pennsylvania
INSURANCE DEPARTMENT

Testimony on Senate Resolution 20

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Legislative Budget and Finance Committee

June 25, 2019

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

Background

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

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

Adjusting Claims

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

Collecting Assessments

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

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

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

Conclusion

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

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