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

WEDNESDAY, JUNE 26, 2019
9:04 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 MICHELE BROOKS
HONORABLE H. SCOTT CONKLIN
HONORABLE CRIS DUSH
HONORABLE KRISTIN PHILLIPS-HILL

COMMITTEE STAFF PRESENT:
PATRICIA BERGER
EXECUTIVE DIRECTOR

* * * * *

Debra B. Miller
dbmreporting@msn.com

I N D E X

TESTIFIERS

* * *

SUBMITTED WRITTEN TESTIMONY

* * *

See submitted written testimony and handouts online under "Show:" at:

https://eur04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.legis.state.pa.us%2Fcfdocs%2FLegis%2FTR%2FPublic%2Ftr_finder_public_action.cfm%3Ftr_doc_typ%3DT%26billBody%3D%26billTyp%3D%26billNbr%3D%26hearing_month%3D%26hearing_day%3D%26hearing_year%3D%26NewCommittee%3DLegislative%2BBudget%2B%2526%2BFinance%26subcommittee%3D%26subject%3D%26bill%3D%26new_title%3D%26new_salutation%3D%26new_first_name%3D%26new_middle_name%3D%26new_last_name%3D%26new_suffix%3D%26hearing_loc&data=02%7C01%7C%7C0d0e333067014f15efa208d6fe49558f%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1%7C0%7C636975988255196696&sdata=jwscXRTuVh9GsYuceAvk4L2yVkMa2fCAxKX0%2F2oTFcU%3D&reserved=0

P R O C E E D I N G S

* * *

CHAIRMAN MENSCH: All right. The appointed hour being here, let us call to order today's meeting of the Legislative Budget and Finance Committee.

Good morning, and today we're here to have our second day of hearings to accept testimony as requested by Senate Resolution 2019-20, and that resolution concerns the impact of venue for medical professional liability actions on access to medical care and maintenance of the health-care system in the Commonwealth.

Ms. Berger, please call the roll.

(Roll call was taken.)

CHAIRMAN MENSCH: All right. Thank you. We will begin.

This is an even more unusual day than yesterday, with schedules changing as early as this morning. So please, we beg your indulgence, all of you. We will probably have some people coming in and out, and that's just to be expected on a day like today.

I want to thank all the stakeholders who are here and are taking their time to present testimony to us today. Yesterday, we did have an interesting session, and as I

stated in the opening remarks, having this type of hearing is unusual for the LBFC, or Legislative Budget and Finance Committee. However, the rest of our work under Senate Resolution 20 will follow the approach our staff has always taken in conducting its work.

Let me expand on that for a little bit.

I view the Legislative Budget and Finance Committee as somewhat of an operations research function to the Legislature. As a consequence, the staff particularly will be dealing with data. We need solid information. Anecdotal information is good, it's important to each of you and all of us, but when we do our final report, and particularly when we try to extract the notion of venue from the other issues, we will be looking for quantitated analysis.

So to the extent that testifiers today can help us -- and we mentioned this yesterday -- to the extent that you can help us quantify that data, we would greatly appreciate it. So thank you.

And with that, I'll turn the microphone to Senator Brewster for any opening comments.

VICE CHAIRMAN BREWSTER: Thank you, Mr. Chairman.

In the interests of time, I'll defer my comments other than to say that yesterday's session went very well. It was very informative, and hopefully we have the same in

the next hour and a half.

Thank you.

CHAIRMAN MENSCH: Thank you.

I would like to recognize the attendance of Senator Phillips-Hill. Good morning. Welcome.

SENATOR PHILLIPS-HILL: Thank you.

CHAIRMAN MENSCH: So like yesterday, each panel is going to have 30 minutes to present, and then our Members will have 30 minutes after each panel's presentation to ask questions.

PANEL I:

INSURANCE

CHAIRMAN MENSCH: So with that, let's begin. I believe our first testifier today is the Insurance Federation. Sam Marshall is going to be presenting.

So, Mr. Marshall, when you're ready.

VICE CHAIRMAN BREWSTER: You need to swear him in.

CHAIRMAN MENSCH: Oh, that's right. We need to swear you in.

Sam, if you would rise. Raise your right hand:

Do you swear that all the information that you provide today will be the truth and nothing but the truth?

MR. MARSHALL: Yes.

CHAIRMAN MENSCH: Thank you.

Please begin when you're ready.

MR. MARSHALL: Sam Marshall with the Insurance Federation.

I appreciate the admonition that we focus on data and we get away from the rhetoric and perceptions and to try to stick with the facts. Frankly, that's the way, that's the function that insurers have to do as well. You know, we have to price and make available coverage and make decisions based on data, not on conjecture or hype. So we find ourselves in the same spot you are in.

We'll turn to the impact of the 2003 venue changes.

From our perspective, it is producing an accessible, fair, predictable, and stable liability system. That's the goal of any liability system, whether one is a plaintiff or a defendant. You want that system, the liability system, to be accessible, fair, predictable, and stable.

It's the same goal we have as insurers. Insurance only works when we're covering risk and paying claims within that type of liability system. That type of liability system attracts and retains the best of our industry. It fosters responsible competition, it fosters

lower rates, it fosters more innovative products and marketing, and it fosters better regulation, all of which address the concerns or the primary objective that you have, which is better coverage for our policyholders and our claimants.

That's not hype or theory. You've seen it. Frankly, you've seen it in the medical malpractice reforms of 2002-2003, including the venue changes that are being considered here.

You've also seen it in the auto reforms of 1990 and the workers' compensation reforms of 1993 and '95. They brought similar predictability and stability to their liability systems, and insurers have responded with long-standing availability and affordability of coverage.

Now, you have also seen what happens when you have an unpredictable and unstable liability system. Insurers tend to pull back, rates go up, fiscal stability goes down, because the instability of the liability system encourages more claims and less predictability in settlements and verdicts.

The 2003 venue changes established a more predictable and stable system in which to resolve medical malpractice claims -- nothing more, nothing less. They didn't limit access to the courts. They didn't impose new requirements for the filing of medical malpractice claims.

They simply put restrictions on what was a statutorily recognized problem of venue filing.

Turning to the results of the current venue rules, you heard yesterday a fair amount on the overall, you know, the impact of the overall reforms. Malpractice filings quickly came down, and they have since flattened out for the past decade. The same is true with the verdicts. Insurance rates followed the same trend, and new competitors have entered the market.

In addition, the number of providers in Pennsylvania, at least as measured by Mcare's annual assessment, you know, numbers, that has gone up after being flat and a little bit decreasing in the early days.

Segregating out, and I think you heard this yesterday, segregating out the impact of the venue reforms from the other reforms that were in the package, that's a challenge. To that end, we went, and along with a number of other parties, we hired Milliman -- that's a nationally recognized actuarial firm -- to do just that, to consider the impact of the venue changes and their possible rescission, with the specific purpose of distinguishing the venue reform from the other reforms in the bill.

I have attached a copy of that report to our testimony here. We had submitted it to the Supreme Court, the Civil Rules Procedural Committee, and I appreciate

that, you know, LBFC staff has had the chance to meet and talk with the Milliman team as well, independent of, you know, my own involvement or any of the others.

I think the report is instructive, and you heard a bit of it from the Hospital Association yesterday. It projects, and we'll just go with the numbers:

- It projects that the statewide impact of rescinding the venue reform will increase malpractice costs by as much as 15 percent for physicians.
- It projects that local and county impacts, there will be an increase in those malpractice costs that range from, you know, as low as 5 percent to as much as 45 percent in the counties surrounding Philadelphia.
- And it projects that high-risk specialties could see an additional increase in their malpractice costs of about 17 percent.

The report did emphasize that it was conservative because it hadn't really been able to take in the consolidation, that I think was also referenced yesterday, that you've seen in a number of hospital systems.

Going beyond just the cost savings produced by the 2003 venue changes, we note some other transformations in Pennsylvania's medical malpractice market. They're not solely attributable to the venue changes, but that reform has played a large part.

First, it's a far more vibrant market now than it was 15 years ago. There are more and there are better insurers. The Insurance Department would be best equipped to handle that with numbers.

I don't mean to go to anecdotes, appreciating Senator Mensch's concern, but, you know, beyond those numbers that the Department can have, I can tell you, I mean, providers are never shy about complaining about insurers, nor the trial bar. One thing you haven't seen in the past few years is any complaint that there's not enough insurance out there or that the quality of the insurers who are out there is somehow deficient.

You heard yesterday from the trial bar complaining about the quality of insurers back in 2000, but you don't hear that now. Again, that goes to the quality of the reforms that bring in the better insurers.

I think that improvement is across the State, and it falls to the benefit of all providers -- high risk, low risk, you know, rural, suburban, urban, on down the line. That has the added benefit of making coverage and making

service available for all Pennsylvanians in all regions. Yes, we have regional problems in terms of the availability of health care in certain types of providers, but it's no longer because of medical malpractice costs.

There has also been an improvement in the voluntary market. You can see that in the numbers of the Joint Underwriting Authority, which is a residual market for medical malpractice. That population has gone way down as providers are able to get better coverage, more coverage, from the voluntary market.

And, you know, there was also some talk yesterday about the capacity of the market. I would note that we had zealously, unsuccessfully but zealously, said here there is market capacity to take over what is called the Mcare layer, the second $500,000. We said there is capacity. Interestingly, that has always been opposed, and, you know, we have always lost in the Commissioner's decisions, but it has always been opposed primarily by the trial bar.

Now, we do recognize that the savings alone in medical malpractice should not be the sole determinant of whether these, the venue reforms, have produced a better liability system or a worse liability system. Predictability and stability are, you know, the mother's milk of the insurance industry, but we realize it's a broader concern, and that goes to accessibility and

fairness of the current liability system.

First, I'll talk about the accessibility of the courts.

These rules have taken effect, you know, over 15 years ago and you have a decade-plus of consistent numbers. And one thing there hasn't been is the complaint that somehow these venue rules have denied plantiffs access to the judicial system or imposed undue burdens on them.

The trial bar is an able advocate for its clients. That hasn't been the complaint that it has raised. You know, there's no denial of access to the courts. You know, there's not some undue burden, traveling costs, you know, deposition costs, things of that nature.

You know, if there was a complaint that somehow the current venue rules were making it too difficult to bring experts in, you know, for the plaintiff to come into court, that would be one thing, but that hasn't been the complaint.

You go next to the issue of fairness, and we recognize, and I think we heard it yesterday from panels on both sides, there are regional variations in the likelihood and in the amounts of verdicts and awards in our judicial system. Frankly, that's what led to the problem of venue shopping in the first place.

If you really want to do away with regional variations, then take the regional aspect out of medical malpractice claims entirely. You'd establish a statewide medical malpractice court. And I don't say that just to be a fly in the ointment. We have recommended that, and as a matter of fact, there have been bills in past sessions that have done just that. I think it's a worthy consideration.

But absent a statewide malpractice court, you're going to have regional variations. So the issue is whether they somehow are unfair, that they have come in, you know, if they unfairly come into play because of the 2003 venue changes. I don't see that.

You know, you heard yesterday the complaint, well, in a rural area, you know, somehow the hospital being the major employer, that that produces undue pressure on juries. Frankly, hospitals are major employers in Philadelphia. It doesn't produce undue pressure there.

You know, I think it's also the case, so much of the venue shopping is on a suburban to urban area, not a rural to urban area. And, you know, I come from Montgomery County. A lot of the venue shopping is Montgomery County into Philadelphia County, or Bucks County into Philadelphia County. You know, we in Montgomery County aren't somehow intimidated because hospitals are our sole employer.

So I don't -- you know, I think the one thing you need to be weary of, let's all go back and recognize one thing. In 2003, it was all three branches of government, the Executive branch, the judicial branch, and the legislative branch, that said venue shopping is a problem. They said, I mean, in a word, it was unfair. It instituted those reforms.

Now, I'll grant you that laws are, you know, they're meant to be stable but not stationary, and they can and should change to address problems as you encounter them. That's not what's being proposed here. What's being proposed here is just going back to the old system, the system that all three branches of government, Republican, Democrat, I mean, it was bipartisan and, you know, bicameral and by all branches of government you could possibly find. Everybody said, no, you know what? That system is flawed. That's a wrong system.

I do realize it's tempting that when a reform has worked -- and I think the venue changes combined with the other reforms have worked. It's sort of tempting to say, hey, you know, reform works so now we can get rid of it. I guess, you know, there's sort of a mindset, well, isn't it like training wheels on a child's bike? You know, can't we take it off and the bike will be able to move forward? That's not the case. I mean, rescinding them is just going

to bring back the exact problem that they were meant to solve in the first place, you know, that of venue shopping.

Somebody wanted to recommend a further evolution. All ears. I'm happy to consider it. I haven't heard that. I mean, frankly, I think that's what a statewide malpractice court would be.

But, you know, it's also tempting, and you heard a bit of it yesterday saying, well, you know, if there are enough other reforms, isn't that enough of the savings, you know, the whole private, you know. We're a little bit darned if we do, darned if we don't. Can you, you know, can you take one component out and measure it? Mmm, you know, it's a hard thing to do. We tried to do that. I think we have done a very good job through the Milliman report on that. I haven't heard it discounted by anybody, and it has been out there for, you know, 3, 4 months.

But the reforms do all in the end stand together, and I would be very cautious about saying, ah, you know, what the heck, we'll still keep 95 percent of it if we take out these. I think, first, I think the venue reforms were a bigger part of it, but I also think things tend to unravel the minute you pull one thread.

We do appreciate that the Committee is data driven. To that extent, we not only prepared a report, and an extensive one from Milliman, but we're happy, I know

they have been in to talk with staff. You know, I would be pleased to have staff and the Members of the Committee talk to them as well.

In terms of other data sources that we would recommend, I think the Insurance Department is a good source. And at this point, I think they were supposed to be co, you know, somehow sitting up here with me, or the Mcare was. But I think they should play a role in this in terms of their data, and certainly they can talk about rate filings and how they review them.

I also think that the Annual Rate Surveys of the Medical Liability Monitor, that I understand go back 28 years, would be a good source.

There is also a National Practitioners Data Base that can give some information on settlements and verdicts, and I know the Committee, I know your staff is looking into that as well. And certainly to the extent that you need our help in terms of access to that type of information, we'd be happy to do it.

You know, I would like to touch on a few points yesterday, that were raised yesterday.

You know, there was a general concern that somehow uniformity is the Holy Grail and that you need, all venue rules should be uniform. You know, that's not the way it is in Pennsylvania.

We have venue rules, I mean, across the board, you know, not just medical malpractice and civil litigation, but venue rules generally that vary a great deal. You know, it isn't, you know, venue isn't and shouldn't be a one-size-fits-all scenario. In any event, if you did want to make uniformity the overriding objective, why not consider taking these medical malpractice venue rules and apply it to all civil litigation and hear that come up?

I would also note, you know, that there was so much talk yesterday that somehow the current venue rules have been unfair to rural Pennsylvanians, you know, because somehow those juries are, you know, they're unable to be impartial.

I do want, you know, I did think it was interesting that one of the trial bar members who talked about that was from Erie, and he said here that he's not going to go to Philadelphia, and that's true. You know, I would, and I think the Supreme Court data, you know, reflects it, the venue shopping and the change in venue that occurred isn't so much Mifflin County to Philadelphia County. It's Montgomery County to Philadelphia County. It's Chester County to Philadelphia County. It's Bucks County to Philadelphia County. That's where you have seen in the venue reforms, and you can see it very clearly in

the Montgomery County versus Philadelphia County reforms, you know, the claims filed there.

When you did the venue, actually, claims in Montgomery County went way up. Claims in Philadelphia County went down. That was the venue shopping that was being addressed. So I think to try to couch this in a rural versus, you know, urban concern leaves out where a lot of the venue shopping is, which is suburban to the urban end.

There was also the assertion that somehow these venue changes have lowered the accountability of doctors in hospitals. I have had my tussles with the provider community over the years, and they don't need, you know, they don't need the Insurance Federation to defend them. But particularly I think that that's, I think that's an insult to rural and suburban doctors to somehow suggest that these venue rules have allowed them to short shrift their patients in terms of the quality of care or somehow it has led them to be less committed to quality care.

I do think that you can see from the data from the Patient Safety Authority that there is just nothing to suggest that the venue rules have somehow lowered accountability in the rural and suburban areas. I just don't think there's any, you know, I don't think there's any correlation. Coincidentally, there is just no

connection between the venue rules and the quality of care that has been happening in those areas.

There was also, I thought, a lot of deflection. You know, I understand that there's a bigger problem in the world of health insurance and health care. That doesn't mean that forum shopping and venue shopping isn't and wasn't a problem that was correctly addressed and that has been fairly addressed.

You know, there is also, and I understand it goes with the territory, whenever somebody is talking about something like venue changes, sooner or later you're going to hear yelling, you know what? Insurers are making money. I get it. I don't know that that means the venue changes are good or bad or somewhere in between. I would note that, you know, you want -- I mean, the only thing worse than an insurance company that makes money is an insurance company that goes bust. So, you know, frankly, it doesn't work for anybody if we're not solvent.

You know, there was also, you know, there was some talk, well, gee, isn't all this, you know, wasn't the real problem not so much a bad liability system but insurers were bad underwriters? I will say it's very difficult to be a good underwriter when your liability system is unpredictable and unstable.

There was talk, well, didn't insurance companies

just, you know, make bad investments, bet it all on the hard eight. I would caution you to be very weary on that. We, our finances, are very heavily regulated. We're very conservatively regulated. I mean, we don't get to put money into speculative ventures.

That doesn't mean that insolvencies don't occur. They tend to occur when the liability system is bad, not because the market goes up or down. It's just the nature of where we put our money, you know, of where by law we are required and limited to put our money out there.

So I do think, I do think that when you look at the liability system by all the objective data on what the costs have been, what the access to insurance has been, what the access to the judicial system has been, and the fairness in it, I do think that the 2003 venue changes have improved the liability system. We have tried to quantify those savings, and I'm happy to, you know, take on any questions or objections to that.

I would say that if you step back to the venue rules that were in place before then, that's what you've done, you have stepped backwards. I don't think that that is, I don't think that's what you want to do. If you want to improve the venue rules, I'm all in. That's our point about a statewide malpractice court. But I think if you step back, I don't see how that's a service to the

liability system itself and to the, not just the providers, not just insurance companies, but frankly to the consumers and the plaintiffs and the claimants, you know, who are served by it.

Thank you.

CHAIRMAN MENSCH: Thank you, Mr. Marshall.

Members, questions or comments?

Representative Dush.

REPRESENTATIVE DUSH: Thank you, Chairman, and thank you, Sam.

A couple of things that I want to touch on.

First of all, I'm glad you mentioned about the rural areas, and one of the things that was mentioned here the other day was a $20 million award in Clearfield County where we have more deer than people, and it was one of our larger employers.

But could you go back to doing the actuarials? When you have that unstable environment like we had back in 2000, can you address a little bit of how that impacted trying to do accurate actuarials on where the insurance companies had to be in order to provide the coverage.

MR. MARSHALL: Yeah.

You know, first, I mean, frankly, the best insurance companies just avoid an unstable market. It's not where they go. You know, if it's an unstable liability

system, that doesn't attract good insurance companies. It's just that, you know, particularly when you're dealing with what are in the world of insurance generally long-tail coverage, which is what medical malpractice tends to be. You know, when you -- but it also, frankly, it turns good companies, it makes good companies lesser. And, you know, that is true in any liability system for any form of coverage that you have, and it's true just generally.

If the underlying system in which you have to deal is unpredictable, the best actuaries in the world are going to be hard-pressed, and they're going to make mistakes, and they're going to make -- you know, and that's exactly what you saw. You saw a number of companies go insolvent, and go insolvent because they were making bad investments. They went insolvent because they were trying to project the costs of what was at the time an inherently unpredictable system.

I mean, what the 2003 overall rules did, you know, there were some on the judicial side like the venue change and the certificate of merit. There were other reforms in terms of reducing the amount of coverage and, you know, payment of present value and things of that nature. There were some that just took costs out of the system. But the reforms that brought predictability and stability into the underlying liability system were the

venue rules and the certificate of merit. And that is what has, when you have that, that enables actuaries to make accurate projections, and that is what you have seen in the 15 years since.

REPRESENTATIVE DUSH: And that's the reason I led with this, because this comes to the follow-up, which is, the industry is now looking at taking on that extra $500,000 of insurance. Is that because of the stability that the venue and the other---

MR. MARSHALL: Yes. That's when -- I mean, frankly, our appetite for risk gets greater when you have a predictable and stable system. It gets less when you have an unpredictable and unstable system.

REPRESENTATIVE DUSH: Thank you.

CHAIRMAN MENSCH: Senator Brewster.

VICE CHAIRMAN BREWSTER: Thank you, Mr. Chairman.

Thank you, Sam.

Yesterday we heard that some of these claims were responsible for doctors moving out of State and, in some cases, going out of business. Is that your observation since 2002?

MR. MARSHALL: Um, fortunately or unfortunately, I'm old enough to remember back then.

VICE CHAIRMAN BREWSTER: I don't want to age you, but is that the same -- would you have the same opinion

prior to 2002?

MR. MARSHALL: You know what? Prior to 2002, yes, there were providers. I mean, it's not my opinion; it's what you can see in the numbers from the Mcare annual assessments. You had providers, I mean, the numbers of providers in Pennsylvania were lower than they are now.

Now, is that attributable just to the venue reforms? No. Is that even attributable to the overall medical malpractice reforms exclusively? No. But you did see -- and the provider community I thought provided, you know, the best evidence of it -- you did see a problem.

And where you also saw it, I mean, you know, I understand the problem with people leaving the State, but you also saw it in terms of people wanting to leave certain areas of the State. You know, they didn't want to practice in one area versus another because they get, invariably they get dragged in to, you know, they would be more prone to being a victim of venue shopping than not.

And in southeastern Pennsylvania where I'm from, that was a problem. I can't say that that was necessarily as driving a concern out in your part of the State, Senator, but certainly that was a concern in southeastern Pennsylvania.

VICE CHAIRMAN BREWSTER: Well, what I'm having trouble, and I'm not supporting venue shopping and things

of that nature. I'm having a hard time translating the testimony from yesterday and so far today. My issue is, we should see costs going down, and we're not seeing that.

So if there are fewer claims and some of these exaggerated claims, which are clearly out of line -- we see them weekly on the nightly news -- it would seem to me that if what you said and what folks said yesterday was occurring, that this is a better system and that cases are being settled out of court, insurance rates are not being raised, doctors are not fleeing the area, and I can't speak for regional differences, because I know there are some, I'm not seeing the reduction to the consumer. I'm not seeing the reduction to the employers. I'm still seeing 25 percent of a person's salary going towards their health care. And it would seem to me that if things were working so good, that that rate should be going down with the predictability that you have mentioned.

So I just---

MR. MARSHALL: Okay.

VICE CHAIRMAN BREWSTER: I'm not grasping---

MR. MARSHALL: No, no. I appreciate, and, you know, I mean, it is the never-ending challenge that all of you have when the overriding, you know, the overall problem of the health-care system is far bigger than just medical malpractice.

VICE CHAIRMAN BREWSTER: Right.

MR. MARSHALL: We're here today, I mean, and sometimes to solve it you have to keep your focus on the broader problem, but sometimes you have to solve elements of it one step at a time.

In terms of medical malpractice rates, those actually have gone down, and it's not just because that -- now, to some extent, okay, it went down because people had, you know, providers had to have 1.2 million before and then it went down to 1 million, so that's some reduction. But they also have gone down because of the other reforms, and, you know, we've been talking in the judicial context. That's, you know, the venue reforms and the certificate of merit. So that part has.

Now, has been translated into lower overall costs in health insurance rates? No. But that's a factor, frankly, not just of medical malpractice, you know, rates. You know, your reasoning, and I don't want to take up the time going into the whole realm of health insurance, but there are a lot of other factors that go into that -- utilization patterns, you know, things of that nature.

I would say that one of the things that has helped because of medical malpractice reforms is putting, you know, maybe not an absolute curve, but slowing down what we would call in our business defensive medicine,

where tests and procedures would be ordered, not so much because it was for the patient's betterment but to, you know, practice defensive medicine and insulate yourself from a liability suit.

But I would -- look, I mean, you can change or you can take a step back in medical malpractice and go back to the old rules and invite venue shopping, and you'll see an increase in the medical malpractice costs, or you can, you know, don't do it and you won't. And I'm not going to say, gee, the impact on overall health insurance rates is going to be X, Y, or Z. You know, those overall health insurance rates are determined by far more than the med mal costs.

VICE CHAIRMAN BREWSTER: Well, I'll just close by saying, and this is not a reflection on you, Sam, but in my experience as mayor, we had a deductible of $10,000. So every case I had, we settled for something below the deductible, and what happened invariably is my deductible would go up.

So I never got an advantage by settling out of court. And I think there's a parallel between a municipal government and medical malpractice in a lot of ways. And in every case we settled, we did nothing wrong, and I'm wondering how that plays in the medical field.

You know, I'm just wrestling with the numbers we

saw yesterday. The first panel that spoke talked about how claims were going down, whether they would be nuisance claims or something more serious. So logically thinking that if claims are going down, there's less time in the court system, less need for an attorney, and then 80 percent of those claims are being settled out of court.

So, you know, it seems like the process is working now and was working before 2002. So I'm not sure I understand why numbers aren't going down.

I'll just shut up on that issue.

MR. MARSHALL: Okay. But on that, Senator---

VICE CHAIRMAN BREWSTER: I think I mentioned yesterday -- you were in the audience -- I said, I don't see any insurance companies going out of business, and I don't know any doctors that went bankrupt.

MR. MARSHALL: But on that, on that, Senator, prior to the venue reforms, you did see insurers go out of business. And as a matter of fact, that was a cost that was then imposed on the rest of our industry, because when an insurance company goes under, the rest of the insurance industry has to pick up the tab. So prior to then, you did see companies going under.

And as I mentioned, you know, from a plaintiff's perspective, from a policyholder's perspective, it's really bad when your company goes under. It leaves you with a

void. It's costly. Yes, we have a guaranty association, but it's never as simple, it's never as easy, it's never as convenient as if the insurance company had been there.

So, I mean, that's one of the reasons why we urge you not to take that step back in time, because we saw what the market happened when it was unstable and unpredictable.

And your broader question of the full savings of this. You know, they are realized by our policyholders, yes. I mean, that's why malpractice rates have gone down or stabilized or been flat over the last, you know, however many years.

You know, how does it directly translate into the overall cost of health care? I think it plays a beneficial role. But in terms of the overall costs of health care and health insurance, there are so many other factors that we would need far more than this morning is going to allow. But I'm happy to have that discussion. As you know, I'm not shy about that.

CHAIRMAN MENSCH: Senator Phillips-Hill.

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

Mr. Marshall, thank you for being here today.

I think there has been some confusion between consumer health insurance and professional liability insurance that is carried by physicians.

And clearly, you know, as you articulated, there's a lower risk -- well, when there's a lower risk of frivolous malpractice suits, that will lower the rates of medical liability for insurance for those medical professionals, and that will help improve accessibility and availability of health-care professionals all across the State, I would think. I mean, is that what you were trying to succinctly share with us?

MR. MARSHALL: That's what I was trying to say.

SENATOR PHILLIPS-HILL: Okay.

MR. MARSHALL: Instead, you stated it far better.

SENATOR PHILLIPS-HILL: Okay.

MR. MARSHALL: I appreciate that.

SENATOR PHILLIPS-HILL: Because it is, we're dealing with a very complex issue, and there's a lot of things that come into play here. So if we could, can we take it back to just the insurance premiums for that medical liability insurance. Right?

So yesterday we were here. The plaintiffs' bar in their testimony, they did not claim undue burden and excessive costs as a basis for reverting back to that original venue rule. So can you talk about the impacts of costs on defending a case and what that impact is to insurers when they make decisions on the premiums that they

charge those medical professionals.

MR. MARSHALL: Okay. But first, our rates are regulated. I mean, we make decisions, but we don't make them unilaterally. You know, they are reviewed by the Insurance Department. So, you know, this is not -- I mean, we have a pen, we don't have the pen in terms of setting them.

And then they're also determined by the marketplace. You know, if Company A is offering uncompetitive rates, Company A is not going to get the business.

But when you have a liability system, you know, that has -- and we acknowledge that there are regional variations in the settlement practices and the verdicts, you know, that happen. You know, that's a reality. You're not going to take that out of the system unless you do something like a statewide malpractice court.

When you have that, if you are pricing the premiums, the challenge is, how do you regulate -- you have to take into account those regional variations. Where you face the challenge is being unable to accurately project where a certain amount of cases are going to be brought, which region. And when you have venue rules that determine where a case is going to be brought, not on where the malpractice occurred, which is what the current rule is,

but more on the randomness or irrelevance or serendipity of other unrelated events, which is what the old rules allowed, that makes it challenging to set accurate premiums, and what you find in that is exactly what you found before. You found great fluctuations in premiums on an annual basis.

I mean, you know, the evidence, it's not just lower premiums, it's stable premiums over a period of time. It doesn't do any provider, it doesn't do any business any good if the rates go way up one year and then down the next year. I mean, a yo-yo effect of insurance premiums is a bad thing for the policyholder as well as for the insurance company and the premium people.

SENATOR PHILLIPS-HILL: So essentially this venue decision stabilized insurance market rates for professionals.

MR. MARSHALL: Yes.

SENATOR PHILLIPS-HILL: Medical professionals.

MR. MARSHALL: And, you know, it did that because it stabilized, it stabilized where claims can be brought and it made it something that somebody could accurately predict.

You're still going to have the regional variations, but you took the unpredictability out of where the claims were going to come.

SENATOR PHILLIPS-HILL: Okay. Thank you very much.

Thank you, Mr. Chairman.

CHAIRMAN MENSCH: Thank you.

Sam, maybe we can put a little more context to this if you could, going forward, provide us with some information, things like members' payouts and settlements in cases. Would that be possible, and, you know, how far back could we go? Can we go to 2000 or go back further than that?

I realize they would all be constant dollar data, but, you know, could we begin to develop some understanding of what happened pre- and post- the venue change?

MR. MARSHALL: I think certainly the Milliman team that we retained tries to do that in its report, and I think that's a start. But I'm also thinking, you know, I hear, well, you know, okay, you paid for them. Okay. I mean, look at -- that doesn't discredit them.

CHAIRMAN MENSCH: That's already been done, right?

MR. MARSHALL: I mean, that doesn't mean that it's wrong. You know, so if somebody wants to get up and say, here, I want to do my own actuarial analysis, you know, I'm more than happy to see that done.

But I do think, and I'm not an expert on it, but

I'm happy to dig in and make it available to your team. But I think the National Practitioners Data Base, you know, I think that might have to be changed for privacy reasons so that it becomes aggregate data rather than individual provider data, which is how it's used now. So there's some privacy concerns in how it's allowed to be used.

I do think the Medical Liability Monitor and its Annual Rate Surveys may shed some light on what you're talking about, and I think that's there.

But I also think the Insurance Department filings, you know, they go into some of that, our rate filings over an extended period of time.

CHAIRMAN MENSCH: How about, would we go to the same sources to find out members' premiums for malpractice information as well?

MR. MARSHALL: When you say "members," you mean---

CHAIRMAN MENSCH: Your members, insurance.

MR. MARSHALL: Oh, okay.

CHAIRMAN MENSCH: Subscribers to insurance services for malpractice.

MR. MARSHALL: Yeah; yeah. I mean, you know, the annual rates are our rates, and they do it for, you know, a number of companies, and, you know, they have been doing it for 28 years. And some of it, at least now, I don't know

that it's the case historically, how far back, but it's done, you know, on a county basis as well, and with specialties.

CHAIRMAN MENSCH: All right. Very good.

You know, I'm asking you because you're the nexus of insurance rates.

MR. MARSHALL: Mm-hmm.

CHAIRMAN MENSCH: You as the testifying panel. But if there's anyone else listening who would have that information as well, we welcome it from any source.

MR. MARSHALL: Sure.

CHAIRMAN MENSCH: Okay.

Thank you.

Representative Conklin, anything? No?

REPRESENTATIVE CONKLIN: I'm just here. I'm just enjoying listening.

CHAIRMAN MENSCH: Well, Sam, thank you very much.

MR. MARSHALL: Thank you.

CHAIRMAN MENSCH: Enlightening testimony. Thank you.

PANEL II:

MEDICAL COLLEGES

CHAIRMAN MENSCH: And we will begin our last

panel with the medical colleges: the University of Pennsylvania; the Lake Erie College of Medicine; the Penn State College of Medicine as well.

Gentlemen, thank you for joining us today. If you could, please rise.

I'm going to ask you to swear in. Raise your right hand:

Do you swear or affirm that the information you will provide today will be the truth?

(Testifiers responded "I do.")

CHAIRMAN MENSCH: All right. Thank you. Please have a seat.

Why don't we begin to my left, your right, and introduce yourselves.

DR. BRENNAN: I'm Dr. Patrick J. Brennan from the University of Pennsylvania.

CHAIRMAN MENSCH: Okay.

DR. BLACK: I'm Kevin Black. I'm currently Chair of Orthopedics at Penn State, Vice Dean of our University Park Regional Medical Campus, and on July 1 of this week, I'll become Interim Dean of the college.

CHAIRMAN MENSCH: Very good.

MR. VISNOSKY: Hi. I'm Michael Visnosky. I am

Chairman of the Board Emeritus of the Lake Erie College of Osteopathic Medicine.

CHAIRMAN MENSCH: Okay.

So we have two microphones and the three of you. We'll see whether you like each other and you can share the few mics.

We would ask that when you testify, make sure the microphone is on, and you do that by pushing the button and seeing the green light.

So in whatever order you have decided, please feel free to begin your testimony. And again, I want to stress, we're looking for data. We are looking to understand quantitatively the set of issues. So it's up to you gentlemen who would like to begin.

DR. BLACK: I'm happy to start.

CHAIRMAN MENSCH: Okay. Go ahead.

DR. BLACK: So good morning, Chairman Mensch, Vice Chairman Brewster, and Members of the legislative committee, the Legislative Budget and Finance Committee. Thank you for the opportunity to appear before you.

I also want to thank Senator Lisa Baker for introducing the resolution that allowed these hearings to occur.

I have been a faculty member and physician at Hershey Medical Center and the Penn State College of

Medicine for 26 years, during which time I have practiced orthopaedic surgery. I continue to practice. I have taught medical students. I have taught orthopaedic surgery residents and served as a residency program director.

For the past 16 years, I have served as the Chairman of the Department of Orthopaedics and Rehabilitation and for the past 6 years as Vice Dean of our University Park Regional Medical Campus. And next week, I will assume responsibilities as Interim Dean.

Having practiced in Pennsylvania since 1993 and having those types of experiences, I have lived through firsthand the impact of how a malpractice crisis impacts not only the care of our patients but the educational experience of our medical students and residents.

There is abundant peer review literature, some of which I will share with you now, and I would be happy to share additional literature with you and follow-up, which is very supportive of what I have already experienced.

I would like to address this from two different but very much related domains. One question is, will we be able to attract and retain teaching physicians to our medical schools?

In 2003, one year after the Mcare Act went into effect and in response to Pennsylvania's malpractice crisis, researchers from the Harvard School of Public

Health and Columbia Law School surveyed physician specialists from this State to obtain further information regarding the impact of malpractice on their plans to change practices, to retire early, and their perceptions related to access to those patients that they were caring for.

Strong majorities reported increased waiting times and driving distances for patients. Eleven percent of those surveyed said they would definitely move their practice out of State in the next 2 years or retire in the next 2 years, and another 29 percent said that they were very or somewhat likely to move their practice out of State. That was just 1 year after the Mcare Act went into effect.

In addition, 42 percent of specialists have reduced or eliminated high-risk aspects of their practice. It begs the question, why would we want anyone to run the risk of this happening, when in 2016 and more recently in 2019, the Association of American Medical Colleges, in which every combination of scenarios was modeled, reports a physician shortage of 50,000 to 100,000 physicians or more.

Parallel to this was the enormous challenge that I was experiencing in trying to recruit physicians to this State in the era of the malpractice crisis. Every physician that I was trying to bring into my department

would ask the question, and I'm referring to the early 2000s, what about malpractice in this State? But that really is only the tip of the iceberg.

I do not have data to show you, but I could tell you that I spent hours upon hours reviewing data sources from the American Academy of Orthopaedic Surgeons looking at physicians that were seeking employment. And as part of their demographic, they would describe States that they were interested in working in, and it was tremendously concerning to me to see New Jersey, Delaware, Maryland, New York, and then to see Pennsylvania excluded. So when I say that physicians approached me and expressed concern about the malpractice climate, I think I was really only scratching the surface of the concern that was centered around this State in malpractice.

Numerous investigations clearly indicate the association between the malpractice environment and the practice of defensive medicine. The latter includes the ordering of unnecessary tests, deviation from clinical guidelines, doing more to protect yourself, and the avoidance of high-risk patients. While each of these by itself is harmful to patient care in the health-care value equation, their practice in a teaching hospital will result in a generation of physicians that adopt similar unhealthy practice patterns.

In addition, the avoidance of high-risk behavior of community physicians will result in an increased number of the most complex patients coming to the teaching physicians at our medical schools, contributing to increased stress and burnout, which are already at unprecedented levels.

Burnout, for which the rate is already twice as high amongst physicians as it is the general population, will only be exacerbated to the malpractice climate of 15 to 20 years ago. This will impact all aspects of a physician's personal and professional life. Not only is burnout positively associated with medical error, but it will also negatively impact the other core missions of medical schools and academic medical centers.

In 2018, Medscape surveys rated Pennsylvania the 14th highest burnout rate among physicians nationally. Although burnout is definitely multifactorial in origin, Pennsylvania's malpractice climate, even now, is likely a contributing factor with the fourth highest malpractice award payout rate per capita.

The second domain I would like to review with you relates to one of the core missions of a college of medicine, and that is to improve the health and quality of life of our communities. One of the ways in which we do this is in the training of the next generation of

physicians, with the hope that the most outstanding will remain to practice in our State.

From 2002 to 2005, 16 percent of residents completing their training at the Penn State Hershey Medical Center remained in our State. Between 2006 and 2019, that number has doubled and now averages 30 percent. These physicians are caring for many people in this room today, your families, and your friends. I have no doubt that the elimination of venue shopping in 2002 and the concerns in the malpractice climate contributed significantly to our ability to retain our best and brightest.

I close in quoting from the cover letter associated with the 2015 Pennsylvania Joint State Government Commission to study the issue of physician shortages, and I quote:

"Physician shortages exist nationally and in Pennsylvania. Large numbers of...physicians are nearing retirement. An aging population, longer lifespans, increased health care utilization, improved health care access, and a growing population all contribute to pressure on the health care system. Student debt and other educational limitations are negatively affecting the training of new physicians.

"We hope this report will assist the Commonwealth in mounting a vigorous and effective response to a serious

and growing physician shortage."

Thank you again for the opportunity to appear before this Committee and share my concerns regarding the deleterious impact of the proposed rule change and what it could potentially have on undergraduate and graduate medical education.

Thank you.

DR. BRENNAN: Good morning, Chairman Mensch, Vice Chairman Brewster, and the Members of the Committee.

My name is Patrick J. Brennan. I'm the Chief Medical Officer and Senior Vice President of the University of Pennsylvania Health System, as well as a professor of medicine and infectious diseases at the Perelman School of Medicine at the University of Pennsylvania.

I would like to thank Chairman Mensch and the Committee for allowing me to provide testimony regarding the impact of venue for medical professional liability actions on access to medical care in the Commonwealth of Pennsylvania.

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

Rules Committee.

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

The crisis led to insurers leaving the market, limiting their insurance offerings and experiencing significant downgrades in their credit ratings. As a result, there was a dramatic decrease in the availability in medical liability insurance and significant increases in the costs associated with professional liability coverage.

As reported by the Pennsylvania Medical Society, the State's major medical malpractice insurers increased their premium rates between 80 and 147 percent between 1997 and 2001. This led some providers to retire prematurely or leave the Commonwealth and, in some instances, threaten the financial viability of hospitals and health systems.

At Penn, medical students were acutely aware of the crisis, and many opted to pursue their residency training out of State or not remain in the Commonwealth once their training was completed.

I regularly interact with medical students at Penn in small group settings. I can tell you from firsthand exposure that the students of that era were aware of the liability crisis as they entered medical education at the beginning of medical school and factored it into their choices of specialty training and the location of their residencies, avoiding higher risk specialties and the Philadelphia market.

All of these factors jeopardized the availability of comprehensive and high-quality health care across the Commonwealth and led the Legislature and the Supreme Court to act in 2002 and 2003. It is not in the public's interest to plunge the health-care industry in Pennsylvania into crisis once again.

As recognized by the Legislature in the Mcare Act, changes in the health-care provider system had unduly expanded the reach and scope of the existing venue rules and negatively impacted the training of new physicians and health-care services as a whole.

Since 2003, health care in Pennsylvania has experienced further consolidation, with hospitals and

providers throughout the State increasingly merging or being acquired by health systems in major metropolitan centers. This has enhanced training opportunities for new physicians as well as access to specialty care for more citizens of the Commonwealth.

Given this interim development, the impact of reverting to pre-2003 rules in medical malpractice actions would have an even more profound impact than it did prior to the 2003 rule changes.

Our health system is illustrative in that regard, with several facilities and numerous health-care providers providing patient care in the counties surrounding Philadelphia and in central Pennsylvania through our merger with Lancaster General Health.

If the new venue rule is adopted, simply by virtue of Lancaster General Health being part of a Philadelphia-based health system, cases that involve care exclusively provided in Lancaster County could be brought in Philadelphia County. The impact of requiring an entity such as Lancaster General Health to impact medical liability claims in Philadelphia cannot be overstated. It not only will dramatically impact the cost of insurance due to Philadelphia County's associated higher risk profile but will also be disruptive to patient care if physicians and other providers are unavailable while participating in

proceedings in a distant venue.

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

The Supreme Court Civil Procedural Rules Committee also expressed concern about fairness in affording special treatment to a particular class of defendants. Special venue rules reflect the determination of policymakers that in some instances, specific parties and certain types of litigation warrant different treatment.

In this instance, the Legislature determined that there was sufficient basis for concern about the impact of the then existing venue rule on the health-care market that it included a provision creating an Interbranch Commission on Venue in the Mcare Act. The Commission, which was comprised of representation from all

three branches of government, was charged to study the venue issue and make recommendations to the Legislature and the Supreme Court.

After completing its study in August 2002, the Commission recommended the venue rule which is currently in existence. It was overwhelmingly approved by the Legislature and subsequently adopted by the Supreme Court.

The Committee's further contention that the rule change is warranted as fewer victims of medical negligence are compensated appears to be based on unspecified reports, not data. A review of the data available on the claims payments made by the State Mcare Fund does not support this assertion.

Indeed, the Mcare Fund claim statistics indicate that both the average number of cases closed with payment and the average case value have been relatively constant. Moreover, this contention is at odds with the insurance industry's experience, which has been trending toward increased severity.

To the extent the Committee was referencing statistics suggesting a decrease in the number of jury verdicts in favor of claimants, it is important to note that these statistics also indicate a decrease in the overall number of cases being tried to verdict and do not reflect the increasing number of cases resolved via

pre-litigation resolution, mediation, and other forms of alternative dispute resolution, including high/low arbitrations and high/low trial arrangements.

At Penn Medicine, we have seen a tenfold increase in pre-litigation resolution.

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

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

I thank the Committee for allowing me to testify today and for evaluating this important issue. I'm happy to answer any questions the Committee Members may have.

MR. VISNOSKY: Good morning, Mr. Chairman and distinguished Members of the Committee.

My name is Michael Visnosky, and I am Chairman of the Board Emeritus of the Lake Erie College of Osteopathic Medicine, which will celebrate its 27th birthday of accreditation on December 24, 2019.

We are now the largest medical school in the United States and have held that status since 2011. But we are far more than just a school that educates doctors. We also operate two pharmacy schools and a dental school and a very active dental clinic in Erie, Pennsylvania.

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

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

The student doctor graduating from LECOM in 2018 in Pennsylvania had an average of $157,833 in student loan debt for medical school only. This represents a 10- to 30-year monthly payment obligation. This amount does not include any undergraduate debt.

Many of these young doctors have families relying

on them for financial support. LECOM is the least expensive medical school in Pennsylvania at $34,570 for tuition and fees in fiscal year 2019. That is at least $15,000 per year less than other Pennsylvania medical schools.

According to a recent U.S. News Report, it is the second least expensive private medical school in the country. When you add this debt to daily expenses for necessities, the tuition repayment controls their economic futures. Then, add a burdensome medical liability insurance premium to those expenses.

According to the medical malpractice insurance rates filed with the Pennsylvania Department of Insurance, an emergency medicine doctor faces an average annual premium of $38,049, a general surgeon pays an average annual premium of $47,255, and an obstetrics and gynecology physician pays an average annual premium of $67,498. Those premiums add a significant monthly or quarterly burden to a young physician's existing financial responsibilities.

While these may be high-risk practices, medical malpractice insurance is not inexpensive for a family practice physician with an average annual premium of $13,371, or $1,114 per month without interest; or an internal medicine doctor with an average annual premium of $13,705, or $1,142 a month without interest; or a

pediatrician with an average annual premium of $13,599, or $1,133 per month without interest. These monthly or quarterly expenses could wreck anyone's budget. These physicians are in demand, but they have the same student loan debt as other medical students but are at the bottom of the earnings ladder.

I know that you must consider the relationship of medical malpractice insurance premiums to retaining physicians in Pennsylvania while ensuring the ability for valid medical malpractice claims to have an adequate recovery and the social and economic costs of both.

During this deliberation, remember that these new doctors will not necessarily be employed by group practices or hospital systems that will offer a fringe benefit of paying their two major expenses, namely student loan debt and the medical malpractice insurance premiums. If the employer does offer one or both of these perks, they will appear on the doctor's W-2 as taxable income. In fact, many hospitals don't offer the payment of student loan debt as a fringe benefit.

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

The practice atmosphere for doctors should not subject them to any more obstacles than they already face, particularly as new physicians. The venue rules adopted in 2002 and 2003 have served their purpose of confining the trial of an alleged medical malpractice claim to the county in which it occurred. Pennsylvania already has high medical liability costs, even with the reforms of 2002 and 2003 when compared to other States.

I encourage policymakers not to retreat on the venue reforms and to consider additional opportunities to reduce medical liability costs in Pennsylvania. More work must be done to reduce the cost of medical malpractice insurance, and the venue rule should not be changed.

And as a side note, I would like to add, we, too, have experienced a shortage of teaching physicians at LECOM. So what we have done is in-house, we require all of our residents to go through a master's in medical education program for which we pay all tuition.

We also have started two doctoral programs in anatomy education and microbiology education, where we currently have six students in anatomy and three in microbiology, because we were having trouble recruiting anatomists and microbiologists. This is a real problem.

And you must also know that student awareness is at its height. If you were to go talk to medical students

today, they would tell you that they were going to go out of Pennsylvania to practice, and they were looking at States like North Carolina, Nebraska, Kansas, California, Nevada, and Texas where rates are much lower and claims are less frequent.

Now, we believe that a quality medical education is imperative, and we train doctors, as do the University of Pennsylvania and Hershey Medical Center, to be quality physicians. We do not believe the quality of medical care improves with the practice of defensive medicine.

I thank you for this opportunity to address the Committee on this very important issue and urge you to recommend no change in the current venue rule.

CHAIRMAN MENSCH: Gentlemen, thank you for your testimony.

The Chair would like to recognize the presence of Senator Brooks.

And we will begin with questions from Members, and we'll start with Representative Conklin.

REPRESENTATIVE CONKLIN: Thank you, Senator.

I'll ask you the same question I asked one of the panels yesterday.

We were fortunate enough to -- we have a retail store, and we were fortunate enough to have college students who go to high school and college and worked for

us the whole time through, and one of the individuals that worked for us went to college and just became a doctor. And when I was talking to this individual here a few weeks ago, she was telling me how she was leaving the State for her internship and to practice. And not only was she leaving, but many of her friends were leaving as well, and the reason wasn't the venue rule. Their reason wasn't malpractice insurance. Their reason was simply this: We're dealing with a new generation of young people who actually use statistics as a guide to their future, and when you look, and I looked after she told me, when you look at Pennsylvania, we're literally in the bottom five for paying physicians in this State. In the mid-160s is the average pay. They're all leaving, quite bluntly, because they can make $100,000 more outside of this State. So when you couple that with the exorbitant cost of their schooling and knowing full well that they can be much better off in another place, and this isn't -- I'm sorry I got off the venue rule -- what can we do?

I mean, when I'm talking to the individuals that you work with or you're training and they are telling me that they're leaving because their student debt is astronomical and they can make more money in 45 of the other States, what can we do as Pennsylvania to change that?

DR. BRENNAN: Well, thanks for that question.

There's no question that medical education is far too expensive and on top of college tuition loans that students have taken. I think there are a number of things that you -- and this is not my area of expertise, but I'll offer you some opinions.

At Penn, we're trying to establish scholarships through philanthropy, and a very large percentage of the students have no tuition or significantly reduced tuition at a very expensive, at a very expensive place.

I think there are ways in which the State can induce students to stay. I can recall meeting with Secretary Karen Murphy when she was the Secretary of Health, talking to her about my mother in Schuylkill County who had just lost her primary-care physician. And she was interested in rural health initiatives, and I said, how are you going to get people to go there? And I think, you know, the State can do things with loan forgiveness and inducements that enable people to enter practice at a time when they have significant startup costs and are at the lower end of the spectrum of pay and enable them to pay off their loans or pay back their loans with payback. There are certainly other precedents for that at the Federal level. So again, not my area of expertise, but I think this is an opportunity.

I will bring it back to the venue rule, however, by saying that the change in the venue rule is not going to make that better. They're clearly not leaving the State now because the venue rule is better than it was. And, you know, I told you of my experience with students at Penn, who clearly were thinking about this from the time they entered medical school.

MR. VISNOSKY: The venue rule changed 17 years ago. The students now face different problems encountering and entering medical practice. Student loan debt is probably one of their primary problems and one of their reasons that they may leave Pennsylvania.

Right now, our school graduates 69 percent of its graduates in the four basic medical specialties. These four specialties, unfortunately, are the lower paying specialties in Pennsylvania as well as many other States. These four specialties are family practice, internal medicine, pediatrics, and OB/GYN. Sixty-nine percent of our students go there. What we have done internally is we have, because we had no graduates 27 years ago, we have started our own scholarship fund. Last year, we awarded $5 million in in-school internal scholarships, just as these two gentlemen's schools do.

Secondly, we tried to recruit our best physician graduates to stay in Erie by offering to pay for their

fellowships and putting them under contract. In fact, our succession plan for Dr. John Ferretti and his sister, Dr. Silvia Ferretti, included two of these students who followed our fellowship plan and have come back to Erie and are part of our leadership and administrative staff. You have to try to be creative to get people to stay here.

Secondly, malpractice insurance is a problem, because the costs are high even for a nonsurgical family practice physician. We are fortunate to be able to work our budget and live in a lower-cost section of Pennsylvania to keep our tuition costs down, but our weather is not the most attractive thing for physicians in Pennsylvania.

REPRESENTATIVE CONKLIN: Thank you.

DR. BLACK: I would just emphasize I think the point that Dr. Brennan was making. The fact that the students are not leaving Pennsylvania because of malpractice concerns or the culture of malpractice I think speaks to what has happened in the past 15 years or so relative to that level of awareness and how the State is perceived.

The finances of physician compensation are complex. There are States that have greater physician shortage challenges than we do, and many of those States are providing significant incentives for physicians to go there. But without knowing the particulars, I don't think

I should say more.

REPRESENTATIVE CONKLIN: That's fine.

CHAIRMAN MENSCH: All right. Thank you.

Representative Dush.

REPRESENTATIVE DUSH: Thank you, Chairman.

Mr. Visnosky, I want to thank you also. LECOM has created an internship program down in DuBois at Penn Highlands, and Lisa Witherite-Rieg, the doctor who is running that, actually was my general practitioner prior to the problems we were experiencing back in the nineties. She ended up going to work for a hospital, and the guy who actually took over the practice after her left to Ohio because of the malpractice insurances.

What you guys have done, you said you have to be creative to keep people here. Creating, doing something like that, bringing an internship program into a place like DuBois where the cost of living is, as you were highlighting in the rest of your program, very inexpensive, it is actually starting to get some interns looking at staying in rural Pennsylvania and practicing in rural Pennsylvania.

What do you see would happen both with the university with that kind of a program? What kind of an impact would it be if the venue shopping were to perhaps---

MR. VISNOSKY: Well---

REPRESENTATIVE DUSH: ---bring one of those interns down to Philadelphia? What kind of impact would it have on that?

MR. VISNOSKY: Well, Mr. Dush, let me answer that question two ways.

First of all, we have created, through our OPTI, over 200 residency programs, mostly in the Appalachia area, and those are areas which are truly rural America and need physicians.

The change in the venue rule in a rural community would be significant, because it would mean, as one of the speakers pointed out yesterday, that the doctor who allegedly committed an act of malpractice would be required to go out of county and leave his practice or her practice vacant, because there probably isn't another physician there to cover, and go to the city where the case is being tried, and in DuBois, in all likelihood it would be in Allegheny County and Pittsburgh, and spend a week or 2 weeks there while his practice was standing idle and hopefully being managed through the hospital emergency room or some other cobbled together physician group from even as far away as a different county.

The retention of physicians in Pennsylvania should be the number-one goal of this Committee and the

State, and there are probably a couple of ways to do it. One would be for putting some creativity in handling student loan debt.

In Texas, if you're a Texas resident and you go to a Texas medical school, half of your tuition is paid by the State. I don't know if you want to get that creative. And in California, the costs of medical school are greatly reduced through State subsidies.

But, you know, I understand your budgetary problems and how you had to wrestle with the budget this year to get it pared to $34 billion. But if you're serious about keeping doctors in this State and having high quality medical care for the citizens, you have to do something to coordinate your efforts to solve all of these problems.

REPRESENTATIVE DUSH: And, Dr. Black, you touched on something else that I wanted to try and address. It goes along with Representative Conklin's questions.

When they're looking at higher incomes outside of the Commonwealth, another factor in that is there are also other cost-of-living factors, and the higher malpractice -- everybody is looking at what their take-home pay is going to be. How does that, the higher malpractice premiums that would come about as a result if we were to go back to those days, how is that going to affect trying to recruit and retain people in the Commonwealth?

DR. BLACK: So I don't know that I can answer that with certainty. In most medical schools, the model is one of employed physicians, but not all. Certainly in my medical center, we are.

As those expenses are absorbed by the institution, I think the first thing we would start to see is compromise in the research and in the education missions before any decrease in physician salaries. Because if there are no physicians, there are no patients going into the hospital, and almost every medical school in this country is dependent upon hospital revenue to subsidize medical education and research.

CHAIRMAN MENSCH: Thank you.

Senator Brooks.

SENATOR BROOKS: I would like to thank the panel for their testimony.

I'm very concerned about health care in rural Pennsylvania, and, Mr. Visnosky, you and I have had several conversations regarding health care in rural Pennsylvania.

The panel briefly touched on the differences between health care in urban Pennsylvania and rural Pennsylvania. Could you further elaborate on that?

And also, you had mentioned the loan forgiveness program. Are any of you concerned or are you aware of the loan forgiveness program distribution and whether it is

equitably distributed between urban and rural Pennsylvania?

DR. BLACK: So I know that our loan forgiveness program is internally generated. So within our family medicine department, we offer loan forgiveness to graduates as an incentive to stay with us as part of Penn State, regardless of where they will practice.

We do have a campus in State College, as we mentioned before, a major emphasis of which is to improve the delivery of primary care in central Pennsylvania and in rural areas of central Pennsylvania.

MR. VISNOSKY: We have entered an agreement with Highmark where they donate -- they have donated a million dollars to us so far where we award competitively five $20,000 scholarships annually to students, who will then sign a contract with Highmark to practice in an underserved area in rural Pennsylvania for each year that the student received the scholarship.

We also recruit a lot of students from rural Pennsylvania, because studies show that a student will establish a medical practice within 50 to a hundred miles of where he or she does his resident training. So the key is to get them into graduate medical education programs in Pennsylvania at smaller hospitals like DuBois and Clarion and other places in Pennsylvania so that these students establish there. Because once a student, once a doctor is

established in a community for 5 years, he establishes a persona and reputation within the community and usually becomes one of its leading citizens.

That's a very difficult problem, because the rural physician's earnings are not as significant as a Pittsburgh physician or a Philadelphia physician or an Erie or Scranton's physician's earnings just by virtue of the setting and the volume of medical practice which he or she will attract.

DR. BRENNAN: I would just add that despite having a wealth of academic medical centers in major urban areas, there is still a need in many neighborhoods in those areas for primary-care services, because the urban academic medical centers tend to deal with the most complex medical problems -- transplantation, Level I trauma centers, cardiac surgery, and those sorts of things -- and they are role-modeling students for a certain type, a certain type of practice. So we need some of those primary-care physicians in urban neighborhoods as well and inducements for them to return.

CHAIRMAN MENSCH: Senator Phillips-Hill.

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

Gentlemen, thank you for being here today.

I was recently appointed to the PHEAA Board, and certainly college affordability and now medical school

affordability is a topic of great interest. But I want to kind of circle us back to medical malpractice venue shopping insurance, liability insurance, because that's really why we're here today.

So I'm hoping that you can share with me how medical malpractice premiums impact the ability of a school, a hospital, you know, or a physician's practice group to offer competitive salaries that are sufficient to keep quality doctors interested and here in Pennsylvania.

DR. BRENNAN: Well, I would suggest that in some ways, medical malpractice costs are akin to the cost of health care overall. And if you look at wages in the United States over the last 40 years, most workers have gotten their wage increases through their health insurance, the cost of their health insurance, which employers have had to take on. Premiums have been higher, but their wages haven't increased. They have gotten good health coverage, but premiums in health care have gone up significantly.

I would suggest that malpractice operates in the same way. It's another cost that has to be factored in to the cost of employing a physician. And while physicians are, even the lowest paid physicians would be the envy of most people in the economy in terms of their wages, malpractice rates will hold down the growth in physician income, particularly in the private sector.

MR. VISNOSKY: Go ahead.

DR. BLACK: I think it also creates a paradoxical relationship, and every person in this room is concerned about the value of health care in this country, what we pay for the health care that we receive.

I think there will be, as our malpractice rates and expenses collectively go up, I think it will incentivize us, despite what we say about the need to manage populations and population health, I think it will incentivize or has the potential to incentivize a fee-for-service system in order to meet those expenses and continue to survive.

MR. VISNOSKY: What we have found in our health system, which is not a very large health system, we have found that to afford to retain quality physicians in the areas that we practice as an acute-care hospital and a critical-access hospital, that we became self-insured about 15 years ago, because our hospital's premium for its insurance for the doctors which it employs was growing unmanageable. So we started our own insurance trust so that we could maintain higher physician salaries and retain the physicians whom we were training in Erie and the surrounding area.

We have also tried to influence other hospitals in the area by entering partnerships with them to do the

same thing and to follow that model. Recently, we did that at Warren General, where we have entered a partnership with them and Allegheny Health to prevent their hospital from closing.

So you have to be willing to go into these underserved areas with your health system to try to preserve the quality of medical care in the community.

SENATOR PHILLIPS-HILL: Gentlemen, thank you.

Thank you, Mr. Chairman.

CHAIRMAN MENSCH: Thank you.

Gentlemen, a lot of commentary about doctors educating in Pennsylvania and not staying in Pennsylvania, or doctors not staying in Pennsylvania because of insurance rates and other things. So let me begin first with the insurance rates themselves.

You want us to believe that there's a crisis with malpractice if we change back to the older venue system and that will drive doctors. So to believe that, I think we have to first understand what happened in 2002 and 2003. So my first part of the question is, quantitatively, can you tell us if the doctors left when the malpractice crisis was increasing, and I'm using your term there, Dr. Black. That's question number one.

Let me stop there and ask you, how do you prove to me that doctors left because rates were actually

increasing?

DR. BLACK: So in what was a relatively small department at that time, I can tell you that 20 percent of my faculty left.

CHAIRMAN MENSCH: And where did they go?

DR. BLACK: They went to Maryland. Both of them went to Maryland. And a third one, I will tell you, went to Upstate New York.

CHAIRMAN MENSCH: So is there, at a higher level than just a group, is there an association or does your health system have aggregate data that we could look at in this?

DR. BLACK: I am not aware of it. It might exist. I'm not aware of data that would indicate where people who left Penn State Hershey Medical Center went to. It may be retrievable. I just don't know. But I understand why you would ask that.

CHAIRMAN MENSCH: Okay. Anyone else?

MR. VISNOSKY: All right.

In 2002 and 2003, our hospital, Millcreek Community Hospital, was forced into merger talks by the Court of Common Pleas of Erie County, Pennsylvania, with another osteopathic hospital in Erie, Doctors Osteopathic Hospital, which was a failing hospital because of a loss of physicians and revenue from the loss of physicians. And

even though those negotiations were unsuccessful and no merger occurred and we adopted a different business plan, we felt that.

So that's how it affected us. And we did lose an OB/GYN to Florida, and we lost a couple of other physicians because of malpractice verdicts against them. One of them was to retirement and another was he moved to California. So quantitatively, it would be difficult to establish that, but there were impacts.

CHAIRMAN MENSCH: But we have to be able to do that. If we're going to understand this issue, if we're going to separate venue from the rest of the argument, we have to be able to quantify that.

MR. VISNOSKY: Well, it probably could be quantified with further study, but I was not expecting you to ask that question today, Senator Mensch.

DR. BRENNAN: Senator?

CHAIRMAN MENSCH: Yes?

DR. BRENNAN: I would respond in this way.

First, in terms of our practice plans, we're talking about a 20-year period when we have gone through consolidation and mergers and acquisitions, and it would be hard to put our fingers on that. Within the University of Pennsylvania, I can tell you with certainty about the conversations that I had.

But more importantly, look at the obstetrics situation in Philadelphia. There are 11 hospitals that deliver babies -- I believe it's still 11 that deliver babies -- for a city with a population in excess of a million and a half, and many, many high-risk mothers, and most of those hospitals don't deliver high-risk babies. So those are concentrated in, those high-risk deliveries are concentrated in just a few hospitals.

Between 34th and Spruce, where the Hospital of the University of Pennsylvania is located, and 63rd Street, the western boundary of the city, there are no hospitals delivering babies for a vast area of West and Southwest Philadelphia. So I think that really speaks volumes about what has happened.

People, hospitals, are voting with their feet and getting out of high-risk businesses in favor of more remunerative and lower-risk areas, like cardiac catheterization and imaging services where the risks are relatively smaller and the remuneration is greater.

CHAIRMAN MENSCH: Thank you.

I don't mean to suggest that we're doubting what you are providing here anecdotally. I think we all appreciate, you know, that there are elements of truth in what you are providing, and probably all of it is true.

DR. BRENNAN: Yes, sir.

CHAIRMAN MENSCH: But I need to be able to understand it much more quantitatively, okay?

So I have to believe -- I'm an economist -- I have to believe that there is data, if we look hard enough, that would suggest that in the year 2000, this was the circumstance, and 2005, 2010. I should be able to trend that and benchmark it, and that's what I'm looking for, for help here.

DR. BRENNAN: It's a little harder -- you know, it's easier to quantitate, I think, the reasons why the rank-and-file staff leave an organization, because of their exit interviews and there is capture of that sort of information, than there is for the physician population, who have much greater autonomy, and, you know, we just don't conduct those same sort of exit interviews. People may know. People may know from conversations. But, you know, that's anecdote and that's not what you're looking for.

CHAIRMAN MENSCH: Yeah. I appreciate that. Thank you.

And you provoke another thought entirely, a little bit tangential to venue itself.

But for people pursuing an education in any field, some come from Pennsylvania, some come from outside of Pennsylvania. They study here because we have good

schools. And then some stay in Pennsylvania and some leave. We hear repeatedly that we have great medical schools and people come here to study, and then they leave. Is that unusual, or do we expect them all to stay in Pennsylvania?

I'm just interested in your feelings on that. And can we in any way say that venue provokes the low rate of retention in Pennsylvania, if indeed there is a low rate.

DR. BRENNAN: I'll let the Dean go first.

DR. BLACK: So, no, we do not expect all of our students to stay in Pennsylvania whether they are from Pennsylvania or not, and I'm talking about moving on to residency training.

Now, I think there is a closer link between the transition from residency training to where they ultimately practiced in medical school and where they do their residency, and the reason being that when they complete their residency, their postgraduate training, they are selecting where they want to work.

When they are applying to a residency, they are participating in a match process where they apply to residency training programs. Residency training programs are interviewing and ranking them. Those lists go into a computer, so they lose a much greater amount of control

relative to where they do their residency. At the end of their residency training, they pick where they want to work.

CHAIRMAN MENSCH: So you have the same influences on your industry or your business as any manufacturing company might as well, right? Okay. Thank you.

MR. VISNOSKY: We have found that the two great influences on where a physician ultimately locates are, as the doctor pointed out, the residency training location and the location of the wife's family. So we have lost a few---

CHAIRMAN MENSCH: We're all married. We understand.

Senator Brewster says that's a real venue.

Thank you.

Any other questions or comments?

Yes; Representative Dush.

REPRESENTATIVE DUSH: Thank you, Chairman.

Mr. Visnosky, you brought up about a trust that the hospital had to go into. Are you saying that you went to being self-insured?

MR. VISNOSKY: Yes, we did. We became self-insured. We have a self-insured trust.

REPRESENTATIVE DUSH: And have your actuaries actually taken a look at where we would be if you had to

start factoring in the venue shopping returning?

MR. VISNOSKY: No, we have not, but I can ask them to do that, Representative.

REPRESENTATIVE DUSH: Thank you.

And it also brings up, I would like to -- I know Sam is not here, but I would like to try and see if they could put that kind of information together for us as well. I think it would be instructive.

MR. VISNOSKY: But could I point out one thing?

You know, the venue shopping rule has not diminished verdicts particularly in Erie. There were two medical malpractice verdicts rendered within the last 5 years which were significant. One was for $6.4 million and the other was for $2.4 million, and those aren't exactly chump change. But, you know, I believe that you can get a fair trial anyplace in Pennsylvania. It's just in proving your case.

REPRESENTATIVE DUSH: And also the -- I agree with you. And like I said, over in Clearfield County, they had a $20 million verdict. So you can trust rural Pennsylvanians, even though it is a large employer, you can trust the jurors and the judges to be fair.

And with the venue shopping, it would also, I think, be instructive to factor in how the costs, if you had to go down to Allegheny County from Erie, ended up,

because when those physicians are taking time off from their practice, there are a lot of costs, and those would actually be, I realize, hard to quantify. But if there's any way that your people can come up with those kinds of numbers, that would be helpful.

MR. VISNOSKY: Well, the locum tenens rates are published rates, and if you have to bring a locum tenens physician in to manage your practice, first of all, you're paying him a per diem which not only covers his professional fee but all of his expenses. Secondly, you're introducing an unfamiliar doctor to your regular patients, which interrupts the continuity of care.

So, you know, it's not, it's not all about dollars and cents. There are a lot of intangibles that go into operating a family practice, medical practice, or an internal medicine practice, or being a pediatrician. It's not just money.

And, you know, money is important because of the burdens that a young doctor faces. If you look at the article in USA Today in the financial section, the lead article is about student debt, and it has a very chilling effect, and it discusses some of the consequences.

So, you know, by causing a doctor to go someplace else and leave his practice, that's just not a good idea.

REPRESENTATIVE DUSH: Well, and to help us quantify that, if you could get those rates to us as well that are published---

MR. VISNOSKY: Sure.

REPRESENTATIVE DUSH: ---it would be, I think, a benefit to helping us.

Thank you.

CHAIRMAN MENSCH: Thank you.

Members, thank you for your attendance again.

Gentlemen -- and, Dr. Black, you and I had a conversation earlier. You said you might have some additional data. I'm sure the rest of you do, the other two of you do as well. Please feel free. Too much is better than not enough.

In closing, let me just say that we will be focusing only on the costs of venue. We do appreciate that educations are expensive, but that is outside the purview of this Committee and this particular study.

And just let me say -- a personal opinion, not a Committee opinion -- when we talk about these costs of education, education has always been expensive. It's expensive for an engineer. It's expensive for an MBA. It's expensive for a doctor. But those costs are not controlled by the government. Those costs are controlled by the institutions that provide the education.

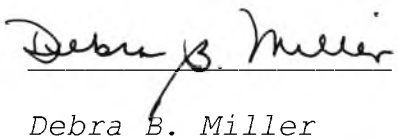
So while we appreciate that it is expensive -- all right? -- it's not fair to mix that with the cost of venue in this particular situation. So we will be only considering venue and its impact of costs therein.

So thank you very much. Have a good day.

This concludes the hearing of LBFC, and we're at recess until the call of the Chair.

(At 10:50 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.



Debra B. Miller

Transcriptionist

dbmreporting@msn.com