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SENATE JUDICIARY HEARING
RE: LEGISLATIVE BUDGET AND FINANCE COMMITTEE STUDY ON VENUE
WRITTEN REMARKS, SEPTEMBER 8, 2020

These written remarks are being provided on behalf of the Pennsylvania Association for Justice ("PAJ"), a non-profit organization comprised of over 2,000 members of the trial bar of the Commonwealth of Pennsylvania. For over 50 years, PAJ has promoted the rights of Pennsylvanians by advocating for the unfettered right of access to justice and maintenance of a free and independent judiciary.

EXECUTIVE SUMMARY

The Legislative Budget and Finance Committee's (herein, "LBFC") Senate Resolution 20 study demonstrates that adoption of the Civil Procedural Rules Committee's proposed amendment relating to venue would not lead to any of the "doom and gloom" predictions made by opponents of this amendment.

As such, opponents of the amendment will inevitably line up to refute the findings of the LBFC study. This study, however, is not the only study that shows that claims made by "tort reformers" are unsupported by data. Simply stated, there is no measured connection between a rule of procedure pertaining to venue and medical malpractice insurance costs, the number of doctors, or the access to or availability of healthcare.

Instead, the unfairness of the existing and unconstitutional venue rule, which provides an unjustifiable advantage to medical malpractice defendants, tips the scales of justice in favor of billion-dollar insurers and hospitals, impugning the integrity of Pennsylvania's civil justice system.

Study after study reveal that claims justifying the creation and continued use of this unfair rule are unsupported. The LBFC study is another one of these studies. As such, it is time for the Supreme Court to remedy this unconstitutional and unfair violation that provides special treatment for medical practice defendants at the expense of Pennsylvanians.

Key points:

- The LBFC was not able to find that reversion of the Special Venue Rule would yield a measurable impact on medical malpractice rates, access to care, or quality of care.

- Justifications for the draconian reforms that occurred in the early 2000s relating to medical malpractice litigation have all been debunked. As such, the unfairness of these reforms can no longer be justified requiring their immediate reversion.

- In 2008, Milliman, Inc., the same consultants relied upon by those challenging the LBFC study, found that medical error cost the United States $19.8 billion. $17 billion of that was the result of providing inpatient, outpatient and prescription drug services to individuals effected by medical errors. Milliman now joins advocates seeking to perpetuate a rule that reduces scrutiny of these errors and denies justice to those who were harmed.

- "Tort reforms" such as the Special Venue Rule that benefit only medical malpractice defendants relieve culpable parties of liability, shifting the financial burden of a victim of medical malpractice's treatment costs and lost wages to taxpayers.

INTRODUCTION

In January 2019, the Pennsylvania Supreme Court's Civil Procedural Rules Committee proposed amendments to the Rules of Civil Procedure relating to venue ("the Special Venue Rule").[1] Specifically, the Committee proposed that the Supreme Court remove the Special Venue Rule to remedy an unconstitutional inequity.[2]

Although the decision regarding the continued use of the Special Venue Rule lies exclusively within the province of the Supreme Court of Pennsylvania, the Senate directed the Legislative Budget and Finance Committee to study the impact of the Special Venue Rule on the medical malpractice insurance marketplace, availability of medical staff, and access to care.[3] After extensive hearings, submission of substantial data and expert analysis, and intensive study by the LBFC, the Senate's questions were answered as follows:

- Is there an evidence-based link between the Venue Rule and medical malpractice insurance availability, cost, and affordability*?*

  "*Available data does not support a conclusion that changes in the availability, cost, and affordability of medical professional liability insurance are the result of the 2003 venue rule change."*

- Will returning the Venue Rule to the same rule applied to all other litigants in Pennsylvania impact access to quality care*?*

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[1] *See* Pa. Civil Procedural Rules Committee, *Notice of Proposed Rulemaking (Proposed Amendment of Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179)*, Exploratory Comment.
[2] *Id.*
[3] *See* Pa. Senate Resolution 20 of 2019.

"*The available data indicates no statewide trends between medical malpractice insurance rates and the number of active medical staff with clinical privileges.*"

- Will returning the Venue Rule to the same rule applied to all other litigants in Pennsylvania impact access to care*?*

> *"The data did not lead to a conclusion on the effect of venue on the availability of hospitals and/or hospital services statewide."*[4]

Each claim made by proponents of the perpetuation of the unfair Special Venue Rule was debunked by the LBFC study. The Special Venue Rule was implemented along with numerous other reforms. Consequently, the LBFC concludes that, "statistically speaking, it is largely not possible to isolate one variable if multiple changes are occurring (in this case, the changes provided for in the MCARE Act) at the same time."[5]

Notwithstanding the factual, statistical, and common-sense foundations of the LBFC study, opponents of the reversion of the Special Venue Rule now attack the LBFC Study simply causing further delay in the Supreme Court's decision-making. There is no empirical data that exists that provides even a rational basis allowing for the perpetuation of Pennsylvania's unconstitutional Special Venue Rule.

HISTORY OF THE SPECIAL VENUE RULE

As members of this Committee are aware, circa 2000, special interest groups launched significant lobbying efforts focused on enacting wide-ranging "tort reform" measures to combat an alleged medical malpractice insurance "crisis." Those groups made several claims that have repeatedly been proven as unsupported by data or fabricated: "doctors will flee," "insurance premiums will increase," and "access to care will be reduced."[6] They conveniently left out the fact that all but one state contiguous to Pennsylvania have the same venue rule as the one being proposed by the Court.[7] They also failed to mention the fact that the defense wins eighty percent of the jury verdicts statewide in all medical malpractice cases.[8] They also falsely suggested that anyone can file a lawsuit in any county they want.[9]

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[4] *See* Pennsylvania Legislative Budget and Finance Committee, *A Study of the Impact of Venue for Medical Professional Liability Actions*, Feb 2020, report summary.

[5] *Id.* at 5.

[6] Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform"*, 5 Yale J. Health Pol'y L. & Ethics (2005).

[7] Delaware, New York, New Jersey, Ohio, and West Virginia all provide venue for malpractice actions in the county where the Defendant resides or conducts business. The only state contiguous to Pennsylvania that prohibits venue where the Defendant conducts business is Maryland. Note: In W.V. actions against nursing homes may only be filed where the nursing home in question is located.

[8] Pennsylvania Medical Malpractice Case Filings Statewide: 2000 - 2018, maintained by the Admin. Office of Pa. Courts (AOPC), available at http://www.pacourts.us/assets/files/setting-2929/file-7458.pdf?cb=02eea5. During the measured period there were 2,020 total jury verdicts, and of those 1,634 were for the defense.

[9] *Schroder: New court rule may reignite lawsuit venue shopping*, MediaNews Group (Jan. 24, 2019), available at https://www.dailylocal.com/news/local/schroder-new-court-rule-may-reignite-lawsuit-venue-shopping/article_07fda348-1fe1-11e9-a0e3-57e449fab66b.html, stating "[s]hould this rule be adopted, lawyers

Without regard and access to the data revealing the real cause of the insurance "crisis," various legislative and judicial reforms were enacted, including passage of the Medical Care and Reduction of Errors Act (hereinafter "MCARE Act").[10] Among the many reforms were the reduction in the amount of liability coverage health care providers were required to maintain (from 1.2 million to 1 million dollars); elimination of the collateral source rule; abrogation of joint liability[11]; reduction to present worth for future earnings losses; and periodic payments of future medical and personal care expenses that are extinguished upon death of the malpractice victim.

We know this for certain—claims used to manufacture the "crisis" that led to all of these changes were unsupported, if not fabricated. Doctors were not leaving Pennsylvania in droves "because they could not afford their malpractice insurance any longer."[12] Data shows that doctors were not leaving, but in fact they were gaining numbers. "Despite claims that Pennsylvania is losing doctors to other states as a result of high liability insurance premiums, official statistics from the American Medical Association and from the Federation of State Licensing Boards show an actual per capita increase in treating physicians."[13] Insurance rates were increasing because of market forces, not lawsuits.[14]

As part of the omnibus tort reform measures, the General Assembly also passed legislation creating a special rule providing that professional liability actions against medical professionals could only be brought in the county in which the cause of action arose.[15] This enactment occurred despite general venue provisions already existing in the Rules of Civil Procedure.[16] Within a year, the General Assembly's enactment was declared unconstitutional by the Commonwealth Court in that it invaded the province of the Supreme Court as the exclusive power to prescribe general procedural rules governing operation of the courts.[17]

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will once again 'venue shop' by filing suit in a locale most likely to provide a juicy contingency fee as opposed to where a case should be filed."

[10] 40 P.S. § 1303.101—§ 1303.910.

[11] Joint liability was abrogated via Act 57 of 2002. That enactment was later declared unconstitutional for violation of the single-subject rule (*See DeWeese v. Weaver*, 880 A.2d 54 (Pa. Cmnwlth. 2005)). Act 17 of 2011 ultimately abrogated joint liability.

[12] Steve Esack, *Politics, money and fears in Pennsylvania medical malpractice fight*, The Morning Call (Feb. 10, 2019), http://www.mcall.com/news/pennsylvania/mc-nws-medical-malpractice-court-change-fight-20190204-story.html. "For years, insurance companies set malpractice rates artificially low to gain customers. That practice caused three major malpractice insurance companies to go belly up in the 1990s and early 2000s. Then, following a 2001 stock market swoon, insurers raised rates to offset investment losses."

[13] *Id. See also*, *Medical Misdiagnosis in Pennsylvania: Challenging the Medical Malpractice Claims of the Doctors' Lobby*, Public Citizen (Apr. 2003).

[14] *See* Boehn at n.6, stating "historically, the cause of skyrocketing rates has little to do with the legal system." Boehm further notes that the fall in insurance company's investment income that occurred between 2002 and 2003 had more to do with increased medical malpractice premiums than litigation (at 8-10).

[15] 42 Pa.C.S.A. § 5101.1.

[16] Pa.R.C.P. 1006.

[17] *See Weaver*, n.11 for citation.

Concurrent with the Commonwealth Court's striking down of the legislation, the Pennsylvania Supreme Court amended the Venue Rule provided for in the Rules of Civil Procedure[18] to include virtually identical language from the General Assembly's now unconstitutional enactment.[19] In addition to the modification of the Special Venue Rule, the Supreme Court also required that medical malpractice cases be filed with a Certificate of Merit from a physician stating that there is a reasonable probability that a medical malpractice defendant deviated from the accepted standard of medical care, which caused the plaintiff harm.[20] While the Certificate of Merit requirement applies to all professional negligence claims—including those against accountants, architects, engineers, and attorneys—the current preferential Special Venue Rule only applies to healthcare professionals.

There was not then, nor is there today, data that connects the stabilization of the medical malpractice insurance industry or access to health care with venue restrictions. The LBFC (through its analysis conducted pursuant to Senate Resolution 20) and generally accepted statistical analysis standards confirm that it is impossible, despite what will be said by those who wish to perpetuate the unfair rule, to point to the impact of venue limitations in isolation. [21]

FILING A MEDICAL MALPRACTICE ACTION

Under Pennsylvania law, a medical malpractice action can only be filed if the patient was injured or killed through a negligent act or omission of a healthcare provider.

To establish liability in a medical malpractice lawsuit, the injured party (plaintiff) must prove each of four elements: duty, breach, causation, damages.

- Duty: Did the doctor or facility owe a duty of care to the patient?
- Breach: If the doctor or facility owed a duty, did the care provided fall below the reasonable or accepted standard care? [22]
- Causation: Was the unreasonable or substandard care the factual cause of the patient's injury or death?
- Damages: Are there compensable damages attributed to the injury caused by the unreasonable or substandard care?

Additionally, as part of the "tort reform" movement of the early 2000s, the Courts enacted a rule requiring that a certificate of merit be filed with (or within 60 days of) the lawsuit.[23] A certificate of merit is one of several procedural hurdles that a plaintiff must jump over in order to file a medical

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[18] *See,* Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179 for "Venue Rule."

[19] *See,* Pa.R.C.P. 1006(a.1).

[20] *See* Pa.R.C.P. No. 1042.3 for "Certificate of Merit."

[21] It is generally not possible to isolate and measure the impact of any one variable of multiple variables that have all been introduced at the same time. *See* Jeffrey M. Wooldridge, *Introductory Econometrics: A Modern Approach,* 4th ed. (2009), p.85 for a discussion of what is known as the "perfect collinearity."

[22] In medical malpractice actions, the standard of care is determined by asking "what would the same type of doctor have done under the same set of circumstances." If the care provided was "reasonable" or not below the accepted standard of care, the plaintiff's case cannot prevail.

[23] *See* n.20 for citation for "certificate of merit."

malpractice action.[24] Under Pennsylvania law, a qualified medical professional must be hired and attest in writing that they believe that there is a reasonable probability that the doctor's care "fell outside acceptable professional standards" causing the plaintiff's injury or death.[25]

VENUE, SPECIFICALLY

Once the plaintiff has established negligence and obtained a certificate of merit, the next step is determining venue – in which county to file the lawsuit. Opponents of the proposed venue rule change suggest that should the change occur, trial lawyers will be allowed to "venue shop," meaning choose the county most favorable to the plaintiff. This is not true.

First, it's important to note that Pennsylvania Supreme Court possesses the sole authority to prescribe general procedural rules governing the operation of the courts.[26] Venue is such a procedural rule that falls under the exclusive purview of the Supreme Court.[27]

Second, prior to the enactment of the Special Venue Rule in 2003, the venue rules were fair – all classes of defendants were treated equally, irrespective of the nature of the plaintiff's injury or the defendant's line of business. A plaintiff could file a lawsuit either where the cause of action (the incident giving rise to the lawsuit) occurred or where the defendant regularly conducts business (such as the county where their corporation is headquartered). The current law treats healthcare providers that conduct business in multiple counties differently, limiting where they can be held accountable for their actions.

Even before the enactment of the Special Venue Rule, there has existed a procedural safeguard to prevent so-called "venue shopping." Pennsylvania Rule of Civil Procedure 1006(d)(1), which existed before the carve out of the Special Venue Rule and remains today, provides that "[f]or the convenience of parties and witnesses the court upon petition of any party may transfer an action to the appropriate court of any other county where the action could originally have been brought." This oft-used mechanism allows defendants who can show that the forum chosen by the plaintiff, even if technically appropriate, is so "inconvenient" that justice requires that the matter be transferred to a different venue, often the home county of the defendant.

Yet there are several reasons why a victim of medical malpractice should not have their venue options unfairly restricted to benefit the defendant – after all, the victim was the one who was injured by the defendant.

> *Example: A corporate hospital group buys a community hospital. The community hospital now advertises that they deliver "big-city, high-quality care," because their protocols, recruiting, staffing decisions, and medical policy are controlled by the parent facility. Based on those advertisements, rather than traveling to a different hospital, the*

[24] Note, as of 2014, Pennsylvania was one of only 28 states that required an affidavit or certificate of merit. (*Available at http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-merit-affidavits-and-expert-witnesses.aspx*)
[25] *See* n.20
[26] *See,* Article V, Section 10(c).
[27] *See Weaver*, n.11.

patient goes to the community hospital because they want the "big-city" care that was advertised. While at the community hospital, the patient suffers an injury caused by medical negligence.

General fairness: It is unfair that the corporate hospital group came into the community, bought the local hospital, implemented its own controls, and advertised that patients would get the same care as those residing in the county where the parent facility is located, but the patient is prohibited from filing a lawsuit challenging those decisions and controls implemented from the parents facility in the county where those actions were taken.

It is even more unfair that if this example involved any business/industry other than healthcare, a victim could file the lawsuit in the county where either the parent facility or affiliate property was located. However, what is most unfair is that healthcare providers hide behind the Special Venue Rule when they are the defendant in a medical malpractice action, but they utilize the full venue rule for all other legal actions where they may be the plaintiff.[28] Said another way, when a hospital affirmatively sues to protect its own financial interests, it has the full spectrum of venue options available to it. Why should those rules be different when it is being sued in a malpractice action seeking accountability?

Fair jury: What if the community hospital is the county's largest employer? Why would the injured victim want to file his or her lawsuit where it is nearly, if not actually, impossible to find twelve jurors who do not work for or have friends or family members who work for that community hospital? How is it fair to the victim who suffered an injury caused by medical negligence to be forced tried by twelve jurors wearing shirts with the community hospital's logo embroidered on its sleeve?

Corporate decisions led to negligence: It is no secret that most preventable medical harm is a result of institutional failures. Even a simple Google search for "understaffing" and "medical error" will lead the reader to scores of articles and studies showing that a hospital's decision to understaff was a significant factor in the occurrence of medical errors.[29] Rare is the case where a doctor simply showed up and was negligent. More often, the negligence is the result of a series of systemic failures: a failure to communicate a patient's condition between departments (such as an allergy or heart abnormality); failure to implement well-known protocols; failure to address massive deficiencies in electronic medical records systems; or understaffing, or long shifts burdening nurses and doctors.[30] In these common examples, the negligence is systemic and a result of decisions made in the corporate office, not necessarily where the negligence occurred. This circumstance illustrates that where the injury occurred is not always the location of the cause of the injury. Venue rules in Pennsylvania and the federal system,

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[28] *I.e.,* Breach of contract claims against a subcontractor, defamation lawsuits, breach of non-compete agreements with doctors who attempt to work at a nearby healthcare facility, etc.

[29] *See, i.e., "Are You Way Too Stressed Out?"* Survey Results: An Assessment of the Stress Levels of Nurses in the United States. Vickie Milazzo Institute (2014). Located at https://www.legalnurse.com/wp-content/uploads/2014/06/RN-Stress-Survey-Results-2014-VickieMilazzoInstitute.pdf

[30] *See*, Ashish Jha (Director of the Harvard Global Health Institute), *The Real Cause of Deadly Medical Errors,* Scientific American (2016). Located at https://blogs.scientificamerican.com/guest-blog/the-real-cause-of-deadly-medical-errors/. *See also*, Steven A Yourstone & Howard L. Smith, *Managing System Errors and Failures in Health Care Organizations: Suggestions for Practice and Research,* Health Care Management Review. 50-61 (Jan. 2002).

other than the Special Venue Rule, recognize this business reality and therefore permit those harmful decisions to be challenged where they were made. The healthcare industry exemption is not fair.

THE REFORMS OF THE 2000s DECREASE PATIENT SAFETY AND ACCESS TO JUSTICE

In addition to preventing the exodus of doctors (which was not true[31]), and stabilizing insurance rates caused by malpractice lawsuits (also not true[32]), "tort reform" was also supposed to make Pennsylvanians safer.[33] Unfortunately, that has not happened. The citizens of Pennsylvania, like the balance of this country, face an epidemic. As the internationally renowned team of researchers at Johns Hopkins University School of Medicine concluded, preventable medical error accounts for over 250,000 deaths per year, making it the third leading cause of death in the United States behind only heart disease (611,000 deaths per year) and cancer (585,000 deaths per year).[34]

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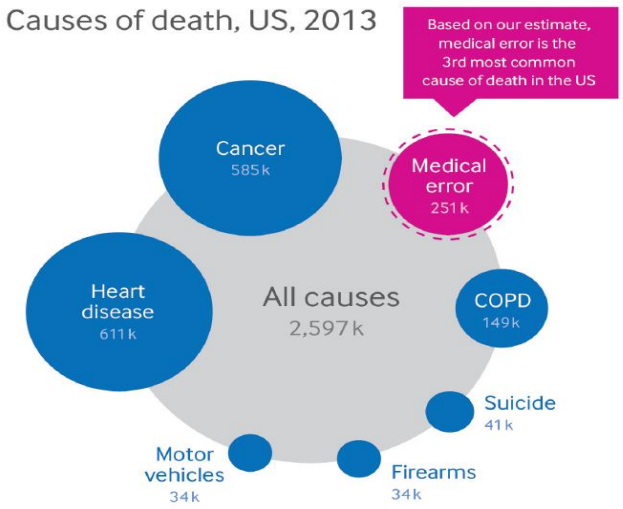
[31] *See* LBFC Study (citation at n.4), p. 30, which shows that the number of total active medical staff with clinical privileges per 10,000 residents increased prior to the 2003-2004 reforms, but decreased the years immediately after the reforms were enacted. While LBFC took considerable care to enunciate, as we have, that the Venue Rule cannot isolated in a fashion to prove or disprove its impact on the number of medical staff, Exhibit 2 demonstrates that claims of doctor flight in the early 2000s and now are unsupported by data.

[32] Rates did in fact decline after the 2003 reforms. However, the decline that occurred in Pennsylvania occurred at a lesser proportionate level than what was observed in other states that did not enact the same reform measures that Pennsylvania did during the same period. *See,* Jonathan Klick, *Comment on Milliman Research Report (Review of Proposed Amendment of Pa. Rules of Civil Procedure Nos. 1006, 2130, 2156, and 2179)* Oct. 2019, available at Pa. Assoc. for Justice, stating, "any change in Pennsylvania premiums was statistically indistinguishable from contemporaneous changes in neighboring states."
See also, for example, Scott Harrington, Patricia Danzon, and Andrew Epstein (2008), *Crises' in Medical Malpractice Insurance: Evidence of Excessive Price-Cutting in the Preceding Soft Market*, Journal of Banking and Finance, 32(1): 157-169.

[33] The MCARE Act provides that "[e]very effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety. *See,* 40 P.S. § 1303.102(5).

[34] Martin A. Makary and Daniel Michael (John Hopkins Medicine), *Medical error - the third leading cause of death in the US*, 353 BMJ 2139 (2016). *See also*, Dep't of Health and Human Services, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*, OEI-06-09-00090 (Nov. 2010), concluding that in 2010, up to 180,000 Medicare patients alone died each year from medical errors; John T. James, *A New Evidence-based Estimate of Patient Harms Associated with Hospital Care*, Journal of Patient Safety p. 122- 128 (Sept 2013), estimating in 2013 that the annual number of deaths attributed to medical error was between 210,000 and 440,000 per year.



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Specific to Pennsylvania, the Patient Safety Authority statistics reveal that health care facilities, which do not even include physician offices and outpatient care, reported 7,881 "serious events" in 2017.[36] At the same time, there were only 1,449 lawsuits filed against all health care providers combined in the Commonwealth.[37] Despite the glaring disparity between the rate of serious events compared to the number of actual lawsuits brought seeking accountability for preventable harm, we know from repeated experience that these "reports" are a gross understatement of the actual number of serious events.[38] These statistics demonstrate that our Commonwealth faces a much greater threat from preventable medical error than the lawsuits brought by victims seeking accountability for preventable harm.

As stated by the Civil Procedural Rules Committee, the Special Venue Rule and other rules are resulting in "far fewer compensated victims of medical negligence."[39] Additionally, despite the requirement that all filed cases must be supported with a Certificate of Merit confirming the validity of the claim, medical

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[35] *Id* at Fig 1, citing CDC data found at http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

[36] A "serious event" is an adverse event resulting in patient harm. An "adverse event" is an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient. Patient Safety Authority, Annual Report, 2017 (www.patientsafetyauthority.org).

[37] The Unified Judicial System of Pennsylvania Medical Malpractice Filings, http://www.pacourts.us/assets/files/setting-2929/file-7458.pdf?cb=02eea5 (accessed August 22, 2020).

[38] Across the Commonwealth, our members report that overwhelmingly most of the serious events that result in settlements or verdicts involve cases where the hospitals failed to report the event to the Patient Safety Authority. Our experience of massive under-reporting of serious events comports with the peer-reviewed findings of patient safety researchers. *See e.g.* Adler L, Yi D, Li M, McBroom B, Hauck L, Sammer C, Jones C, Shaw T, Classen D, *Impact of Inpatient Harms on Hospital Finances and Patient Clinical Outcomes*, J Patient Saf 2018;14:67-73 ("Estimates of inpatient harms are often underreported and rely on self-reported events, the use of administrative data, or internal hospital incident reporting systems.")(citations omitted).

[39] *See* Pa. Civil Procedural Rules Committee, *Notice of Proposed Rulemaking (Proposed Amendment of Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179)*, Exploratory Comment.

malpractice verdicts in Pennsylvania overwhelmingly favor defendants.[40] This trend is especially concerning in light of a national study published in the New England Journal of Medicine concluding that "[a]lthough the number of claims without merit that resulted in compensation was fairly small, the converse form of inaccuracy – claims associated with error and injury that did not result in compensation – was substantially more common. One in six claims involved errors and received no payment."[41]

As the LBFC and others have concluded, it is not possible to measure exactly how much any one change has contributed to the "stabilization" of the medical malpractice insurance industry. Knowing now that among the causes of the insurance "crisis" was not the number of lawsuits nor the venue of the lawsuits, it is clear that a reversal of the Special Venue Rule to the same rule applicable to all other defendants in the Commonwealth will have no impact on the insurance market. Interestingly, in support of their lobbying efforts, the Insurance Federation of Pennsylvania and the Hospital and Healthsystem Association of Pennsylvania, joined by others, submitted to the LBFC a report from Milliman (herein, Milliman study).[42] This report is based on overtly inaccurate assumptions and rhetoric-inspired conjecture rather than the actual data regarding actual claims and actual payments. The report's authors go to great lengths to reveal their lack of access to critical data and even provide a disclaimer admitting the limited usefulness of its study; yet, the sponsors of the Milliman study are the ones that possess the actual data such as the numbers of claims brought (which includes filed and unfiled claims) and those that are settled—numbers that dwarf the numbers of cases that are tried to verdict and relied upon by Milliman. Curiously, if the opponents of the reversal of the Special Venue Rule wanted the LBFC or this Committee to see the truth, they would have disclosed that data.

If this Committee seeks to study the LBFC Report, then we respectfully suggest that this Committee also study the motives of the insurers, hospitals, and health systems who now criticize the LBFC findings. Why would these institutions persistently advance arguments based on conjecture that has been universally debunked rather than actual data they possess? The answer should not surprise this Committee—windfall profits at the expense of Pennsylvanians.

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[40] *See* Medical Malpractice Jury Verdicts: January 2016 to December 2016, The Unified Judicial System of Pennsylvania, prepared August 30, 2017, available at http://www.pacourts.us/assets/files/setting-771/file-6329.pdf?cb=8929e6 (finding that nearly 80% of verdicts were in favor of the defense in 2017). Even in Philadelphia nearly 62% of the cases tried were defense verdicts and not one verdict in 2017 was over $5,000,000.

[41] See David M. Studdert, et al., Claims, errors, and compensation payments in medical malpractice litigation, N. Engl. J. Med. 2006; 354, 2024-33 (May 2006).

[42] *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 Inc., Research Report, February 20, 2019, by Thomas Ryan and Carissa Lorie. Review sponsored by The Hospital and Healthsystem Association of Pennsylvania, Insurance Federation of Pennsylvania, 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.

DEBUNKING THE DEBUNKERERS

It is hard to imagine a scenario where any Senator, yet alone those on the Senate Judiciary Committee, have not been told by insurers, hospitals, and health systems of the cataclysmic predictions made in the Milliman study.

In 2019, groups opposed to the reversion of the Special Venue Rule hired Milliman, Inc. to perform "a quantitative analysis that evaluates the impact of the proposed change on MPL costs in Pennsylvania" (herein, Milliman study). [43]

The Milliman study suggests that:

- Statewide Impact: The current average statewide medical professional liability insurance costs and insurance rates for physicians in Pennsylvania will likely increase by 15%;
- Local/County Impact: Many individual counties will likely see increases in physician medical professional liability rates of 5%, while counties surrounding Philadelphia will likely see larger increases of 45%;
- Physician Specialty Impact: High-risk physician specialties, such as OB/Gyn and General Surgery, will likely experience additional cost and rate increases of 17%, on top of the local/county change noted above.[44]

These predictions are the result of skewed, improper, and unsound data analysis. Not only were these conclusions debunked by the aforementioned LBFC Study, you could debunk the Milliman study without even reading the LBFC Study.

Ignoring the fact that the Milliman study conveniently fails to consider the important implications of the requirement of a certificate of merit[45] and to account for the fact that the Pennsylvania Rules of Civil Procedure provide a mechanism to guard against unfettered and unfair forum shopping,[46] the Milliman study is flawed for four main reasons.

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[43] *Id.*

[44] *Id.* at 3.

[45] *See*, Pa.R.C.P. 1042 which requires that a plaintiff files a certificate of merit in "any action based upon an allegation that a licensed professional deviated from an acceptable professional standard." The certificate must show that either (1) an appropriate licensed professional has supplied a written statement that there exists a reasonable probability that the case, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm; (2) the claim that the defendant deviated from an acceptable professional standard is based solely on allegations that other licensed professionals for whom this defendant is responsible deviated from an acceptable professional standard; or (3) expert testimony of an appropriate licensed professional is unnecessary for prosecution of the claim.

[46] *See* Pa.R.C.P. 1006(d) which allows for a change of venue for the convenience of a party or witness to any other county where the claim could have been brought.

First, the Milliman study makes unsupported assertions regarding the impact of the change in the venue rule. The Special Venue Rule was implemented at the same time as a long list of legislative and judicial enactments directed at medical malpractice litigation.[47] As a result, it is statistically impossible to analyze the impact of a reversion of the Special Venue Rule independent of those other enactments.

Second, the Report fails to provide the LBFC or any other reader any way to assess whether its findings are statistically significant or random chance.[48] As a result, the estimates in the Milliman study are just as likely to be based on statistical noise or coincidence.

Third, the Milliman study failed to note national medical malpractice insurance trends occurring at the time. During the period analyzed by Milliman, it was well-known that the number of medical malpractice lawsuits being filed had been declining nationwide, not just in Pennsylvania.[49] The Report remains strategically silent on the fact that this decline in lawsuits occurred in states that did not change their venue rules or adopt any 'tort reform' at all.[50] As virtually every independent entity that evaluated the post MCARE Act data nationally concluded, the "stabilization" in the medical malpractice insurance marketplace was a function of improving past risky underwriting and investment practices in the medical malpractice insurance industry—not because of change in the number of lawsuits.[51]

Finally, the Milliman study ignores data found in the National Practitioners' Data Bank (NPDB).[52] Analysis of the NPDB data would have been beneficial because it could disentangle results occurring in Pennsylvania from those occurring nationally or in other states. Such a reference to the NPDB would have prevented fatal errors like those noted in the paragraph above. Additionally, while the NPDP data does not break down data by county, it is much more comprehensive than the AOPC data which Milliman chose as its sole source of data. By doing so, Milliman used a much smaller data set which does not capture data regarding settlements which gives a more complete picture of the liability environment. Additionally, the NPDB contains the same data sets dating back to the early 1990s which permits a more comprehensive and credible analysis of pre-MCARE and post-MCARE trends.

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[47] *See supra.*

[48] *See* Klick at n. 35 stating: "[a]t no point in their analysis did the authors ever provide any way for a reader to assess the statistical significance of their estimates of the effect of the change in the venue rule. Failure to engage in tests of statistical significance leaves open the possibility that the declines in premiums and litigation metrics could be consistent with mere random chance alone. By not providing an assessment of these drops relative to the natural variation in the data, it is hard to draw any systematic conclusions. All of the estimates in the Milliman Report could be based on statistical noise."

[49] Myungho Paik, Bernard Black, and David A. Hyman (2013), "The Receding Tide of Medical Malpractice Litigation: Part 1 – National Trends" Journal of Empirical Legal Studies, 10(4): 612-638.

[50] "Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992 – 2014," JAMA Internal Medical, 177(5): 710-718 find a similar decline in medical malpractice litigation rates nationwide.

[51] *See* Boehn at n.6; Esack at n.12; Public Citizen at n.13; Harrington, Danzon, and Epstein at n.35; and Studdert at n.44.

[52] The Milliman study, p.8, states that it analyzed "publicly available information from two main sources," physician rate filings for the Pennsylvania Professional Liability Joint Underwriting Association (PAJUA) and medical malpractice claim filings data from the Association of Pennsylvania Courts (AOPC).

WHY DO THEY WANT TO PERPETUATE ALL TORT REFORM – EVEN IF IT IS UNCONSTITUTIONAL AND UNFAIR? THE $4.5B ANSWER

While there is no data linking the impact of the Special Venue Rule with insurance rates or access to health care, there is data linking the benefits enjoyed by insurers, hospitals, and health systems when victims' access to justice is limited and there is no financial accountability. Since the passage of the MCARE Act, medical malpractice insurers (whether independent companies or captive entities controlled by the hospitals and health systems) have had to report their underwriting profits to the Pennsylvania Insurance Department. Each year, entities providing medical malpractice insurance provide data to the Insurance Department and, in turn, the Insurance Department publishes some of that information in its Annual Statistical Report.[53] According to this data, the insurers, hospitals, and health systems have reaped in excess of $4.5B in mere underwriting profits.[54] Stated differently, they have taken in $4.5B more in premiums than they have paid out in claims. On average, the Pennsylvania medical malpractice insurance marketplace enjoys a 9% advantage when it comes to underwriting profits which includes a significant number of states that have much more draconian tort reform measures.[55]

Setting aside for a moment that these underwriting profits do not include investment income and other financial advantages, these profits benefit the insurers and hospitals/health systems at the expense of Pennsylvanians. First, because virtually all of the insurers and captive insurance entities are domiciled outside of Pennsylvania and/or are subsidiaries of behemoth "non-profit" hospitals and health systems, these massive profits are not taxed like the rest of Pennsylvania's businesses – if they are even taxed at all. Second, it has been shown that the Special Venue Rule inevitably burdens taxpayers for their future medical care and inability to work as a result of the malpractice.[56]

The suggestion that a change in the Special Venue Rule back to the one governing all other Pennsylvanians will impact healthcare and insurance industries at a "crisis" level is absurd. The reason the Insurance Federation of Pennsylvania and the Hospital and Healthsystem Association of Pennsylvania continue to press for the status quo of an unconstitutional Special Venue Rule is clear—massive profits.

THE BURDEN SHIFT TO PENNSYLVANIA'S TAXPAYERS

Insurers and hospitals have made billions thanks to "tort reform." But who ultimately pays for it all? The taxpayers.

"Tort reform" is about one thing, and one thing only—allowing culpable parties to escape accountability. As discussed earlier, medical errors in U.S. hospitals cause 250,000 approximately deaths annually,

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[53] These reports are available at https://www.insurance.pa.gov/Companies/IndustryActivity/Pages/Departments-Prior-Annual-Industry-Statistical-Reports.aspx .

[54] *See,* Attachment 1.

[55] NAIC Countrywide Summary of Medical Professional Liability Insurance 2005-2019, at https://content.naic.org/sites/default/files/inline-files/MED%20MAL%20RPT%202019_0.pdf (accessed August 31, 2020).

[56] Discussed further, *infra.*

making it the third leading cause of death in the country.[57] That's over 684 deaths per day. "If a 747 jetliner crashed every day, killing all 500 people aboard, there would be a national uproar over aviation safety and an all-out mobilization to fix the problem. However, in the nation's hospitals . . . about the same number of people die on average every day from medical 'adverse events,' many of them preventable errors, such as infections or incorrect medications."[58] Rather than working to improve public safety, or owning up to these tragedies, hospitals and insurers continue their campaign to reduce or eliminate payments to patients who were wrongfully injured or killed.

This begs an important question—if the party ultimately responsible for the tragedy is not paying for the medical care and lost wages of the injured patient, who is? Someone needs to pay for the corrective surgery and increased medical needs. What about future medical costs? What happens when the injured patient cannot return to work and earn a living? Those costs, which should have been the burden of the responsible party, and/or perhaps its insurer, now fall on the taxpayers who fund social programs such as Medicare, Medicaid, food assistance programs (such as SNAP), and Welfare.

Interestingly, a study conducted by Milliman (funded by different sponsors in 2008) revealed that medical errors cost the United States about $19.5 billion.[59] Of that, "$1.4 billion could be attributed to increased mortality rates, with $1.1 billion or 10 million days of lost productivity from missed work based on short-term disability claim. . . . [T]he economic impact is much higher, perhaps nearly $1 trillion annually when quality-adjusted life years are applied to those that died [from medical errors]."[60] A subsequent study released in 2011 found that the annual cost of medical error was $17.1 billion.[61] What other industry can cause preventable harm to another and then escape accountability at the expense of taxpayers?

It is ironic that many of the same elected officials who often support these types of "tort reform" measures are also the same ones who oppose increasing taxes. It is axiomatic that if policy makers want to absolve culpable parties of liability, someone else will ultimately be financially accountable for the medical bills and lost wages of the victims of the multi-billion-dollar industry that is medical error. That someone, unfortunately, is taxpayers. In Pennsylvania alone, the Medicaid system receives numerous claims accounting for millions of dollars paid to health care providers because the culpable party was able to escape accountability due to tort reform.

In this era of inevitable devastating budget deficits due to the pandemic, a vote to promote more tort reform is a vote to increase the tax burden on Pennsylvanians.

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[57] *See* n.37.

[58] *See Death by Medicine: Where's the Outrage*, USA Today (Nov. 11, 2010).

[59] Milliman (sponsored by the Society of Actuaries' Health Section), *The Economic Measurement of Medical Errors,* (June 2010), https://www.soa.org/globalassets/assets/files/research/projects/research-econ-measurement.pdf.

[60] Charles Andel, Stephen L Davidow, Mark Hollander, David A Moreno, *The economics of health care quality and medical errors*, J Health Care Finance Fall 2013;39(1);39-50 (citing Milliman 2010, n.45).

[61] Jill Van Den Box, Karan Rustagi, Travis Gray, Michael Halford, Eva Ziemkiewicz, and Jonathan Shreve, *The $17.1 Billion Problem: The Annual Cost of Measurable Medical Errors,* Health Affairs, 30, no.4 (2011):596-603.

THE VENUE RULE VIOLATES THE UNITED STATES AND PENNSYLVANIA EQUAL PROTECTION CLAUSES

No rule should give one group of individuals or corporations special treatment and a preferred status under the law. Section 1 of the Fourteenth Amendment to the U.S. Constitution provides, in pertinent part, that, "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." Similarly, Article I, § 26 of the Pennsylvania Constitution provides that, "[n]either the Commonwealth nor any political subdivision thereof shall deny to any person the enjoyment of any civil right, nor discriminate against any person in the exercise of any civil right." Whether the questioned law is a statute or rule of civil procedure, it is subject to scrutiny under the protections afforded by the federal and state constitutions.[62]

Fundamentally, equal protection requires that the law treat similarly like persons in like circumstances.[63] These Constitutional protections do not require all parties to be treated identically, but do require that the Supreme Court create distinctions that have a fair and substantial relationship to the object of the rule.[64] Recognizing that there are different types of classifications that impact different levels of rights ranging from fundamental rights, important rights, and mere rights, different standards are employed depending upon the level or rights implicated.[65] Because the classification here related to venue limitations favoring health care providers in professional liability actions does not implicate a fundamental right, the analysis is whether any rational basis for this distinction exists.[66] Said differently, is there a rational reason why the Venue Rule is different in medical malpractice actions, than other legal actions? If not, the disparate treatment is unconstitutional.

To apply the rational basis test, there is a two-step analysis. First, the Court must determine whether the challenged rule seeks to promote any legitimate state interest or public value. If so, the Court must next determine whether the classification adopted is reasonably related to accomplishing that articulated state interest or interests.[67]

The LBFC has now answered the fundamental question—is there proof rising to the level of a rational basis that limiting venue bears any relationship to these concerns? The answer is no.

The Venue Rule was borne out of an era when medical malpractice insurance companies were in financial crisis. As multiple non-partisan studies have detailed since, the causes of the financial crisis were self-imposed by insurers who were engaging in unconventional underwriting risks and relying upon even riskier investment strategies to make up for the inevitable underwriting losses.[68] Nevertheless, in a bold effort to hide these mistakes from legislators and regulators, the insurance industry strategists promoted a message blaming these high loss ratios and astronomical premium increases on a medical

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[62] *See e.g., Laudenberger v. Port Authority of Allegheny Cty*, 436 A.2d 147 (Pa. 1981)(Constitutional analysis of Pa.R.C.P. 238).
[63] *Id.*
[64] *Commonwealth v. Parker White Metal Co.*, 515 A.2d 1358 (Pa. 1986).
[65] *Curtis v. Kline*, 666 A.2d 265, 267-8 (Pa. 1995).
[66] *See id*.
[67] *Id*. at 269.
[68] *See* Harrington, Danzon, and Epstein, citation at n.35.

malpractice claims system run amok. In response to these well-orchestrated claims of so-called "frivolous lawsuits" and a tsunami of physicians leaving each state, legislatures and courts across the country implemented a wide array of tort reform measures. As the LBFC and most governmental and academic researchers before them have found, neither the number of medical malpractice lawsuits nor the alleged departure of physicians from Pennsylvania had or has any impact on the stability of the medical malpractice insurance market. Consequently, the LBFC conclusions, which align with most other non-partisan researchers, confirm that no rational basis existed or exists to support the current Venue Rule. (Not to mention that physicians did not depart the Commonwealth.)

THE VENUE RULE VIOLATES U.S. AND PA DUE PROCESS CLAUSES

Section 1 of the Fourteenth Amendment to the U.S. Constitution provides, in pertinent part, that, "nor shall any State deprive any person of life, liberty, or property without due process of law . . .." Similarly, Article I, Section 1 of the Pennsylvania Constitution provides that "[a]ll men are born equally free and independent, and have certain inherent and indefeasible rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing and protecting property and reputation, and of pursuing their own happiness." The touchstone of substantive due process, as with equal protection, is whether the law in question is rationally related to a legitimate state goal, or whether the state action arbitrarily works to deny an individual of life, liberty, or property.[69]

With the exception of some issues impacting criminal defendants, challenges under both the federal and Pennsylvania due process clauses are analyzed accordingly:[70] "a law which purports to be an exercise of the police power must not be unreasonable, unduly oppressive or patently beyond the necessities of the case, and the means which it employs must have a real and substantial relation to the objects sought to be attained."[71] As described above, the preferential treatment for venue purposes afforded to health care providers bears no relation, no less a rational relationship to the goals of maintaining quality health care. In fact, all the data collected in this regard suggests the contrary.

The Supreme Court of Pennsylvania is empowered to "prescribe general rules governing practice, procedure, and the conduct of all courts . . . if such rules are consistent with this Constitution and neither abridge, enlarge, nor modify the substantive rights of any litigant . . .."[72] As a result, if the Venue Rule is not rescinded, it must inevitably be declared unconstitutional.

ADDITIONAL CONSIDERATIONS

Prior to passage, we argued that Senate Resolution 20 would further delay the Pennsylvania Supreme Court's consideration of fairness and access to justice that the reversion of the Special Venue Rule would allow. While we are pleased, but not surprised, that the LBFC Study yielded results that support

[69] *See Rogin v. Bensalem*, 616 F.2d 680 (3d Cir. 1980).
[70] *Commonwealth v. Snyder*, 713 A.2d 596 (Pa. 1998).
[71] *Gambone v. Commonwealth*, 101 A.2d 634, 637 (1954).
[72] Pa.Const. Art. V, Sec. 10(c).

reversion of the Special Venue Rule, we ask that we end the stream of endless requests for studies and hearings seemingly designed to cause further delay.

We ask that the Supreme Court end the unconstitutional treatment of victims of medical malpractice by adopting their proposed amendment. Once that injustice is remedied, we urge the Senate to take action to reduce the number of preventable medical errors that unnecessarily kills thousands of Pennsylvanians every year. Preventable medical error has become the third leading cause of death in the United States. Each and every year, Senators rise to recognize the dangers of heart disease and speak of the horrors of cancer while ignoring deaths by preventable medical error. As such, we recommend immediate action:

- Identify the number of horrific tragedies that are concealed by settlements containing nondisclosure agreements (preventing improved public safety);
- Examine whether increased insurance profits led to a fair and proportionate decrease in insurance premiums;
- Learn what hospitals, health systems, and insurance companies do with the profits they take out of Pennsylvania;
- Study the burden that preventable medical error has on Pennsylvanians in terms of increased tax burdens and lost productivity; and
- Identify and punish those health care institutions that conceal their medical errors.

We also suggest that the following data be obtained and analyzed by the Senate:

- All rate filings, whether approved or not, from 2003 to present;
- All data showing annual Direct Premiums Written, Direct Premiums Earned, Direct Losses Incurred, Surplus, and Loss ratio by county for 2003 to present;
- The amount of taxes paid to the Commonwealth of Pennsylvania for each year from 2003 to present;
- The amount of surplus used to secured loans, distributed as dividends, or used to support additional lines of coverage for all captives from 2003 to present;
- All investment income from 2003 to present for premiums earned by county;
- All empirical data used by the underwriting department of each insurer from 2003 to present to account for venue;
- All data showing claims costs of cases that were ultimately settled versus those tried to a verdict from 2003 to present;
- All “other information” used by Milliman referenced in the report;
- The number of deaths caused by medical error compared to COVID-19;
- The amount of taxes paid and to whom by insurance companies providing offerings in Pennsylvania; and
- The burden ‘tort reform’ has imposed on Pennsylvania’s taxpayers through the shifting of responsibility away from culpable parties to state-funded health and social programs.

CLOSING

While opponents of this proposed rule change have again resorted to the repeated and ongoing fear-mongering sound bites of “doctors will flee” and “hospitals will close,” the proposed change has no impact on those issues. Rather, fulfilling this proposed change accomplishes the goal of returning fairness and equality to the rules and the basis of our legal system—that all parties are treated equally under the law. No rule should give one group of individuals or corporations special treatment and a preferred status. The special venue rule has, if anything, fostered the unchecked growth of lethal negligent conduct and restricts injured individuals’ access to the courts.

It is time to end the special treatment for medical malpractice defendants. Instead it is time to focus on the goal of the MCARE Act itself: to make every effort to reduce and eliminate preventable medical errors, and identify problems and implement solutions to promote patient safety.

	# of Companies (#)	Direct Premiums Written (#)	Direct Premiums Earned (#)	Direct Losses Incurred (#)	Underwriting Profit(Premiums Earned - Lossess Incurred)	Pure Direct Loss Ratio (#)	National Average Loss Ratio (@)
2018	193	$655,973,000	$644,202,000	$417,435,000	$226,767,000	64.80%	68.62%
2017	191	$646,113,000	$654,434,000	$437,674,000	$216,760,000	66.88%	70.77%
2016	194	$683,902,000	$666,819,000	$375,908,000	$290,911,000	56.37%	73.21%
2015	186	$654,302,000	$664,886,000	$299,778,000	$365,108,000	45.09%	65.50%
2014	184	$648,925,000	$624,225,000	$305,484,000	$318,741,000	48.94%	60.90%
2013	112	$692,423,000	$694,876,000	$340,236,000	$354,640,000	48.96%	59.42%
2012	176	$705,832,000	$697,060,000	$279,605,000	$417,455,000	40.11%	60.65%
2011	176	$704,233,000	$702,491,000	$334,908,000	$367,583,000	47.67%	54.68%
2010	47	$368,916,000	$364,262,000	$100,813,000	$263,449,000	27.68%	51.00%
2009	162	$741,485,000	$721,279,000	$326,153,000	$395,126,000	45.22%	55.66%
2008	102	$741,135,000	$722,274,000	$317,824,000	$404,450,000	44.00%	54.62%
2007	156	$734,621,000	$709,922,000	$369,151,000	$340,771,000	52.00%	60.37%
2006	162	$768,352,000	$745,104,000	$372,480,000	$372,624,000	49.99%	65.26%
2005	158	$738,257,000	$710,923,000	$460,733,000	$250,190,000	64.81%	74.63%
2004	170	$757,121,000	$716,373,000	$515,800,000	$200,573,000	72.00%	84.28%
				Total	**$ 4,785,148,000.00**		
				Average	**$ 319,009,866.67**	**52%**	**64%**
#	Pennsylvania Department of Insurance Annual Statistical Report						
+	AOPC Report of Pennsylvania Medical Malpractice Filings						
@	NAIC Countrywide Summary of Medical Professional Liability Insurance						
*	U.S. Census Bureau, Population Estimates Division						
^	Pennsylvania Department of Health Division of Health Informatics						