Dr. Gregory Sorensen, M.D. Testimony of Tower Health

Senate Judiciary Committee

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Chairwoman Baker, and members of the Committee, thank you for the opportunity to participate in this hearing today. My name is Dr. Greg Sorensen and I am the Executive Vice President and Chief Medical Officer at Tower Health, a regional, non-profit hospital system consisting of seven hospitals which is devoted to improving patient care. I submit these comments on behalf of our health system. I would like to offer some data regarding Tower Health and my own observations and then make myself available to answer questions.

Tower Health's Story

Until October 2017, I was Senior Vice President and Chief Medical Officer of the Reading Health System in Berks County. In October 2017, Reading Health System purchased five hospitals from a national, for-profit company called CHS. After the purchase of these additional facilities, our name changed from Reading Health System to Tower Health. One of the five hospitals we purchased is Chestnut Hill Hospital in Philadelphia. Under the proposed venue change that is the focus of today's hearing, that purchase may be considered to be sufficient to hail into court in Philadelphia County any of the approximately 800 physicians affiliated with Tower Health or employed by Tower Health Medical Group, 90% of whom practice outside of Philadelphia County. At the end of 2018, Tower Health also entered into a joint venture with Drexel University and purchased St. Christopher's Hospital after the parent company declared bankruptcy. Setting aside St. Christopher's, Reading Hospital has more beds than the other five Tower Health affiliated hospitals combined, subjecting hundreds of providers exclusively serving patients in Berks County to being sued in Philadelphia.

Unlike some of the other Pennsylvania health systems, Tower Health's flagship hospital is not based in Philadelphia. In fact, almost 90% of the beds in Tower affiliated hospitals and practices are outside of Philadelphia County.

Had current Rule 1006(a.1) not been in place in 2017, purchasing the hospitals would have been a wholly different financial calculation. While I cannot speculate as to whether the purchase would not have been made, it is certain that the financial burdens would have needed to be considered carefully. In any case, Rule 1006(a.1)'s role in stabilizing the pre-2003 crisis in Pennsylvania healthcare can hardly be overstated. As recently as 2012, the Administrative Office of Pennsylvania Courts (AOPC) has observed that the rules promulgated by Pennsylvania Supreme Court in 2002 to address the "medical malpractice 'crisis'," including Rule 1006(a.1), "have been very successful in helping address the problem." The AOPC has noted that Rule 1006(a.1) is one of the two rules, along with the rule requiring certificates of merit to support medical malpractice claims, that "have been especially effective" in this regard as it "eliminated a practice of 'venue shopping' in which lawyers might file cases in counties where they believe juries would be most sympathetic to their clients." *See* "Background on Medical Malpractice," *available at* http://www.pacourts.us/assets/files/setting-2236/file-1736.pdf?cb=ee37a5. It is not a coincidence that since the rule change in 2003, the number of system-affiliated rural hospitals in Pennsylvania has almost doubled. There were 29 system-affiliated hospitals in rural PA counties in 2002; by 2018 there were 57.

Tower Health remains devoted to delivering excellent care, but, as I will explain today, there will be costly and significant impacts if the venue rule changes. At a minimum, the proposed change is likely to delay the expansion of services and to burden providers in the system and make coverage costs soar. I understand that the Supreme Court's Civil Procedural Rules Committee originally considered eliminating Rule 1006(a.1) in late 2018. In the two years since this issue was brought to the table, hospitals have come to face a very different world. The last six months in particular have unexpectedly imperiled our healthcare providers. The COVID-19 pandemic has placed hospitals, including ours, in a more precarious financial position. Eliminating Rule 1006(a.1) would only exacerbate the risks to healthcare in Pennsylvania. I fear that altering any of the changes previously made to address and relieve the pre-2003 medical malpractice crisis may result, not only in a return to the prior crisis situation, but - in light of changes in Pennsylvania hospitals since that time - an even greater crisis.

If the rule is changed, physicians who practice exclusively in Berks County or Montgomery County or Chester County will be sued in Philadelphia County. A plaintiff can initiate a lawsuit in Philadelphia against a family physician providing care in Womelsdorf just by naming the medical group that also employs physicians in Philadelphia, even though the family physician's care never extends beyond the four walls of her Berks County office. Indeed, the primary care area of Tower includes Lancaster and Carbon counties. This would include Tower Health's urgent care facilities and home health practitioners. The venue rule will not allow patients to have a greater access to justice. It will, however, expose physicians to forums from which they, and the care at issue, are completely removed.

The Commonwealth remains in the midst of the COVID-19 pandemic. Some predict another surge of cases this fall. Health systems, including Tower Health, have been thrown into difficult financial positions. Pandemic mitigation was the causal factor in the reduction of Tower Health affiliated entity's workforce by 1,000 employees and places our hospitals in a more precarious financial state. The delivery of care has been made more challenging by the current situation. Tower has had to make difficult, financially-compelled decisions to limit services in particular areas in this uncertain time. And these times will be made even less certain for Pennsylvania's hospitals and those who depend on them if the venue rule is eliminated.

The 2003 Change Addressed a Crisis

It was my observation that prior to 2003, the healthcare environment in Pennsylvania was broken and in crisis. It is my understanding that **prior to the implementation of Rule 1006(a.1), nearly half of all medical malpractice lawsuits filed in Pennsylvania were venued in Philadelphia, where Plaintiffs verdicts were higher and more common**. In the three years leading up to the Rule's adoption, Philadelphia had the greatest percentage of plaintiff verdicts and 70% of Pennsylvania's medical malpractice verdicts in excess of $1 million were rendered in Philadelphia. Most of the jury awards that exceeded $10 million were in Philadelphia.

This resulted in the skyrocketing of malpractice premiums:

- Between 2000 and 2003, general surgery annual premiums increased 380% (from $33,600 to $128,500)

- Between 2000 and 2003, OB/GYN premiums increased 428% (from $37,600 to $161,000)

During those years, three major malpractice carriers (St. Paul, Princeton, and MIIX) abandoned Pennsylvania. Four major malpractice carriers (PHICO, PIC, PIE of Ohio, and AHSPIC) failed. Hospitals could not obtain reinsurance to cover risk above the physician's $1 million.

MCARE's modest tort reform did not limit damages for plaintiffs, but did stabilize the industry. Doctors and insurance companies have come to rely on the current rule; doctors in choosing where to practice and insurance companies in setting premiums. The LBFC Report discusses both. LBFC Report, p. 23, Findings 2 and 3, and p. 114, n. 122. Changing the rule will upset this reasonable reliance by the doctors and their insurers. It can lead to an unpredictable market and destabilization of premium rates. On the other side of this equation, there is no such reliance on the part of plaintiffs. It would be silly to think that a patient chose his or her health care provider based on where the provider could be sued in the event of alleged medical negligence. And Rule 1006(a.1) offered the greatest impact. It is only being considered here because a plaintiff's lawyer who makes his living suing health care professionals and seeks a return to the good old days of forum shopping wrote to the Supreme Court's Civil Procedural Rules Committee and asked that Rule 1006(a.1) be eliminated. *See* LBFC Report, p. 16, n.25 and Appendix B. That is hardly a valid reason for the Legislature to reconsider its determination when enacting Act 127 of 2002 which provided that, "as a matter of public policy, there existed a need to change venue requirements for medical professional liability actions" and adopted section 5101.1 of the Judicial Code, 42 Pa.C.S. § 5101.1. *See* Act 20 of 2019, p. 5, lines 1-3.

Such a return would not ensure justice as some of the other witnesses have told you. There are simply no barriers to justice when a patient sues her physician in the place where she was treated and received care. Since 2003, Pennsylvania has ranked second in high value medical malpractice payouts ($500,000 or greater). In fact, in 2018, Pennsylvania doctors resolved more claims between $500,000 and $1 million than doctors in any other state. Lawsuits have remained consistent since 2003. In fact, since 2017, medical malpractice trials have increased. The AOPC data shows that 2018 saw 106 jury trials involving medical malpractice, an increase of almost 4% from the year before. Indeed, Prof. Klick confirms: "It is clear that Pennsylvania did not exhibit statistically significant declines in litigation rates, settlement/judgment amounts, or insurance premiums relative to other states" following the change in the venue rule. Assuming the accuracy of that statement, it's clear that the change in the venue rule (and the other rule changes that resulted from MCARE, including the certificate of merit requirement) did no harm to plaintiffs. If there's no harm, there's no need to change any of the rules as a change would be similarly inconsequential.

Professor Klick and Mr. Latta of the LBFC emphasize that the LBFC report is inconclusive because it was inappropriate to try to make conclusions based on one factor when other factors (including certificates of merit and MCARE's "collateral source" rule) also impacted the statistics. The obvious may be missed in all of this: every one of the changes had positive results. While Jason Matsus, Esq., the plaintiff's lawyer who started the discussion of changing the venue rule, quoted a news article which quoted the former chief justice as saying, in 2011, "the crisis is over," the full context of the quote is critical. The news article attorney Matsus refers to quotes the chief justice as noting that "Pennsylvania's judiciary collaboratively addressed a complex medical malpractice litigation crisis, and the latest [i.e. 2010] figures show the progress made in the last seven years. One of our fundamental priorities is to assure the Commonwealth's citizens that the legal process will not be abused in malpractice cases. We're very encouraged by these statistics." *Then* he says: "The crisis is over."

The combination of rules, restricting venue to the county of the alleged malpractice and requiring certificates of merit, have both been identified by the AOPC as having been successful in helping to address what had been a serious problem. There is no reason to have to decide if one change was or was not more important than another when the combination of rules has aided in alleviating the problem that the Legislature and the Court recognized. This seems to be particularly so when

it appears that it cannot be conclusively determined that changing one of the rules will not return the Commonwealth to the situation that resulted in the rules changes in the first place.

As a physician, I find it helpful to compare this situation to a clinical setting. When treating a patient with a complex medical diagnosis who has stabilized with the help of a number of therapies, it would seem ill-advised to remove a single one of them. If a combination of therapies have brought a patient's system to stability, the risk of de-stabilizing her by removing one would not be prudent. The removal of Rule 1006(a.1) from the remedies which addressed the pre-2003 crisis would seem similarly dubious and risky.

Reverting to the Pre-2003 Rule Will Have a Devastating Effect on Care

While Tower Health's history and story is unique, the phenomena of health systems replacing independent hospitals in the years since the adoption of Rule 1006(a.1) is statewide. Since 2002, the number of Pennsylvania hospitals in health systems has increased by 63% (2002 (77) vs 2017 (128)), while the number of independent hospitals has been reduced by 75% (2002 (79) vs. 2017 (27)). I believe this change is the result, at least in part, of reliance on that rule. In any event, **reverting to the general venue rule will have a devastating impact of Pennsylvania's health system model**:

Of the 7 hospitals owned in whole or in part by Tower Health, 5 hospitals have no presence in Philadelphia; with the old venue rule reinstated, all its providers, including those practicing exclusively in Berks, Montgomery and Chester counties can be sued in Philadelphia.

The insurance premiums paid by the healthcare community directly reflect the effect of potentially being subject to a lawsuit in Philadelphia. Physicians practicing in Philadelphia are subject to a Prevailing Primary Premium and Assessment that is more than twice as high compared to physicians practicing in the same specialty in the remainder of the Commonwealth. For instance, OB/GYNs in Philadelphia pay more than $100,000; OB/GYNs in Berks, Cumberland, Lancaster, York, and 35 other counties pay less than $50,000. Neurosurgeons in Philadelphia pay upwards of $150,000 while neurosurgeons in Berks, Cumberland, Lancaster, York, and 35 other counties pay less than half of that amount. The 2.25 times "Philadelphia malpractice premium" will apply to critical specialties, including trauma and emergency physicians.

Tower Health affiliated providers and facilities will face sharply increased costs of insurance due specifically to the proposed change to the venue rule. Tower Health's actuary has estimated that the cost of its primary medical malpractice coverage (only the first $500,000 of coverage) will increase approximately $1 Million in the first year alone. In addition, if the MCARE surcharge is aligned to the Philadelphia county code for pricing for Tower affiliated physicians and entities since all may be subject to suit in Philadelphia, that change will result in an additional $3.3 Million more per year for MCARE coverage.

The expected increase to the excess coverages are likely to increase at an even greater rate. Already, insurers (including Swiss Re, OneBeacon, Munich Re, Zurich and QBE) are leaving the market. Others are restricting limits. The mere possibility of reverting to pre-2003 venue rules has begun to cause disruptions and restrictions and, if the rule changes, more are expected.

While the LBFC Report may have been inconclusive in some respects, it did state that:

(1) "[b]ased on the available data, there was a correlation between medical malpractice insurance rates and the number of active medical staff with clinical privileges in certain counties and specialties; however, the data also did not indicate any overwhelming statewide trends;"

(2) "[t]he available data leads to the conclusion that medical malpractice insurance may have an effect on a physician's decision on where to practice, however, there are many other factors outside the scope of this study that may influence those decisions;" and

(3) "[i]nsurance companies value stability and predictability. A change in the venue rule, coupled with the regionalization of hospital services, would likely create a less predictable market in the near term. If insurance companies have a more difficult time predicting their costs, rates may destabilize soon after as they adjust to the new rule."

Pennsylvania continues to have difficulty retaining physicians and this problem will be exacerbated by reverted to the general venue rule. Despite ranking 4th in the nation for the percentage of enrolled medical students per population, Pennsylvania only manages to retain 31.9% of those physicians after graduation, ranking 34th in the country. Tower is devoted to recruiting and retaining talented physicians. As part of Tower's joint venture with Drexel and at its campus in Reading, the system has made an aggressive move to train and retain 500+ residents. This puts that strategy in some degree of jeopardy.

Rural hospitals are already at risk. So far in the last year, two rural hospitals in our Commonwealth have closed: UPMC Susquehanna Sunbury closed in February 2020 and Ellwood City Medical Center closed in December 2019. Nationally, 19 rural hospitals closed in 2019 - the most since 2005. The fate of other Pennsylvania hospitals may depend upon maintaining the stability and fairness that Rule 1006(a.1) offers. The availability of quality care and expansion of services, particularly in rural areas, depends upon claims against medical professionals being brought where the care was given.

Two firsthand experiences underscore the data before the Committee regarding the impact on care this rule change will have:

1) I used to practice on the west coast in Seattle, Washington as executive director of the service line at large, not-for-profit health system and, as a result, had vision into physician recruiting. Prior to 2003, a disproportionate number of the applicants for neurosurgery were from Pennsylvania. They were seeking to leave this Commonwealth and willing to move their families to the west coast in order to escape the medical malpractice insurance crisis here. I have no doubt we will see the same result if the venue rule is changed.

2) At Tower Health's urgent care facilities, the top two diagnoses right now are anxiety disorder and depression. Physicians, those who have been on the frontline of the recent pandemic and all of them affected by it in some way, are not immune from the issues plaguing all Americans. Without any other perturbing factors in their practices many are already thinking of leaving the practice of medicine. The losses that our health system has experienced from COVID-19, when combined with the proposed rule change, will drive physicians away from providing care into other jobs.

The data over the last 17 years has shown that plaintiffs continue to receive more compensation from Pennsylvania healthcare providers compared to healthcare providers throughout the country. Access to justice has not been diminished by Rule 1006(a.1). That modest, reasonable rule has

stabilized the healthcare environment, allowing patients in the Commonwealth greater access to quality care and longevity for all systems.