to the Legislature and say, here is something that we believe has merit so far as a piece of legislation. We don't make the legislation. It would be incumbent upon Senator Baker to first take that lead.

So I hope you take my point. Did you have a comment? Were you trying to raise your hand?

MS. KRAVITZ: No. Sorry.

CHAIRMAN MENSCH: Okay. I'm also a Caucus Chairman, so I'm always looking for these subtle moves, you know. It's kind of like an auctioneer looking for the bids.

All right. Well, thank you. That concludes the first half of our hearing on venue. We will continue again in this room tomorrow at 9 o'clock with two more panels. So thank you very much, everyone.

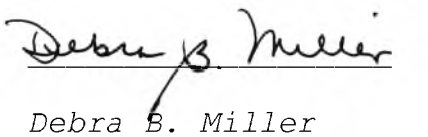
MR. LAWN: Thank you, Senator.

MS. BENZIE: Thank you.

MS. KRAVITZ: Thank you.

(At 11:52 a.m., the public hearing adjourned.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.



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