Testimony of

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Hearing on the LBFC's Report on Medical Liability Venue

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Chairman Baker, Chairman Farnese, and members of the Judiciary Committee, thank you for this opportunity to comment on the Legislative Budget and Finance Committee's (LBFC) report: A study of the Impact of Venue for Medical Liability Actions (LBFC Report).

My name is Christopher Tait. I am a Principal and Consulting Actuary with Milliman, Inc. (Milliman). I am a Fellow of the Casualty Actuarial Society (FCAS) and a Member of the American Academy of Actuaries (MAAA). One of my primary areas of expertise is medical professional liability (MPL) reserving and ratemaking. In addition, I have worked with the Pennsylvania Professional Liability Joint Underwriting Association (PAJUA) for more than 30 years and have been the PAJUA's appointed actuary for the past 20 years.

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Overview

On February 20, 2019, we issued a report titled *Review of Proposed Amendment of Pennsylvania Rules of Civil Procedure Nos. 1006, 2130, 2156, and 2179: Governing Venue in Medical Professional Liability Actions in Pennsylvania* (Milliman Report). The following organizations are sponsors of our research and requested that Milliman provide an analysis of the effect of repealing the venue reform, specifically the potential impact on MPL insurance rates on a statewide, county, and specialty basis:

- The Hospital and Healthsystem Association of Pennsylvania,
- Insurance Federation of Pennsylvania on behalf of MedPro Group and NORCAL Group,
- Medical Mutual Insurance Company of North Carolina,
- the Pennsylvania Medical Society,
- the Pennsylvania Coalition for Civil Justice Reform,
- the Pennsylvania Health Care Association, and
- The Doctors Company.

Based on our review of publicly available documents such as physician insurance rate filings and data available from the Supreme Court of Pennsylvania (SCPA), we estimate the impact of the proposed change to the venue rules for MPL claims to be as follows:

- **Statewide Impact: The current average statewide MPL costs and insurance rates for physicians in Pennsylvania could increase by 15%;**
- **Local/County Impact: Many individual counties could see increases in physician MPL costs and rates of 5%, while counties surrounding Philadelphia could see larger increases of 45%;**
- **Physician Specialty Impact: High-risk physician specialties, such as Obstetrics/Gynecology (OB/Gyn) and General Surgery, will likely experience additional cost and rate increases of 17%, on top of the local/county change noted above.**

These estimated increases are likely low, as our analysis did not account for the following items that could also increase MPL costs and rates:

- the impact of health care provider consolidation in recent years allowing easier access to bring forth a claim in any venue;
- an increased incentive to bring smaller borderline claims;
- a knock-on effect of potential higher verdicts and settlements on all areas of the state;
- higher defense costs as a result of venue change;
- potential increases to the Mcare assessments; and
- higher rates due to uncertainty in pricing.

Note that while our analysis focused on the impact on physicians due to the limited time frame and data available for this analysis, we believe similar cost increases will affect other healthcare providers, facilities (such as hospitals and long-term care facilities), and entities within the state as well.

Besides the projected increase in MPL costs and insurance rates, additional consequences of changing the venue rules could include:

- Reduced availability of MPL insurance coverage; and
- Adverse impact on self-insured health care entities.

It is also important to note that while the tort reforms in place since 2003 have improved and stabilized the MPL insurance market in Pennsylvania, the MPL costs in Pennsylvania are still among the highest in the country. According to a 2018 Benchmark Study of Healthcare Professional Liability Claims performed by the Zurich Insurance Group, Pennsylvania consistently has the highest claim severity (i.e. the average dollar amount per claim) of any state.

Methodology

To estimate the impact of the venue rule change on average statewide rates and territory rates, we relied on publicly available information from two main sources. These included:

- Physician Rate Filings for the PAJUA and
- Medical Malpractice claim filings data from the SCPA.

Each of the sources relied upon has certain advantages and disadvantages, but we believe the combined use of both the sources provides a reasonable view of the overall range of possible cost and rate increases. Each of the methods used is discussed below and in more detail in the Milliman Report.

To provide a view of the impact of the proposed venue change, we reviewed MPL rate filings for the PAJUA, the insurer of last resort for physicians in Pennsylvania. The advantage of using this information is that the territory relativities[1] for the PAJUA were determined based on information provided by several market-leading insurers, increasing the credibility of the results. Also, the PAJUA's occurrence coverage rates are the "prevailing primary premium" used in calculating assessments for Mcare. The disadvantage is that due to reliance on information from outside sources, the territory relativities for the PAJUA generally had a long lag before the improvement from the venue rules change were reflected in its results.

The results using the PAJUA data are shown on Exhibit 2 of the Milliman Report and indicate that average statewide costs and rates would likely increase by 15-16% as shown in row (15). The impact by area indications in column (13b) show that most areas will likely increase by at least 5% with a 47% increase indicated for Area 2, the counties surrounding Philadelphia.

For our second method, we employed data made available by the Unified Judicial System of Pennsylvania, specifically related to medical malpractice case filings and jury verdicts. The advantage of using this data is that it allows a direct view on the impact on claim filings on a timely basis and includes claims not just related to individual physicians but also other healthcare providers and systems. The disadvantage is that only summarized data is available in regards to the cost of claims – i.e., verdicts are only provided in buckets (<$500k, $500k - $1M, etc.).

On Exhibit 3, Sheet 1 of the Milliman Report, we summarize MPL court filings by area by year for 2000 thru 2017. The impact of the reforms effective in 2002-2003 can be observed in the large drop in filings made between 2002 (2,904) and 2003 (1,712). In addition, the movement of claims between counties can also be observed on Exhibit 3, Sheet 2 that provides the distribution of the claim filings by area by year on a percentage basis. The increase in the number of claims in Area 2 (Counties surrounding Philadelphia County), Area 4 (Counties surrounding Allegheny County) and Area 6 (Counties surrounding Lackawanna County) starting in 2003-2004 is due to the venue reform. That is, claims that were previously filed in Philadelphia, Allegheny, or Lackawanna Counties prior to 2003 were now being filed in surrounding counties. The only reasonable explanation for this shift is the venue reform enacted in 2002-2003.

Jury verdicts by award bucket, grouped by area, are provided on Exhibit 3, Sheet 3 of the Milliman Report. We have summed the data provided for 2000 through 2017 in order to increase the credibility and stability of the information. As we did not have access to the actual severity of the claims in each of

[1] MPL insurance companies do not make rates at the individual county level. Rather, they group counties together based on loss experience and geography to create rating "territories". For example, PAJUA has seven rating territories, with Philadelphia County as Territory 1 and Delaware, Fayette, Luzerne, and Mercer Counties combined as Territory 4.

the award buckets, we made assumptions regarding the average awards within each bucket as shown in row (13).

- Based on the distribution of claims by bucket and the average award assumptions, we estimated the average award by area as shown in column (8). We then developed a weighted average of the awards based on the claim filing distribution from Exhibit 3, Sheet 1 as shown in columns (9) through (12). Using an assumed trend of 3% to represent the average increase in the cost of a claim over time, we calculated average awards, shown in row (14) and compared them as shown in row (15).

- The implied impact on the statewide severity due to the venue reform was a decrease of over 18% between the 2000-2002 average and 2017 ($722,150 / $889,508). This implies that if the venue rules were removed, average awards and their resulting costs and rates will likely increase by as much as 23% ($889,508/$722,150).

Milliman Response to Issues Raised in the LBFC Report

1. In his remarks to the LBFC during its public meeting, Chris Latta, author of the report stated: "…the only way to isolate the effects of venue would be to assume that all of the other changes affected different regions and medical specialties the same way. This is not an assumption we are comfortable making." In addition, page 6 of the LBFC Report states, "Thus, the collateral source rule may have a larger impact on Philadelphia than Montgomery County, for example. To assume that all of the Mcare changes affect all of the counties equally, save the change in the venue rule, is not prudent."

    - In the Milliman Report, we assumed that the majority of other reforms (e.g., Certificate of Merit, jury instructions on non-economic losses, expert testimony, statute of repose, punitive damages) would not have a varying impact by county, other than they may have made it less attractive to file claims at all if they couldn't be filed in a Philadelphia court. For example, there is no reason that the impact of the Certificate of Merit requirement would be different between, say, Philadelphia County and surrounding counties, as Certificate of Merit does not affect the location where the claim is brought.

    - We agree that the collateral source rule could have a slightly different impact by county, due to differences in the portion of population that is without health insurance, but we believe that the impact is negligible. The collateral source rule only applies to pre-trial medical expenses. As stated on page 15 of the LBFC Report, it does not apply to:

        - Future medical expenses
        - Past wage losses
        - Future wage losses
        - Past non-economic damages (e.g., pain and suffering, loss of consortium)
        - Future non-economic damages

    - There isn't much hard data on the split of MPL settlements into these buckets, but based on discussions with colleagues, total medical expenses are typically around 25% of the total award. Thus, the pre-trial medical expenses represent a fairly small portion of the total award, perhaps 12% to 15% of the total award.

- The difference in the percentage of population that is without health insurance[2] between Philadelphia (8.2%) and Montgomery County (4.6%) isn't large enough to impact a significant portion of MPL claims. That is, there is only a 3.6% difference in percentage uninsured between the two counties.

- To summarize, there is only a 3.6% difference in the portion of population that is without health insurance between Philadelphia County and Montgomery County. The small difference in percentage of the population without insurance, combined with pre-trial medical expenses being a small percentage of the total award, implies a negligible difference in the impact of the collateral source rule between Philadelphia County and Montgomery County.

- Based on discussions we've had with claims experts from several of the largest MPL insurers in Pennsylvania regarding the 2002-2003 reforms, the venue change and Certificate of Merit were much more impactful than the collateral source rule.

2. Page S-7 of the LBFC Report states, "The available data does not support a conclusion that changes in the availability, cost, and affordability of medical professional liability insurance are the result of changes in Pennsylvania law. The changes may be the result of national trends." On the same page it states, "Since 2007, the cost of medical professional liability insurance decreased, and therefore became more affordable. This change also appears closely aligned to a national trend, however, whether insurance is more affordable varies by county."

    - Exhibit 4, Page 1, Exhibit 4, Page 2, and Table 2 (page 8, and below) of the Milliman Report is an attempt to look at changes in MPL rates for states in proximity to Pennsylvania, relative to changes in Pennsylvania, between 2003 and 2018. We looked at OB/GYN and General Surgery rates, relative to Internal Medicine rates, in Pennsylvania compared to Maryland, New York, New Jersey, and Ohio. All of those states, except New York, showed improvements between 2003 and 2018, but the improvements were of much smaller magnitudes than those in Pennsylvania.

[2] https://pasdc.hbg.psu.edu/Data/PaSDC-Dashboards/Healthcare-in-Pennsylvania

Table 2
Milliman Estimated Impact of Venue Changes on Specialty MPL Rates

State/Region	Average Change in Relativity to Internal Medicine	
	OB/GYN	Gen Surgery
Maryland	91.7%	100.3%
New York	104.5%	133.3%
New Jersey	92.1%	117.0%
Ohio	93.6%	88.0%
Non PA Average	95.5%	109.6%
PA-Philadelphia	85.0%	83.0%
PA - Remainder of State	78.8%	77.4%
PA Average	81.9%	80.2%
Potential Increase	16.6%	36.7%

- The indicated change in Table 2, above, is calculated as follows. Note that this table reflects a correction to the General Surgery column in Table 2 from the Milliman Report:
    - OB/GYN: 16.6% = [95.5% ÷ 81.9%] - 1.0
    - Gen Surgery: 36.7% = [109.6% ÷ 80.2%] - 1.0
- Exhibit 50 on page 105 of the LBFC Report shows that Pennsylvania had the lowest percentage increase in payouts between 1996 and 2018, compared to New York, Florida, California, and New Jersey (i.e., the other four highest payout states). This implies that the reforms in Pennsylvania had a significant impact beyond "national trends".
- The LBFC Report does not attempt to analyze the impacts of national trends on Pennsylvania, nor does it provide any proof that national trends account for a large majority of the improvements in Pennsylvania; rather, it defaults to a position that the data "does not support a conclusion that changes in the availability, cost, and affordability of medical professional liability insurance are the result of changes in Pennsylvania law." Appendix G of the LBFC Report shows that the largest reductions in OB/Gyn rates were in Montgomery, Bucks, and Chester Counties. If national trends were responsible for the decreases in Pennsylvania's MPL rates, there is no reason to think that their impact would vary by county. In particular, there is no reason to think that national trends would impact Philadelphia County materially less than the counties immediately surrounding Philadelphia.

<u>Specific Deficiencies and Errors in the LBFC Report</u>

1. Page 93 of the LBFC Report says, "The Fund's 2012 annual report, cited AOPC data, which showed a decrease in medical liability claims that may have previously been filed in Philadelphia—now being

shifted to other counties. In the report, Mcare clearly states this could be due to venue reform or possibly 'not at all.'"

- The actual quote in the Mcare report was, "Furthermore, the reduced number of case filings, with a particular concentration in Philadelphia County, is likely a combination of some cases that would have been brought in Philadelphia previously that are now being brought outside Philadelphia (as a result of venue reform) or not at all."

- **Clearly, the Mcare report was not implying that venue reform was not responsible for the shift in claims to other counties. They were saying that the claims were being shifted to other counties or not being filed at all.**

2. Page S-5 and page 78 of the LBFC Report mentions the decrease in Mcare counts and payments from 1996 to 2018, but doesn't mention that the Mcare attachment point[3] increased from $100,000 to $500,000 and the Mcare coverage layer decreased from $1 million to $500,000 during that time period[4]. The higher attachment point and shrinking coverage layer had a significant impact on the number of claims in the Mcare coverage layer (because claims now have to be larger to pierce the Mcare layer) and the size of the Mcare payments (because Mcare is now responsible for a coverage layer that is half of what it was in 1996). Also, Mcare is no longer responsible for the first $500,000 of coverage for "Section 715" claims.

   - Exhibit 42 on page 91 of the LBFC Report shows how the number of Mcare claim counts decreased from 2001 to 2011, then began to increase starting in 2012. That is due to a combination of the higher attachment point, the shrinking coverage layer, the impact of the reforms and, eventually, the impact of loss trend more than offsetting those reductions.

   - Section 715 (Extended Claims) of the Mcare Act modified the coverage[5] for claims reported more than 48 months after the incident date. For such claims occurring on or before December 31, 2005, Mcare covers the first $1 million of indemnity loss[6]. For claims occurring on or after January 1, 2006, Mcare covers $500,000 in excess of $500,000.

3. Pages S-8 and 156 of the LBFC Report incorrectly state that losses = payments to claimants. The losses shown in the Pennsylvania Insurance Department Annual Statistical Report (ASR) are calendar year incurred losses, which are current year payments plus changes in reserves on older coverage years. In addition, the losses in the ASR include allocated loss adjustment expenses (e.g., legal fees, court costs), not just indemnity losses.

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[3] Attachment point refers to the point at which Mcare starts to pay for an individual claim. Currently, the primary insurance company pays the first $500,000 of indemnity loss for each claim, so Mcare "attaches" at $500,000.

[4] The changes in the Mcare attachment point and coverage layer are shown in footnote 109 on page 88 of the LBFC Report.

[5] (d) Extended coverage required.--Notwithstanding subsections (a), (b) and (c), all medical professional liability insurance policies issued on or after January 1, 2006, shall provide indemnity and defense for claims asserted against a health care provider for a breach of contract or tort which occurs four or more years after the breach of contract or tort occurred and after December 31, 2005.

[6] Indemnity losses are the amounts awarded to the plaintiff, including pre- and post-judgment interest, if any. They do not include allocated loss adjustment expenses, which consist of the defendant's legal fees, expert witness fees, court costs, etc.

4. Regarding Exhibit 53 on page 112, the report says, "Together, these data points show a more competitive insurance market and a greater availability of medical malpractice insurance. That said, we must note that the trend began prior to the 2003 Mcare changes, prior to premiums coming down, and prior to a decrease in lawsuits filed."

    - The LBFC Report is referring to a small uptick in the number of insurers writing more than $1 million in MPL premiums between 2002 and 2003. Prior to 2003, a number of things happened in the MPL market:

        - St. Paul Ins Co, the largest writer of MPL insurance in the country, pulled out of the MPL market entirely,
        - PHICO Ins Co, one of the largest MPL writers in PA, was declared insolvent,
        - PIC Insurance Company and PIE Mutual Insurance Company were declared insolvent, and
        - PMSLIC stopped writing occurrence coverage entirely and re-underwrote their entire book of business (i.e., they non-renewed many policies)

    - Thus, there were a few start-up MPL companies in 2003 that perceived an opportunity to gain significant market share in an increasing rate environment.

5. Section VII (Availability, Cost, and Affordability of MPL Insurance) is based entirely on NORCAL data. There are several problems with this:

    - The NORCAL territory relativities are based on NORCAL data alone. The PAJUA territory relativities, which are used in the Milliman Report, are based on data from multiple Pennsylvania insurance carriers, including NORCAL, so they have much larger credibility.
    - In Exhibits 78-85, the LBFC Report compares the rates for multiple smaller counties to the rates for an "anchor" county with one or more large health systems (i.e., Philadelphia, Allegheny, or Lackawanna) and imply that the rates for the smaller counties have moved towards those of the anchor counties post-reform.

        - MPL carriers don't make rates for individual counties, since the data at the county level isn't credible. Rather, they combine counties into rating territories based on a combination of geography and loss experience.
        - The movement of, for example, Centre County relative to Philadelphia may have very little to do with experience in Centre County itself. Rather, it is based on the collective experience of all of the counties that are combined with Centre County (see all of the counties that have the identical $48,367 rate in 2018 in Exhibit 64 of the LBFC Report).

    - In 2018, NORCAL decreased its rates in Philadelphia County and Delaware County and moved Bucks, Montgomery, and Chester Counties into a lower rated territory. The rates for all other counties in Pennsylvania were unchanged between 2017 and 2018. These changes significantly distort any comparison of individual county rates to Philadelphia County rates.

- We intended to use both PAJUA and NORCAL rates in our analysis, but the NORCAL 2018 rates looked unusual. We asked NORCAL about the 2018 change and they told us that it was done for competition/retention reasons. That is, NORCAL decreased its rates in Philadelphia and surrounding counties in an attempt to retain their market share in those counties.
    - Because of this change, all of the other counties in Pennsylvania (except those surrounding Philadelphia) look worse compared to Philadelphia in 2018 than they did in 2017. Had the LBFC Report used NORCAL's 2017 rates, they would have reached a different conclusion.

6. The 2nd to last column of Appendix G is mislabeled. It says "2003-2008", but should say 2003-2018. If it actually showed 2003-2008, every number would be negative (i.e., every county's rates were lower, relative to Philadelphia County rates, in 2008 than in 2003, other than Delaware County).

    - Because NORCAL reduced its rates for Philadelphia and surrounding counties in 2018, the last two columns of Appendix G give the appearance that all of the other counties rates are higher, relative to Philadelphia County, than they were in 2003. Note that the rates for every county in Pennsylvania are significantly lower in 2018 than they were in 2003.

    - Below is an example of what Appendix G of the LBFC Report would look like if 2017 rates had been included.

County Rates Compared to Philadelphia

County	2003	2008	2017	2018	2003 to 2008	2008 to 2017	2017 to 2018
Adams	55,821	51,662	48,367	48,367			
Philadelphia	93,033	92,261	86,489	75,798			
	60.00%	56.00%	55.92%	63.81%	-4.01%	-0.07%	7.89%
Allegheny	55,821	51,662	48,367	48,367			
Philadelphia	93,033	92,261	86,489	75,798			
	60.00%	56.00%	55.92%	63.81%	-4.01%	-0.07%	7.89%
Armstrong	55,821	51,662	48,367	48,367			
Philadelphia	93,033	92,261	86,489	75,798			
	60.00%	56.00%	55.92%	63.81%	-4.01%	-0.07%	7.89%
Beaver	55,821	51,662	48,367	48,367			
Philadelphia	93,033	92,261	86,489	75,798			
	60.00%	56.00%	55.92%	63.81%	-4.01%	-0.07%	7.89%
Bedford	55,821	51,662	48,367	48,367			
Philadelphia	93,033	92,261	86,489	75,798			
	60.00%	56.00%	55.92%	63.81%	-4.01%	-0.07%	7.89%
				•			
				•			
				•			
Bucks	93,033	85,642	68,256	59,555			
Philadelphia	93,033	92,261	86,489	75,798			
	100.00%	92.83%	78.92%	78.57%	-7.17%	-13.91%	-0.35%
				•			
				•			
				•			
Chester	93,033	85,642	68,256	59,555			
Philadelphia	93,033	92,261	86,489	75,798			
	100.00%	92.83%	78.92%	78.57%	-7.17%	-13.91%	-0.35%
				•			
				•			
				•			
Delaware	93,033	92,261	86,489	75,798			
Philadelphia	93,033	92,261	86,489	75,798			
	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%
				•			
				•			
				•			
Montgomery	93,033	85,642	68,256	59,555			
Philadelphia	93,033	92,261	86,489	75,798			
	100.00%	92.83%	78.92%	78.57%	-7.17%	-13.91%	-0.35%

Conclusion

There have been significant reductions in Pennsylvania's MPL rates since 2003, with even larger reductions in the counties surrounding Philadelphia. These changes are a direct result of the reforms enacted in 2002 and 2003, not a result of "national trends". If the venue rule were to be reversed, the impact on MPL rates in Pennsylvania would be significant and immediate rate increases, particularly in the counties surrounding Philadelphia. The potential rate increases shown in Exhibit 2 of the Milliman Report show the impact if the rule reversal put things back to "the way they were prior to 2003". However, due to consolidation, the healthcare industry in Pennsylvania is far different than it was prior to 2003. For example, it would be much easier today to file a claim in Philadelphia County under the old venue rule, since health systems based in Philadelphia have expanded into additional counties since 2003. This is described in detail on pages 68-73 of the LBFC Report.

Changing the venue rule could potentially increase the number of claims filed statewide, and would certainly result in a shift to a much larger percentage of claims being filed in Philadelphia County. Exhibit 3 of the Milliman Report shows that the average award in Philadelphia County is about three times larger than awards for claims filed outside of Philadelphia County. MPL rates are based on the county in which the physician practices, not the county in which claims are filed. However, an increase in the size of the awards due to a larger proportion of claims being filed in Philadelphia County would have a material impact on the MPL rates for counties statewide.