LEGISLATIVE BUDGET AND FINANCE COMMITTEE

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

A Study of the Impact of Venue for Medical Professional Liability Actions

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Objectives and Scope

- *Hold a public hearing to accept testimony from affected parties.*
- *Determine the impact of venue for medical professional liability actions on access to medical care.*
- *Determine the effects of the 2003 changes governing venue in medical professional liability actions on physicians, hospital services, and medical professional liability insurance in Pennsylvania.*
- *Determine the effects of the proposed amendment to Pa.R.C.P. No. 1006 on physicians, hospital services, medical professional liability insurance and the prompt determination of, and fair compensation for, injuries and death resulting from medical negligence.*
- *Provide a history of payouts made by the Pennsylvania JUA.*

Our study covered the period 1996 through 2018, unless otherwise noted.

Report Overview

Senate Resolution 2019-20 (SR 20) directs the LBFC to conduct a study of the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in Pennsylvania. See Appendix A for a copy of SR 20.

The sections of our report are:

- **Section I – Objectives, Scope, and Methodology**
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Our study covered the period 1996 through 2018 unless otherwise noted.

Background Information

Senate Resolution 2019-20 (SR 20) directed the LBFC to study the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in Pennsylvania. Venue refers to the geographic location where a legal case can be heard. Determining proper venue for a civil trial generally involves choosing a location for the trial that is fair and convenient for adjudicating the merits of a case, is convenient to the parties, and is fair and equitable in resolving the dispute.

Venue is different from jurisdiction. Jurisdiction is the *authority* to decide a legal matter and pertains to what court may exercise control over both the matter to be decided as well as the defendant in the case. Venue, however, addresses the place or geographic location where that judicial authority is to be exercised for expediency purposes. As such, venue determines the court location within the proper jurisdiction that is most suitable for fairly deciding the matter. Parties to a case may waive or consent to a particular venue; this is not so with jurisdiction. The typical rule with regard to venue is that an action is properly brought where the defendant resides or where the cause of action accrued.

Venue in Pennsylvania is predominately a matter of procedure, largely set by rules of the court. The Pennsylvania Supreme Court Rules of Civil Procedure Rule 1006 allows a civil action to be brought in a county where 1) the defendant may be served, 2) the cause of action arose, 3) a transaction or occurrence took place out of which the cause of action arose, or 4) venue is otherwise authorized by law. If property is the subject of the claim and equitable relief is sought, then venue may also be had in the county where the property is located. In 2003, as part of tort reform, venue for medical professional liability actions was changed by adding subparagraph (a.1) to Rule 1006 to restrict venue to a county in which the cause of action arose (unless the cause of action arises out of state).

On December 22, 2018, the Supreme Court's Civil Procedural Rules Committee filed notice in the *Pennsylvania Bulletin* that it was planning to propose to the Supreme Court an amendment to Rule 1006 that would eliminate the subparagraph (a.1) special exception for venue in medical professional liability cases.

Access to Medical Care and Maintenance of Health Care Systems

LBFC was directed to determine the impact of venue for medical liability actions on access to medical care and maintenance of health systems in the Commonwealth.

Access to health care involves many different variables: timeliness, health outcomes, health insurance coverage, geographic locations, and personal relationships with providers. Much of the analysis done after the 2003 tort reform affecting medical professional liability actions changes relied on anecdotal information, which we did not find reliable to make conclusions nearly two decades later.

Availability of health care services is a subset of access. We defined availability of health care services (physicians and hospitals) by comparing

population data for each of Pennsylvania's regions to the number of physicians in selected specialties, number of hospital beds, and hospital services.

We found:

- Access to health care is a complicated concept and the expansive data collection and analysis needed to determine access is outside the scope of this study.
- Availability of health care services (physicians and hospitals) is measureable, and therefore, was applied to our analysis.

Venue in Medical Professional Liability Actions and Availability of Physicians

We determined the availability of physicians by comparing the ratio of physicians (total number of physicians and physicians in certain specialties) to the population during the period 1996 to 2018. Using this data, we compared the number of physicians in obstetrics/gynecology (OB/GYN), general surgery, and internal medicine specialties to the medical liability insurance rates from two providers, for the respective specialty. We conducted research on national trends for physicians in selected specialties.

We also reviewed trends in the number of medical interns/residents, and medical school graduates in Pennsylvania.

We found:

- There is a lack of comprehensive and detailed data on the number of physicians practicing in Pennsylvania.
- Based on the available data, there were no statewide trends between medical malpractice insurance rates and the number of active medical staff with clinical privileges.
- The available data leads to the conclusion that medical malpractice insurance rates 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, e.g., compensation, benefits, location, commute time, proximity to family, job satisfaction, work-life-balance, and access to continuing education, that may influence those decisions.
- The number of full-time medical interns/residents on payroll at hospitals appeared unaffected by the 2003 tort reforms.
- The data indicates there were no measureable effects of venue on the availability of physicians across the Commonwealth from the 2003 tort reforms; however, the health care landscape in

Pennsylvania has significantly changed for physicians since that time.

- In 2018, a majority of Pennsylvania physicians received their graduate medical education in-state. Of the physicians who completed their graduate medical education in Pennsylvania, fewer than half practiced medicine in Pennsylvania after completing their education.

Venue in Medical Professional Liability Actions and Availability of Hospital Services

We reviewed the number of General Acute Care Hospitals (GACH) and Specialty Hospitals throughout the Commonwealth. Our analysis found that the number of GACHs began to decline during both pre- and post-tort reform; whereas the number of Specialty Hospitals increased during both periods. We also analyzed hospital services, and the number of hospital beds set up and staffed.

For the period we reviewed (FY 1996-97 through CY 2018) we found:

- The total number of GACHs in Pennsylvania has declined by 23.4 percent from FY 1996-97 to CY 2018; Specialty Hospitals have increased by 25.0 percent.
- Statewide, the total number of GACH beds set up and staffed declined by 16.6 percent from FY 1996-97 to CY 2018.
- The Southeast and Southwest health care districts have the highest concentration of GACHs and Specialty hospitals in the Commonwealth.
- Southeast and Southwest health care districts had the highest number of hospital beds set up at staffed.
- The ratio of beds set up and staffed per 10,000 persons by Health Care District from FY 1996-97 to CY 2018, was consistently higher among the Southwest and Northeast districts.
- In Philadelphia, Blair, Jefferson, Northumberland, and Schuylkill Counties we observed a negative correlation (linear relationship) between medical liability insurance rates and the number of OB/GYN hospital beds set up and staffed; as insurance rates increased among OB/GYN's, the number of OB/GYN beds decreased.
- The availability of hospital services vary by facility and there is no identified set of "standard" service(s) within GACHs.
- Our analysis of GACHs, which have had an increase and/or decrease in services from FY 1996-97 to CY 2018 (based on results from the Pennsylvania Department of Health, Annual Hospital Questionnaire), showed that out of the 60 counties that have a

GACH, a total of 25 counties have experienced changes in the number of GACHs.
- The health care landscape, much like the national trends, has changed in Pennsylvania with the increase in the number of hospitals in health systems and those health systems that extend beyond a single county.
- Due to the multiple variables involved, such as the number of hospitals located in a region, the data did not lead to a conclusion about the effect the proposed change to venue would have on the availability of hospitals and/or hospital services.

Determination and Compensation for Injuries and Death Resulting From Medical Negligence by Health Care Providers

We reviewed all publicly available data for 1996 to 2018 and present data on: (1) the cost of professional medical liability actions, (2) pre- and post-tort reform changes, (3) MCARE fund payouts, (4) national medical liability payments, and (5) the effects of the proposed rule change.

For the period we reviewed (CY 1996 through CY 2018), we found:

- In Pennsylvania from the period 2000 to 2002 compared to the period 2015 to 2017 there was a 44.9 percent decrease in medical malpractice filings. The shift in claims from Philadelphia and Allegheny Counties is prominent and at least one surrounding county has also shown a dramatic increase in claims.
- The Medical Care Availability and Reduction of Error Fund (MCARE) total claims paid from 1996 to 2018, experienced an overall decrease of 21.9 percent. Pre-tort reform (1996 to 2002) total paid claims increased by 28.8 percent; and post-tort reform (2003 to 2018) total paid claims decreased by 44.2 percent.
- MCARE's total claim count(s) for all health care providers (1996 to 2018) decreased by 27.2 percent. Pre-tort reform (1996 to 2002) total claim count(s) increased by 11.8 percent; and post-tort reform (2003 to 2018) total claim count(s) decreased by 37.4 percent.
- Our analysis of data from the National Practitioner Data Bank (NPDB) from CY 1996 through CY 2018, showed that the value of payments made on behalf of all medical practitioner types has increased by 17.5 percent, while the number (count) of payments has decreased by 43.5 percent.
- Pre-tort reform (1996 to 2002) the value of payments made on behalf of Pennsylvania physicians (MD/DO) increased by 21.6 percent; and the total number (count) of payments decreased by 9.9 percent.

- Post-tort reform (2003 to 2018) the value of payments made on behalf of Pennsylvania physicians (MD/DO) decreased by 13.7 percent; and the total number (count) of payments decreased by 39.9 percent.
- Due to the complexity of medical malpractice cases and limited data available on medical malpractice case duration from the time of filing to award or settlement, we were unable to determine if medical malpractice cases were promptly concluded.
- Among the five states with the highest medical malpractice payouts, Pennsylvania had the 2nd lowest percentage (12.1 percent) of increase in total payout costs per capita from $26.87 (1996) to $30.13 (2018).
- The effects of the proposed rule change on the number of medical malpractice filings and/or the value of medical malpractice payments in Pennsylvania could not be determined with any certainty. Due to the multiple variables involved in medical malpractice cases, we could not isolate the effect, if any, the proposed rule change to venue would have on the prompt determination of, and fair compensation for injuries as a result of medical negligence by a health care provider.

Availability, Cost,[1] and Affordability of Medical Professional Liability Insurance

To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability, cost, and affordability of medical professional liability insurance in all geographic regions of Pennsylvania, we reviewed the following information:

- Medical professional liability rate information from the *Medical Liability Monitor Annual Rate Survey*.
- The number of insurance companies writing medical professional liability insurance policies, their market share, and premium amounts from the Pennsylvania Insurance Department (Department) *Annual Statistical Report*.

We reviewed the available data for 1996 to 2018 using the *Medical Liability Monitor* and for 2002 to 2017 using the Department's *Annual Statistical Report*.

[1] Insurance 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.

The cost of medical professional liability insurance in Pennsylvania as well as the nation as a whole, increased significantly from 1996 to its peak around 2007. Thereafter, rates decreased.

In Pennsylvania, medical professional liability insurance rates for internal medicine increased, on average by county, roughly 348 percent from 1996 to 2018. Doctors practicing internal medicine in eleven counties experienced an increase of more than 464 percent over that period.

The change in the affordability of medical professional liability insurance varies depending on the county and medical specialty. For example, general surgeons in Montgomery County saw the smallest increase (99 percent) in medical professional liability insurance rates from 1996 to 2018. Doctors practicing internal medicine in eleven counties experienced an overall rate increase of 464 percent from 1996 to 2018.

We found:

- 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.
- The availability of medical professional liability insurance has increased since 2002:
    - The number of insurance companies writing more than $1,000 in direct premiums increased from 89 in 2002 to 144 in 2017.
    - The number of insurance companies writing more than $1 million in direct premiums increased from 39 in 2002 to 70 in 2017.
    - The market share of the 10 largest medical professional liability insurers (as measured by direct written premium) decreased from 71.6 percent in 2002 to 49.4 percent in 2017.
- The cost of medical professional liability insurance increased dramatically from 1996 through 2007 before declining. However, this change appears closely aligned to a national trend:
    - Total direct premiums fluctuated over time, from a low of $499 million in 2002, peaking at $768 million in 2006, and declining to $646 million in 2017.
- 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.

JUA Claims and Payments

The Pennsylvania Professional Liability Joint Underwriting Association (JUA) is a non-profit association established in the Medical Care Availability and Reduction of Error Act (MCARE) to offer medical professional liability insurance covering the provision of health care services in Pennsylvania.

The Pennsylvania Professional Liability Joint Underwriting Association saw a decrease in premiums earned from 2003 to 2017. In 2003, the direct premiums earned by the JUA totaled $38.6 million. By 2017, that number declined to $3 million.

The losses (payments made to claimants) incurred by the JUA declined from $21 million in 2000 to $2 million in 2017.

We found:

- Premiums earned by the JUA decreased significantly from 2003 to 2017.
- Payments made to claimants declined from $21 million to $2 million over the same period.

SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

Senate Resolution 2019-20 directs the Legislative Budget and Finance Committee (LBFC) to conduct a study on the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in Pennsylvania.

On March 27, 2019, the LBFC Officers adopted this study.

Objectives

Our objectives for this report were:

1. To hold at least one public hearing prior to preparing a report and accept testimony from affected parties, including, but not limited to, representatives of the health care industry, the insurance industry, and the legal community.

2. To determine the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth.

3. To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability of physicians in Pennsylvania.

4. To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability of, and access to, a full spectrum of hospital services across Pennsylvania.

5. To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability, cost, and affordability of medical professional liability insurance in every geographic region of Pennsylvania.

6. To determine the effects of the 2003 changes governing venue in medical professional liability actions on the prompt determination of, and fair compensation for, injuries and death resulting from medical negligence by health care providers in Pennsylvania.

7. To determine the effects of the proposed amendment to Pa.R.C.P. No. 1006 ("rule change") on the availability of physicians in Pennsylvania.

8. To determine the effects of the proposed rule change on the availability of, and access to, a full spectrum of hospital services across Pennsylvania.

9. To determine the effects of the proposed rule change on the availability of, cost, and affordability of medical professional liability insurance in every geographic region across Pennsylvania.

10. To determine the effects of the proposed rule change on prompt determination of, and fair compensation for, injuries and death resulting from medical negligence by health care providers in Pennsylvania.

11. To provide a history of payouts made by the Pennsylvania Professional Liability Joint Underwriting Association from 2003 through the present.

Scope

Our study covered the period from 1996 through 2018, unless otherwise noted.

Methodology

To hold at least one public hearing prior to preparing a report and accept testimony from affected parties, including, but not limited to, representatives of the health care industry, the insurance industry, and the legal community we contacted representatives of stakeholders for attorneys, medical providers, insurers, patients, and medical colleges.

Public hearings were held in Harrisburg on June 25 and 26, 2019. A list of those interest groups that provided testimony to the Legislative Budget and Finance Committee (LBFC) can be found in Appendix C.

In addition to the hearings, we met with several stakeholders who provided context for this study. Much of the information provided, however, was anecdotal in nature, and could not serve as the basis of our analysis. As discussed below, we sought out data to support our analysis.

To determine the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth, we researched definitions of access to health services. We also reviewed a 2003 study completed by the United States Government Accountability Office regarding medical malpractice insurance rates' impact on access to health care, which included Pennsylvania.

To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability of physicians in Pennsylvania, we reviewed Pennsylvania Department of Health (PDH) data on the number of active medical staff with clinical privileges at hospitals, and the number of full-time medical interns/residents on hospital payrolls. We performed a simple linear regression analysis between the number of active medical staff with clinical privileges in specialties of obstetrics/gynecology, general surgery, and internal medicine along with the rates for the respective specialties published by the *Medical Liability Monitor*.[2] We also reviewed other studies published regarding medical malpractice tort reforms in other states and/or nationally, and physician shortages in Pennsylvania.

To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability of, and access to, a full spectrum of hospital services across Pennsylvania, we obtained information from the PDH, *Annual Hospital Questionnaire* from FY 1996-97 through CY 2018. We reviewed hospital reports 1-A, 1-B, 2-A, and 7 which included all General Acute Care and Specialty Hospitals, beds set up and staffed, and the availability of selected hospital services. The information was reviewed to quantify the number of hospitals, services, and beds set up and staffed throughout the Commonwealth by health district. We also performed a simple linear regression analysis between the number of obstetrics/gynecology (OB/GYN) beds set up and staffed compared to medical malpractice insurance rates of OB/GYN physicians.

We also conducted research on the continually evolving health care landscape, both in Pennsylvania and nationally.

To determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability, cost, and affordability of medical professional liability insurance in every geographic region of Pennsylvania, we obtained information from the *Medical Liability Monitor* and the Pennsylvania Insurance Department's *Annual Statistical Report*. We used that information to calculate the change in the cost of medical professional liability insurance from 1996 to 2018 for every county in Pennsylvania; determine the number of insurers offering coverage in Pennsylvania; determine the market share of large insurers; and determine the amount of direct premiums.

To determine the effects of the 2003 changes governing venue in medical professional liability actions on the prompt determination of, and fair compensation for, injuries and death resulting from medical negligence

[2] The *Medical Liability Monitor Annual Rate Survey* surveys major writers of medical malpractice insurance for Internal Medicine, General Surgery, and Obstetrics/Gynecology. The *Survey* has been used by the United States Government Accountability Office, Department of Health and Human Services, and the Congressional Budget Office for studies, analysis, policymaking, etc.

by health care providers practicing in Pennsylvania, we obtained information from the Administrative Office of Pennsylvania Courts (AOPC) on medical malpractice filings and jury awards from calendar year (CY) 2000 through CY 2017, we used that data to quantify the average number of medical malpractice filings statewide and by county, determine the percent of change in filings, identify the number of jury awards statewide and by county, and calculate the rate of success. Lastly, we reviewed verdict slips[3] in an effort to determine prompt determination of medical malpractice claims. In addition, we reviewed Philadelphia Court of Common Pleas' annual reports in an effort to gain insight into the county's medical malpractice case inventory.

We obtained claims paid data from the Medical Care Availability and Reduction of Error Fund (MCARE) and reviewed annual reports for the period of CY 1996 to CY 2018, in an effort to analyze the trends in payments by specific region and type of health care provider.

We reviewed the National Practitioner Data Bank (NPDB) medical malpractice payment information from CY 1996 to CY 2018 for all practitioners and physicians (MD/DO) in Pennsylvania and nationwide. The data was used to analyze the value and number (count) of payments made on behalf of all practitioners and physicians in comparison to the national trends.

We also reviewed a series of studies conducted by the Pew Charitable Trust, "Medical Liability in Pennsylvania (2003)." We reviewed this series to understand the pre- and post-reform changes in Pennsylvania. In an effort to understand "fairness" as it pertains to medical malpractice compensation, we reviewed reports from the Institute of Medicine (IOM), The United States Department of Health and Human Services (DHHS), and research conducted by Randall R. Bovbjerg and Frank A. Sloan in an attempt to define "fair" as it pertains to medical malpractice compensation.

We obtained summarized statutory information from the National Conference of State Legislatures (NCSL), for the other states' medical malpractice laws and regulations we reviewed for this report. This information was used to compare the top five medical malpractice payout states' current statutory provisions.

To determine the effects of the proposed rule change on the availability of physicians in Pennsylvania we applied what we found in previous sections about pre- and post-2003 tort reforms to the current health care marketplace. We also reviewed the number of Doctor of Osteopathic Medicine (DO) and Doctor of Medicine (MD) graduates, first year residency quotas, and the match rate of open residency positions. Additionally, we researched where Pennsylvania physicians receive their graduate

[3] A verdict slip is a form that documents the finding or decision of a jury on the matter submitted to it in trial.

medical education (GME) versus the practice locations of physicians who completed their GME in Pennsylvania.

To determine the effects of the proposed rule change on the availability of, and access to, a full spectrum of hospital services across Pennsylvania, we used information from The Hospital and Healthsystem Association of Pennsylvania (HAP), Agency for Healthcare Research and Quality (AHRQ), American Hospital Association (AHA), and PDH, from 1996 through 2018 (where applicable) in an effort to determine pre-and post-tort reform changes in the number of hospitals, hospital services, beds set up and staffed, and health systems in Pennsylvania and nationwide. The information was reviewed in an effort to determine what change(s) the proposed venue rule would have on the availability of hospitals and hospital services in Pennsylvania.

To determine the effects of the proposed rule change on the availability of, cost, and affordability of medical professional liability insurance in all geographic regions across Pennsylvania, we obtained information from the *Medical Liability Monitor* and the Pennsylvania Insurance Department's *Annual Statistical Report*. We used that information to calculate the change in the cost of medical professional liability insurance from 1996 to 2018 for all counties in Pennsylvania; determine the number of insurers offering coverage in Pennsylvania; determine the market share of large insurers; and determine the amount of direct premiums.

To determine the effects of the proposed rule change on prompt determination of, and fair compensation for, injuries and death resulting from medical negligence by health care providers in Pennsylvania, we obtained data from AOPC, MCARE, and NPDB. We used this data to determine pre-and post-tort reform changes in medical malpractice filings, and jury verdicts. The information was also reviewed to consider the impact the proposed venue rule would have on the number of medical malpractice filings and payments in Pennsylvania.

To provide a history of claims made to, and payouts made by, the Pennsylvania Professional Liability Joint Underwriting Association from 2003 through the present, we used information from the Pennsylvania Insurance Department's *Annual Statistical Report* to calculate payments made to claimants and premium volume.

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. In order to do so, one would have to assume that all changes, save the one we would wish to isolate, must be held equal. This is an assumption we are unwilling to make.

Different changes in the MCARE Act are likely to affect the various counties differently. For example, the collateral source rule would likely affect

counties differently depending on the number of residents who have health insurance and the income level of the residents. A county with fewer residents with health insurance and higher rates of poverty may have a higher reduction in medical malpractice claims because those claims are no longer as economically viable due to the collateral source rule. 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.

Acknowledgements

We acknowledge and appreciate the cooperation we received from the staff of the Pennsylvania Insurance Department and the Pennsylvania Professional Liability Joint Underwriting Association.

We also appreciate the input we received from the numerous stakeholder groups and associations with which we met during the course of this study. In particular, we thank those individuals who participated in the hearings held on June 25 and 26, 2019.

Important Note

This report was developed by the staff of the Legislative Budget and Finance Committee, including Deputy Executive Director, Christopher Latta, staff analysts, Stevi Sprenkle, Shanika Mitchell-Saint Jean, and Anna Amsbaugh, and Counsel Rick Jones. The release of this report should not be construed as an indication that the Committee as a whole, or its individual members, necessarily concur with the report's findings or conclusions.

Any questions or comments regarding the contents of this report should be directed to the following:

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SECTION II
BACKGROUND ON VENUE IN MEDICAL LIABILITY ACTIONS

Fast Facts...

- *Venue rules regulate the geographic location where the merits of a legal dispute can be fairly and conveniently adjudicated.*
- *Venue is different from jurisdiction.*
- *Venue evolved from England's King's courts prior to 1800 and has chiefly been a concept centered on convenience and connection.*

Overview

Senate Resolution 2019-20 (SR 20) directs the LBFC to study the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in Pennsylvania. Venue refers to the geographic location where a legal case can be heard. Determining proper venue for a civil trial generally involves choosing a location for the trial that is fair and convenient for adjudicating the merits of a case, is convenient to the parties, and is fair and equitable in resolving the dispute. This section provides an overview of the historical development of venue, its Pennsylvania context, the developments in the early 2000's, and changes proposed in 2018.

A. Purpose

Venue rules regulate the geographic *location* where the merits of a legal dispute can be fairly and conveniently adjudicated. Venue is different from jurisdiction. Jurisdiction is the *authority* to decide a legal matter and pertains to which court may exercise control over both the matter to be decided as well as the defendant in the case. Venue, however, addresses the place or geographic location where that judicial authority is to be exercised for expediency purposes. As such, venue determines the court location within the proper jurisdiction that is most suitable for fairly deciding the matter. Parties to a case may waive or consent to a particular venue; this is not so with jurisdiction. The typical rule with regard to venue is that an action is properly brought where the defendant resides or where the cause of action accrued.[4]

B. History in English and American Law

Venue evolved from England's King's courts prior to 1800 and has chiefly been a concept centered on convenience and connection. The choice of location—or venue—of holding the king's court initially operated, to

[4] Note, there is no constitutional requirement for proper venue in order to have a valid judgment.

In 1803, Lord Ellenborough declared that "If the inconvenience of trying the cause in the one or the other county were balanced in any degree, we should not interfere with the acknowledged general right of the plaintiff to try his cause where any part of the cause of action arose."

accommodate the convenience of the king. The court initially followed the location of the king. Venue developed to relate to the neighborhood from which jurors would be drawn. The necessity of using jurors connected to the neighborhood in which the claim arose gradually decreased over the years.

After 1200, the King's courts no longer traveled because moving court equipment and records became too cumbersome and the territory of the sovereign was divided into counties with judges assigned by the King. The courts also began to distinguish between local and transitory actions. Local actions related to lands and so had to be brought in the county where the land was located. The courts recognized that some actions did not arise out of issues related to land but were connected, instead, to persons, and as such were viewed as "transitory."

Transitory actions included such actions as in contracts or arising from injuries, such as torts. Transitory actions, therefore, could possibly be brought in more than one county, as long as there was a connection with the defendant to be able to bring the defendant to court or in any county where there was a connection with the action involving the defendant arose. Where a single county was not clearly the only county in which the transitory action arose, a defendant could seek a change of location of the case—a change of venue—on grounds of convenience. The principle convenience consideration for the court at this point was the inconvenience and expense of bringing witnesses to court from a distant county.[5]

Mistreatment of legal venue, was an issue in the American Revolution, as the perceived abuse of English criminal venue law was one of the enumerated grievances in the Declaration of Independence, which accused King George III of "transporting us beyond Seas to be tried for pretended offenses." Moreover, in developing the Federal Judiciary Act of 1789, the United States Senate modified the language of the draft bill to increase the number of places at which federal District Courts were to be held "recognizing the sentiment relative to the dragging of persons from their homes long distances to the District Courts."[6]

The concepts of convenience and connection that generally determine venue today may be a particular county for cases in state court or a district or division for cases in federal court.[7]

[5] In 1803, Lord Ellenborough declared that "If the inconvenience of trying the cause in the one or the other county were *balanced in any degree*, we should not interfere with the acknowledged general right of the plaintiff to try his cause where any part of the cause of action arose." [Emphasis added.]

[6] Warren, Charles. "New Light on the History of the Federal Judiciary Act of 1789." *Harvard Law Review* 37, 49: 79 (1*923*).

[7] The general venue statute for United States federal courts is 28 U.S.C. § 1391 with special rules listed in §§ 1392-1413. Venue in state courts is determined by state law and court rules.

C. Venue in Pennsylvania

Under Pennsylvania's constitution, both the Supreme Court and the General Assembly have responsibilities relating to judicial powers.

Venue in Pennsylvania is predominately a matter of procedure, largely set by rules of court. The state Judicial Code recognizes this providing (with regard to the courts of common pleas) "the venue of a court of common pleas concerning matters over which jurisdiction is conferred by this section shall be as prescribed by general *rule*."[8]

Prescribing rules of court is within the authority of the Pennsylvania Supreme Court. The Pennsylvania Constitution provides that "The Supreme Court shall exercise general supervisory and administrative authority over all the courts…" and that "The Supreme Court shall have the power to prescribe general *rules* governing practice, procedure and the conduct of all courts…."[9] Complete oversight of the judicial power of the state, however, is not granted solely to the Supreme Court. The General Assembly has constitutional authority over which courts have jurisdiction over certain matters, what divisions of what courts have jurisdiction over certain matters, allocation of state resources to various judicial districts, the right to establish additional courts or divisions of existing courts, and to determine the jurisdiction of the courts.[10] Moreover, while the power to change venue is also vested by the constitution in the state courts, the state constitution provides that how change of venue is to work is to be determined by the legislature.[11] In fact, the state Supreme Court has held that "the causes for which and the manner in which [change of venue] must be exercised are entirely under legislative control … and when the legislature has enacted and provided the causes and the mode of procedure [for change of venue], it is the duty of the courts to comply strictly with the statutory provisions in determining the right of the applicant to have his case tried in another jurisdiction.[12]

The Pennsylvania Supreme Court's Rules of Civil Procedure address venue at Rule 1006:

> (a) Except as otherwise provided by subdivisions (a.1), (b), and (c) of this rule, an action against an individual may be brought in and only in a county in which
>
> (1) The individual may be served or in which the cause of action arose or where a transaction or occurrence took place out of which the cause of action arose or in any other county authorized by law,

[8] 42 Pa.C.S. § 931(c) [Emphasis added]
[9] Pa Constitution, Article V, Section 10(a) & (c). [Emphasis added]
[10] See, Pa Constitution, Article V, Sections 2-5 and 8.
[11] Pa Constitution, Article III, Section 23 states "[t]he power to change venue in civil and criminal cases shall be vested in the courts, to be exercised in such manner as shall be provided by law."
[12] See, *Little v. Wyoming County*, 63 A. 1039 (1906).

or

(2) The property or a part of the property which is the subject matter of the action is located provided that equitable relief is sought with respect to the property.[13]

Subdivision (a.1) that is referenced in the rule was amended into the rule in the early 2000's to address venue in medical professional liability actions and provides:

(a.1) Except as otherwise provided by subdivision (c),[14] a medical professional liability action may be brought against a health care provider for a medical professional liability claim only in a county in which the cause of action arose. This provision does not apply to a cause of action that arises outside the Commonwealth.

Generally in Pennsylvania, tort plaintiffs may file claims in a county in which the defendant may be served, the cause of action arose, or a transaction or occurrence out of which the cause of action arose took place.

D. Venue in Medical Professional Liability Actions

Pre-2002

As can be seen in Rule 1006 above, Pennsylvania law generally requires tort plaintiffs—which without the special rule in Subdivision (a.1) would include plaintiffs in medical professional liability actions—to file claims against individuals in one of three locations: a county in which:

(1) the defendant may be served,
(2) the cause of action arose, or
(3) a transaction or occurrence out of which the cause of action arose took place.

[13] Moreover, in cases involving corporate defendants, venue is generally expanded. Rule 2179 states

(a) Except as otherwise provided by an Act of Assembly, by Rule 1006(a.1) or by subdivision (b) of this rule, a personal action against a corporation or similar entity may be brought in and only in
(1) the county where its registered office or principal place of business is located;
(2) a county where it regularly conducts business;
(3) the county where the cause of action arose;
(4) a county where a transaction or occurrence took place out of which the cause of action arose; or
(5) a county where the property or a part of the property which is the subject matter of the action is located provided that equitable relief is sought with respect to the property.

[14] Subdivision (c) addresses claims brought against more than one defendant and allows venue to lie where it may against any one of the defendants.

In cases brought against corporations, plaintiffs generally have additional options. Venue against a corporate defendant is proper where:

(1) the company has its registered office or principal place of business,
(2) the company regularly conducts business,
(3) the cause of action arose,
(4) the transaction or occurrence out of which the cause of action arose took place, or
(5) the property or a part of the property which is the subject matter of the action is located provided that equitable relief is sought with respect to the property.

Conditions during the early 2000's generated an apparent crisis atmosphere regarding how medical malpractice claims were handled.

Medical Care Availability and Reduction of Error Act (MCARE)

Conditions during the early 2000's generated an apparent crisis atmosphere regarding how medical malpractice claims were handled. For example, three of the state's five major private medical-liability insurers stopped writing policies in Pennsylvania, insurance premiums quickly increased in certain specialties threatening providers' financial viability, and reinsurance costs soared after the 9/11 terrorist attacks.

In response to these conditions, the state debated reform measures, including changes to venue rules for medical professional liability actions. The 2002 Medical Care Availability and Reduction of Error Act (Act 13 of 2002) (MCARE) sought to restructure medical professional liability law. MCARE did not itself change venue rules but created an Interbranch Commission on Venue to further study the issue.

Interbranch Commission on Venue

The Interbranch Commission on Venue was to "review and analyze the issue of venue as it relates to medical professional liability actions filed in this Commonwealth." The Commission was comprised of:

- The Chief Justice of the Supreme Court or a designee of the Chief Justice
- The chairperson of the Civil Procedural Rules Committee, who served as the chairperson of the Commission
- A judge of a Court of Common Pleas appointed by the Chief Justice
- The Attorney General or a designee of the Attorney General
- The Governor's General Counsel
- Two attorneys-at-law appointed by the Governor
- Four individuals, one each appointed by the:

The Interbranch Commission on Venue did not have unanimous clarity as to whether any or what branch of government could or should make the 2002 venue rule change.

- President Pro Tempore of the Senate
- Minority Leader of the Senate
- Speaker of the House of Representatives
- Minority Leader of the House of Representatives

The Commission was to recommend legislative action or the promulgation of court rules on the issue of venue as the Commission deemed appropriate.

Under amended Rule 1006, a medical professional liability claim against a health care provider can only be brought in the county in which the cause of action arose.

The Commission discussed and reviewed a mix of proposals for addressing venue in medical malpractice cases. The Commission took into consideration the possibility of allowing cases to be brought where the cause of action arose, a transition or occurrence took place out of which the cause of action arose, the registered office or principal place of business of the dependent is located, the plaintiff resides, or a defendant regularly conducts its business.

The Venue Commission voted in favor of endorsing the idea that venue for medical professional liability claims be limited to filings in the county in which the cause of action arose precisely identical to proposal 1). Six of the eleven Commission members supported this recommendation with five of those six members recommending that the rule change be promulgated by the PA Supreme Court.

The Pennsylvania Supreme Court also changed its rules such that any legal action filed on or after January 27, 2003, claiming professional negligence must contain a filed written statement that a licensed professional[18] has reviewed the case facts and concluded that there is a reasonable probability that the person against whom the claim is being made deviated from the accepted standard of care.

On October 17, 2002, the Commission's recommendation became law via Act 127 of 2002. Act 127 amended the Judicial Code by adding Section 5101.1 thereby requiring medical professional liability actions "may be brought against a health care provider … only in the county in which the cause of action arose." Furthermore, by order of January 27, 2003, the Pennsylvania Supreme Court amended its Rules of Civil Procedure to incorporate the provisions of Section 5101.1 into Rule of Civil Procedure 1006.[15]

Rule 1006 applies to all cases filed on or after January 1, 2002. Under Rule 1006, a medical professional liability claim against a health care provider can only be brought in the county in which the cause of action arose. Where there are multiple health care providers as defendants, the case may be brought in any county where there can be venue against one of the providers. If non-health care providers are co-defendants, the

[15] In 2003, Pennsylvania's Commonwealth Court held Section 5101.1 to be unconstitutional. See, *North-Central Pennsylvania Trial Lawyers Assoc. v. Weaver*, 827 A. 2d 550 (Cmwlth 2003). The court held that inasmuch as venue is procedural in nature and regulation of court procedure is committed to the exclusive authority of the Pennsylvania Supreme Court under Article V, Section 10(c) of the state constitution, Section 5101.1 usurped the Supreme Court's authority to enact general procedural rules governing the operation of the courts. The state Superior Court, however, has since declined to rule on the constitutionality of Section 5101.1 when given the opportunity noting the Superior Court is not bound by any Commonwealth Court opinion. See, *Connor v. Crozer Keystone Health System*, 832 A. 2d 1112 (Pa Superior 2003).

action must still be brought in a county where a health care provider may be sued.

Certificate of Merit

The other major change from the early 2000's was the court's addition of a required certificate of merit. The Pennsylvania Supreme Court changed its rules such that any legal action filed on or after January 27, 2003, claiming professional negligence must contain a filed written statement that a licensed professional[16] has reviewed the case facts and concluded that there is a reasonable probability that the person against whom the claim is being made deviated from the accepted standard of care.[17]

Prior to this rule, a plaintiff could file a claim on conjecture. The certificate of merit rules developed over several years. Today they apply to any case where it is alleged that a licensed professional deviated from a required professional standard of care. Such a certificate of merit must be filed within 60 days of the filing of the complaint and state:

1) that an appropriate licensed professional provided a written statement that the treatment was below the standard of care and caused harm to the plaintiff, or

2) that a claim against a professional defendant is based solely on allegations that other professionals for whom the defendant is responsible were negligent (a vicarious liability claim.) (There must be a certificate for the agent even if the agent is not a named defendant or that expert testimony is unnecessary for prosecution of the claim.)

If no certificate is timely filed the case may be dismissed for failure to prosecute. Even if a case is not expressly stated in the complaint to be a professional negligence case, certificate of merit still applies where the substance of the allegations assert a claim for professional malpractice. Before a certificate is filed, the defendant professional does not need to answer the complaint, and discovery may not be obtained.[18]

[16] "Licensed professional" under the certificate or merit rules means: any licensed 1) health care provider (as defined in MCARE); 2) accountant; 3) architect; 4) chiropractor; 5) dentist; 6) engineer or land surveyor; 7) nurse; 8) optometrist; 9) pharmacist; 10) physical therapist; 11) psychologist; 12) veterinarian; and 13) attorney-at-law.
[17] See, Pa Rules of Civil Procedure 1042.1 – 1042.8.
[18] Although requests for production of documents and for entrance upon land are allowed.

Other Relevant Changes

In addition to venue and certificate of merit, the following changes to the Pennsylvania tort system were effectuated in 2002-03.[19] These included the following:

At least eight additional changes to the PA tort system were effectuated throughout the 2002-03 time period.

- *Affidavit of noninvolvement*: Allows a health care provider named in a lawsuit to submit an affidavit stating he or she had no involvement in the alleged injury and thereby have the claim dismissed. This suspends the statute of limitations, however, and there are penalties for a false affidavit.

- *Jury instructions on non-economic losses*: The trial judge must provide the jury with guidance on how to determine damage awards by articulating components of non-economic losses including past and future "pain and suffering," "embarrassment and humiliation," "loss of ability to enjoy the pleasures of life," and "disfigurement." The jury is told to consider eight criteria regarding claims for damages: plaintiff's age; severity of injuries and whether they are temporary or permanent; the extent to which the injuries affect the basic activities of daily living; etc. Prior to this rule change, judicial instructions were more general and the jury had to rely on submissions by the plaintiff and defense lawyers during closing arguments.

- *Expert testimony*: MCARE requires that, with a few exceptions, expert testimony is necessary to prove the standard of care was violated. The law specifies strict criteria for experts.[20] The criteria for determining the "standard of care" is clearly defined so that the trial judge may make an informed ruling on whether the expert is competent to testify. Medical expert testimony as to causation as well as standard of care will require an expert who has an unrestricted physician's license in any state and has been engaged in active clinical practice (even if retired at the time of trial) within the previous five years. The court may waive this requirement.

- *Punitive damages*: MCARE also limits punitive damages in medical malpractice cases to only those instances in which the provider engaged in "wanton conduct or reckless indifference to the rights of others," or "gross negligence." Punitive damages may not be awarded vicariously unless the party knew of and allowed the conduct and may not exceed 200 percent of the amount of compensatory damages. Also, 25 percent of a punitive award shall be paid to the MCARE Fund with the remaining paid to the plaintiff.

[19] Generally see, Kahn, James "Recent Development in Pennsylvania Medical Malpractice Law", Margolis Edelstein, January 3, 2017; and Vidmar, Neil, "Medical Malpractice Litigation in Pennsylvania," (Report commissioned and funded by the Pennsylvania Bar Association, May 2006).

[20] Namely a person with the education and experience to offer a competent opinion to the jury or other trier of fact in the area relevant to the issues in dispute.

- *Statute of repose*: MCARE established a time limit of seven years from the date of the alleged medical negligence for the plaintiff to file a lawsuit; a wrongful death claim must be filed within two years of the death.[21] This applies even when the injury was discovered later.[22] It does not apply to minors who still may sue until their 20th birthday.

- *Collateral source rule and damages*: MCARE also began the prohibition on a plaintiff recovering damages for past medical expenses or lost earnings to the extent the loss was paid by public or private insurance prior to the trial. In the past, a plaintiff could claim those losses even if they had been paid by another source.[23]

- *Determination of damage award and payments*: MCARE also made a number of changes to the way the jury or other trier of fact determines damages and how the payments are made. Prior to MCARE, juries returned "general" verdicts, meaning a lump sum amount was awarded without any specific valuation of the different components of the damage award. There now must be separate findings for past medical related expenses, past loss of earnings and past non-economic loss, future medical and related expenses, loss of future earnings and earning capacity, and future non-economic loss. Future medical expenses are paid quarterly based upon present value with adjustments for inflation and life expectancy. Periodic payments terminate upon the death of plaintiff. Loss of future earnings and earning capacity and non-economic losses are assessed in a lump sum to be paid at the time of judgment. Future damages for loss of earnings or earning capacity must be reduced to present value but plaintiff may introduce the effect of productivity and inflation over time. MCARE requires that each party liable for future medical and related expenses fund them by means of annuity contract or other court-approved plan. Interest does not accrue on future payments. Future medical expenses may be paid by a lump sum if they do not exceed $100,000. Once there has been funding of future medical costs by an annuity, the judgment may be discharged, although the court retains jurisdiction in the event of future disputes.

- *Remittitur review of damages*: MCARE also requires the judge in malpractice cases to review the damage award and "consider evidence of its impact, if any, upon the availability or access to health care in the community." Therefore, the jury's verdict is not the final word until the trial judge approves the verdict and enters judgment. Judges had remittitur power prior to MCARE, but MCARE directs judges' attention to verdict review and allows a lower standard for adjusting a jury verdict.[24]

[21] Except where there was affirmative misrepresentation or fraudulent concealment.
[22] Does not apply to foreign objects left in the patient's body.
[23] This does *not* apply to life insurance benefits, pension or profit sharing payments, deferred compensation payments, Social Security benefits, Medicaid and Medicare payments and public benefits under an ERISA program.
[24] This does not apply to a health care provider that is sued for *ordinary* negligence as opposed to professional medical negligence. *McManamon v. Washko*, 906 A.2d 1259 (Pa. Super. 2006).

Supreme Court Civil Procedural Rules Committee Proposed Venue Rule Amendment—2018

On December 22, 2018, the Pennsylvania Supreme Court Civil Procedural Rules Committee published a proposed amendment to the PA Rules of Civil Procedure Rule 1006 pertaining to venue in the *Pennsylvania Bulletin*.[25] The proposed amendment would remove the special rule applicable to medical professional liability actions that was implemented in 2002 following recommendation of the Venue Commission. The section to be removed, Subdivision (a.1), states as follows:

> Except as otherwise provided by subdivision (c), a medical professional liability action may be brought against a health care provider for a medical professional liability claim only in a county in which the cause of action arose.

The explanatory comment included with the proposed rule change states:

> The current rule provides special treatment of a particular class of defendants, which no longer appears warranted. Data compiled by the Supreme Court on case filings on medical professional liability actions … indicates that there has been a significant reduction in those filings for the past 15 years. Additionally, it has been reported to the Committee that this reduction has resulted in a decrease of the amount of claim payments resulting in far fewer compensated victims of medical negligence.

The explanatory comment goes on to state that "[t]he proposed rescission of subdivision (a.1) is intended to restore fairness to the procedure for determining venue regardless of the type of defendant."

[25] Multiple sources, including Justice Max Baer in his public testimony before the Senate Appropriations Committee on February 26, 2019, stated that the primary catalyst for considering a change to the venue rule was a letter received by the court. LBFC staff identified that letter as being a December 1, 2017 letter sent by Jason Matzus, Esq., to the Chair of the Civil Procedural Rules Committee. Attorney Matzus's letter is attached to this report, with his consent, as Appendix B.

SECTION III
ACCESS TO MEDICAL CARE AND MAINTENANCE OF HEALTH CARE SYSTEMS

Overview

Fast Facts...

- *Access to health care involves timeliness, health outcomes, insurance coverage, availability, trust and communication with provider, among other variables.*
- *Availability of health care is a subset of access and is measured by comparing the number of physicians/hospital beds to population.*

Senate Resolution 2019-20 (SR 20) directs LBFC to study "the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth." We reviewed the following information:

A. United States Department of Health and Human Services' definition of "access to health services."
B. A 2003 Government Accountability Office study about medical malpractice premiums and access to health care.

We found:

1. Access to health care is a complicated concept and the expansive data collection and analysis needed to determine access is outside the scope of this study.
2. Availability of health care services (physicians and hospitals) is measureable, and is discussed throughout the other sections of the report.

Issue Area

A. Impact of Venue for Medical Professional Liability Actions on Access to Medical Care and Maintenance of Health Care Systems

In order to determine the "impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in the Commonwealth" we were required to determine a reasonable definition of *access*.[26] Other objectives in this report directed LBFC

[26] Pennsylvania Senate Resolution 2019-20.

to determine *access* and/or *availability* of physicians and/or hospital services. We will first define access and availability, then apply the definition throughout the report.

Access. Access to health care, often cited as important, has no universally accepted definition. One multidimensional definition often cited in public health circles includes the five "A's" of access: availability, accessibility, accommodation, affordability, and acceptability.[27] This definition is from 1981, therefore we sought a similar, but more updated, version. We chose the following from the United States Department of Health and Human Services (USDHHS):[28]

> Access to health services means 'the timely use of personal health services to achieve the best health outcomes.' It requires 3 distinct steps:
>
> - Gaining entry into the health care system (usually through insurance coverage)
> - Accessing a location where needed health care services are provided (geographic availability)
> - Finding a health care provider whom the patient trusts and can communicate with (personal relationship)

USDHHS further explains "barriers to health services include: high cost of care, inadequate or no insurance coverage, lack of availability of services, and lack of culturally competent care[29]. . . access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location."[30]

In other words, access to medical care varies greatly person-by-person in the Commonwealth. Pennsylvania citizens living in the same region with the same health insurance plan may have differing levels of access. Reviewing health insurance coverage rates alone is not enough as a person

[27] Penchansky R, Thomas JW. "The Concept of Access: Definition and Relationship to Consumer Satisfaction." *Med Care*. (February 1981).

[28] "Access to Health Services." Healthy People 2020. *Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.* https://www.healthypeople.gov/2020/topics-objectives/topic/access-to-health-services.

[29] Georgetown University's Health Policy Institute explains what cultural competence in health care means: "Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system. The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy." ("Cultural Competence in Health Care: Is it important for people with chronic conditions?" https://hpi.georgetown.edu/cultural/#)

[30] "Access to Health Services." Healthy People 2020. *Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.* https://www.healthypeople.gov/2020/topics-objectives/topic/access-to-health-services.

may have insurance, but may be unable to pay for copayments and/or deductibles. Conclusions about access should not be made based on broad demographic information and personal health insurance data; doing so could significantly mischaracterize the situation.
It is difficult to measure all variables across Pennsylvania without having specific data on every Pennsylvanian's insurance coverage, regional availability of hospitals and physicians, their personal satisfaction with health services received, health outcomes, timeliness of services, and demographics. Although we have attempted to measure the availability of hospitals and physicians, as explained later in this section, the expansive data collection and analysis needed to determine access is outside the scope of this study.

Later in this report, the impact of the venue rule on liability insurance rates will also be discussed. In theory, if there is a change in the venue rule which results in (1) insurers raising malpractice insurance premiums and (2) a doctor decides to practice medicine in another state, then there could be a change in access subsequently for the patients of that doctor and the direct region.

A 2003 Government Accountability Office (GAO) study highlights the complexities of using the limited data at the time of their study to draw conclusions about access to health care as it is related to medical malpractice insurance decisions.[31] The GAO focused on five "crisis" or "problem" states (identified by a national medical organization), which included Pennsylvania. With no "reliable national sources of data concerning provider responses to rising malpractice premiums" the GAO relied on national and state industry organization surveys, and anecdotal information.[32] This included targeted follow-up at the hospitals identified by the anecdotal information. The GAO also analyzed Medicare data, though they noted that was also limited in determining access to specific high risk services.

The GAO defined access in terms of the loss of access: "the direct loss or newly limited availability of a health care provider or service resulting largely from actions taken by providers in response to malpractice concerns."[33] Their analysis regarding access in Pennsylvania was based mostly on anecdotal accounts with follow-up interviews at the hospitals identified. Ultimately the GAO concluded that a variety of factors were contributing to localized changes in access including:

- Malpractice insurance premiums
- Physicians nearing or at retirement age

[31] "Medical Malpractice: Implications of Rising Premiums on Access to Health Care." *United States Government Accountability Office*. (August 2003). https://www.gao.gov/new.items/d03836.pdf.
[32] *Ibid.*
[33] *Ibid.*

- Rural hospital locations (more difficulty with recruitment compared to urban locations)
- Low Medicaid reimbursement rates in dense Medicaid client population areas
- Changing population in a region (specifically fewer females of childbearing age related to a decline in the number of obstetrics/gynecologists)[34]

A 2003 Government Accountability Office report on the implications of rising medical malpractice insurance premiums on access to health care did not isolate the impact of venue on malpractice insurance and physician decisions.

The GAO's August 2003 report further highlights the complicated nature of access, particularly as it is related to medical malpractice insurance. The rhetoric surrounding physician decisions at the time of the GAO report that lead the GAO to certain hospitals in Pennsylvania was solely based on medical malpractice premiums; however, upon further review the GAO found there were other factors impacting physician decisions. It should be noted, the GAO report did not isolate the impact of venue on malpractice insurance and physician decisions. As previously stated, the GAO did note the problems in concluding that medical malpractice insurance was the sole variable in physician decisions about where to work.

Much like the GAO in 2003, we could not identify reliable data needed to analyze access to health care as it is related to medical malpractice liability in Pennsylvania. Additionally, we determined that anecdotal information, similar to that used by the GAO from two decades ago, was not an acceptable approach for this report. With such diverse variables and lack of data, we will not conclude whether venue for medical professional liability actions impacts access to medical care. The next section will discuss a subset of access: availability.

Availability. While USDHHS does not provide a specific definition for availability of physicians and/or hospital services, availability is mentioned twice in the definition of access. Part of access is geographic availability: "accessing a location where needed health care services are provided."[35] The second is as one barrier to health services, which is "lack of availability of services."[36] For the purposes of our report we measure availability by comparing population data for each region in Pennsylvania to the number of physicians practicing across specialties, number of hospital beds, and hospital services pre- and post-2003 tort reform.

For our analysis, we will include statewide data as well as regional/county data. We acknowledge that individuals may not receive health services in their county or region of residence and instead go to a neighboring county, or further for specialized care. However, for analytic purposes we assume the availability is equally attainable for the population of a region. We will discuss the services, hospitals, and physicians present

[34] *Ibid.*
[35] "Access to Health Services." Healthy People 2020. *Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.* https://www.healthypeople.gov/2020/topics-objectives/topic/access-to-health-services.
[36] *Ibid.*

within a region without regard to the population's ability to access the available medical services (as explained previously). See Section IV for availability of physicians, and Section V for availability of hospital services.

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SECTION IV
VENUE IN MEDICAL PROFESSIONAL LIABILITY ACTIONS AND AVAILABILITY OF PHYSICIANS

Fast Facts...

- *The number of active medical staff with clinical privileges in Pennsylvania hospitals grew over the period 1996 to 2018.*
- *In 2018, 60 percent of Pennsylvania physicians completed their graduate medical education in Pennsylvania.*
- *From 1997 to 2018 while the population of Pennsylvania increased, the number of females of childbearing age (15 to 44 years old) decreased.*

Overview

We were asked to determine the impact of the 2003 changes governing venue in medical professional liability actions on the availability of physicians in the Commonwealth. To accomplish this task, we reviewed the following information:

A. Pennsylvania Department of Health hospital questionnaire data on active medical staff with clinical privileges in selected departments or specialties and the number of full-time residents/medical interns on payroll at hospitals.
B. A 2015 report by the Pennsylvania Joint State Government Commission on physician shortages in the Commonwealth.
C. Peer reviewed studies about medical malpractice tort reforms in other states and/or nationally.
D. Pennsylvania population data from the United States Census Bureau.
E. Medical professional liability rate information from the *Medical Liability Monitor* and Pennsylvania Professional Liability Joint Underwriting Association.

We reviewed the available data from 1996 through 2018, unless otherwise noted.

We found:

1. There is a lack of comprehensive, detailed data on the number of physicians practicing in Pennsylvania.
2. Based 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.
3. The 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.
4. The number of full-time medical interns/residents on payroll at hospitals appeared unaffected by the 2003 tort reforms.

5. The data indicates there were no measureable effects of venue on the availability of physicians across the Commonwealth from the 2003 tort reforms; however, the health care landscape in Pennsylvania has significantly changed for physicians since then.
6. In 2018, a majority of Pennsylvania physicians received their graduate medical education in-state. Of the physicians who completed their graduate medical education in Pennsylvania, fewer than half practiced medicine in Pennsylvania.

Issue Areas

A. Physician Availability Pre- and Post-Tort Reform

Recruitment and retention of physicians is important for all communities in the Commonwealth. As explained previously, we define availability of physicians as the number of physicians in a region compared to that region's population. Prior to the 2003 tort reforms in Pennsylvania, the rhetoric surrounding rising medical malpractice premiums was that specialists were leaving Pennsylvania, retiring early, or entering a different field of work. This same argument was made with the possibility of physicians getting sued in a county other than where they were practicing, causing physicians to stop practicing medicine in Pennsylvania.

In order to determine the availability of physicians pre- and post-tort reform, we reviewed various sources of physician data, including data published by federal and state governments, and professional organizations. We found most of these sources to be inadequate for this study. The data published in most cases did not cover our review period, was not specific (i.e., by county, by specialty), was not published annually, and/or was not consistently reported from year-to-year.

Pennsylvania House Resolution 735 of 2014 directed a review of physician shortages in the Commonwealth by the Pennsylvania Joint State Government Commission (JSGC). In their 2015 report, JSGC was asked to complete "a comprehensive analysis of physician shortages and its impacts by region and specialty . . ."[37] As a result of their analysis, the first recommendation in the JSGC study was to "improve physician workforce data collection and analysis." Specifically, JSGC noted this data should include "the number of physicians, the geographic distribution and the

[37] "The Physician Shortage in Pennsylvania." Pennsylvania *Joint State Government Commission*. (April 2015). http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2015-411-physician%20shortage%20report%204-20-2015.pdf.

specialty distribution of physicians in the Commonwealth." While the objectives of the JSGC study were different than what is reviewed in this study, they arrived at the same conclusion that reliable and specific data is lacking about physicians.

Despite the lack of comprehensive data, we are able to provide some analysis on the availability of physicians. In order to review physician data by specialties and on a county-by-county basis to determine regional availability trends for the period 1996 to 2018, we relied on the Pennsylvania Department of Health (PDH) *Annual Hospital Questionnaires* (questionnaires).

State law requires all hospitals licensed by PDH to complete the questionnaires annually.[38] Hospitals are licensed biennially and compliance with the questionnaires is enforced during the relicensure process. We reviewed data pertinent to this study contained in the questionnaires. The information we did review appeared complete from 1996 to 2018.[39]

We found some limitations with the physician data contained in the questionnaires, however, we determined this to be the most detailed source of data needed to analyze the availability of physicians in certain specialties by Pennsylvania region. Additionally, the data was consistent over the review period. For example, in *Report 5, Active Medical Staff with Clinical Privileges in Selected Departments or Services*, the questionnaire asked hospitals for the same information over the review period. The only change that was made to this particular report over the period 1996 through 2018, was to change from reporting based on the state fiscal year (FY) (July 1 through June 30) to a calendar year (CY) (January 1 through December 31) in FY 2015-16. This was also at the same time that PDH changed the questionnaire results format from a portable document format to a spreadsheet.

As previously noted, although there are limitations in using this data, it is was the best data available that is both detailed (by specialty and county) and consistently covers the time period of this study. The data limitations include the following:

- The information is self-reported by the hospitals. The data is not audited, however, PDH does some analysis for outliers and works with hospitals to get the data as accurate as possible. For example, PDH statisticians pair the current year questionnaire with historical data and contacts the hospitals that have significant deviations from previous years.

[38] PA Code 28 § 101.56.

[39] The one exception to this is federally-owned hospitals which are not required to respond to the questionnaires because they are not licensed by Pennsylvania.

- The data includes physicians with clinical privileges at Pennsylvania hospitals, therefore, physicians that do not have clinical privileges are not included in the totals. This also means that a physician may be counted more than once because they may have clinical privileges at more than one hospital and/or in more than one specialty. The practitioners counted must be active staff only, and had to provide patient medical care in the hospital during the survey period.
- The data includes licensed MD's and DO's, but also includes dentists and podiatrists with clinical privileges.
- The data excludes seven[40] counties that do not have hospitals, however, over our review period the population of these seven counties only totaled one to two percent of Pennsylvania's total population.

For these reasons we know the total number of physicians from the questionnaires may be more than the actual total number of physicians. For example, the totals from the questionnaires do not match the number of physician license renewals reported by PDH's Bureau of Health Planning. Conversely, the data from the Bureau of Health Planning was not detailed enough for all specialties included in our analysis that follows, nor did it cover our review period.

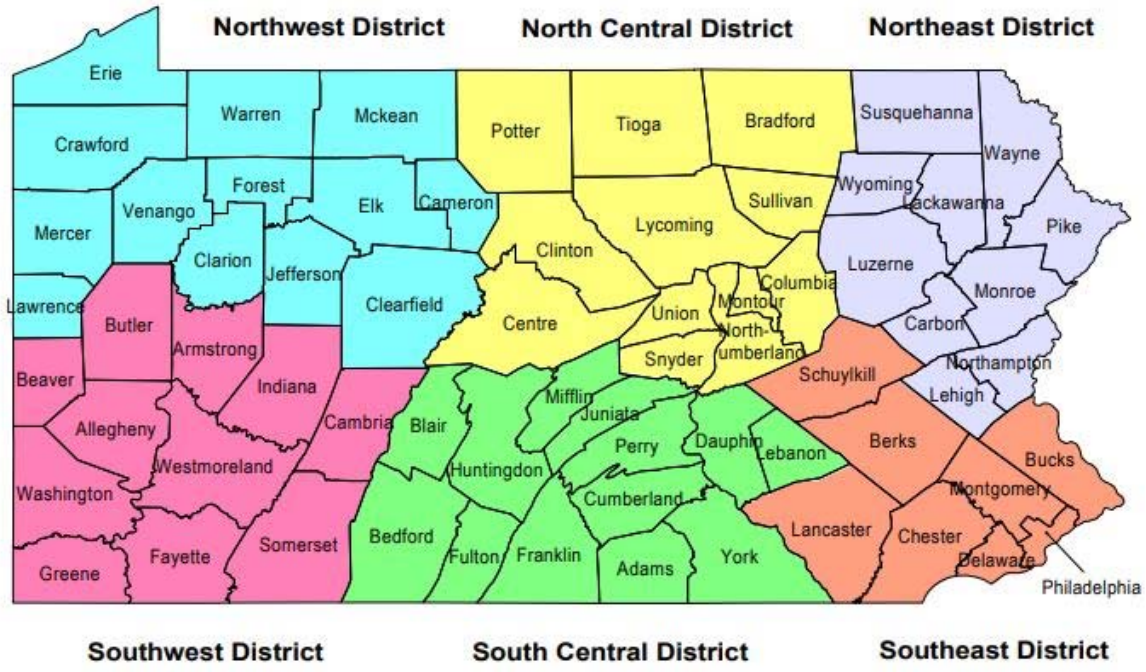
We reviewed *Report 5, Active Medical Staff with Clinical Privileges in Selected Departments or Services* for FY 1996-97 through CY 2018. This data included physicians in general acute care hospitals, state hospitals, and specialty hospitals across 29 specialties.[41] We focused on obstetrics/gynecology (OB/GYN), general surgery, and internal medicine as these are the three specialties used by the *Medical Liability Monitor* in publishing their Annual Rate Survey (discussed in greater detail later in this report). We used the data on these three specialties, plus the total of all specialties included in *Report 5*, to review changes that occurred in each health region over the period 1996 to 2018. In this section when we refer to regions or districts, we are using PDH's health regions as shown in Exhibit 1.

[40] The seven counties without hospitals include: Cameron, Forest, Juniata, Perry, Pike, Snyder, and Sullivan.

[41] The specialties in *Report 5* include: allergy/immunology, anesthesiology, cardiology, colon/rectal, dentistry, dermatology, emergency medicine, family practice, internal medicine, neurological surgery, nuclear medicine, obstetrics/gynecology, oncology, ophthalmology, oral surgery, orthopedic surgery, otolaryngology, pathology, pediatrics, physical medicine/rehabilitation, plastic surgery, podiatry, preventative medicine, psychiatry/neurology, radiology, surgery, thoracic surgery, urology, and "all others."

Exhibit 1

Pennsylvania Health Regions



Source: PA Department of Health.

Availability of Physicians

SR 20 directs LBFC to determine the effects of the 2003 tort reform changes governing venue in medical professional liability actions on the availability of physicians in Pennsylvania. We ultimately concluded there are too many variables at play to isolate venue (from the other MCARE changes) and then determine what impact, if any, it has on the availability of all physicians in Pennsylvania. At the end of the day, physicians are human beings, not widgets. While medical malpractice premiums may be a factor in determining the availability of physicians in a county and/or a particular specialty, there are also other economic and social factors involved.[42]

Just as many workers in the Commonwealth and United States have a choice in determining where to work, so do physicians. It is unlikely that a single factor determines the location of a physician. Like other workers,

[42] Rabinowitz, Howard and Nina Paynter. "The Rural vs Urban Practice Decision." *The Journal of the American Medical Association*. (January 2002).

physicians consider compensation, fringe benefits, location, commute time, open positions, proximity to relatives, other family factors, work-life-balance, access to continuing education, job satisfaction, etc., in their employment cost-benefit analysis.

Although the data indicates medical malpractice premiums likely factor into the availability of physicians (particularly in some counties and specialties) it may not be the sole or most important factor for every physician statewide (as discussed throughout this section). At the same time, the data does not indicate that medical malpractice premiums exist in a vacuum and therefore, likely have some impact on physician availability.

In addition, health care is an ever evolving industry. Even after removing personal economic and social factors in physician employment decision making, there are many variables outside of the control of physicians. For example, there is an increasing trend in the number of nonphysician clinicians (i.e., physician assistants, nurse practitioners, certified midwives, etc.), who, under the supervision of a physician, can perform some of the same functions for a lesser cost.[43] The practice of medicine is changing with increases in technology and there are also fewer independent hospitals and more hospitals in health systems. During our review period there was also a significant change in the health insurance marketplace, with the Patient Protection and Affordable Care Act of 2010. These are all external factors that affect physician availability, but are outside of the control of physicians.

We also reviewed other studies for methodologies that would isolate tort reform impact on availability of physicians in a measureable way. We found no studies that related to medical malpractice venue. In summary, the studies we reviewed conclude the following about tort reforms and availability of physicians:

Hyman *et al*. studied tort reforms in Texas and concluded:

> The bottom line: There is no evidence that the number of active Texas physicians per capita is larger than it would have been without tort reform. Any effect of tort reform is too small for us to measure, against the background of other, larger forces affecting physician supply, both in Texas and nationally.[44]

[43] The U.S. Bureau of Labor Statistics (USBLS) estimates these non-physician occupations' job outlooks from 2018 through 2028 will be "much faster than average." USBLS estimates a growth of 31 percent for physician assistants and 26 percent for nurse anesthetists, nurse midwives, and nurse practitioners. This compares to a job outlook of 7 percent increase for physicians over the same period. See *Occupational Outlook Handbook, Healthcare Occupations* at https://www.bls.gov/ooh/healthcare/home.htm.

[44] Hyman, David, et al. "Does Tort Reform Affect Physician Supply? Evidence from Texas." *International Review of Law and Economics*. (2015).

Yang *et al*. studied tort reforms and the supply of OB/GYNs nationally, and concluded:

> Our results, consistent across every version of the analytic model, suggest that malpractice insurance premium levels and the presence of liability-limiting tort reforms in a state do not significantly affect the supply of OB/GYNs at the state level. These results are at odds with assertions of an exodus of OB/GYNs from states with high and rapidly rising insurance premiums. They also undercut suggestions that caps on noneconomic damages and other tort reforms help states attract and retain high-risk specialists by providing relatively good insulation from malpractice judgments.[45]

Agarwal, Gupta, and Gupta studied the impact of tort reforms on a variety of factors including physician supply. They concluded:

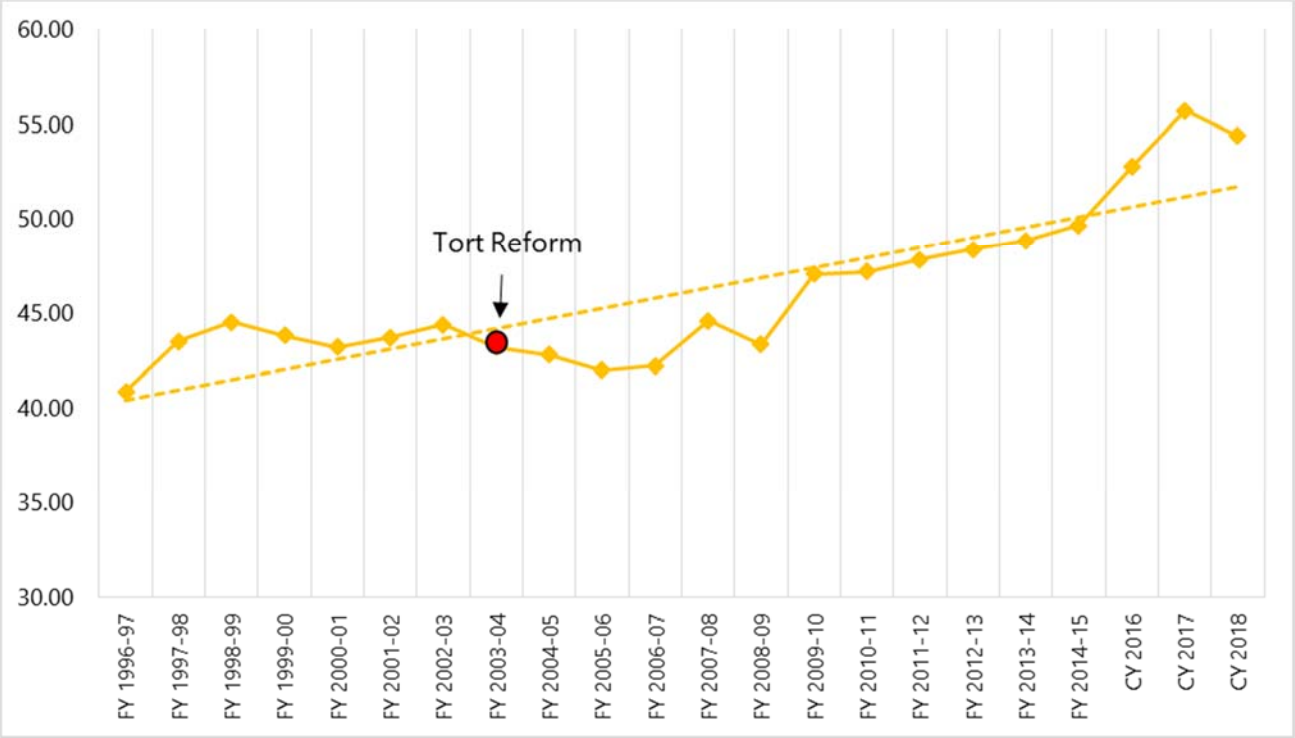
> Our systematic review summarizes the published evidence on the effects of the various tort reform measures on key outcomes. We found that caps on noneconomic damages were associated with a decrease in health care utilization and spending, and an increase in physicians supply, but had no effect on the quality of care. The other tort reform methods had limited impact on outcomes or insufficient evidence.[46]

As previously stated we compared the number of active medical staff with clinical privileges to the population. We again caution the use of our physician data as it has limitations as previously outlined. Exhibit 2 shows the statewide total of active medical staff with clinical privileges per 10,000 Pennsylvania residents. Overall, the availability of physicians has increased during our review period. Availability of physicians has decreased a few times year-to-year over the period reviewed: two percent in FY 1999-00, one percent in FY 2000-01, three percent in FY 2003-04, one percent in FY 2004-05, two percent in FY 2005-06, three percent in FY 2008-09, and two percent in CY 2018. Our analysis of the year-to-year variations statewide did not conclude that these decreases were associated with any one variable.

[45] Yang, Y. Tony, et al. "A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists." *Journal of Empirical Legal Studies*. (March 2008).
[46] Agarwal, Rajender, Ashutosh Gupta, and Shweta Gupta. "The Impact of Tort Reform on Defensive Medicine, Quality of Care, and Physician Supply: A Systematic Review." *Health Services Research*. (2019).

Exhibit 2

Pennsylvania Statewide Total Active Medical Staff with Clinical Privileges Per 10,000 Residents



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in Section IV.

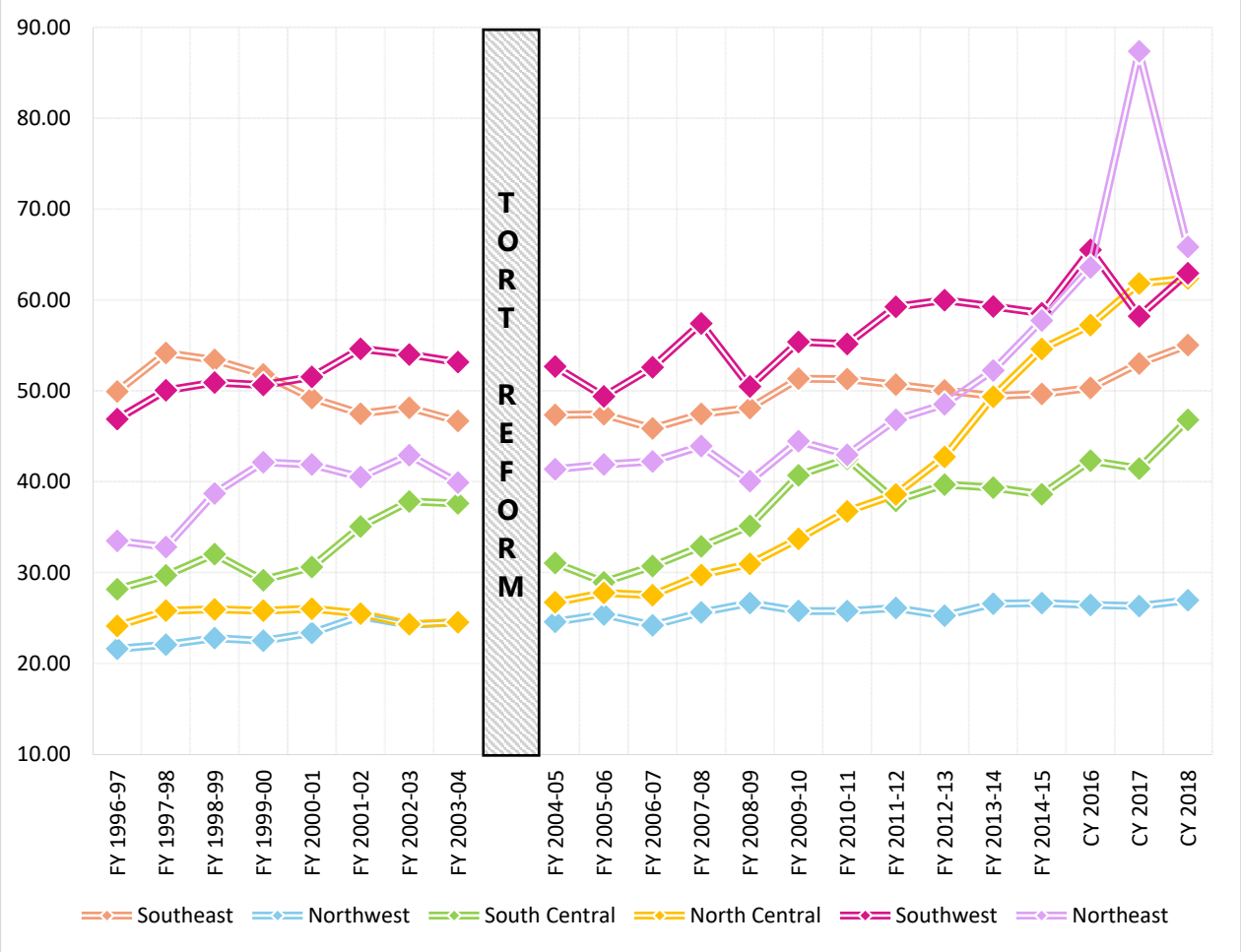
Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires* and U.S. Census Bureau.

As will be discussed throughout this section of our report, data did not provide overwhelming evidence of statewide trends regarding the availability of all physicians as it relates to the venue rule.

Exhibit 3 shows the regional breakdown of total active medical staff with clinical privileges per 10,000 residents. As shown, each region has its own unique trend.

Exhibit 3

Total Active Medical Staff with Clinical Privileges per 10,000 Residents



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in Section IV.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires* and U.S. Census Bureau.

The availability of active medical staff with clinical privileges varied greatly between the different regions over our review period. There were no similar trends among the regions. The Northwest Region maintained the same trend pre- and post-tort reform. The North Central Region had a rather flat availability of physicians until around the time of tort-reform. The Northeast Region also saw an increase directly following tort reforms. Both of these regions did not have counties often associated with the venue rule discussions. The South Central Region saw a decrease around the time of tort reform, and a gradual increase began two years after.

The Southwest and Southeast regions, which include the two counties most associated with venue issues (Philadelphia and Allegheny), plus their surrounding counties, saw an initial decrease in availability directly following tort-reform. Eventually there was an increase in these two regions. We would not, however, expect to see an immediate increase initially following reform as it would take physicians some time to relocate. For these reasons the analysis that follows will be at the county level, as that is the level in which medical malpractice claims are filed and malpractice premium rates are set.

As previously stated, we will review three specialties in more detail: OB/GYN, internal medicine, and general surgery as these are the three specialties used by the *Medical Liability Monitor* to publish rates.

Availability of Obstetrics/Gynecology Physicians.

Obstetrics and Gynecology physicians (OB/GYNs) were often discussed surrounding tort reform as these physicians typically have one of the higher rates of malpractice insurance premiums and are considered a high-risk specialty. OB/GYN is defined as:

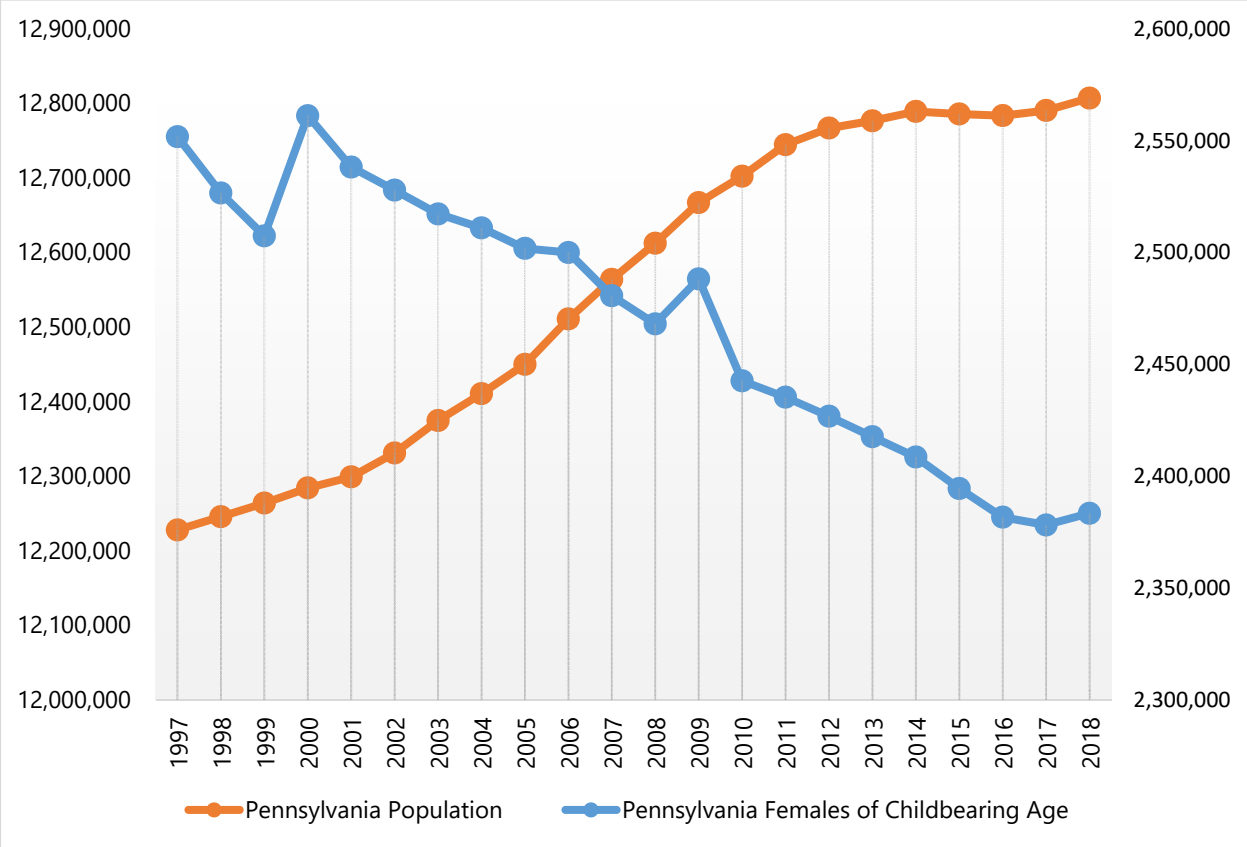
> A branch of medicine that specializes in the care of women during pregnancy and childbirth and in the diagnosis and treatment of diseases of the female reproductive organs. It also specializes in other women's health issues, such as menopause, hormone problems, contraception (birth control), and infertility.[47]

While Pennsylvania's population steadily increased over our review period, the number of females of childbearing age declined. Females of childbearing age are defined by PDH as females between the ages of 15 and 44 years old. The trend of an increase in the total population versus the decrease in females of childbearing age is shown in Exhibit 4.

[47] "Obstetrics and gynecology." *NCI Dictionary of Cancer Terms, National Cancer Institute.* https://www.cancer.gov/publications/dictionaries/cancer-terms/def/obstetrics-and-gynecology

Exhibit 4

Pennsylvania Population Compared to the Number of Females of Childbearing Age (15 to 44 Years Old)

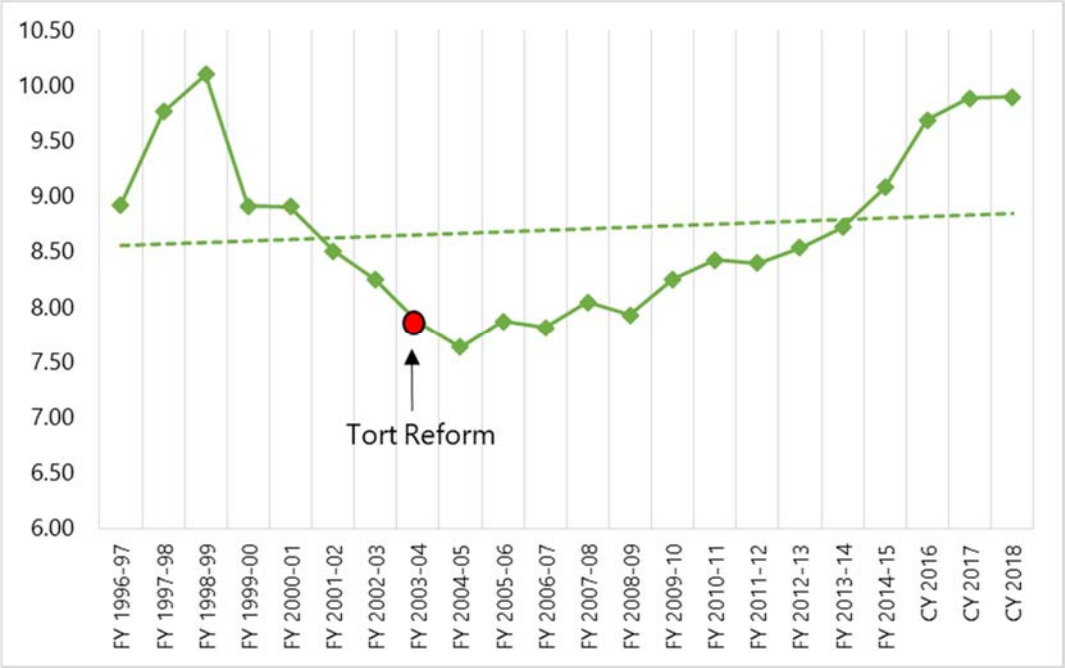


Source: LBFC staff from population data obtained from the U.S. Census Bureau and Females of Childbearing Age data received from the Pennsylvania State Data Center.

As shown in Exhibit 5, overall, the availability of medical staff with clinical privileges in obstetrics/gynecology declined prior to tort reforms and slowly increased post-reforms; however, OB/GYNs never rebounded to the peak of 10.1 physicians per 10,000 females of childbearing age in FY 1998-99.

Exhibit 5

Pennsylvania Statewide Total Active Medical Staff with Clinical Privileges in Obstetrics/Gynecology Specialty Per 10,000 Females of Childbearing Age



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires* and PA State Data Center.

While there will be a more in-depth discussion about medical malpractice insurance rates in a later section, we did run a simple linear regression analysis between the number of active medical staff with clinical privileges in the OB/GYN specialty and two different insurance provider rates. We chose the rates from the Pennsylvania Professional Liability Joint Underwriting Association (JUA) and Pennsylvania Medical Society Liability Insurance Company (PMSLIC) because both entities provided insurance services through our entire review period.

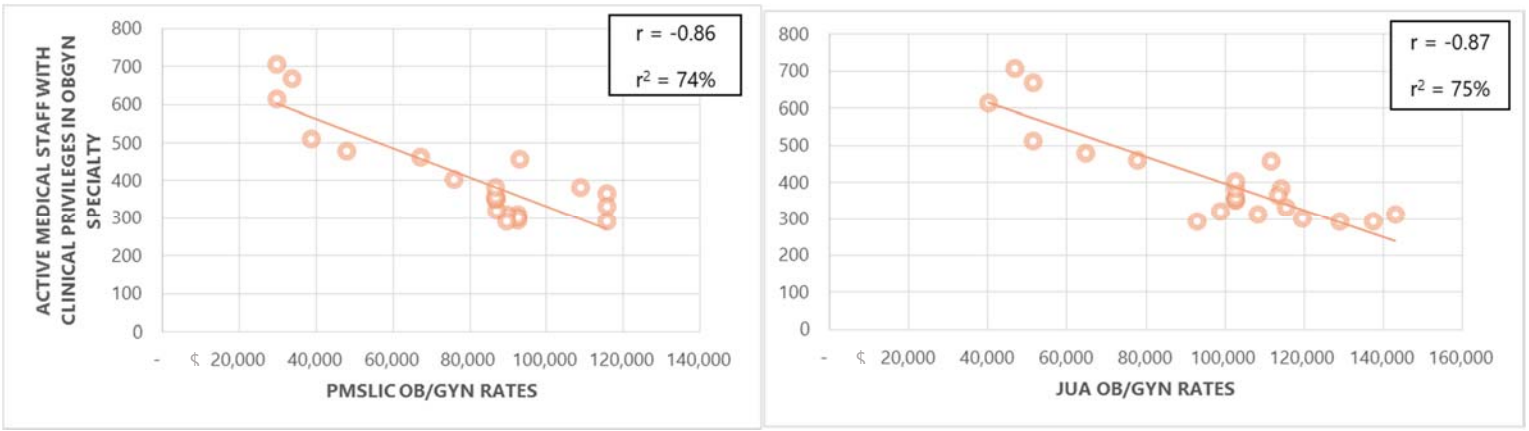
Of the 60[48] counties for which we completed the simple linear regression, the data indicated five counties had a moderate or higher negative correlation[49] between the number of OB/GYNS and JUA/PMSLIC rates during our review period. The five counties were Cambria, Fulton, Lawrence,

[48] As previously mentioned, there are no hospitals in seven of Pennsylvania's counties.
[49] We defined this as a correlation between -0.70 and -1.00.

Philadelphia, and Westmoreland. Exhibit 6 shows the coefficient of correlation[50] between rates and active medical staff with clinical privileges in the OB/GYN specialty in Philadelphia County. We present Philadelphia County as an example, to show the data indicated a linear relationship between PMSLIC or JUA OB/GYN rates and active medical staff with clinical privileges in the OB/GYN specialty.[51]

Exhibit 6

Philadelphia OB/GYN Rates Compared to Active Medical Staff with Clinical Privileges in OB/GYN Specialty



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*, *Medical Liability Monitor*, JUA.

As shown, there was a strong negative correlation (represented as "r") between both sets of rates and active medical staff with clinical privileges specializing in OB/GYN in Philadelphia. In other words as the price of medical malpractice premiums increased, the number of OB/GYNs decreased, and vice versa. We also calculated the coefficient of determination (represented by the r^2), which expresses the proportion of the variance in the dependent variable (number of physicians) by the independent variable (rates).

[50] This represents how correlated the independent (rates) and dependent (number of physicians) variables are. In this case, the closer to -1.00, the stronger the correlation is.
[51] Without a linear relationship between the two variables the correlations calculated would be moot.

The remaining four counties with correlations between -0.70 and -1.00 are shown in Exhibit 7.

Exhibit 7

Counties with Moderate to Strong Correlation between OB/GYN Rates and Active Medical Staff with Clinical Privileges in OB/GYN Specialty

County	Health Region/District	PMSLIC	JUA
Blair	South Central	r = -0.79 r^2 = 63%	r = -0.81 r^2= 66%
Fulton	South Central	r = -0.83 r^2 = 69%	r = -0.75 r^2 = 57%
Lawrence	Northwest	r = -0.82 r^2 = 68%	r = -0.74 r^2 = 55%
Westmoreland	Southwest	r = -0.85 r^2 = 72%	r =-0.86 r^2 = 75%

Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*, *Medical Liability Monitor*, and JUA.

Interestingly, the data indicated one county had a strong positive correlation, when PMSLIC OB/GYN rates went up, so did the number of active medical staff with clinical privileges:

Centre County (North Central region): r = 0.78, r^2 = 60%.

In theory, if the implementation of the venue rule led to a decrease in rates statewide, we would expect the data to indicate more counties with a strong negative correlation (as rates went up, number of physicians went down and vice versa) between rates and number of physicians. For example, if applying the theory that the venue rule impacted the availability of physicians, we would expect to see the counties surrounding Philadelphia, and Allegheny County and its surrounding counties (although one surrounding county is included: Westmoreland) with strong correlations. These were the counties identified as the reason for the venue rule change. It cannot be discounted that rates did have <u>some</u> effect, but it appears to be isolated to certain counties.

Without data indicating significant widespread statewide trends, we are led to conclude that there are more factors that determine the availability of OB/GYNs than just medical malpractice insurance rates. For example, based on our research, it appears there are a variety of trends occurring nationally with OB/GYNs. A 2013 study predicted that between 2010 and

2020, Pennsylvania would see a three percent decline in patient demand for OB/GYNs.[52] Another study we reviewed concluded that nationally "the percentage of women who visit an ob-gyn has declined since 2000."[53] The American Congress of Obstetricians and Gynecologists (ACOG) highlighted the following trends impacting the specialty (though they note the trends are not unique to OB/GYNs and could be compared with physicians in primary care and surgical specialties as well):

- A decreased number of residency graduates in relation to the growing population
- An increased number of graduates electing to pursue subspecialty training
- A new generation of physicians with an increased emphasis on work-life integration
- Changing practice patterns, including flexible or part-time schedules
- Relatively decreased professional satisfaction
- Slow or nonexistent growth in adjusted income
- Changes in delivery of women's health care
- Continued maldistribution of the OB/GYN workforce[54]

It is understandable that OB/GYNs are often at the forefront of medical malpractice tort reform discussions. An American Medical Association (AMA) study from 2016 found that OB/GYNs (and general surgeons) had over a 30 percentage point higher probability of being sued and getting sued two or more times than did internists.[55] Of the survey respondents that identified as OB/GYNs, 63.6 percent stated they were sued once, and 44.1 percent were sued two or more times.[56]

It is often assumed that as long as there are births, OB/GYNs will be available. Though we could not compare this data over our entire review period,[57] we found that of physicians practicing direct patient care in Pennsylvania who delivered babies as part of their practice, only about half identified as OB/GYNs. Exhibit 8 shows these survey results.

[52] Dall, Timothy, et al. "Estimated Demand for Women's Health Services by 2020." *Journal of Women's Health*. (2013).
[53] Simon, Alen and Sayeedha F. G. Uddin. "Trends in Seeing an Obstetrician-Gynecologist Compared with a General Physician Among U.S. Women, 2000-2015." *The American College of Obstetricians and Gynecologists*. (2017).
[54] Rayburn, William. "The Obstetrician-Gynecologist Workforce in the United States: Facts, Figure, and Implication." *The American Congress of Obstetricians and Gynecologists*. (2017).
[55] Guardado, Jose. "Medical Liability Claim Frequency Among U.S. Physicians." *American Medical Association*. (2017).
[56] *Ibid*.
[57] The data was presented in a different format in physician surveys prior to 2010.

Exhibit 8

Physicians Practicing Direct Patient Care in Pennsylvania Who Delivered Babies as Part of their Practice by Primary Specialty

	2010	2012	2014
OB/GYN	53%	52%	51%
Emergency Medicine	30	34	37
Family Medicine	11	9	8
Other Specialties	6	5	4

Source: LBFC staff from information obtained from PDH *Pulse of Pennsylvania's Physician and Physician Assistant Workforce* surveys.

For these reasons we conclude that the data shows OB/GYN medical malpractice rates are one of many factors affecting the availability of OB/GYNs, particularly so in five counties. Without widespread trends, and access to detailed physician data, we could not measure the specific effects of the tort reforms on the availability of OB/GYNs, including the specific effect of the venue change alone.

Availability of General Surgeon Physicians. The next specialty we reviewed was general surgery. General surgery is defined as:

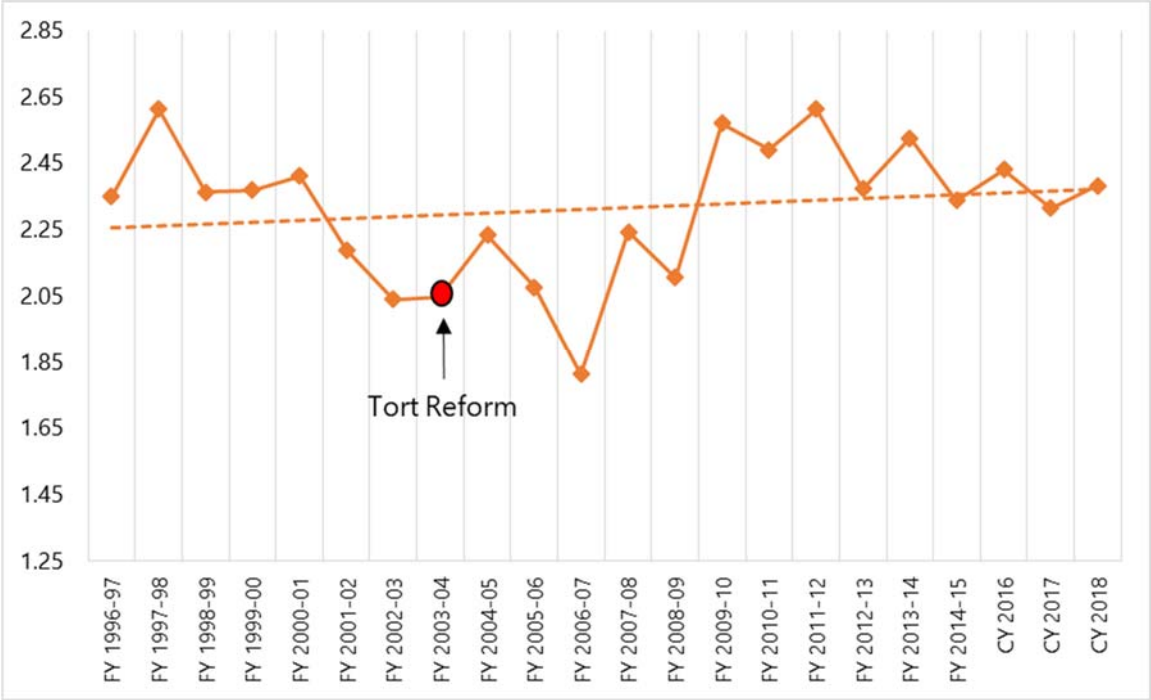
> The branch of surgery that covers the main areas of surgical treatment. General surgeons treat diseases of the abdomen, breast, head and neck, blood vessels, and digestive tract. They also manage care of patients who have been injured or who have deformities or other conditions that need surgery.[58]

This specialty is also considered high risk given the nature of procedures general surgeons perform. General surgeons were also often mentioned in discussions surrounding tort reform. We repeated the same analysis for general surgeons as we did for OB/GYNs. Exhibit 9 shows the statewide total number of active medical staff with clinical privileges in the general surgery specialty per 10,000 Pennsylvania residents.

[58] "General surgery." *NCI Dictionary of Cancer Terms, National Cancer Institute*. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/general-surgery

Exhibit 9

Pennsylvania Statewide Total Active Medical Staff with Clinical Privileges in General Surgery Specialty per 10,000 Residents



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires* and U.S. Census Bureau.

Overall, as the trend line shows there was a slight increase in the number of active medical staff with clinical privileges in the general surgery specialty during our review period. There were periods of decline in the total number, however, with the lowest drop occurring post-tort reform, in FY 2006-07.

We again completed a simple linear regression analysis and the data indicated three counties had a moderate or higher negative correlation (r = -0.70 to -1.00) between the number of active medical staff with clinical privileges in the general surgery specialty and JUA and/or PMSLIC rates. These counties are presented in Exhibit 10.

Exhibit 10

Counties with Moderate to Strong Correlation between General Surgeon Rates and Active Medical Staff with Clinical Privileges in General Surgery Specialty

County	Health Region/District	PMSLIC	JUA
Fayette	Southwest	r = -0.70 r^2 = 48%	r = -0.81 r^2= 65%
Lawrence	Northeast	r = -0.78 r^2 = 61%	r = -0.78 r^2 = 61%
Philadelphia	Southeast	r = -0.74 r^2 = 54%	Did not meet correlation criteria

Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*, *Medical Liability Monitor*, and JUA.

Similar to OB/GYNs, without data indicating significant widespread statewide trends we are led to believe that medical malpractice insurance rates alone do not determine the availability of general surgeons. For example, from our research, it appears there are a variety of trends occurring nationally with general surgeons that are not all that different from trends occurring with OB/GYNs:

- While the United States population continues to grow, the number of graduating general surgery residents has remained static
- The changing nature of the work force
- Preference for a controllable lifestyle
- Increasing workload due to an aging population and declining work hours represent a challenge[59]

As mentioned in the OB/GYN discussion, a 2016 AMA study found that general surgeons (and OB/GYNs) had over a 30 percentage points higher probability of being sued and being sued two or more times than did internists.[60] Of the survey respondents that identified as general surgeons, 63.2 percent stated they were sued once, and 50.1 percent were sued two or more times.[61]

[59] Satiani, Bhagwan, David Etzioni and Thomas Williams. "Trends in the General Surgery Workforce." *Seminars in Colon and Rectal Surgery*. (December 2013).
[60] Guardado, Jose. "Medical Liability Claim Frequency among U.S. Physicians." *American Medical Association*. (2017).
[61] *Ibid*.

For these reasons we conclude that the data shows that general surgeon medical malpractice rates are one of many factors affecting the availability of general surgeons, particularly so in three counties. Without widespread trends, and access to detailed physician data, we could not measure the specific effects of the tort reforms on the availability of general surgeons, including the specific effect of the venue change alone.

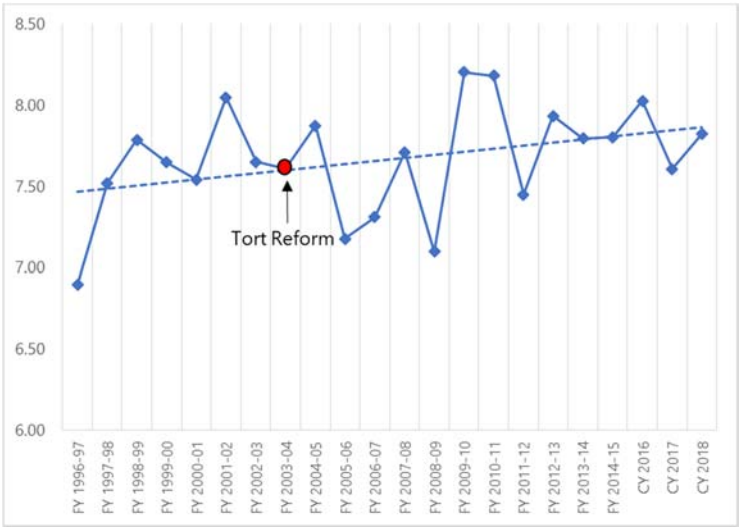
Availability of Internal Medicine Physicians. Internal medicine physicians, or internists, represent the largest group of active medical staff with clinical privileges in a specialty in Pennsylvania. Internal medicine is defined as:

> A branch of medicine that specializes in preventing, diagnosing, and treating diseases in adults, without using surgery. An internal medicine doctor is often a person's main health care provider and may coordinate treatment given by other specialists.[62]

Exhibit 11 shows the statewide total number of active medical staff with clinical privileges in the internal medicine specialty per 10,000 Pennsylvania residents.

Exhibit 11

Pennsylvania Statewide Total Active Medical Staff with Clinical Privileges in Internal Medicine Specialty per 10,000 Residents



Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires* and U.S. Census Bureau.

[62] "Internal medicine." *NCI Dictionary of Cancer Terms, National Cancer Institute.* https://www.cancer.gov/publications/dictionaries/cancer-terms/def/internal-medicine

As shown by the trend line in Exhibit 11 the number of active medical staff with clinical privileges in the internal medicine specialty per 10,000 Pennsylvania residents overall increased during our review period. The number ranged from a low of 6.90 in FY 1996-97 to a high of 8.20 in FY 2009-10. We did not see any pronounced trend attributable to tort reform.

Similarly to OB/GYN and general surgery specialties, we again completed a simple linear regression analysis and the data indicated four counties had a moderate or high negative correlation (r = -0.70 to -1.00) between the number of active medical staff with clinical privileges in the internal medicine specialty, and JUA and PMSLIC rates. See Exhibit 12.

Exhibit 12

Counties with Moderate to Strong Correlation between Internal Medicine Rates and Active Medical Staff with Clinical Privileges in Internal Medicine Specialty

County	Health Region/District	PMSLIC	JUA
Blair	South Central	r = -0.74 r^2 = 54%	r = -0.82 r^2= 67%
Clinton	North Central	r = -0.80 r^2 = 63%	r = -0.80 r^2 = 64%
Fayette	Southwest	r = -0.77 r^2 = 60%	r = -0.73 r^2 = 53%
Philadelphia	Southeast	r = -0.78 r^2 = 61%	r =-0.81 r^2 = 65%

Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*, *Medical Liability Monitor*, and JUA.

Interestingly, the data also indicated three counties had a moderate to strong positive correlation, when PMSLIC or JUA internal medicine rates went up, so did the number of active medical staff with clinical privileges:

- Clearfield County (Northeast region): r = 0.72, r^2 = 51% (PMSLIC).
- Mercer County (Northeast region): r = 0.80, r^2 = 65% (JUA).
- York County (South central region): r =0.71, r^2 = 50% (JUA).

As mentioned in the OB/GYN and general surgeon discussions, internists are less likely to be sued than those two groups of specialties. Internists are not immune from being sued however. In the 2016 AMA study, of

the survey respondents that identified as internists, 31.7 percent stated they were sued once, and 14.8 percent were sued two or more times.[63]

As we concluded in the OB/GYN and general surgeon discussions, the data shows internal medicine medical malpractice rates are one of many factors affecting the availability of internists, particularly so in four counties. Without widespread trends, and access to detailed physician data, we could not measure the specific effects of the tort reforms on the availability of internists, including the specific effect of the venue change alone.

Medical Students, Interns, and Residents

This group of soon-to-be physicians or physicians-in-training, represents the "future" of medicine. A medical student is a student enrolled in medical school. A medical intern is typically the term for a medical school graduate completing their first year of on-the-job training. Medical interns may not have passed all exams at the time of the internship, and cannot practice unsupervised medicine. Residents are physicians (meaning they passed all exams as required by the state) and are completing on-the-job training. During residency, physicians further develop skills and knowledge needed for specialties. Some residents go on to become fellows which is additional training that may be needed for subspecialties.

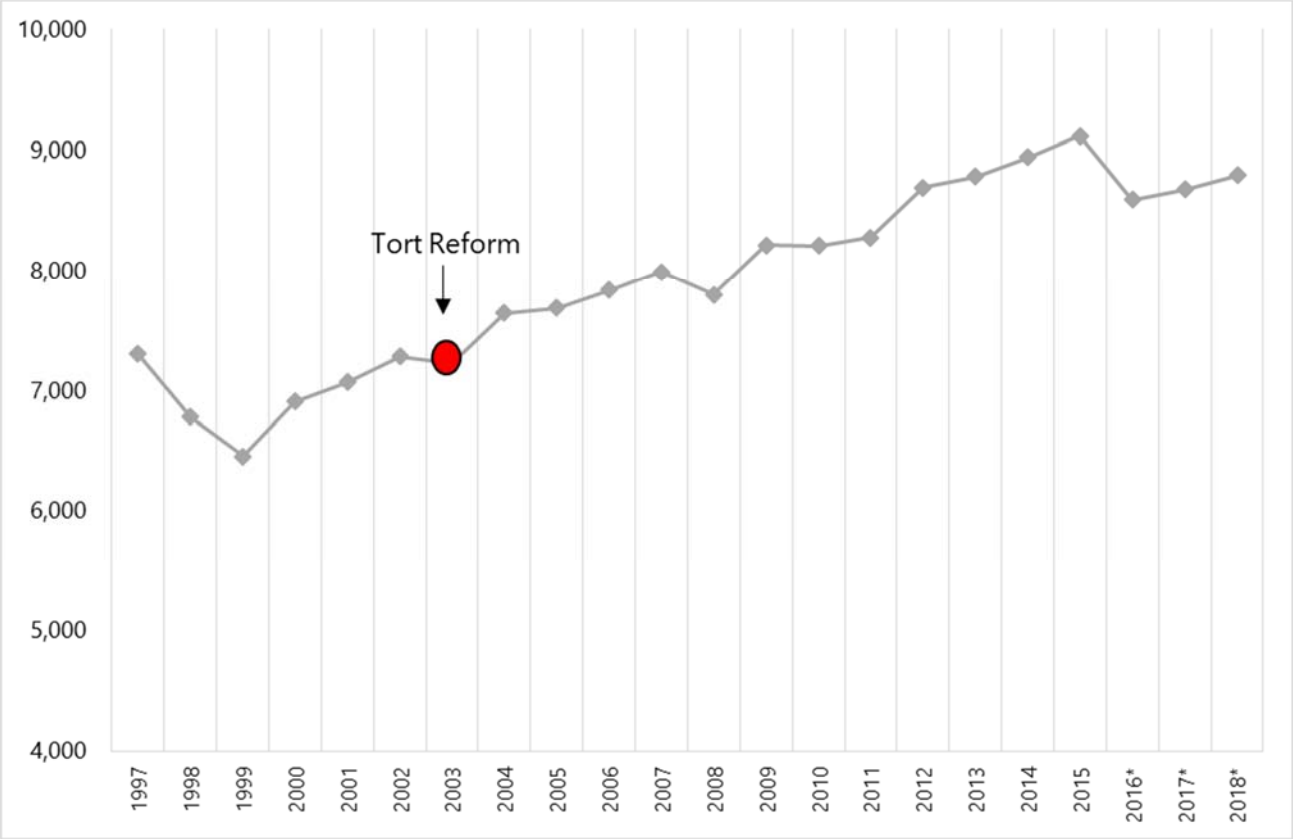
We reviewed the number of full-time medical interns and residents on payroll at Pennsylvania hospitals as that group of physicians represent a large number of potential physicians who may ultimately practice medicine in the Commonwealth. In discussions with stakeholder groups, it was conveyed to us that prior to tort reform medical students looking towards graduation were increasingly worried about Pennsylvania's medical malpractice insurance market. According to these stakeholders, Pennsylvania medical school graduates were leaving the Commonwealth for internships and residencies in other states with lower insurance rates.

As shown in Exhibit 13, after a dip in the number of medical interns and residents on payroll in Pennsylvania hospitals around 1999, the number of medical interns/residents has generally increased, though we do not know whether they were from in-state or out-of-state medical schools. Note this data does not include part-time or contracted residents.

[63] *Ibid.*

Exhibit 13

Number of Full Time Medical Interns and Residents on Payroll at Pennsylvania Hospitals



* The data for 1997 through 2015 was collected in June of each year, however, data collected 2016 through 2018 was collected in December.

Note: Please refer to limitations in using the *Annual Hospital Questionnaires* data, noted previously in this section.

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*.

This data does not lead to the conclusion that the venue rule change was a significant factor in determining the number of medical interns and residents on hospital payrolls.

Location of residency is important because, according to the Association of American Medical Colleges (AAMC), "sixty-eight percent of doctors who complete all their training in one state end up practicing there."[64] AAMC tracks data on state retention of medical students for all 50 states. This information is included in the AAMC *State Physician Workforce Data*

[64] Beitsch, Rebecca. "To Address Doctor Shortages, Some State Focus on Residencies." *Pew Charitable Trusts.* (August 2015). https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/08/11/to-address-doctor-shortages-some-states-focus-on-residencies

Report, but has only been published starting in 2007. Therefore, we could not compare Pennsylvania's retention rate rank to other states prior to tort reform.

B. The Impact of the Proposed Venue Rule Change on the Availability of Physicians

As previously discussed, many variables are involved in decision-making for physicians when determining where to practice, it is difficult to determine what impact (if any), a change in the venue rule would have on the availability of physicians. Because the data did not show statewide trends, there was no measureable way to isolate the venue rule. Without isolating the impact of venue, there is no way for the data to forecast the impact of the proposed venue rule change on availability of physicians. If insurance providers react to a change in the venue rule and a market destabilization occurs, hypothetically we would expect an impact on the counties (and specific specialties) for which we found a negative correlation between active medical staff with clinical privileges and rates.[65]

Although the data indicated no measurable effects of venue on the availability of doctors across the Commonwealth previously, we would be remiss not to consider the continually evolving landscape of Pennsylvania health care that has occurred since 2003 tort reforms. For example, Section V highlights the trend in the decreasing number of independently-owned hospitals versus the increasing number of hospitals in health systems. With this has been an increase in the number of health systems that cross county lines. Factoring in the health system expansions, a venue rule change back to the pre-tort reform era could mean that physicians in suburban and rural counties may be faced with lawsuits in Philadelphia, Allegheny, or Lackawanna Counties (the headquarters of the majority of the large health systems in Pennsylvania). While the data did not lead to a conclusion of how this added risk would affect certain physicians, and then affect the availability of all physicians, we do think the evolution of the health systems in Pennsylvania is an important consideration.

We also had no reliable method to measure the decision-making factors by physicians (aside from the counties and specialties we noted in Section IV, A) to get a sense of how significantly medical malpractice premiums influence their practice decisions. We reviewed survey results collected by PDH Bureau of Health Planning during licensing renewals of physicians (osteopathic and allopathic) and physician assistants, which

[65] Blair (OB/GYN and internal medicine), Clinton (internal medicine), Fayette (internal medicine and general surgery), Fulton (OB/GYN), Lawrence (OB/GYN and general surgery), Philadelphia (OB/GYN, general surgery, and internal medicine), and Westmoreland (OB/GYN).

occur every two years. We wanted to use these results to get a sense of what factors influenced physician decisions on where to practice pre- and post-tort reform. The data was insufficient to do so. The questions were not consistent from survey-to-survey, which did not allow us to compare answers over the survey period.

We were also curious as to how many physicians pay for all or a portion of their own medical malpractice insurance versus how many employers include the premium (or part of the premium) as a fringe benefit; however, no available data indicated this for Pennsylvania physicians.

Because we did not see widespread (measurable) changes to the availability of Pennsylvania physicians in all specialties after the 2003 MCARE Act changes, we would not expect to see a significant decline in Pennsylvania physicians practicing medicine in Pennsylvania should the venue rule change again. It is also important to remember that the outside influences on availability of physicians have changed (in some ways dramatically) since 2003. This includes (but is not limited to) the health insurance marketplace, the rise of health care systems, national medical malpractice forces, and the effects of technology on the practice of medicine.

Medical Students, Interns, and Residents

We thought it was important to include this group in discussions about availability of physicians as this group represents the future of the profession. For Pennsylvania in 2018, 31.3 percent of physicians were retained in state from undergraduate medical education (UME), ranking Pennsylvania 33rd among the other states.[66] The median state retention rate was 38.5 percent. As mentioned earlier in this section, the Association of American Medical Colleges (AAMC) considers the location of residency and/or advanced training to be the most important factor in determining where a physician will ultimately practice. For this advanced training in Pennsylvania in 2018, 39.8 percent of physicians were retained in state from graduate medical education (GME), ranking the Commonwealth 37th among the 50 states.[67] The median state retention rate was 44.9 percent.[68]

The statistics just presented about UME and GME retention could be interpreted to mean Pennsylvania is not very successful at turning medical students into Pennsylvania physicians. It is important to remember that there are far more medical students in Pennsylvania than other states. In

[66] "2019 State Physician Workforce Data Report." *Association of American Medical Colleges*. (November 2019). https://store.aamc.org/downloadable/download/sample/sample_id/305/
[67] *Ibid.*
[68] *Ibid.*

2018, there were 64.0 MD and DO students per 100,000 Pennsylvania residents.[69] In this regard, Pennsylvania ranked 4th among the 50 states, where the average was 32.7 MD and DO students per 100,000 state residents.[70] Additionally, Pennsylvania had 69.7 residents/fellows (in Accreditation Council for Graduate Medical Education programs) per 100,000 residents, again ranking Pennsylvania 4th among the 50 states.[71] As we presented previously, the number of full-time residents on payroll in Pennsylvania hospitals steadily increased throughout our review period. Exhibit 14 compares the number of medical school graduates in Pennsylvania versus the number of residencies available and then filled.[72]

Exhibit 14

Number of Medical Graduates, First-Year Residency Slots

	2015	2016	2017	2018
PA MD Graduates	1,253	1,198	1,274	1,283
PA DO Graduates	622	607	618	627
Total PA Graduates	1,875	1,805	1,892	1,910

	2015	2016	2017	2018
First-Year Residency Quota	1,896	1,898	1,969	2,008
First-Year Residency Matched	1,798	1,824	1,889	1,924
Number of Unfilled Available Positions	98	74	80	84
Match Rate	95%	96%	96%	96%

Source: LBFC staff from information retrieved from the American Association of Colleges of Osteopathic Medicine, Association of American Medical Colleges, and National Resident Matching Program.

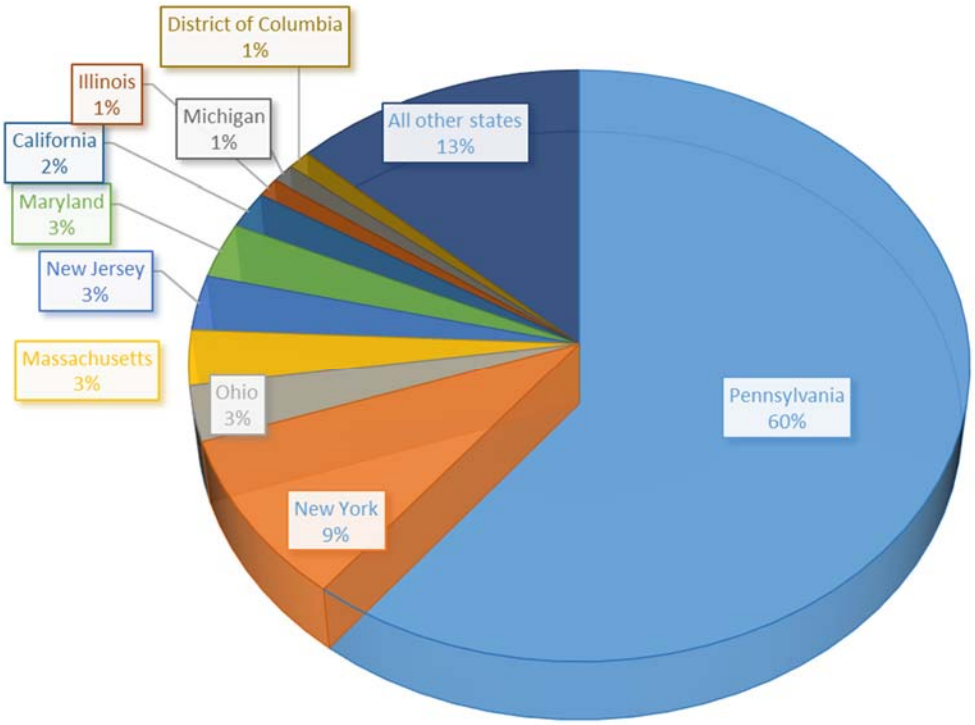
Without considering any additional factors, there were enough residencies/GME available for each medical student graduating from UME in Pennsylvania for the period 2015 to 2018. The state with the highest retention rate of physicians from in-state UME was California, which had a retention rate of 62.8 percent.[73] Of active physicians who completed GME in-state and were active in state in 2018, California again was the leader nationally and had a 70.6% retention rate.[74] California's population was three times that of Pennsylvania's in 2018.

[69] *Ibid.*
[70] *Ibid.*
[71] *Ibid.*
[72] Not all of this data existed for us to compare prior to the MCARE Act.
[73] *Ibid.*
[74] *Ibid.*

All of this analysis begs the question, where do Pennsylvania physicians receive their GME? According to the AAMC, in 2018, 60 percent of Pennsylvania physicians received their medical education from in-state medical schools and 40 percent received their medical education from out-of-state medical schools.[75] Exhibit 15 shows the AAMC's results.

Exhibit 15

Where Pennsylvania Physicians Received their Graduate Medical Education 2018



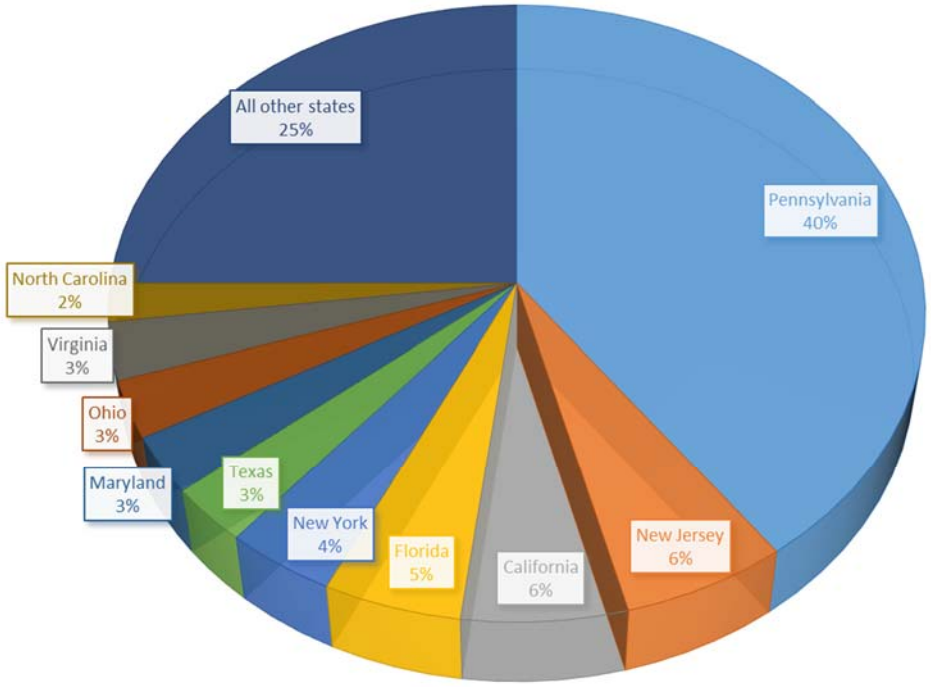
Source: LBFC staff from information obtained from AAMC *2019 Pennsylvania Physician Workforce Profile*.

[75] "2019 Pennsylvania Physician Workforce Profile." *Association of American Medical Colleges.* https://www.aamc.org/system/files/2019-12/state-physician-Pennsylvania-2019%5B1%5D.pdf

We also reviewed where physicians who completed their GME in Pennsylvania were practicing in 2018. Exhibit 16 shows the AAMC data.

Exhibit 16

Practice Location of Physicians Who Completed Graduate Medical Education in Pennsylvania 2018



Source: LBFC staff from information obtained from AAMC *2019 Pennsylvania Physician Workforce Profile*.

The states with the largest number of physicians who completed GME in Pennsylvania during 2018 were not states with "safer" medical malpractice climates, according to National Practitioner Data Bank data. We would note that the top five states where Pennsylvania GME physicians are practicing are the same five states that have the highest medical malpractice payouts.[76] There is no data to determine how a change in the venue rule may affect the ratio of in-state educated physicians versus out-of-state educated physicians. Additionally, there is no data to determine how a change in the venue rule may affect the practice location of physicians who completed their GME in Pennsylvania.

[76] Singh, Harnam. *National Practitioner Data Bank.* Generated using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool. National Practitioner Data Bank (2019): Adverse Action and Medical Malpractice Reports (1990 to March 31, 2019). *Accessed: August 15, 2019 (Dates queried: 1996 to 2018)*

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SECTION V
VENUE IN MEDICAL PROFESSIONAL LIABILITY ACTIONS AND AVAILABILITY OF HOSPITAL SERVICES

Fast Facts...

- *In Pennsylvania, General Acute Care Hospitals have decreased, while Specialty Hospitals have increased.*
- *The number of hospitals within a health system has increased in Pennsylvania and nationwide.*
- *To-date there has been no identified set of "standard" services within hospitals, and the availability of hospital services varies by hospital and county.*

Overview

We were asked to determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability of, and access to, a full spectrum of hospital services across Pennsylvania in addition to the effects of the proposed rule change on access and availability of hospital services. To accomplish this task, we reviewed the following information:

A. General Acute Care Hospitals' (GACHs) and Specialty Hospitals' information from the Pennsylvania Department of Health (PDH).
B. General Acute Care Hospitals' and Specialty Hospitals' nationwide information from the American Hospital Association (AHA).
C. Hospitals' in Health Systems in Pennsylvania information from The Hospital and Healthsystem Association of Pennsylvania (HAP).
D. The number of hospitals within a health system nationwide and hospital characteristics information from The United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ), Comparative Health System Performance Initiative.
E. Pennsylvania Population data from the United States Census Bureau.
F. Medical professional liability rate information for the *Medical Liability Monitor* and Pennsylvania Professional Liability Joint Underwriting Association.

We reviewed data from 1996 to 2018 from the Pennsylvania Department of Health, and data from pre-tort reform (2002) and post-tort reform (2018) from of The Hospital and Health-system Association of Pennsylvania. In addition, we reviewed data from 1999 to 2016 from of the American Hospital Association and from 1996 to 2016 from The United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ).

We found:

1. The number of GACHs was declining during both pre-and post-tort reform periods. But, we found no data to support the conclusion that a change to the venue rule would change this trend.
2. The total number of GACHs in Pennsylvania has steadily decreased since FY 2001-02 and the total number of Specialty Hospitals have steadily increased since FY 1999-00.
   a. In FY 1996-97, Pennsylvania had a total of 201 GACHs and in CY 2018 there were a total of 154 GACHs.
   b. The total number of GACH beds set up and staffed in FY 1996-97 was 37,746, and in CY 2018 there was a total of 31,463.
   c. From FY 1996-97 to CY 2018 the total number of GACHs declined by 23.4 percent, while the number of Specialty Hospitals increased by 25.0 percent.
3. The total number of hospitals within a health system has increased in Pennsylvania and nationwide.
   a. In Pennsylvania in CY 2002 there were 79 GACHs within a health system and in CY 2018 there were 133.
   b. In the United States the total number of hospitals within a health system in CY 2002 was 2,606, and in CY 2016 it was 3,231.
      - Forty-one out of fifty states and the District of Columbia have more than 50 percent of their hospitals within a health system.
      - Thirty-six states have more than ten health systems.
4. Based on the availability of hospital services, the data available does not support a conclusion on the effects venue would have on the number of hospitals/services and/or the number of hospitals beds in the Commonwealth.

Issue Areas

A. Availability of Hospitals

In accordance with 28 Pa. Code § 101.56, Subpart B., General and Special Hospitals are required to complete *The Annual Hospital Questionnaire* (*AHQ*) each year if a hospital operates any number or variety of separate or distinct clinical facilities and has been issued a single license. The information requested on the questionnaire and application forms must be separate and distinct according to location of facilities listed. Title 28 defines a Hospital as "a facility having an organized medical staff and providing equipment and services primarily for inpatient care to persons

who require definitive diagnosis or treatment, or both, for injury, illness, pregnancy, or other disability."[77] There are two types of hospitals:

- **General Hospital**—a hospital equipped and staffed for the treatment of medical or surgical conditions, or both, in the acute or chronic stages, on an inpatient basis of 24 or more hours.[78]
- **Special hospital**—a hospital equipped and staffed for the treatment of disorders within the scope of specific medical specialties or for the treatment of limited classifications of diseases in their acute or chronic stages on an inpatient basis of 24 or more hours.[79]

We used the following reports (for years 1996 to 2018) to review the number of hospitals, hospital beds, and hospital services available throughout the Commonwealth:

- *Hospital Report 1-A—Utilization Data by Hospital and County (General Acute Care Hospitals Only)*
- *Hospital Report 1-B— Utilization Data by Hospital and County (Specialty and Federal Hospitals Only)*
- *Hospital Report 2-A—Inpatient Hospital Unit Data by Facility and County (General Acute Care Hospitals Only)*
- *Hospital Report 7—Availability of Selected Services by Facility and County*

In order to determine the effects of the proposed rule change on the availability of, and access to, a full spectrum of hospital services across Pennsylvania—we first analyzed the number of General Acute Care Hospitals (GACH), and Specialty Hospitals throughout the state. In the Commonwealth there are 60 counties with one or more GACHs, and seven counties[80] that do not have any GACHs.

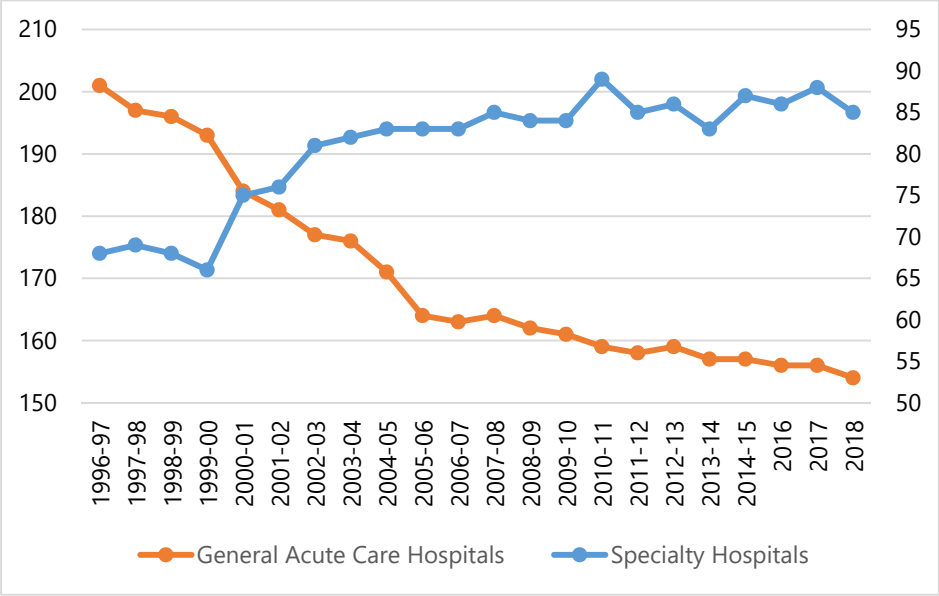
Exhibit 17 shows GACHs and Specialty Hospitals in Pennsylvania from FY

[77] Note: Title 28 defines hospitals as "General" and "Special," throughout our review we will be using the terms General Acute Care and Specialty Hospitals, for consistency with the Pennsylvania Department of Health Annual Hospital Questionnaire reports.
[78] Title 28-Health and Safety, Part IV. Health Facilities: Chapter 101. 28 § 101.4- Subpart B. General and Special Hospitals.
[79] Title 28-Health and Safety, Part IV. Health Facilities: Chapter 101. 28 § 101.5- Subpart B. General and Special Hospitals.
[80] Counties with no General Acute Care Hospital or Specialty Hospital: Cameron, Forest, Juniata, Perry, Pike, Snyder, and Sullivan.

1996-97 to CY 2018.[81] In FY 1996-97, the Commonwealth had a total of 201 GACHs, with a total of 37,746 beds set up and staffed.[82] As of December 31, 2018, there was a total of 154 GACHs, with a total of 31,463 beds set up and staffed.[83] The total number of GACHs has declined by 23.4 percent from FY 1996-97 to CY 2018, while Specialty Hospitals have increased by 25.0 percent—which could be indicative of an increase in the use of more specialized facilities.

Exhibit 17

Pennsylvania
General Acute Care and Specialty Hospitals [a/]



Note:
[a/] *Pennsylvania Department of Health - Division of Health Informatics, Hospital Questionnaire*—excluding (7) Federal/Veterans' Affairs (VA) Hospitals from 1996 to 2018.

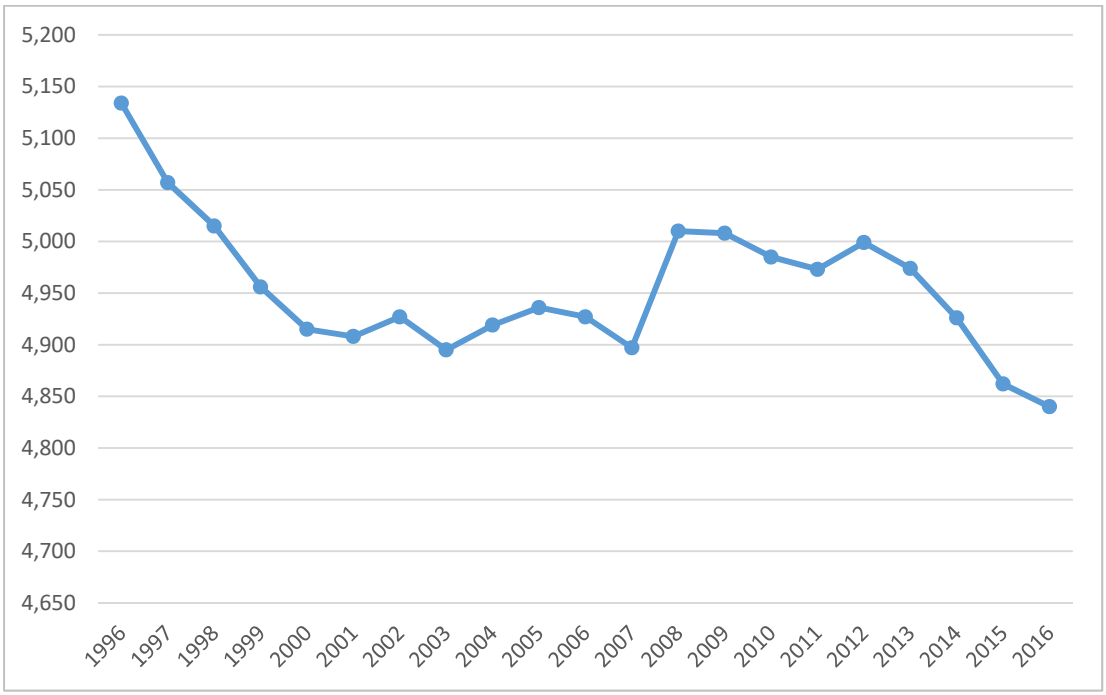
Source: Developed by LBFC staff from information obtained from PDH *Annual Hospital Questionnaire.*

[81] PDH *AHQ* reports are fiscal year 1996-97 through 2014-15 and were changed over to calendar year starting in 2016.
[82] *Pennsylvania Department of Health - Division of Health Informatics, Hospital Questionnaire*—excluding (7) federal Veterans' Affairs (VA) hospitals in 1996 and 2018; and Specialty Hospitals—(68) in 1996 and 85 in 2018 totals. Note: Columbia County: Berks Hospital Center (FY 2000-01) listed via Hospital Report 1-B in error; is a General Acute Care Hospital; Mckean County (2016): Bradford Regional Medical Center was listed under Mercer County in error per review of prior year reports. The information on the *AHQ* is self-reported, but we determined this to be the most detailed source of data needed to analyze the availability of hospitals/beds and hospital services in Pennsylvania.
[83] *Ibid.*

Exhibit 18 shows the number of hospitals in the United States from CY 1996 to CY 2016.[84] In CY 1996, the United States had a total of 5,134 "community hospitals," with a total of 862,352 staffed beds. In CY 2016, there was a total of 4,840 "community hospitals," with a total of 780,272 staffed beds. The total number of "community hospitals" has decreased by 5.7 percent, while the number of staffed beds has decreased by 9.5 percent.

Exhibit 18

Number of Hospitals in the United States[a/]
1996 to 2016



Note:
[a/]American Hospital Association (AHA), *TrendWatch Chartbook 2018*, Trends Affecting Hospitals and Health Systems of American Hospital Association Annual Survey data, 2016, for community hospitals. Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long term acute-care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible to the general public, such as prison hospitals or college infirmaries. Note: excludes 2017 Hospital Statistics data, AHA no longer employs its own methodology to classify hospitals as registered. As a result of this change, the number of hospitals in the 2019 edition (2017 AHA Annual Survey) increased the number of hospitals overall.

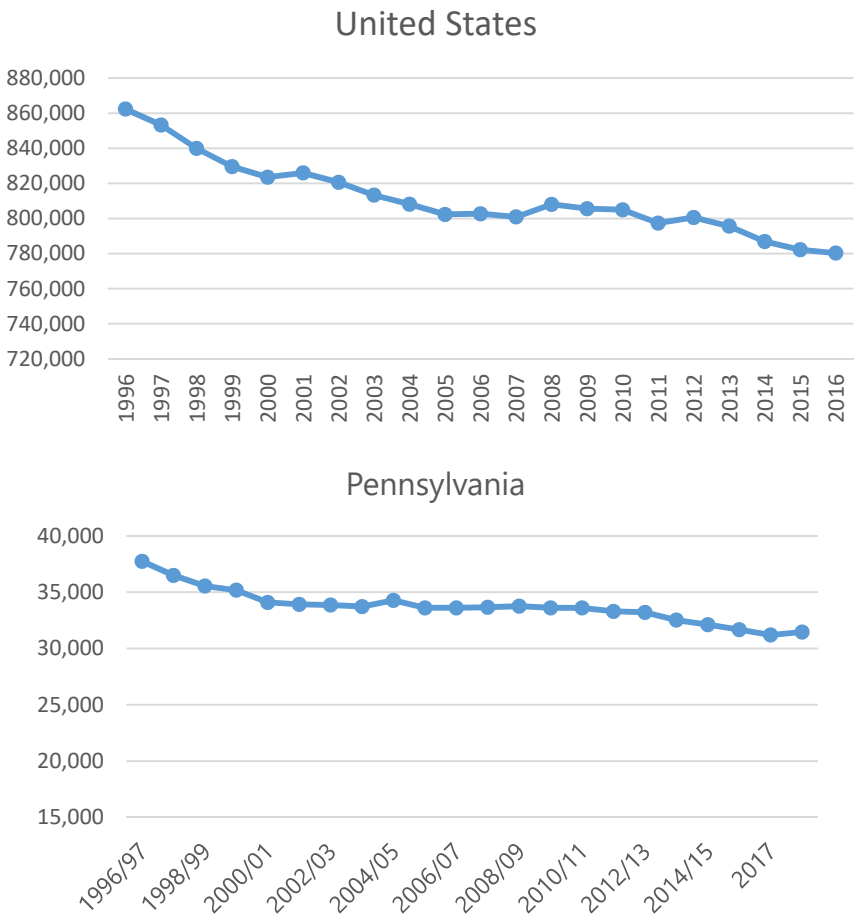
Source: Developed by LBFC staff from information obtained from American Hospital Association.

[84] American Hospital Association (AHA), TrendWatch Chartbook *2018*, Trends Affecting Hospitals and Health Systems of American Hospital Association Annual Survey data, 2016, for community hospitals.

As shown in Exhibit 19 the number of hospital beds in the United States from 1996 to 2016 has declined by 9.5 percent. In Pennsylvania from FY 1996-97 to CY 2017, the number of hospital beds decreased by almost double the national rate—by 17.3 percent. Although, from CY 2017 to CY 2018, the Commonwealth had an increase in hospital beds of less than 1.0 percent.

Exhibit 19

Number of Hospital Beds [a/]
United States vs. Pennsylvania



Note:
[a/]American Hospital Association (AHA), *TrendWatch Chartbook 2018*, Trends Affecting Hospitals and Health Systems of American Hospital Association Annual Survey data, 2016, for community hospitals. Note: excludes 2017 Hospital Statistics data, AHA no longer employs its own methodology to classify hospitals as registered. As a result of this change, the number of hospitals in the 2019 edition (2017 AHA Annual Survey) increased the number of hospitals overall and subsequently the number of hospital beds.

Source: Developed by LBFC staff from information obtained from AHA and PDH *Annual Hospital Questionnaire*.

Nationwide, with the decrease in "community hospitals," the United States subsequently had a decrease in the number of hospital beds. The national data on hospital beds includes all nonfederal, short-term general, and other specialty hospitals.[85] Our review does not include the number of beds within Specialty Hospitals. Therefore, we are unable to make a direct comparison with the trend(s) in total number of hospital beds nationwide to Pennsylvania—as the national number includes staffed beds within all community hospitals.[86]

Health Care Districts. In looking at GACH and Specialty Hospitals across Pennsylvania, the total number of hospitals varies by health care district.[87] As shown in Exhibit 20, the number of GACHs is highest in the Southeast and Southwest health districts. To put this into perspective (See Exhibit 1 Pennsylvania Health Regions), Pennsylvania's population as of July 1, 2018 was 12,807,060[88]—Philadelphia County alone accounts for 12.4 percent of population and with its surrounding counties (Bucks, Chester, Delaware, and Montgomery)—32.2 percent of the state's population—plus additional counties (Lancaster, Berks, and Schuylkill)—the Southeast Health Care District accounts for 40.9 percent of the state's population.

Allegheny County has 9.5 percent of the state's total population, and with its surrounding counties (Beaver, Fayette, Washington, and Westmorland), account for 16.2 percent of the state's population plus additional counties (Armstrong, Butler, Cambria, Greene, Indiana, and Somerset)—the Southwest Health Care District accounts for 20.7 percent of the state's population.

Lastly, Lackawanna County population accounts for 1.6 percent of the state's population, and when the surrounding counties (Luzerne, Monroe, Susquehanna, and Wyoming), are added, accounts for 6.0 percent of the state's population—plus additional counties (Carbon, Lehigh, Northampton, Pike, and Wayne)—the Northeast Health District accounts for 12.6 percent of the state's population.

[85] American Hospital Association (AHA), *TrendWatch Chartbook 2018*, Trends Affecting Hospitals and Health Systems of American Hospital Association Annual Survey data, 2016, for community hospitals. Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long term acute-care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

[86] https://www.aha.org/statistics/fast-facts-us-hospitals.

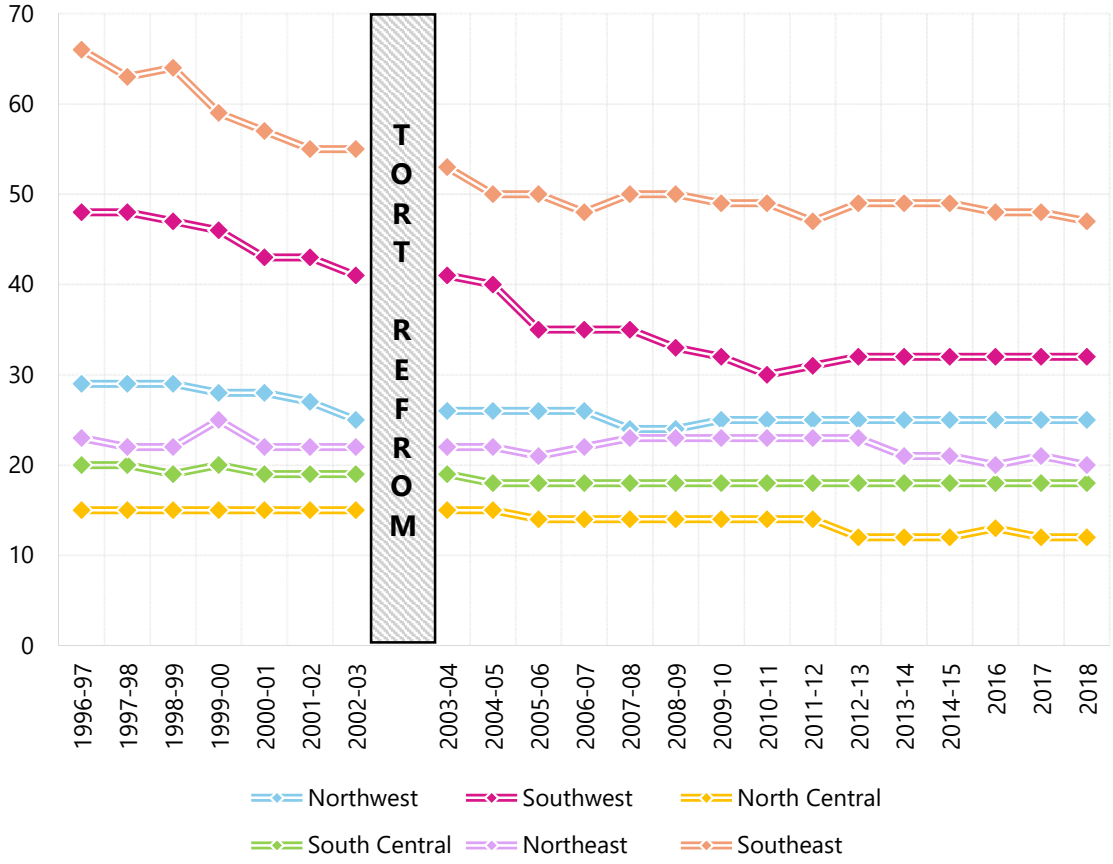
[87] Health Care Districts are defined by the Pennsylvania Department of Health.

[88] US Census Bureau (1996 to 1999 from "Time Series of Pennsylvania Intercensal Population Estimates by County: April 1, 1990 to April 1, 2000"; 2000 to 2010 from "Intercensal Estimates of the Resident Population for Counties of Pennsylvania: April 1, 2000 to July 1, 2010"; 2011 to 2018 from "PEPANNRES: Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018, 2018 Population Estimates.").

The Southeast and Southwest Health Care Districts have the highest concentration of GACHs and Specialty hospitals in the Commonwealth. See Exhibits 20 and 21 which highlights the number of GACHs and specialty hospitals by district.

Exhibit 20

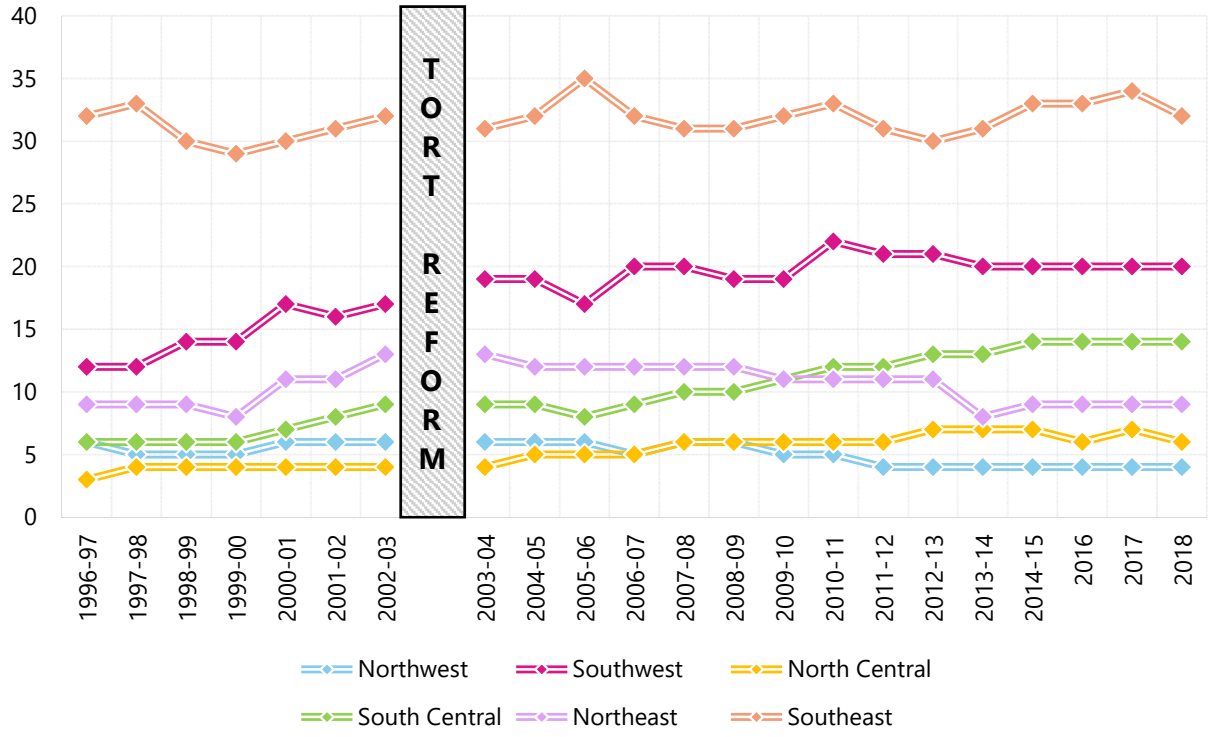
Pennsylvania
General Acute Care Hospitals by Health Care District



Source: Developed by LBFC staff from information obtained from PDH *Annual Hospital Questionnaire* and U.S. Census Bureau.

Exhibit 21

Pennsylvania
Specialty Hospitals by Health Care District

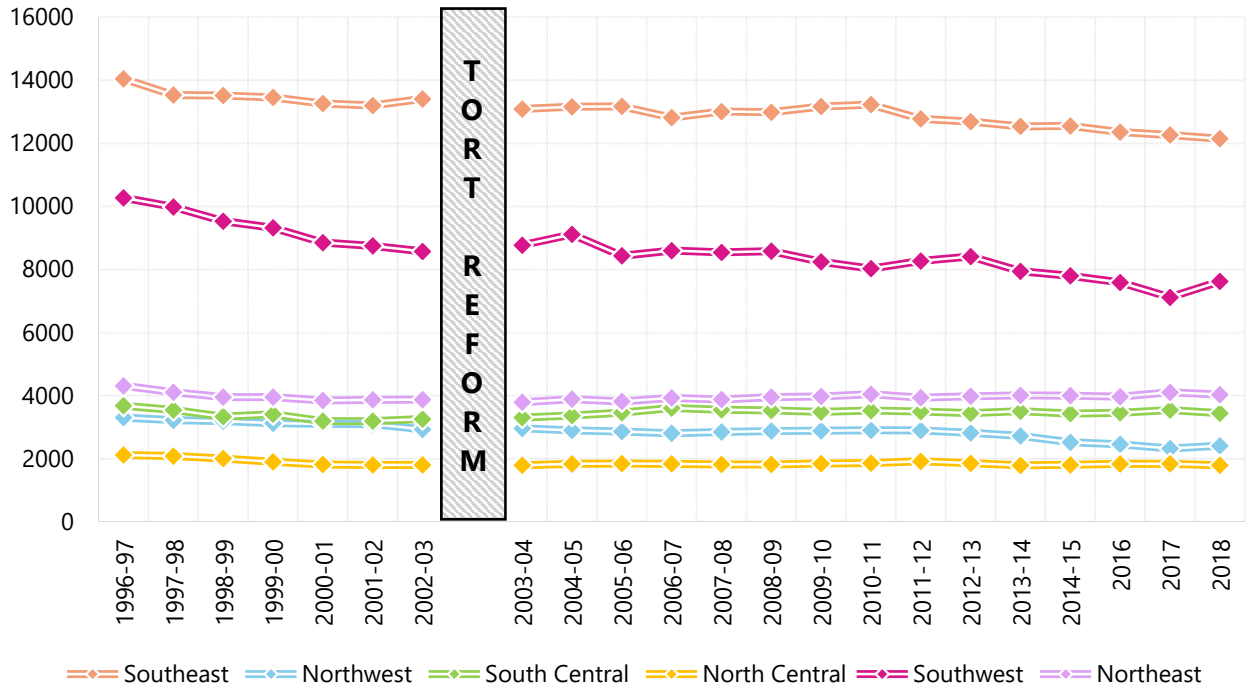


Source: Developed by LBFC staff from information obtained from PDH Annual Hospital Questionnaire and U.S. Census Bureau.

Exhibit 22 shows that number of hospitals beds set up and staffed by health care district. We found that the Southeast and Southwest health care districts had the highest number of hospitals beds set up at staffed.

Exhibit 22

Pennsylvania
General Acute Care Hospital
Beds Set and Staffed by Health Care District [a/]



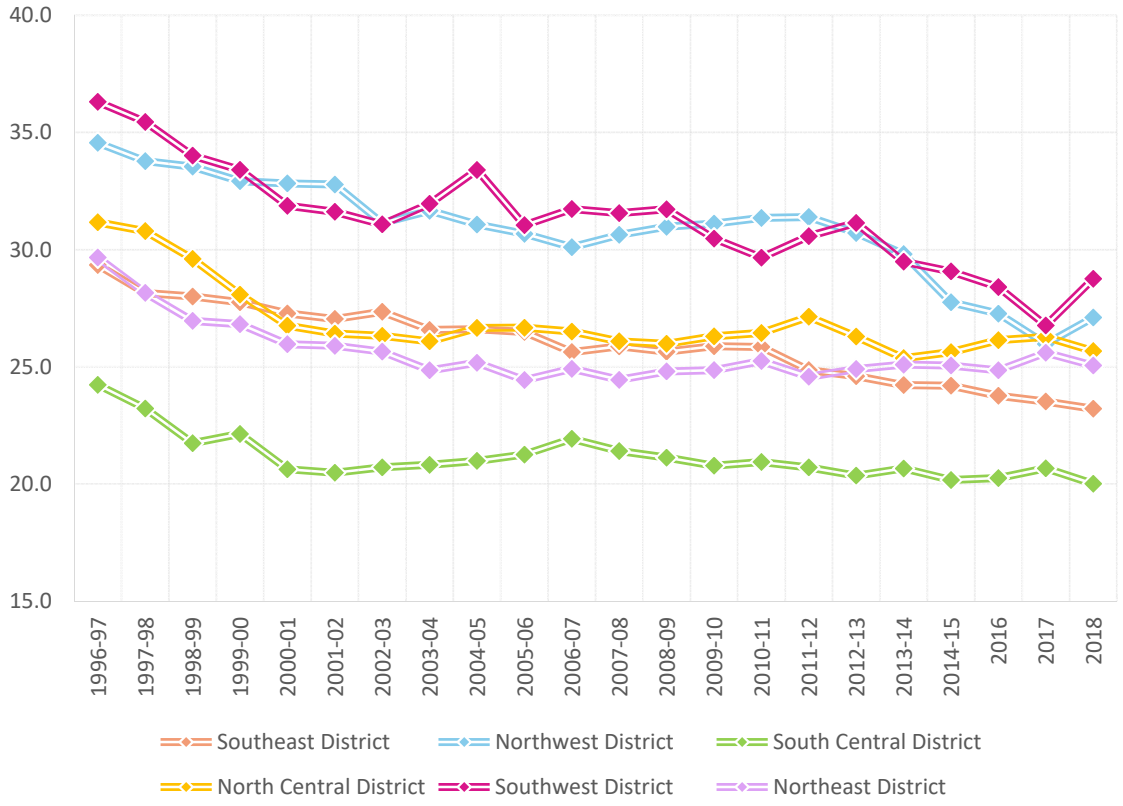
Note:
[a/] Pennsylvania Department of Health - Division of Health Informatics, Hospital Questionnaire, defined number of beds set up and staffed as – "beds which are regularly maintained in the hospital for the use of patients and which furnish accommodations with supporting services (such as food, laundry, and housekeeping) for patients or residents who stay 24 hours or more."

Source: Developed by LBFC staff from information obtained from PDH *Annual Hospital Questionnaire* and U.S. Census Bureau.

We also looked at the ratio of beds set up and staffed per 10,000 persons by Health Care District from FY 1996-97 to CY 2018. See Exhibit 23. The ratio of beds was consistently higher among the Southwest and Northwest districts, but this could be attributable to the size of the populations within the districts.

Exhibit 23

Pennsylvania
General Acute Care Hospitals
Ratio of Beds Set Up and Staffed by Health Care District
Per 10,000 Persons [a/]



Note:
[a/] Pennsylvania Department of Health - *Division of Health Informatics, Hospital Questionnaire, defined* number of beds set up and staffed as - beds which are regularly maintained in the hospital for the use of patients and which furnish accommodations with supporting services (such as food, laundry, and housekeeping) for patients or residents who stay 24 hours or more.

Source: Developed by LBFC staff from information obtained from PDH *Annual Hospital Questionnaire* and U.S. Census Bureau.

We also looked at OB/GYN[89] hospital beds set up and staffed compared to medical malpractice insurance rates. We ran a simple linear regression analysis between the number of OB/GYN beds set up and staffed and

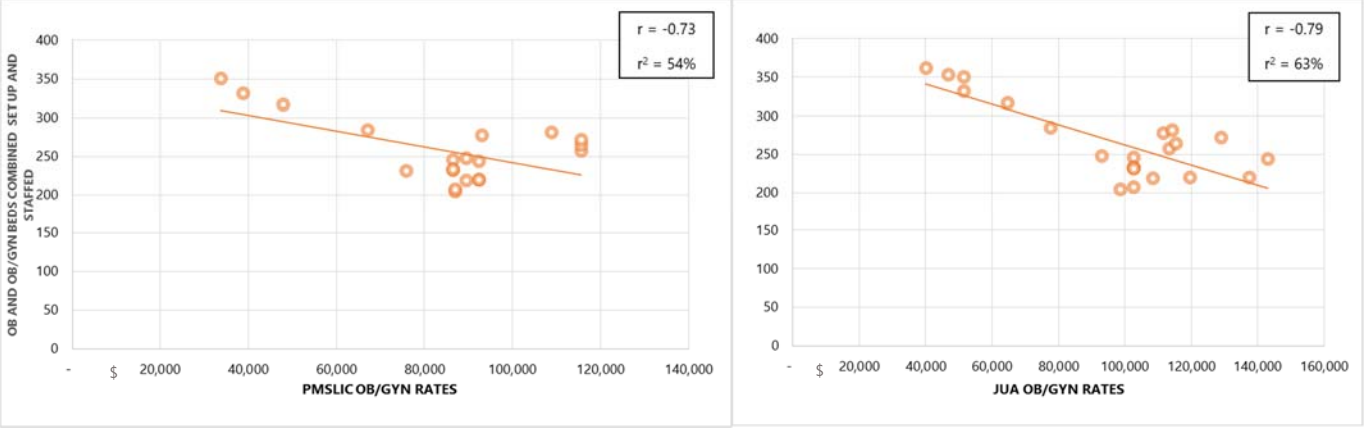
[89] *Pennsylvania Department of Health - Division of Health Informatics, Hospital Questionnaire*—Obstetric (OB) beds are within a clinical care unit with facilities and services pertaining to pregnancy, labor, and puerperium; and OB/GYN Combined beds are within a clinical care unit providing facilities and services for the treatment of both obstetric patients and gynecology patients.

two different insurance provider rates. We chose the rates from the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) and Pennsylvania Professional Liability Joint Underwriting Association (JUA) because both entities provided insurance services through the entire review period of our study. We also calculated the coefficient of determination (represented by the r^2), which expresses the proportion of the variance in the dependent variable (number of physicians) by the independent variable (rates).

In Exhibit 24 we present one example of a county that had a moderate to strong correlation between OB/GYN beds set up and staffed compared to OB/GYN medical malpractice rates. The data indicated that in Philadelphia County, when OB/GYN rates were compared to OB/GYN beds set up and staffed, there was a linear relationship between the variables during our review period. Further the data indicated that Philadelphia County had a strong negative correlation between the insurance rates and the number of OB/GYN hospital beds set up and staffed. In other words, as medical liability insurance rates increased among OB/GYNs, the number of OB/GYN beds decreased.

Exhibit 24

Philadelphia OB/GYN Rates Compared to OB/GYN Beds Set Up and Staffed



Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaire, Medical Liability Monitor,* and *JUA*.

As shown in Exhibit 25, in addition to Philadelphia County there were also four other counties (Blair, Jefferson, Northumberland, and Schuylkill) where the data showed a negative correlation between the rate of insurance and the number of OB/GYN beds set up and staffed. Meaning when the rate of insurance for OB/GYNs (PMSLIC and JUA) in those

counties increased, the number of OB/GYN beds set up and staffed decreased.

Interestingly, the data also indicated that three counties (Chester, Lehigh and Montour) had a positive correlation with OB/GYN insurance rates and the number of OB/GYN beds set up and staffed during our review period. In these three counties, as insurance rates (PMSLIC and JUA) increased, so did the number of beds set up and staffed. This is also shown in Exhibit 25.

Exhibit 25

Counties with Moderate to Strong Correlation between OB/GYN Medical Malpractice Insurance Rates and OB/GYN Beds Set Up and Staffed

County	Health Region/District	Correlation	PMSLIC	JUA
Blair	South Central	Negative	r = -0.76 r^2 = 58%	r = -0.71 r^2= 50%
Chester	Southeast	Positive	r = 0.72 r^2 = 52%	r = 0.80 r^2 = 64%
Jefferson	Northwest	Negative	r = -0.70 r^2 = 49%	r = -0.77 r^2 = 59%
Lehigh	Northeast	Positive	r = 0.81 r^2 = 66%	r = 0.80 r^2 = 64%
Montour	North Central	Positive	r = 0.85 r^2 = 72%	r = 0.76 r^2 = 58%
Northumberland	North Central	Negative	r = -0.89 r^2 = 79%	r = -0.78 r^2 = 61%
Philadelphia	Southeast	Negative	r = -0.73 r^2 = 63%	r = -0.79 r^2= 63%
Schuylkill	Southeast	Negative	r = -0.88 r^2 = 77%	r = -0.68 r^2 = 46%

Source: LBFC staff from information obtained from PDH *Annual Hospital Questionnaires*, *Medical Liability Monitor*, PA Insurance Department's *Annual Statistical Reports*.

We were unable to conduct an analysis on all hospital beds versus medical liability insurance rates due to the fact that the insurance rates published by the Medical Liability Monitor only cover select physician specialties and the *AHQ* data does not break out hospital beds by physician specialty that would interact with a particular bed(s) within a given hospital unit.

The above Exhibit 25 does allow us to show the strength and direction of a linear relationship between the medical liability insurance rates and the

number OB/GYN beds set up and staffed in particular counties. But, the data alone is not strong enough to support a conclusion on whether the number of OB/GYN beds set up and staffed is directly related to medical malpractice insurance rates across the Commonwealth.

B. Availability of Hospital Services

The services available within each hospital in the Commonwealth varies by facility. GACHs and Specialty Hospitals are required to report the availability of their services and facilities on the *AHQ*. The *AHQ* includes 49 selected services for which hospitals are asked to indicate: (1) whether the organized services are offered; (2) whether services are offered but not organized; or (3) whether services are not available/referred out.[90]

It is difficult to gauge the availability of hospital services, in that services may be available within a particular health care district, but not in every hospital within that district. This makes it difficult to group hospital services based on any one variable to measure availability within every hospital within the Commonwealth. As we were unable to review services by individual facility, we reviewed hospital services based on our analysis of GACHs which have had an increase and/or decrease in services from FY 1996-97 to CY 2018. Out of the 60 counties that have a GACH, a total of 25 counties have experienced changes in the number of GACHs.[91]

Exhibit 26 highlights those counties that have experienced changes in GACHs, in addition to a pre-and-post reform analysis on the total number of GACHs and beds set up and staffed in the Commonwealth.

[90] Commonwealth of Pennsylvania, Department of Health, Division of Health Informatics, Hospital Record Format, 2016 to Current. Hospital Services and Facilities: (1) Organized service offered by and located within the hospital or its own satellite locations. There must be written policies and procedures, separate record and budget, and a physician or other professional who is the accountable program director with ultimate responsibility for this service or facility. Maybe provided through a contract or arrangement with a physician, physician group or other agency, but must be onsite or in a satellite location; (2) Services offered by and located within the hospital or its own satellite locations but not formally organized as a separate service or department; or (3) Not available within the hospital or its satellite locations. Services that are obtained off-site by referral or contract with another hospital, physician group or other agency should be included in this category.

[91] Pennsylvania Department of Health, *Annual Hospital Questionnaire* (1996-97 through 2018); and Pennsylvania Health Care Cost Containment Council (PHC4), PHC4-Closing, Mergers and/or Name Changes. Counties that have had an increase in GACHs: Mercer: (+1) Mercer Edgewood Surgical Hospital (FY 2003-04) (Plus, merger w/UPMC—UPMC Horizon formerly Horizon Hospital in 1998); Monroe: (+1) St. Luke's Hospital-Monroe Campus (2016) Northampton (+2): SCCI Hospital-Easton (FY 1999-00) and Coordinated Health Hospital (FY 2011-2012). Note: Butler County not shown in Exhibit 26 as a having a change in GACHs (UPMC-Passavant Cranberry Township), due to merger with UPMC Passavant (Alleghany County) as of July 1, 2005 and system data reporting via the *AHQ* under Alleghany County.

Exhibit 26

Pennsylvania
General Acute Care Hospitals
Beds Set up and Staffed[a/b/c/]

		Pre-Tort Reform				Post Tort-Reform			
		FY 1996-97		FY 2002-03		FY 2003-04		CY 2018	
County	Region[92]	Gen. Acute	Beds	Gen. Acute	Beds	Gen. Acute	Beds	Gen. Acute	Beds
Allegheny	SW	23	6288	17	5232	17	5350	14	4892
Berks	SE	3	743	2	769	2	769	2	873
Blair	SC	4	444	4	407	4	405	3	416
Bucks	SE	7	1132	7	1017	7	1076	6	908
Cambria	SW	4	722	3	583	3	591	2	474
Carbon	NE	2	183	2	181	2	181	1	159
Centre	NC	2	217	2	216	2	221	1	260
Clinton	NC	2	154	2	86	2	84	1	24
Dauphin	SC	3	1202	2	999	2	1020	2	1125
Delaware	SE	6	1375	4	1287	4	1235	4	933
Elk	NW	2	141	1	98	1	83	1	35
Erie	NW	6	1111	4	922	4	950	4	862
Fayette	SW	3	363	3	363	3	321	2	207
Lackawanna	NE	5	887	5	801	5	763	3	661
Lancaster	SE	5	952	4	974	4	912	4	979
Lawrence	NW	3	336	2	308	2	292	2	164
Lehigh	NE	5	1527	4	1319	4	1364	4	1636
Luzerne	NE	5	1020	5	921	5	843	3	774
Lycoming	NC	4	402	4	309	4	298	3	261
Mercer	NW	3	479	3	456	4	466	4	382
Monroe	NE	1	192	1	192	1	192	2	321
Northampton	NE	1	274	1	233	1	233	3	324
Philadelphia	SE	27	6584	20	6222	19	6065	15	5307
Schuylkill	SE	4	539	4	430	4	425	2	240
Westmoreland	SW	6	1027	5	777	5	766	3	425
Total	**All Regions**	201	37746	177	33857	176	33725	154	31463

Note:
[a/]Hospitals may be licensed for additional beds; this analysis was only those beds set up and staffed for each fiscal/calendar year.
[b/]As shown in Exhibit 26 are counties that have had either an increase and/or decrease in the number of GACHs from FY 1996-97 to CY 2018.
[c/]Philadelphia County: As of 9/26/19 Hahnemann University Hospital has closed (496 bed facility); Lancaster County: (FY 1996-97) Missing data for Lancaster General Hospital, used FY 1997-98 year total (166); and Mckean County (FY 1996-97): Missing data for Community Hospital Kane, used FY 1997-98 year total (53).

Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

[92] Southwest (SW), Southeast (SE), South Central (SC), Northwest (NW), Northeast (NE), and North Central (NC).

Having identified the (25) counties that have had a change(s) in the number of GACHs, we looked at availability of the 49 selected services in those GACHs. As previously stated, there is no one variable to measure across all hospitals throughout the Commonwealth because there has been no identified set of "standard" services within hospitals. Therefore, we reviewed the 49 selected services for the 25 counties' GACHs.

The results are shown in Exhibit 27, and include a total of 89 GACHs,

Exhibit 27

Pennsylvania
Total number of General Acute Care Hospitals with Change(s) in Selected Services by County [a/]

		FY 1996-97 to FY 2003-04			FY 2003-04 to CY 2018		
County	**Region**	**+**	**(-)**	**No Change**	**+**	**(-)**	**No Change**
Allegheny	SW	8	3	3	7	5	2
Berks	SE	2	0	0	1	0	1
Blair	SC	1	1	1	0	2	1
Bucks	SE	3	0	2	2	3	0
Cambria	SW	0	1	1	1	0	1
Carbon	NE	1	0	0	1	0	0
Centre	NC	1	0	0	1	0	0
Clinton	NC	1	1	0	0	1	1
Dauphin	SC	1	1	0	1	1	0
Delaware	SE	3	1	0	2	2	0
Elk	NW	1	0	0	1	0	0
Erie	NW	2	1	1	2	2	0
Fayette	SW	1	1	0	1	0	1
Lackawanna	NE	2	1	0	3	0	0
Lancaster	SE	0	2	2	2	2	0
Lawrence	NW	1	1	0	1	1	0
Lehigh	NE	2	1	1	2	1	1
Luzerne	NE	2	0	1	2	1	0
Lycoming	NC	1	1	1	1	1	1
Mercer	NW	1	2	1	2	1	1
Monroe	NE	0	1	1	1	0	1
Northampton	NE	1	0	0	1	0	0
Philadelphia	SE	8	5	2	7	5	3
Schuylkill	SE	0	0	2	1	0	1
Westmoreland	SE	0	1	2	0	3	0

Note:
[a/]GACHs reviewed for FY 1996-97, FY 2003-04, and CY 2018, are hospitals in those counties as of December 31, 2018.

Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health, *AHQ*.

which represents 57.8 percent of hospitals in the Commonwealth within those 25 counties identified as having an increase and/or decrease in GACHs.

Exhibit 27 shows the number of GACHs that have had an increase, decrease, or no change in services from FY1996-97 to FY 2003-04 and from FY 2003-04 to CY 2018. Our analysis does not provide an in-depth review at the hospital-level of those services that have changed within each period, but it does provide insight into how many facilities have had changes in the number of selected services provided. See Appendix D for the total number of available selected services by county.

Health Care Landscape. Over our review period (1996 to 2018) there have been many changes to the health care landscape, both in Pennsylvania and nationally. In addition to tort reforms related to health care, the rise of larger health systems and significant changes in the health insurance market have also occurred.

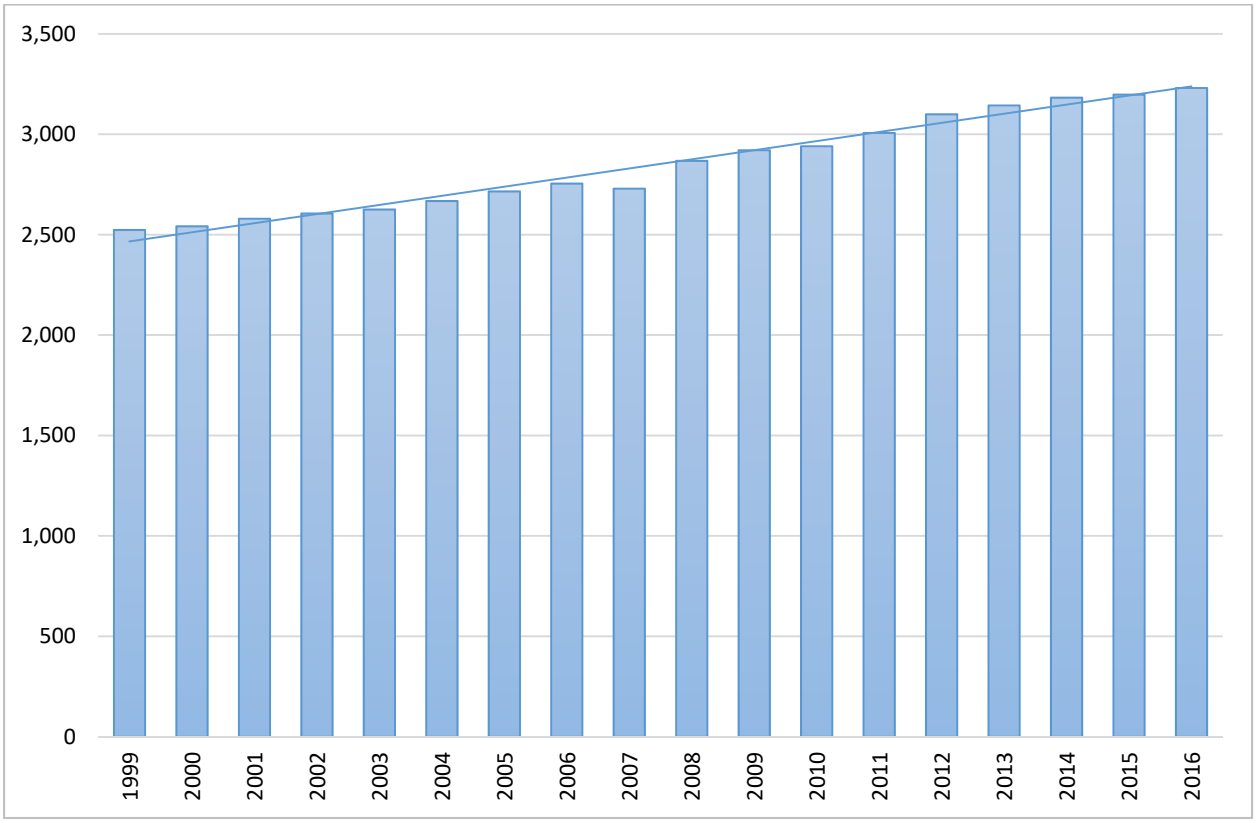
The National Bureau of Economic Research (NBER) Center for Excellence defines health systems based on three types of arrangements between two or more health care provider organizations: (1) organizations with common ownership, (2) contractually integrated organizations (e.g., accountable care organizations), and (3) informal care systems, such as common referral arrangements. Systems include organizations combined horizontally (e.g., a hospital system) or vertically (e.g., a multihospital system also owning physician practices and post-acute care facilities).[93]

Exhibit 28 highlights national trends in hospitals that are within a health system. With the exception of CY 2007, hospitals tied to health systems continue to increase throughout the country.

[93] "Defining Health Systems." *Agency for Healthcare Research and Quality*. (2017). https://www.ahrq.gov/chsp/chsp-reports/resources-for-understanding-health-systems/defining-health-systems.html

Exhibit 28

United States
Hospitals in Health Systems
1999 to 2016 [a/]



Note:
[a/] American Hospital Association (AHA), *TrendWatch Chartbook 2018*, Trends Affecting Hospitals and Health Systems of American Hospital Association Annual Survey data, 2016, for community hospitals. System is defined by AHA as either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital pre-acute or post-acute health care organizations. System affiliation does not preclude network participation. Data available from 1999 to 2017. Note: excludes 2017 Hospital Statistics data, AHA no longer employs its own methodology to classify hospitals as registered. As a result of this change, the number of hospitals in the 2019 edition (2017 AHA Annual Survey) increased the number of hospitals overall and subsequently the number of hospitals in health systems.

Source: Developed by LBFC staff from information obtained from the American Hospital Association.

Similar to the national trend, the Commonwealth has also experienced a change in its health care landscape with an increase in the number of hospitals within health systems. We tracked hospitals in health systems that are headquartered in Philadelphia, Allegheny, and Lackawanna counties pre- and post-tort reform. Philadelphia and Allegheny counties

were at the center of much of the tort reform discussions, particularly related to venue reform in Pennsylvania. We also analyzed Lackawanna County health systems as Lackawanna County is the headquarters of a large health system.

This analysis does not include doctor offices or other centers that are not classified as a hospital and are associated with the health systems discussed. We also excluded from our analysis the Veterans' Administration (VA) health systems, as federally-owned hospitals are not required to respond to the questionnaires as they are not licensed by Pennsylvania.

The following health systems are associated with these counties:

Allegheny: Encompass Health Corporation, Heritage Valley Health System, University of Pittsburgh Medical Center, Select Medical, Allegheny Health Network

Philadelphia: University of Pennsylvania Health System, Einstein Healthcare Network, Good Shepard Home and Rehabilitation, Universal Health Services, Temple University Health System, Jefferson Health, Kindred Healthcare, Tower Health, Trinity Health, Prime Healthcare Services

Lackawanna: Allied Services Integrated Health System, Geisinger Health System, Community Health Systems

Exhibits 29, 30, and 31 show the changes to these health systems pre- and post-tort reform.

Exhibit 29

Counties with Hospitals in Health Systems Tied to Allegheny County

Pre-Tort Reform

1996

2002

Post-Tort Reform
2018

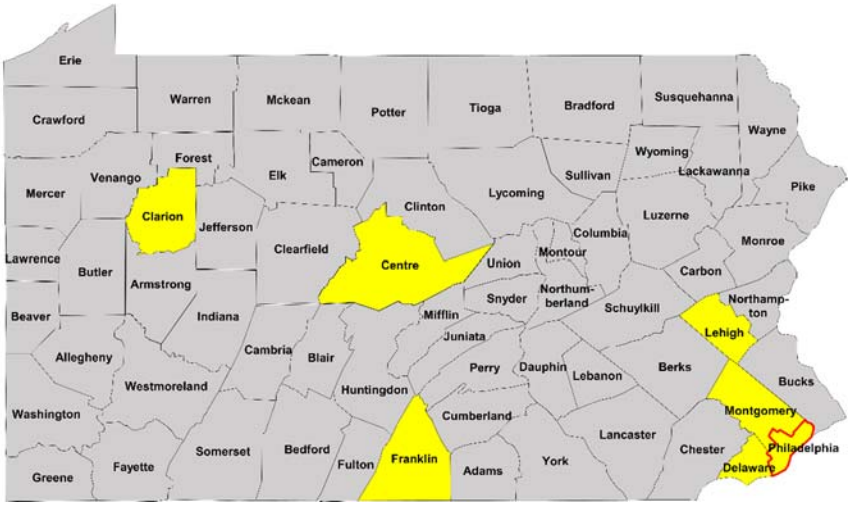
Source: Developed by LBFC staff.

Changes in the health care landscape tied to Allegheny County began pre-tort reform as shown in Exhibit 29, with health systems spreading into both bordering and non-bordering counties. Post-tort reform, the trend continues with health systems entering additional bordering and non-bordering counties as of 2018. The changes in health systems tied to Philadelphia County is show on Exhibit 30.

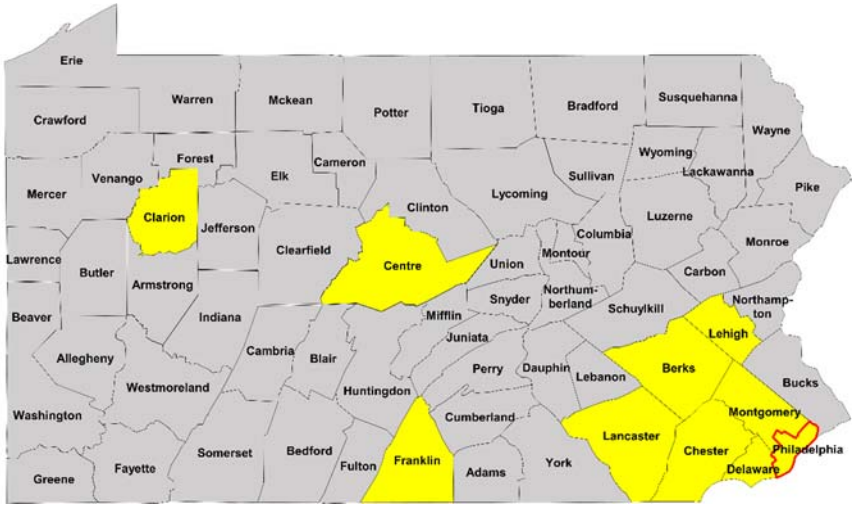
Exhibit 30

Counties with Hospitals in Health Systems Tied to Philadelphia County[a/]

Pre-Tort Reform
1996 and 2002



Post-Tort Reform
2018



Note:
[a/]From 1996 to 2002, there was no change in health systems tied to Philadelphia County

Source: Developed by LBFC staff.

Pre-tort reform in Philadelphia County there were no changes in the counties with ties to Philadelphia as it pertains to a new or existing health system in an additional bordering and/or non-bordering county. But post-tort reforms, the landscape changes with an increase in counties with health systems that have ties to Philadelphia. As shown in Exhibit 30, those health systems were within two bordering and four non-bordering counties; post-tort reform, they increased to two additional bordering counties and one non-bordering county.

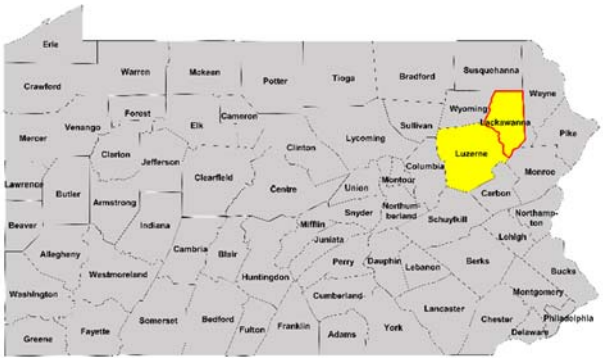
In Exhibit 31, Lackawanna County pre-tort reform showed an increase in health systems within non-bordering counties. Post-tort reform shows changes with health systems moving to additional non-bordering counties.

Exhibit 31

Counties with Hospitals in Health Systems Tied to Lackawanna County

Pre-Tort Reform

1996



2002

Post-Tort Reform
2018

Source: Developed by LBFC staff.

According to the AHA (2017),[94] "with the Affordable Care Act new standards of accountability, affordability, and quality are at the center of patient care, coupled with performance-based payment mechanisms and encouraging greater collaboration across the care continuum." In addition, hospital mergers could have benefits in both cost and quality improvements. A study conducted by Deloitte in 2017 concurs that both mergers and acquisitions have increased over the past decade and provide operational, strategic, and financial value.[95]

The health care landscape, much like the national trends, has changed in Pennsylvania with the increase in hospitals that are within a health system and health systems that are in more than one county.

Exhibit 32 provides a more in-depth analysis from the Hospital and Healthsystem Association of Pennsylvania (HAP) on changes in the state's health care landscape pre- and post-tort reform (CY 2002 and CY 2018) in GACHs and Specialty Hospitals.

[94] Noether, Monica, Sean May and Ben Stearns. "Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis." *American Hospital Association*. (September 2019). https://www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-f.pdf

[95] "Hospital Mergers and Acquisitions: When Done Well, M&A Can Achieve Valuable Outcomes." *Deloitte Center for Health Solutions and the Healthcare Financial Management Association*. (2017). https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/hospital-mergers-and-acquisitions.html

Exhibit 32

Pennsylvania
Change in Health Care Landscape Pre- and Post-Tort Reform [a/b/]

	2002		2018	
	#	%	#	%
Total Hospitals	265	100%[1]	246	100%[1]
Independent hospitals	168	63[1]	63	26[1]
System-affiliated hospitals	97	37[1]	183	74[1]
System-affiliated hospitals in urban counties	68	70[2]	126	69[2]
System-affiliated hospitals in rural counties	29	30[2]	57	31[2]
General Acute Care Hospitals (GACs)	188	71[1]	161	65[1]
Independent GACs	109	58[3]	28	17[3]
GACs within systems	79	42[3]	133	83[3]
Systems with hospitals in Allegheny, Lackawanna, and Philadelphia counties	16	N/A[4]	23	N/A[4]
Number of hospitals across Pennsylvania that are affiliated with those systems that have at least one hospital in Allegheny, Lackawanna, and Philadelphia Counties (including those hospitals within the 3 counties)	66	25[1]	128	52[1]
All hospitals that are affiliated with systems in these 3 counties, but are located outside these 3 counties	24		78	
Rural hospitals that are affiliated with systems in these 3 counties, but are located outside these 3 counties	9		29	

Note:
[a/]For this analysis, the total number of hospitals for 2002 and 2018 were those hospitals licensed in those years by the Department of Health. The 7 federal Veterans' Affairs (VA) hospitals in both 2002 and 2018 are included as VA "system"-affiliated general acute care (GAC) hospitals. Non-GAC hospitals include specialty hospitals (e.g., hospitals for children, psychiatric care, rehabilitation, long-term acute care). [1]Percent is based on the total # of hospitals in each year; [2] Percent is based on the total # of hospitals in systems in each year; [3] Percent is based on the total # of GAC hospitals in each year; and [4] this is a count of systems in the 3 counties in each year.
[b/]Pennsylvania Department of Health - Division of Health Informatics, Hospital Questionnaire Results, 2002 and 2018; system affiliation/independent status data comes from the Hospital & Healthsystem Association of Pennsylvania.

Source: Developed by HAP using information from system affiliation/independent status data and from PA DOH.

HAP data shows an increase in the number of "system-affiliated" hospitals and the number of health systems that now extend outside of their base counties.

The United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) (2016), reported that by the end of 2016, there were a total of 626 health systems in the United States, and as of 2018 a total of 637 health systems. Exhibit 33 shows the United States data (2016) pertaining to the number of health systems and percentage of hospitals that are within a health system.

Exhibit 33

United States
Hospitals within a Health System[a/]

Number of Health Systems	Number of States	Percentage of Hospitals in Health Systems	Number of States
0 to 10	15	1 percent to 49.99 percent	8
11 to 20	20	50 percent to 79.99 percent	28
21+	16	80 percent +	15
Total	51	**Total**	51

Note:
[a/]AHRQ's Compendium of U.S. Health Systems, 2016. Developed as part of the Comparative Health System Performance (CHSP) Initiative, the Compendium is a resource for data and research on health systems. For the purposes of the Compendium, health systems include at least one hospital and at least one group of physicians that provide comprehensive care (including primary and specialty care) and are connected with each other through common ownership or joint management. https://www.ahrq.gov/chsp/ chsp-reports/resources-for-understanding-health-systems/defining-health-systems.html. https://www.ahrq.gov/chsp/data-resources/compendium.html. Data includes all 50 states and the District of Columbia.

Source: Developed by LBFC staff from information obtained from AHRQ.

Exhibit 33 shows that more than half of hospitals within the United States are within a health system—which appears to be a growing trend, and the number continues to rise. So, Pennsylvania does not appear to be an outlier regarding the increase in the number of hospitals within health systems—it is a national trend.

Exhibit 33 also shows that more than half of the states have eleven or more health systems, within a given state.

C. Proposed Rule Change Effect on Availability of Hospital Services

Regarding the availability of, and access to, a full spectrum of hospital services, data shows that GACHs were declining both pre- and post-tort reform. In addition, the number of available hospital services varied from pre- to post-tort reform among the counties that experienced a change in the number of GACHs. But, we found no data to support a conclusion that a change to the venue rule would make GACHs more available (in number), as they declined during pre-and post-tort reform. The same can be said about the number of hospital beds set up and staffed—both pre- and post-tort reform the number of beds set up and staffed declined.

Regarding the availability of hospital services, we found no data to support a conclusion that a change in the venue rule would make hospital services more available (in number), as they varied by hospital/county during both pre- and post-tort reform. The basis of a hospital's decision to increase and/or decrease services was beyond the scope of our study.

Due to the multiple variables involved, such as the number of hospitals in the health care region, the data did not show with any certainty the effect the proposed change to venue would have on the availability of hospitals and/or hospital services in the Commonwealth.

SECTION VI
DETERMINATION AND COMPENSATION FOR INJURIES AND DEATH RESULTING FROM MEDICAL NEGLIGENCE BY HEALTH CARE PROVIDERS

Overview

Fast Facts...

- *Medical malpractice filings have declined by over forty percent across the Commonwealth.*
- *Over sixty percent of all jury verdicts from 2000 to 2017 resulted in no ($0) award.*
- *MCARE Fund paid claims have decreased from 1996 to 2018 among the Eastern and Western Regions of the state; but increased among the Central Region and Other States.*
- *The value of medical malpractice payments made on behalf of all Pennsylvania physicians (MD/DO) from 1996 to 2018 has increased by 12.2 percent, and the total number (count) has decreased by 44.7 percent.*

We were asked to determine the effects of the 2003 changes governing venue in medical professional liability actions on the prompt determination of, and fair compensation for injuries and death resulting from medical negligence by health care providers in Pennsylvania. To accomplish this task, we reviewed the following information:

A. Medical Malpractice Filings and Jury Awards information from the Administrative Office of Pennsylvania Courts (AOPC)
B. Claims paid from the Medical Care Availability and Reduction of Error Fund (MCARE)
C. Medical Malpractice payments made on behalf of all medical practitioners from the *National Practitioner Data Bank*

We reviewed all publicly available data from 1996 to 2018 and present data on: (1) the cost of professional medical liability actions, (2) pre and post-tort reform changes, (3) MCARE fund payouts, (4) national medical liability payments, and (5) the effects of the proposed rule change.

We found:

1. The available data does not support a conclusion on the affect the change of venue would have on the prompt determination of actions and fair compensation for injuries.
2. Medical malpractice filings have decreased by 44.9 percent between the period of FY 2000-02 and FY 2015-17.
   a. Medical malpractice filings decreased in Philadelphia, Allegheny, and Lackawanna Counties; followed by varied increases in filings among their surrounding counties.
3. The number of jury awards vary statewide, but have decreased in number (count) from 2000-03 to 2017:
   a. 22.9 percent of all jury awards in Philadelphia County resulted in no ($0) award.
   b. 62.9 percent of all jury awards in the remainder of the state of Pennsylvania resulted in no ($0) award (excluding Allegheny, Lackawanna, and Philadelphia Counties).

   c. Plaintiff rate of success in jury verdicts in Philadelphia County ranged from 21 percent to 48 percent; and the remainder of the state ranged from 5 percent to 26 percent.
4. MCARE claims paid:
   a. Total claims paid from 1996 to 2018 decreased by 21.9 percent. Pre-tort reform (1996 to 2002) total paid claims increased by 28.8 percent; and post-tort reform (2003 to 2018) total paid claims decreased by 44.2 percent.
5. According to data obtained from the NPDB, the value of medical malpractice payments made on behalf of Pennsylvania Physicians (MD/DO):
   a. Increased by 12.2 percent from 1996 to 2018; and the total number (count) of payments decreased by 44.7 percent.
   b. Pre-tort reform (1996 to 2002) the value of medical malpractice payments increased by 21.6 percent. The total number (count) of payments decreased by 9.9 percent.
   c. Post-tort reform (2003 to 2018) the value of medical malpractice payments decreased by 13.7 percent, and the total number (count) of payments decreased by 39.9 percent.

Issue Areas

A. Medical Malpractice Filings and Compensation in Pennsylvania

In an effort to comprehensively review the effects of the 2003 changes governing venue in medical professional liability actions on the prompt determination of, and fair compensation for injuries and death, we focused our review on pre- and post-tort reform. The specific data collected on medical malpractice filings and compensation varied between both state and federal entities.

We used medical malpractice data from the Administrative Office of Pennsylvania Courts (AOPC), statewide filings and jury awards (2000 to 2017), MCARE paid claims data (1996 to 2018), and lastly, National Practitioner Data Bank (NPDB) data (1996 to 2018) on physician payments for Pennsylvania and nationwide. As previously noted, the analysis will highlight both pre- and post-tort reform change(s) in claims filed, paid, and payments made on behalf of physicians. We also included a review of trends across the United States.

Administrative Office of Pennsylvania Courts (AOPC)

The AOPC's Research and Statistics Department collects and analyzes statistical information relevant to court operations.[96] The department provides data sets for civil, family, and orphans' courts, as well as jury data provided by all 67 counties that comprise the Unified Judicial System of Pennsylvania.[97] Required reporting of Medical Malpractice filings and jury awards from individual counties began July 1, 2003.[98]

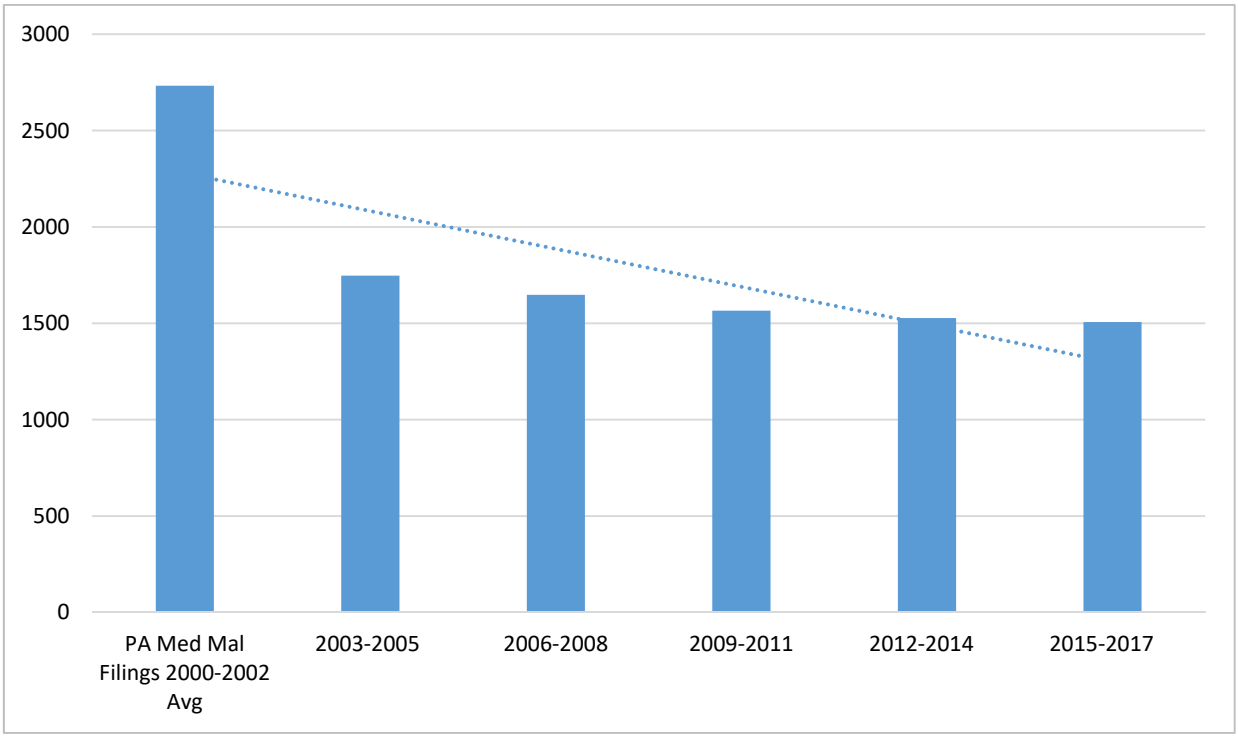
The AOPC's publicly available data does have some limitations: First, there is no statewide medical malpractice filings data available prior to 2000, however, the average number of filings from 2000 to 2002 was available for comparison. Second, jury verdicts (awards) do not provide a total of the medical malpractice payment(s) received by plaintiffs—the majority are settled before they reach trial.[99] Third, the actual jury verdict award could also be reduced in after trial proceedings, through appeal or judicial determination following a bench trial.[100]

Throughout this review we focus on statewide data and county-level data in Philadelphia, Allegheny, and Lackawanna Counties. In order to compare the 2000 to 2002 average medical malpractice filings data, we used 3-year averages for calendar years 2003 to 2017.[101] See Exhibit 34.

[96] http://www.pacourts.us/news-and-statistics/research-and-statistics/
[97] *Ibid.*
[98] A filing is defined as an initial complaint or praecipe for summons. Filings do not indicate merit, outcome, and/or verdict.
[99] AOPC does not collect settlement data.
[100] "Civil Programs in the Philadelphia Court of Common Pleas, Final Report." *National Center for State Courts, Consulting Services Division*. (2004). https://courts.phila.gov/pdf/report/NSCS-Civil-Final-Report.pdf
[101] AOPC: counties with combined reporting of medical malpractice filings/jury award data: Cameron/Elk, Columbia/Montour, Franklin/Fulton, Juniata/Perry, Snyder/Union, and Sullivan/Wyoming.

Exhibit 34

Medical Malpractice Filings in Pennsylvania



Source: Developed by LBFC staff from information obtained from AOPC.

Medical Malpractice Filings. In Pennsylvania, between the period of 2000-2002 and 2015-2017, there was a 44.9 percent decrease in medical malpractice filings. Out of the 67 counties:

- 15 (Bedford, Bucks, Columbia/Montour, Crawford, Greene, Indiana, Lancaster, Lawrence, Luzerne, Mifflin, Monroe, Montgomery, Washington and Wayne) showed an increase in medical malpractice filings
- 4 counties (Juniata/Perry, Pike, and Susquehanna) had no changes in filings
- The remaining 48 counties had a decrease in filings

Philadelphia, Allegheny, and Lackawanna. All three counties experienced a decrease in medical malpractice filings from 2000 to 2002 and 2015 to 2017. As shown in Exhibit 35, while these three selected counties show a decrease in malpractice filings, the number of malpractice filings in surrounding counties varied. Overall, from 2000 to 2002 and 2015 to 2017, medical malpractice court filings have declined.

Exhibit 35

Medical Malpractice Filings
Philadelphia, Allegheny, and Lackawanna Counties
(2000 to 2002 compared to 2015 to 2017)

Allegheny County had a 37.7 percent decrease in medical malpractice filings.
Surrounding Counties:

- Washington County—304.8 percent increase in medical malpractice filings
- Armstrong County—8.3 percent decrease in medical malpractice filings
- Butler County—73.1 percent decrease in medical malpractice filings
- Westmoreland—56.5 percent decrease in medical malpractice filings

Lackawanna County had a 43.6 percent decrease in medical malpractice filings
Surrounding Counties:

- Luzerne County—44.1 percent increase in medical malpractice filings
- Monroe County—6.1 percent increase in medical malpractice filings
- Sullivan/Wyoming Counties—100 percent decrease in medical malpractice filings
- Susquehanna County—no change in medical malpractice filings
- Wayne County—11.1 percent increase in medical malpractice filings

Philadelphia County had a 67.7 percent decrease in medical malpractice filings
Surrounding Counties:

- Bucks County—30.1 percent increase in medical malpractice filings
- Montgomery County—397.0 percent increase in medical malpractice filings
- Chester County—9.4 percent decrease in medical malpractice filings
- Delaware County—31.5 percent decrease in medical malpractice filings

Source: Developed by LBFC staff from information obtained from AOPC.

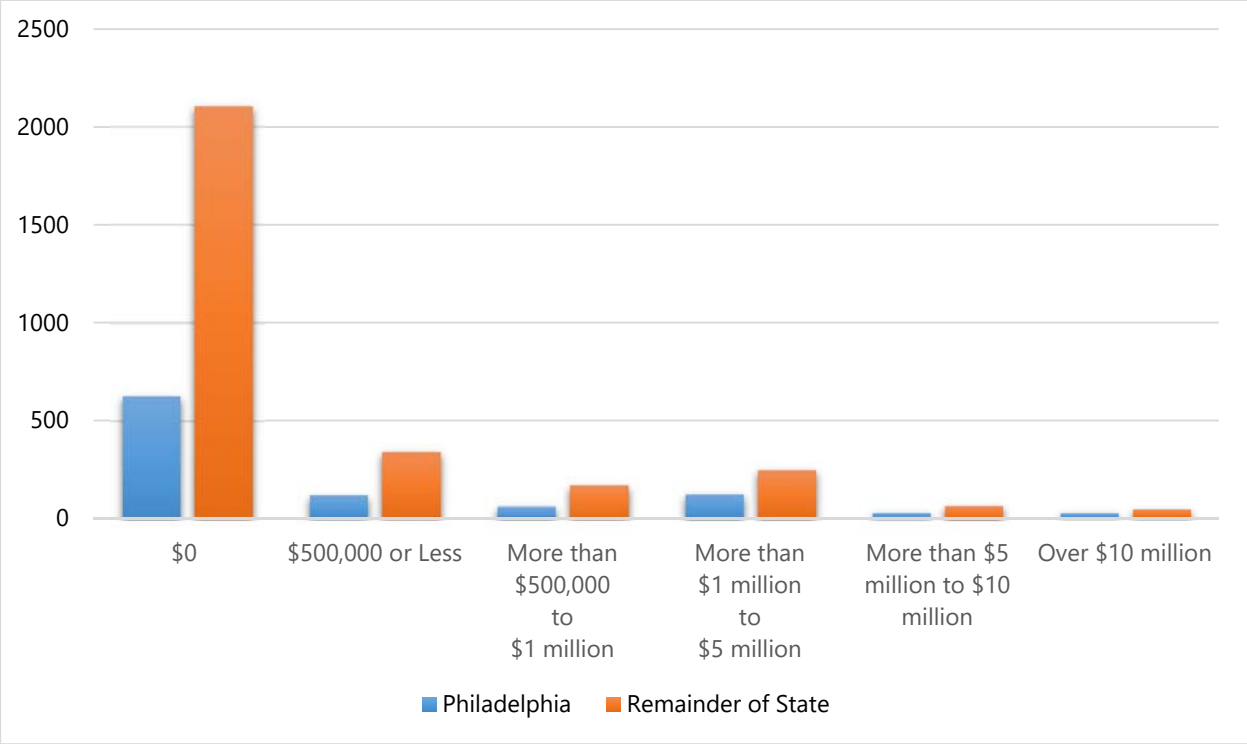
Jury Awards

We isolated Philadelphia due to its large percentage of jury awards compared to the remainder of the state. In CY 2017, 28 percent of medical malpractice filings occurred in Philadelphia County, whereas, only 15.5 percent were filed in Allegheny County, and 2 percent in Lackawanna County. Exhibit 36 shows AOPC medical malpractice jury award data from 2000 to 2017.[102]

[102] AOPC data on jury awards are from: CY 2000 to June 2003, July 2003 to CY 2004, and remaining years are individual years (i.e., 2005, 2006 etc.).

Exhibit 36

Jury Awards
Philadelphia vs. Remainder of the State
2000 to 2017



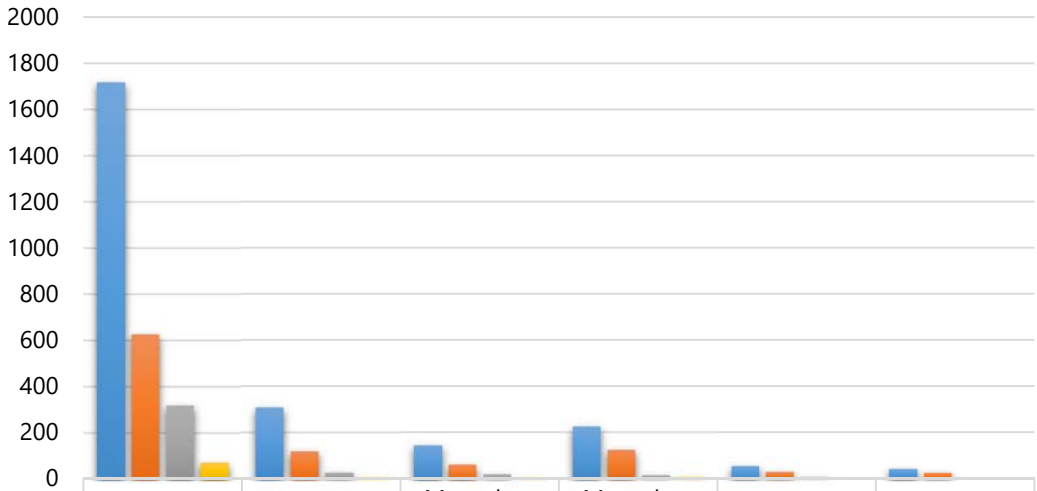
Source: Developed by LBFC staff from information obtained from AOPC.

We also isolated Philadelphia, Allegheny, and Lackawanna Counties from the remainder of the state. See Exhibit 37.

Over sixty percent of all jury verdicts that resulted in no ($0) award were in the remainder of the state, and within each award category from less than $500,000 to over $10 million—60 percent or more of those awards were also in the remainder of the state. Exhibit 37 shows the percentage breakdown by award category for the remainder of the state, Philadelphia, Allegheny, and Lackawanna Counties. The number of awards were greater in Philadelphia County across all award categories in comparison to Allegheny and Lackawanna Counties.

Exhibit 37

Philadelphia, Allegheny, and Lackawanna Counties vs. Remainder of State Medical Malpractice Jury Verdicts [a/]
CY 2000 to 2017



	$0	$500,000 or Less	More than $500,000 to $1 million	More than $1 million to $5 million	More than $5 million to $10 million	Over $10 million
Remainder of State	1718	307	143	224	56	42
Philadelphia	627	118	60	124	29	24
Allegheny	318	28	20	16	8	0
Lackawanna	70	5	4	7	0	1

Note:
[a/]All Counties not including Philadelphia, Allegheny, and Lackawanna Counties.

Source: Developed by LBFC staff from information obtained from AOPC.

It has been estimated that less than 10 percent of all medical malpractice cases go to trial, as the remaining cases have either reached a settlement or been dismissed.[103]

Rate of Success

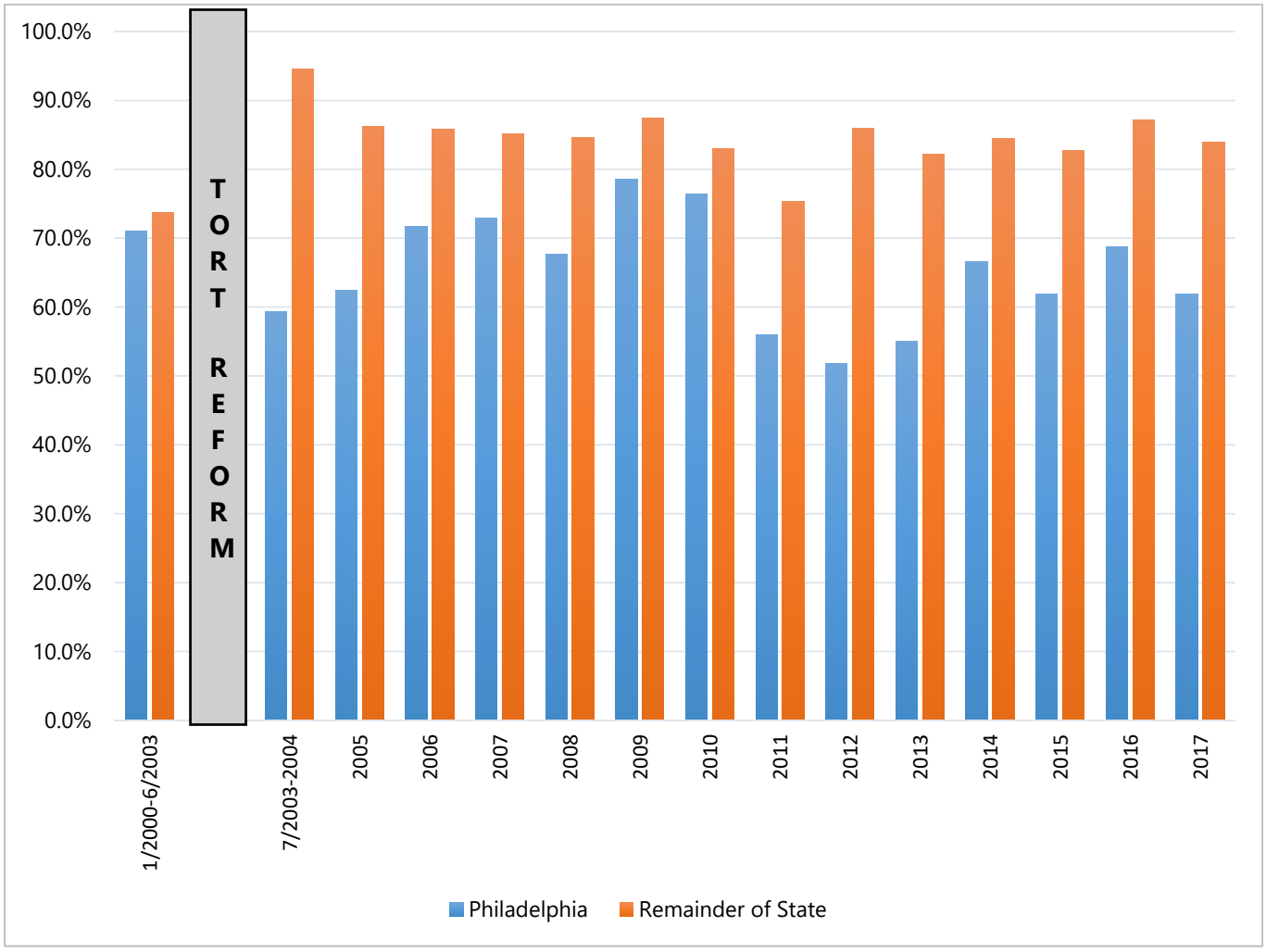
The rate of success for defendants and plaintiffs varied by county in medical malpractice cases that result from a jury trial. For instance, in 2017

[103] Randall R. Bovbjerg and Anna Bartow. "Understanding Pennsylvania's Medical Malpractice Crisis." *The Project on Medical Liability in Pennsylvania, the Pew Charitable Trusts*. (2003).

there were 102 jury verdicts statewide which resulted in 81 defense verdicts (79.4 percent) and 21 plaintiff verdicts (20.6 percent). In an effort to show how the above percentages are dispersed, we again isolate Philadelphia from the remainder of the state. See Exhibits 38 and 39.

Exhibit 38

Pennsylvania
Jury Verdicts
Defense Rate of Success

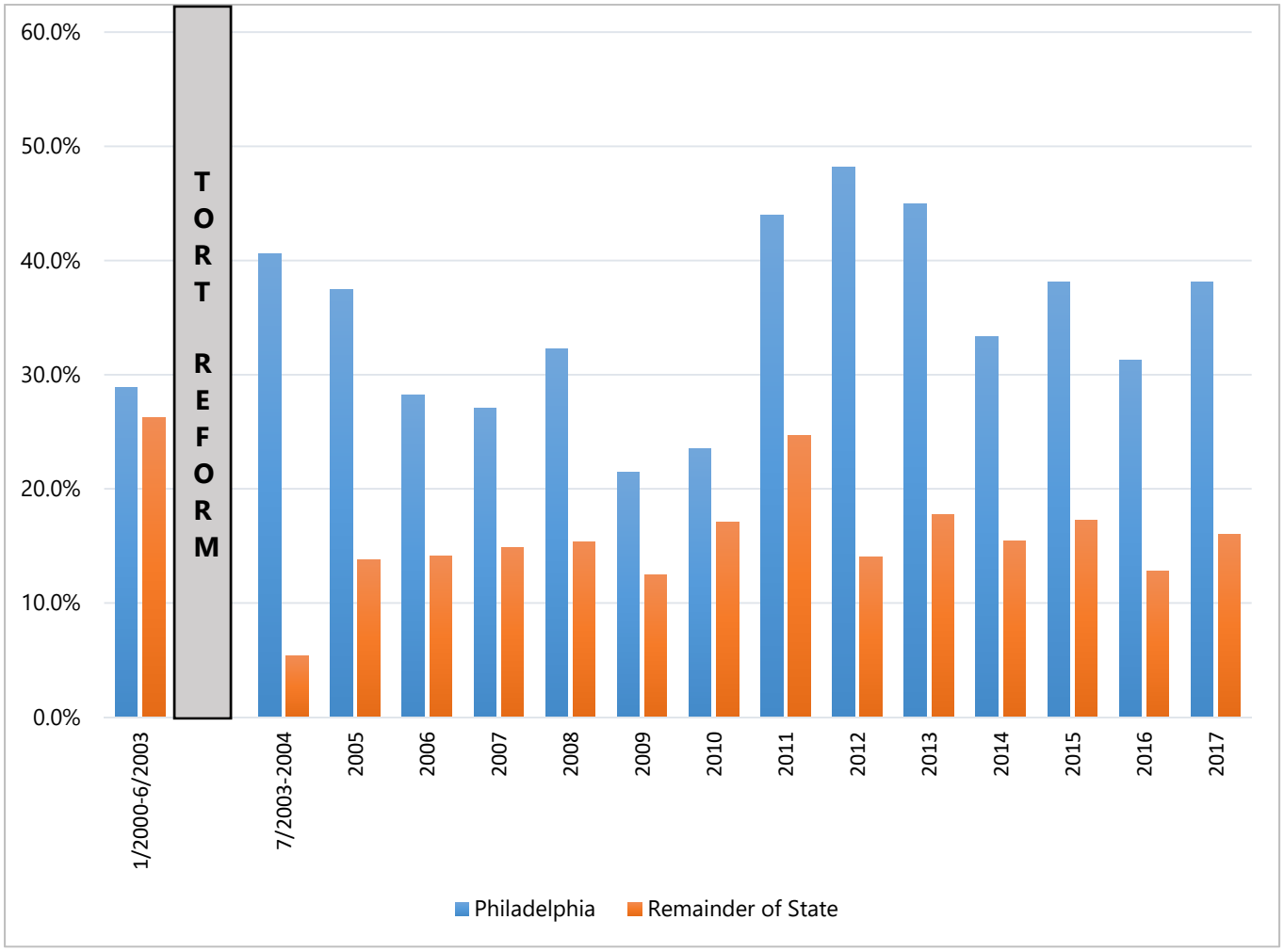


Source: Developed by LBFC staff from information obtained from AOPC.

The defense rate of success during the review period ranged from 73 percent to 95 percent across the remainder of the state; and from 51 percent to 79 percent in Philadelphia County.

Exhibit 39

Pennsylvania
Jury Verdicts
Plaintiff Rate of Success



Source: Developed by LBFC staff from information obtained from AOPC.

Plaintiff rate of success during the review period ranged from 5 percent to 26 percent throughout the remainder of the state, and from 21 percent to 48 percent in Philadelphia County.

Overall, the plaintiff's rate of success was greater in Philadelphia County when compared to the remainder of the state, across the review period. As shown in Exhibit 39, the defense rate of success was greater in the remainder of the state when compared to Philadelphia County.

We also reviewed the counties' jury verdict slips from 2000 to 2017, however, the information recorded on the jury verdict slips was not consistent and varied greatly between the counties.[104] First, information entered on the medical malpractice questionnaire was inconsistent with the corresponding jury verdict slips. Second, corresponding jury verdict slips were either missing verdict dates and/or award amounts. Third, the jury verdict slips were not provided with the questionnaire.

Philadelphia County

The First Judicial District of Pennsylvania (Philadelphia County) is unique based on its sheer size and caseload. Philadelphia has the highest number of both filings and jury awards. In addition, Philadelphia is the 5th largest city in the United States and the largest in the Commonwealth, has the highest number of GACH (15) and Specialty (15) Hospitals, and the highest number of Level I Trauma Centers (7) in the state. No other Commonwealth county is comparable to Philadelphia in these areas.

In 1992, the Philadelphia Court of Common Pleas had a backlog of 28,496 civil cases with jury demands.[105] The County implemented multiple programs, such as, "Day Forward" (January 1, 1993) and "Day Backward" (mid-1992) programs to reduce the size and age of the pending civil cases with jury demands inventory. The Day Forward Program was a major jury program that encompassed all major civil jury cases (except commerce and mass tort cases) filed on and after January 2, 1996.[106] The Day Backward Program was a major jury program that encompassed all major civil jury cases (except commerce and mass tort cases) filed on or after July 1993, and before January 2, 1995.[107] Both programs involved a case flow management system that the Court developed to coordinate and schedule major civil jury cases for trial. By 2000, the Day Forward program had been reduced to fewer than 7,000 pending cases, and the Day Backward program had been reduced to nineteen. The County's backlog could possibly account for the decrease in the number of jury awards across categories, but it would not explain the decrease in filings.[108]

[104] Criminal cases in Pennsylvania are tracked through a unified portal run by AOPC that all counties are required to use. Civil cases do not have this requirement and therefore, tracking of these cases is left mostly to each counties' discretion. Some information is then reported to AOPC manually, but generally speaking, each county courthouse controls the process in which information is stored on civil cases.
[105] "Civil Programs in the Philadelphia Court of Common Pleas, Final Report." *National Center for State Courts, Consulting Services Division*. (2004). https://courts.phila.gov/pdf/report/NSCS-Civil-Final-Report.pdf
[106] *Ibid.*
[107] *Ibid.*
[108] http://www.pacourts.us/news-and-statistics/research-and-statistics/

In the Philadelphia Court of Common Pleas 2010 and 2015 Annual Reports, data was provided on Medical Malpractice–Major Jury Inventory from 2000 to 2015. See Exhibit 40.

Exhibit 40

Philadelphia Court of Common Pleas
Medical Malpractice—Major Jury Inventory [a/]

Year	Major Jury Filed [b/]	Medical Malpractice Records Entered	% of Medical Malpractice Filed in Major Jury
2000	4693	1088	23%
2001	4881	1161	24
2002	4726	1352	29
2003	3886	572	15
2004	3991	559	14
2005	4207	540	13
2006	4252	589	14
2007	4278	595	14
2008	4363	568	13
2009	4462	507	11
2010	4258	389	9
2011	4683	426	9
2012	4799	414	9
2013	5324	376	7
2014	4808	382	8
2015	5009	376	8

Note:
[a/]The First Judicial District of Pennsylvania, The Philadelphia Courts, 2010 and 2015 Annual Reports. All records not disposed of in the same year. See disposition breakdown.
[b/]Major Jury is a case that cannot be settled via arbitration and a trial is requested.

Source: Developed by LBFC staff from information obtained from AOPC.

The percentage of medical malpractice records filed for major jury trials has decreased from 23 percent in 2000, to 8 percent in 2015. However, no public data is available to show the year medical malpractice claims were filed and the year of disposition of claim. Furthermore, Philadelphia County began its changes in mid-1992 and there is also no other county-level data available that dates back far enough to make a comparison as to the prompt determination of cases, and the overall effect of the 2003-changes to venue.

The shift in claims from Philadelphia and Allegheny Counties is prominent and at least one surrounding county has also shown a dramatic increase in claims. However, later in this section we will highlight, other aspects of tort reform and may have had a more direct effect on claim filings, such as the Certificate of Merit.

The Medical Care Availability and Reduction of Error Fund (MCARE)

The Medical Care Availability and Reduction of Error Fund (MCARE) is a special fund within the State Treasury established, among other things, to ensure reasonable compensation for persons injured due to medical negligence.

MCARE. We reviewed MCARE claims paid data from 1996 through 2018, and highlighted trends in claims paid by MCARE region.[109] A continuous reduction in the MCARE fund payouts is evident within the Eastern and Western regions through the 2018 calendar year. But, the opposite was observed among the Central Region and other (i.e. includes all other states where the MCARE defendant was involved). Please see Exhibit 41.

[109] https://www.insurance.pa.gov/SpecialFunds/Pages/MCARE.aspx; Money in the fund is used to pay claims against participating health care providers and eligible entities for losses or damages awarded in medical professional liability actions in excess of basic insurance coverage ("primary coverage") provided by primary professional liability insurance companies ("primary carriers") or self-insurers. MCARE also administers a compliance program to ensure adherence to the provisions of Act 13 and its attendant applicable regulations. Note: CAT Fund/MCARE limits from 1996-present: 1996 and prior $1,000,000 ($200,000 Primary); 1997 to 1999—$900,000 ($300,000 primary); 2000—$800,000 ($400,000 primary); 2001 to 2002—$700,000 ($500,000 primary); 2003 and after—$500,000 ($500,000 primary).

Exhibit 41

MCARE Paid Claims by Region[a/] (In Millions)

	Eastern[b/]	Central[c/]	Western[d/]	Other[e/]	Total Paid Claims	Total Claim Count
1996	$ 178.04	$ 36.32	$ 51.60	$ 4.28	$ 270.24	603
1997	166.32	45.81	52.71	3.48	268.32	617
1998	188.04	37.75	41.13	2.91	269.83	625
1999	214.87	45.07	36.97	3.94	300.85	705
2000	233.88	43.04	51.15	13.27	341.34	699
2001	203.69	55.65	57.99	4.33	321.66	692
2002	219.31	49.11	73.56	6.07	348.05	674
2003	260.36	46.87	66.04	5.45	378.72	701
2004	203.55	57.65	55.31	3.82	320.33	620
2005	143.22	37.39	50.44	1.54	232.59	471
2006	117.81	40.03	43.29	8.39	209.52	422
2007	102.90	32.26	54.93	1.28	191.37	422
2008	94.37	28.57	45.60	5.35	173.89	377
2009	99.00	38.47	36.20	4.57	178.24	396
2010	88.50	15.15	37.50	5.34	146.49	329
2011	88.32	34.11	43.51	4.45	170.39	353
2012	123.93	27.45	39.66	4.70	195.74	404
2013	108.50	39.77	45.63	0.00	193.90	414
2014	86.68	32.90	35.29	0.83	155.70	346
2015	83.62	34.73	39.47	2.45	160.27	352
2016	80.32	57.92	33.21	2.50	173.95	372
2017	81.77	47.33	50.02	2.14	181.26	402
2018	106.04	55.78	43.85	5.49	211.16	439

Note:
[a/]Note: County designation within region is for MCARE claims handling purposes only.
[b/]Eastern Region MCARE Counties: Bucks, Chester, Delaware, Lehigh, Montgomery, Northampton, and Philadelphia.
[c/]Central Region MCARE Counties: Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, and York.
[d/]Western Region MCARE Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland.
[e/]Includes all other states and the United States District Courts where MCARE defendant was involved.

Source: Developed by LBFC staff from information obtained from MCARE.

In reviewing MCARE's total claims paid from 1996 to 2018 we found the fund experienced an overall decrease of 21.9 percent. Pre-tort reform (1996 to 2002) total paid claims increased by 28.8 percent; and post-tort reform (2003 to 2018) total paid claims decreased by 44.2 percent. We analyzed the changes in total claims paid from 1996 to 2018 by region: the Eastern region total claims paid across the review period decreased by 40.4 percent and the Western region total claims paid across the review period decreased by 15.0 percent. But, unlike the other regions, the Central region's total claims paid across the review period increased by 53.5 percent, and Other total claims paid across the review period increased by 28.1 percent.

We also reviewed MCARE total claims count (total number) by health care provider group from 1996 to 2018. The types of health care providers are Individuals (MDs, DOs, Podiatrists, and Certified Nurse Midwives), Medical Corporations, and Institutions (Hospitals, Nursing Homes, Birth Centers, and Primary Care Centers). See Exhibit 42.

Exhibit 42

MCARE Total Claim Counts by Category of Health Care Provider

	Individuals[a/]	Medical[b/]	Institutions[c/]	Total Claim Count
1996	461	30	112	603
1997	486	19	112	617
1998	487	15	123	625
1999	567	30	108	705
2000	550	30	119	699
2001	529	26	137	692
2002	496	21	157	674
2003	495	33	173	701
2004	450	18	152	620
2005	337	20	114	471
2006	304	26	92	422
2007	273	25	124	422
2008	256	16	105	377
2009	285	14	97	396
2010	194	10	125	329
2011	230	18	105	353
2012	256	16	132	404
2013	267	21	126	414
2014	225	12	109	346
2015	241	5	106	352
2016	229	12	131	372
2017	244	19	139	402
2018	269	23	147	439

Note:
[a/]MDs, DOs, Podiatrists, and Certified Nurse Midwives.
[b/]Medical Corporations.
[c/]Hospitals, Nursing Homes, Birth Centers, and Primary Care Centers.

Source: Developed by LBFC staff from information obtained from MCARE.

The Fund's total claim count(s) for all health care providers (1996 to 2018) decreased by 27.2 percent. Pre-tort reform (1996 to 2002) total claim count(s) increased by 11.8 percent, and post-tort reform (2003 to 2018) total claim count(s) decreased by 37.4 percent. Exhibit 43 shows pre- and post-reform changes by health care provider.

Exhibit 43

Percentage of Change in MCARE Paid Claims by Health Care Provider

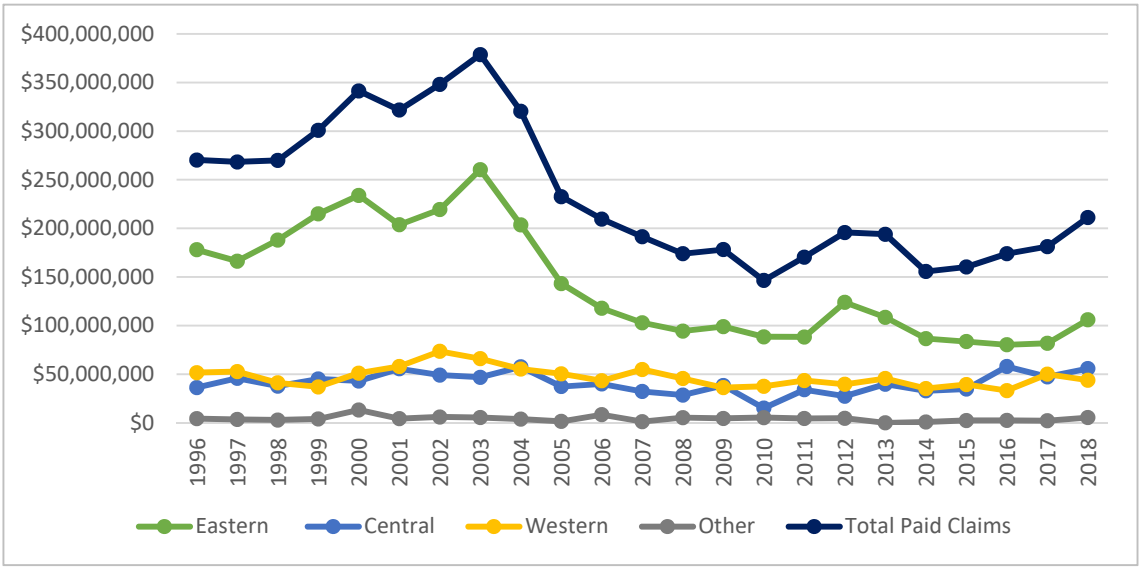
Health Care Provider	1996 to 2002	2003 to 2018	1996 to 2018
Individuals	7.6%	-45.7%	-41.6%
Medical	-30.0	-30.3	-23.3
Institutions	40.2	-15.0	31.3

Source: Developed by LBFC staff from information obtained from MCARE

Exhibit 44 shows MCARE paid claims by regions—with the highest value of paid claims in the Eastern region showing a continuous decline post-2003 tort reform with fluctuations in 2009, 2012, and 2018, and the remaining regions with more subtle declines and fluctuations post-tort reform.

Exhibit 44

MCARE Paid Claims by Region



Source: Developed by LBFC staff from information obtained from MCARE

In MCARE's 2009 Annual Report of Operations, the Fund highlights the decrease in claims activity post-tort reform. Further, reporting that the cause(s) of the decrease is not "clear" but could be attributable to both

"reform and social attitude changes towards medical malpractice." [110] 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."[111]

According to MCARE (2009), the "extent to which this reduction in the number of claims results in a reduction in the total costs to the Fund is uncertain for several reasons:"[112]

> The reduced number of cases may be a reduction in less meritorious cases, in which case a reduction in the number of cases may not lead to a commensurate decrease in costs, particularly in the excess layers of coverage provided by the Fund.
>
> Certain counties or areas may have a tendency for higher awards or settlements because those areas see the most complicated medical cases. To some extent, a higher average award or settlement may be indicative of a higher degree of alleged damage associated with more complicated cases. The movement of cases out of Philadelphia and into surrounding counties may simply increase the average award of the surrounding counties.
>
> As claims have moved to other counties, the process of disposing of those claims may have slowed. Fund payments for recent years have been approximately 20% to 35% lower than we have projected based on historical payment patterns. If this is partially due to a temporary slow-down in payment resulting from venue reform, any resulting savings may be offset, at least partially, by the inflationary impact of delaying the resolution of these claims. Closed-with-Payment Fund claim statistics provided some corroboration of the information observed by the AOPC, allowing for a time delay between case filing and claim payment. Namely, the number of Fund claims closing with payment fell dramatically in 2005 through 2008, as compared to prior years.
>
> The average statewide decrease in claims closed with payment is approximately 35% (40% per 2012 report), with Philadelphia experiencing an average decrease of nearly 50% (55% in 2010, 50% in 2011 and 2012) and ROS (Rest of the State) experiencing an average decrease of approximately 25% (2010, 2011 and 2012 at 30%).

[110] Act 13 of 2002-Medical Care Availability and Reduction of Error Fund: Annual Report of Operations, 2012 (p.16).
[111] *Ibid.*
[112] Act 13 of 2002-Medical Care Availability and Reduction of Error Fund: Annual Report of Operations, 2009 (p.18-19).

Regarding Recent Legislative Provisions, the Report stated:

> Other elements of recent legislation are expected to have a less direct or less significant effect on the Fund's future payments, are more difficult to estimate, or lack sufficient information to actuarially quantify . . .including but not necessarily limited to: Patient Safety initiatives (Chapter 3 of Act 13), Remittitur (Section 515 of Act 13), Statute of Repose (Section 513 of Act 13), Collateral Sources (Section 508 of Act 13), and the "180-day rule" and "continuing course of treatment" provisions (Act 135).

Lastly, MCARE suggests that higher payouts even though concentrated in Philadelphia, could also be due to the level or severity of harm of that particular case which could explain why we see high awards in other counties as well, but with less frequency.

National Practitioner Data Bank (NPDB)

The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.[113] NPDB was created by Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660 (HCQIA), as amended, and was implemented in 1990. NPDB's mission is "to improve health care quality, protect the public, and reduce health care fraud and abuse in the United States." [114]

The NPDB is the only publicly available database that collects data on all medical malpractice payments made on behalf of a health care practitioner—from both settlements and jury awards.[115] Any entity that makes a payment is required to report, "whether a settlement or in satisfaction, in whole or part, of a claim or judgment against the practitioner."[116]

Exhibits 45, 46, 47, and 48 show medical malpractice payments in Pennsylvania made on behalf of all medical practitioners, physicians (MD/DO), and comparable nationwide data from 1996 to 2018. We highlighted changes in calendar years 1996, 2002, 2003, and 2018—to focus on both pre- and post-tort reform.

[113] https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp; "The NPDB is overseen by the Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), Division of Practitioner Data Banks (DPDB)."
[114] *Ibid.*
[115] Title IV of Public Law 99-660 §11131. Requiring reports on medical malpractice payments: Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 11134 of this title, information respecting the payment and circumstances thereof.
[116] "National Practitioner Data Bank—NPDB Guidebook." (October 2018). *U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce*.

All Medical Practitioners. As shown in Exhibit 45:

Pre-Tort Reform (CY 1996 to CY 2002):

The value of payments made on behalf of all medical practitioner types in Pennsylvania increased by 24.4 percent pre-tort reform:

- 1996 ($328.4 million)
- 2002 ($408.4 million)

The total number (count) of payments decreased by 9.7 percent during the same period.

- 1996 (1,592)
- 2002 (1,437)

Post-Tort Reform (CY 2003 to CY 2018):

The value of payments made on behalf of all medical practitioner types in Pennsylvania decreased by 11.0 percent post-tort reform:

- 2003 ($433.8 million)
- 2018 ($385.9 million)

The total number (count) of payments decreased by 38.8 percent during the same period.

- 2003 (1,468)
- 2018 (899)

During the entire review period from CY 1996 to CY 2018:

The value of payments made on behalf of all medical practitioner types in Pennsylvania increased by 17.5 percent:

- 1996 ($328.4 million)
- 2018 ($385.9 million)

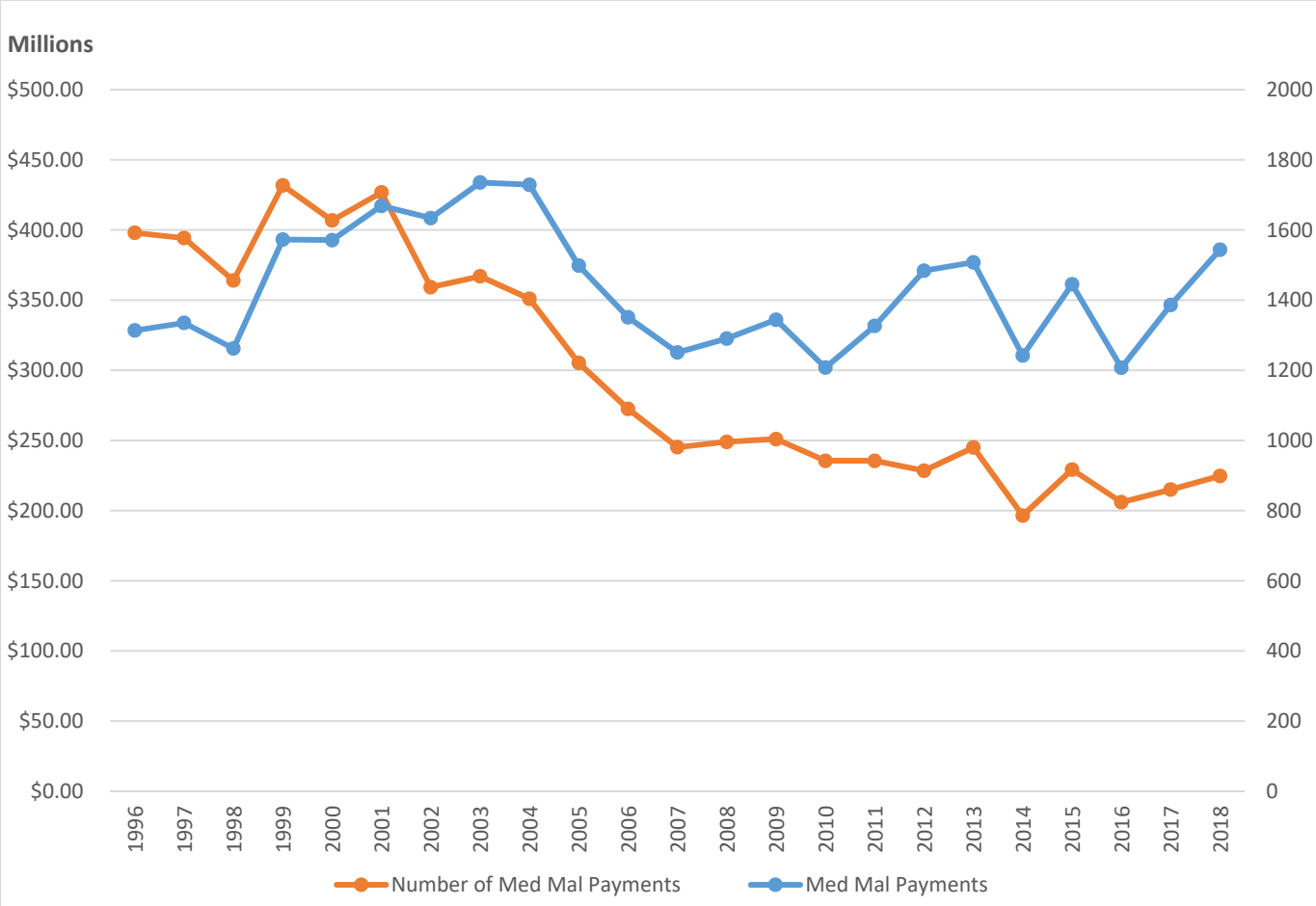
The total number (count) of payments decreased by 43.5 percent during the same period.

- 1996 (1,592)
- 2018 (899)

Overall, the value of payments made on behalf of all medical practitioner types has increased across the review period. However, the number (count) of payments has steadily declined since 1996.

Exhibit 45

Pennsylvania
Number and Amount of Medical Malpractice Payments
All Medical Practitioners [a/b/]



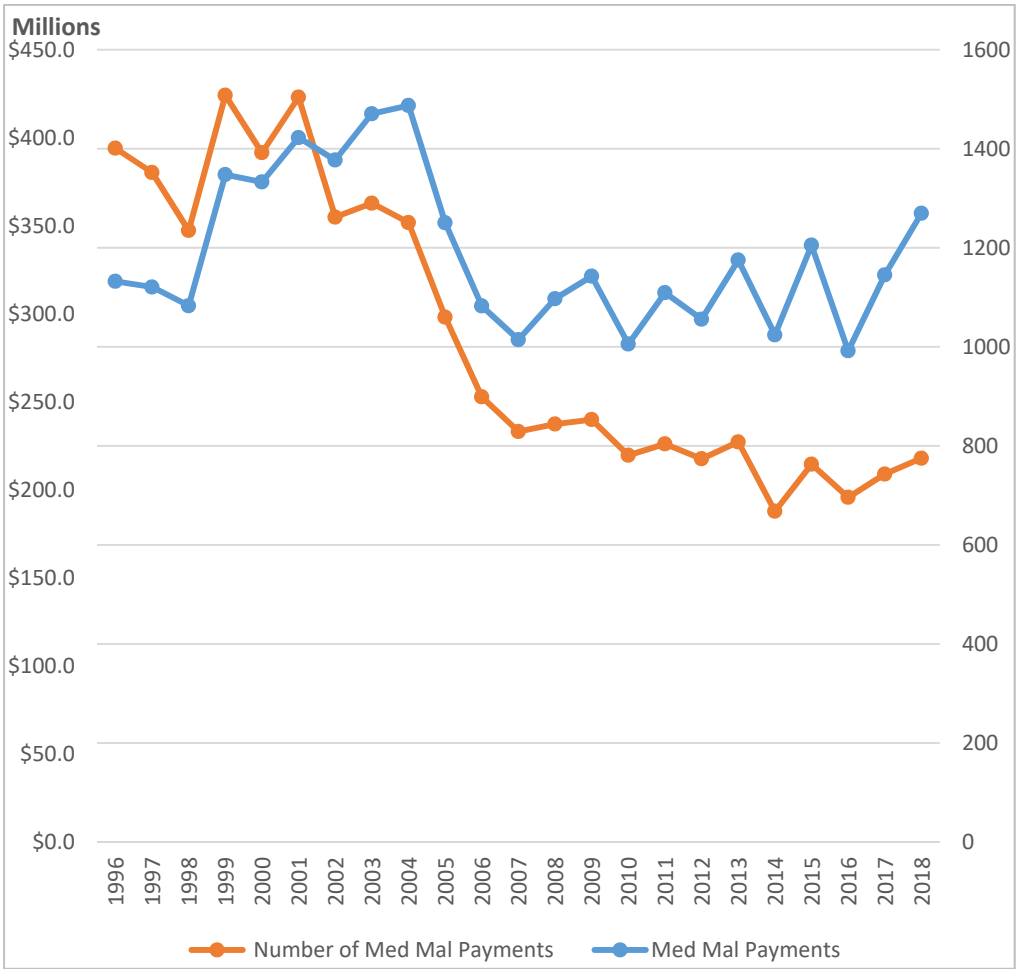
Note:
[a/]Singh, Harnam. National Practitioner Data Bank. Generated using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool. National Practitioner Data Bank (2019): Adverse Action and Medical Malpractice Reports (1990 to March 31, 2019). *Accessed: August 15, 2019 (Dates queried: 1996 to 2018)*
[b/]All practitioner types include: Physicians (MD/DO), Chiropractor, Dental Hygienist/Assistant, Dentist, Nurses (Adv. Practice, Registered Nurse, Licensed Practical Nurse, and Nursing Para-Professionals), Optometrist, Pharmacist, Physician Assistant, Podiatrist, Psychologist, Social Worker, Technician and Assistants, Therapist and Counselors, and others.

Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

We also looked at medical malpractice payments for all Pennsylvania physicians (MD/DO) only, across the review period. See Exhibit 46.

Exhibit 46

Pennsylvania
Number and Amount of Medical Malpractice Payments
Physicians (MD/DO) [a/]



Note:
[a/]Singh, Harnam. National Practitioner Data Bank. Generated using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool. National Practitioner Data Bank (2019): Adverse Action and Medical Malpractice Reports (1990 to March 31, 2019). *Accessed: August 15, 2019 (Dates queried: 1996 to 2018).*

Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

Physicians. As shown in Exhibit 46:

Pre-Tort Reform (CY 1996 to CY 2002):

The value of payments made on behalf of Pennsylvania physicians (MD/DO) increased by 21.6 percent pre-tort reform:

- 1996 ($318.4 million)
- 2002 ($387.3 million)

The total number (count) of payments decreased by 9.9 percent during the same period.

- 1996 (1,401)
- 2002 (1,262)

Post-Tort Reform (CY 2003 to CY 2018):

The value of payments made on behalf of Pennsylvania physicians (MD/DO) decreased by 13.7 percent post-tort reform:

- 2003 ($413.6 million)
- 2018 ($357.1 million)

The total number (count) of payments decreased by 39.9 percent during the same period.

- 2003 (1,290)
- 2018 (775)

During the entire review period from CY 1996 to CY 2018:

The value of payments made on behalf of Pennsylvania physicians (MD/DO) increased by 12.2 percent:

- 1996 ($318.4 million)
- 2018 ($357.1 million)

The total number (count) of payments decreased by 44.7 percent during the same period.

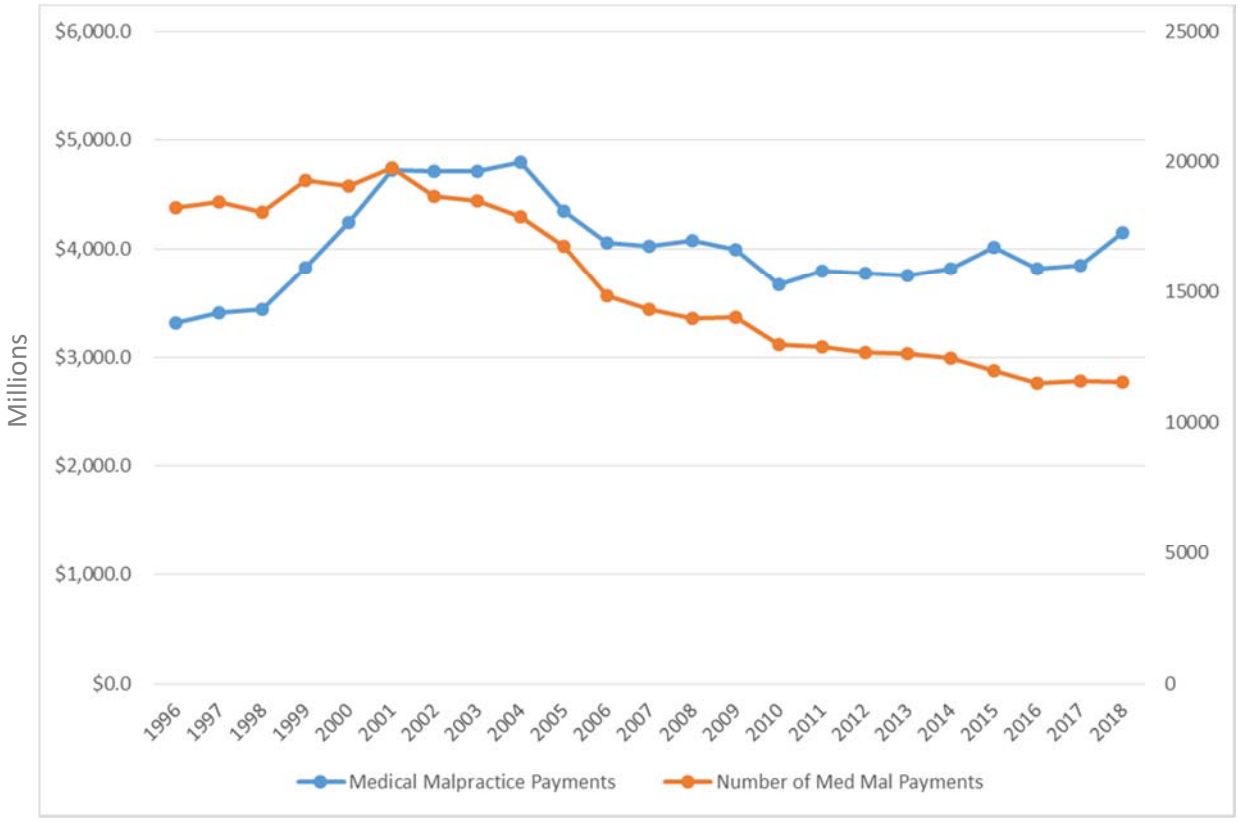
- 1996 (1,401)
- 2018 (775)

Overall, the value of medical malpractice payments on behalf of physicians has increased across the review period, while the number (count) of payments has steadily declined through pre-and post-tort reform.

We also conducted the same analysis on nationwide medical malpractice payments and the number (count) payments for all practitioner types and physicians. See Exhibits 47 and 48.

Exhibit 47

United States
Number and Amount of Medical Malpractice Payments
All Medical Practitioners [a/b/]



Note:
[a/]Singh, Harnam. National Practitioner Data Bank. Generated using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool. National Practitioner Data Bank (2019): Adverse Action and Medical Malpractice Reports (1990 to March 31, 2019). *Accessed: August 15, 2019 (Dates queried: 1996 to 2018).*
[b/]All practitioner types include: Physicians (MD/DO), Chiropractor, Dental Hygienist/Assistant, Dentist, Nurses (Adv. Practice, Registered Nurse, Licensed Practical Nurse, and Nursing Para-Professionals), Optometrist, Pharmacist, Physician Assistant, Podiatrist, Psychologist, Social Worker, Technicians and Assistants, Therapists and Counselors, and Other. Note: includes all 50 states, U.S. Territories, and Armed Forces.

Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

All Medical Practitioners. As shown in Exhibit 47:

Pre-Tort Reform (CY 1996 to CY 2002):

The value of payments made on behalf of all medical practitioner types nationally increased by 42.4 percent pre-tort reform:

- 1996 ($3,314.0 billion)

- 2002 ($4,718.7 billion)

The total number (count) of payments increased by 2.3 percent during the same period.

- 1996 (18,255)
- 2002 (18,677)

Post-Tort Reform (CY 2003 to CY 2018):

The value of payments made on behalf of all medical practitioner types nationally decreased by 12.0 percent post-tort reform:

- 2003 ($4,715.6 billion)
- 2018 ($4,151.5 billion)

The total number (count) of payments decreased by 37.6 percent during the same period.

- 2003 (18,535)
- 2018 (11,560)

During the entire review period from CY 1996 to CY 2018:

The value of payments made on behalf of all medical practitioner types nationally increased by 25.3 percent:

- 1996 ($3,314.0 billion)
- 2018 ($4,151.5 billion)

The total number (count) of payments decreased by 36.7 percent during the same period.

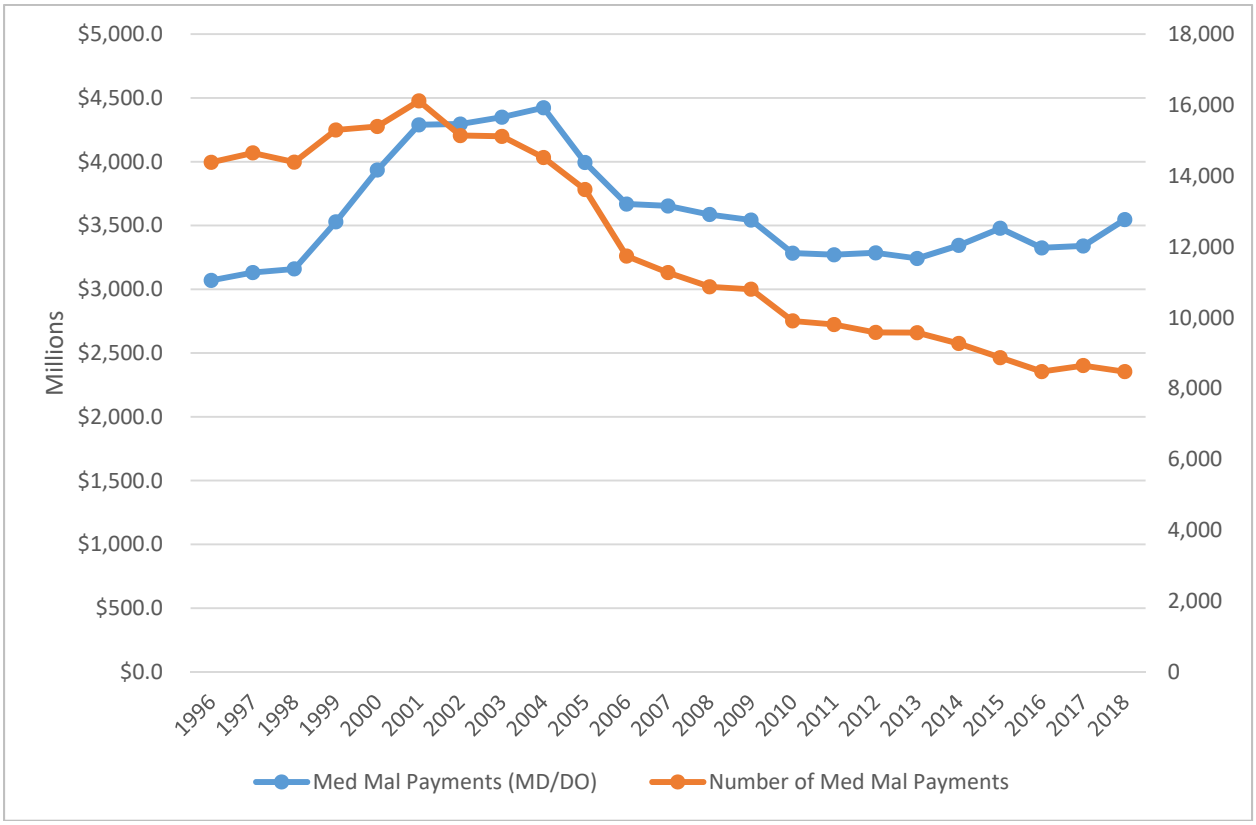
- 1996 (18,255)
- 2018 (11,560)

Overall, the value of medical malpractice payments on behalf of all United States medical practitioners has increased across the review period, while the number (count) of payments post tort reform has decreased.

We also looked at medical malpractice payments for United States physicians (MD/DO) only, across the review period. See Exhibit 48.

Exhibit 48

United States
Number and Amount of Medical Malpractice Payments
Physicians (MD/DO)[a/]



Note:
[a/]Singh, Harnam. National Practitioner Data Bank. Generated using the Data Analysis Tool at https://www.npdb.hrsa.gov/analysistool. National Practitioner Data Bank (2019): Adverse Action and Medical Malpractice Reports (1990 to March 31, 2019). *Accessed: August 15, 2019 (Dates queried: 1996 to 2018).*

Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

Physicians. As shown in Exhibit 48:

Pre-Tort Reform (CY 1996 to CY 2002):
The value of payments made on behalf of all United States physicians (MD/DO) increased by 39.9 percent pre-tort reform:

- 1996 ($3,069.7 billion)
- 2002 ($4,294.9 billion)

The total number (count) of payments increased by 5.2 percent during the same period.

- 1996 (14,383)
- 2002 (15,137)

Post-Tort Reform (CY 2003 to CY 2018):

The value of payments made on behalf of all United States physicians (MD/DO) decreased by 18.5 percent post-tort reform:

- 2003 ($4,349.2 billion)
- 2018 ($3,546.6 billion)

The total number (count) of payments decreased by 43.9 percent during the same period.

- 2003 (15,116)
- 2018 (8,474)

During the entire review period from CY 1996 to CY 2018:

The value of payments made on behalf of all United States physicians (MD/DO) increased by 15.5 percent:

- 1996 ($3,069.7 billion)
- 2018 ($3,546.6 billion)

The total number (count) of payments decreased by 41.1 percent during the same period.

- 1996 (14,383)
- 2018 (8,474)

Overall, from 1996 to 2018, the value of medical malpractice payments has increased for all United States physicians, while the number (count) of payments post-tort reform has decreased.

Medical malpractice payment data for Pennsylvania does mimic that of nationwide data for all physicians. In looking at the pre- and post-tort reform periods separately, the value of payments made on behalf of all United States' physicians increased during pre-tort reform, but similar to Pennsylvania, decreased post-tort reform.

B. Prompt Determination

Due to the complexity of medical malpractice cases and limited data on medical malpractice case duration from the time of filing to award or settlement, we were unable to determine if medical malpractice cases were promptly concluded.

We are, however, able to highlight limited statistics from the NPDB. In 2014, the NPDB reported that from 2003 to 2012, the average time, between incident and payment in Pennsylvania was 5.6 years, and in 2012 it was 5.4 years. In looking at the remaining top payout states from 2003 to 2012, the average time, between incident and payment were: New York (5.8 years), Florida (4.1 years), California (3.2 years), and New Jersey (5.9 years). Unfortunately, no additional individual year data was available for further comparison.[117]

C. Fair Compensation for Injuries

In an effort to understand fairness in the realm of medical negligence we first looked to define "fair" as it pertains to the tort system. A series of research studies conducted by The Pew Charitable Trusts (PEW) titled *Medical Liability in Pennsylvania (2003)*, provided a comprehensive overview on how "medical, legal and insurance-related issues affect the medical liability system in the Commonwealth."[118] According to PEW, the concept of fairness is "elusive" and varies according to "context,"[119] further citing "fairness" as a term used but vaguely defined. We found no measureable definition of "fair" compensation.

Five Highest Payout States

Without a definition of "fair" compensation, we elected to present parallel information on the five highest payout states medical liability/medical malpractice laws and their most recent year's payouts per capita. The section that follows takes a closer look at these states as of 2018: (1) New York, (2) Pennsylvania, (3) Florida, (4) California, and (5) New Jersey.

Exhibit 49 indicates which states have legislation addressing specific aspects of medical malpractice actions.

[117] "National Practitioner Data Bank, 2012 Annual Report." *U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks*. Mean delay in years. (February 2014). Median and Mean Medical Malpractice Payment Delay, in Years, Between Incident and Payment, by Jurisdiction, 2003 – 2012. See Appendix F for all 50 U.S. states.

[118] "Project on Medical Liability in Pa. Report Traces Historic Interplay Between Opposing Sides in Tort Reform." *The Pew Charitable Trusts*. (March 2004). https://www.pewtrusts.org/en/about/news-room/press-releases-and-statements/2004/03/08/project-on-medical-liability-in-pa-report-traces-historic-interplay-between-opposing-sides-in-tort-reform2

[119] Maxwell J. Mehlman. "Resolving the Medical Malpractice Crisis: Fairness Considerations." *The Project on Medical Liability in Pennsylvania, the Pew Charitable Trusts*. (2003). https://www.pewtrusts.org/-/media/legacy/uploaded-files/wwwpewtrustsorg/reports/medical_liability/vfmedicalmalpracticefairnesspdf.pdf

Exhibit 49

Statutory Provisions in Five Highest Medical Malpractice Payout States[a/]

State	Damage/Award Limit of Cap	Limit on Attorney Fees	Periodic Payments	Patient Compensation or Injury Fund	Medical or Peer Review Panels
New York	N	Y	Y	Y	N
Pennsylvania	N	N	Y	Y	Y
Florida	Y	Y	Y	Y	Y
California	Y	Y	Y	N	Y
New Jersey	Y	Y	N	N	Y

Note:
[a/]See Appendix E medical liability/medical malpractice statutory provisions for the five highest medical malpractice payout states.

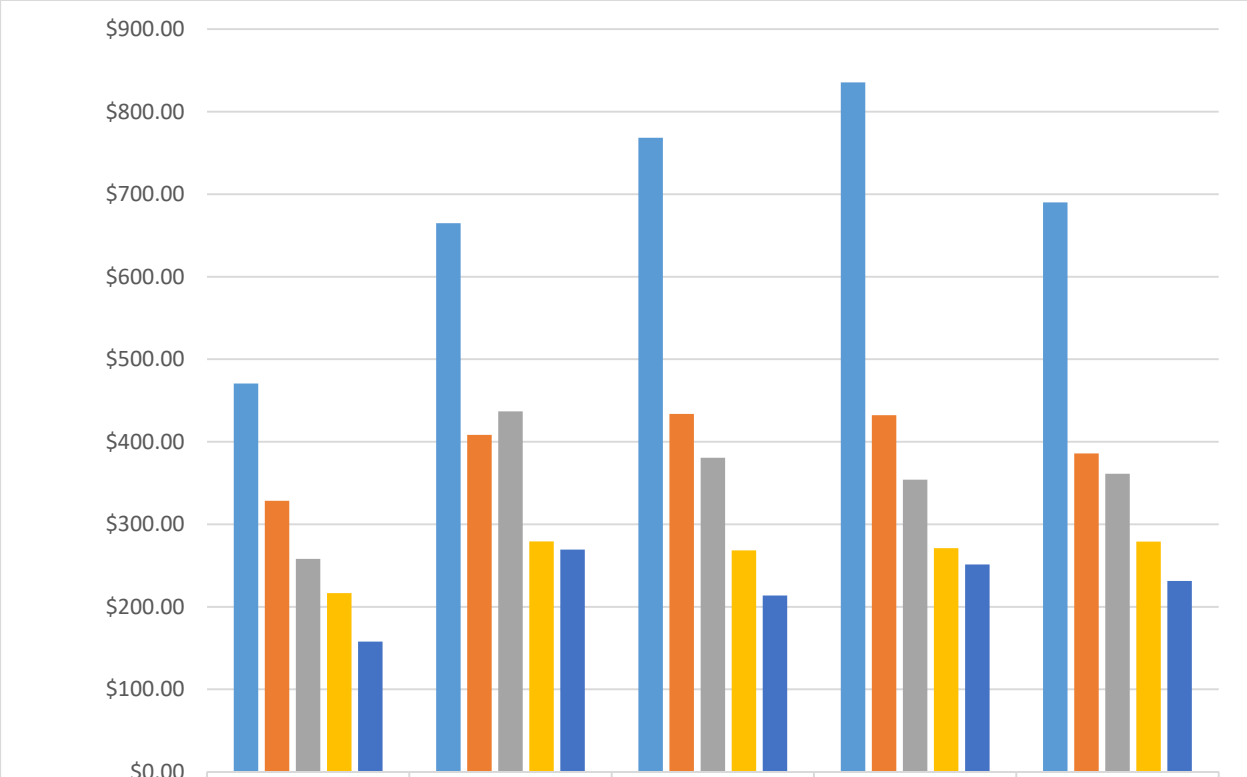
Source: Developed by LBFC staff from information obtained from the National Conference of State Legislatures.

Legislation addressing medical malpractice varies within each of the five highest payout states in regards to damage/award limitations, attorney fees, the use of periodic payments, patient compensation or injury funds, and medical or peer review panels. Pennsylvania does not have statutory damage/award limits, or limits on attorneys' fees.

Next, we reviewed medical malpractice payout data for each of the five states. Exhibit 50 shows the total payout for medical malpractice cases by state for calendar years 1996, 2002, 2003, 2004, and 2018.

Exhibit 50

Payouts for Medical Malpractice in Five Highest Payout States (In Millions)
As of December 31, 2018



	1996	2002	2003	2004	2018
New York	$470.58	$664.92	$768.43	$835.54	$690.19
Pennsylvania	$328.40	$408.47	$433.82	$432.21	$385.92
Florida	$258.12	$436.93	$380.72	$354.18	$361.20
California	$216.53	$279.21	$268.48	$271.17	$279.01
New Jersey	$157.85	$269.33	$213.68	$251.32	$231.40

Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

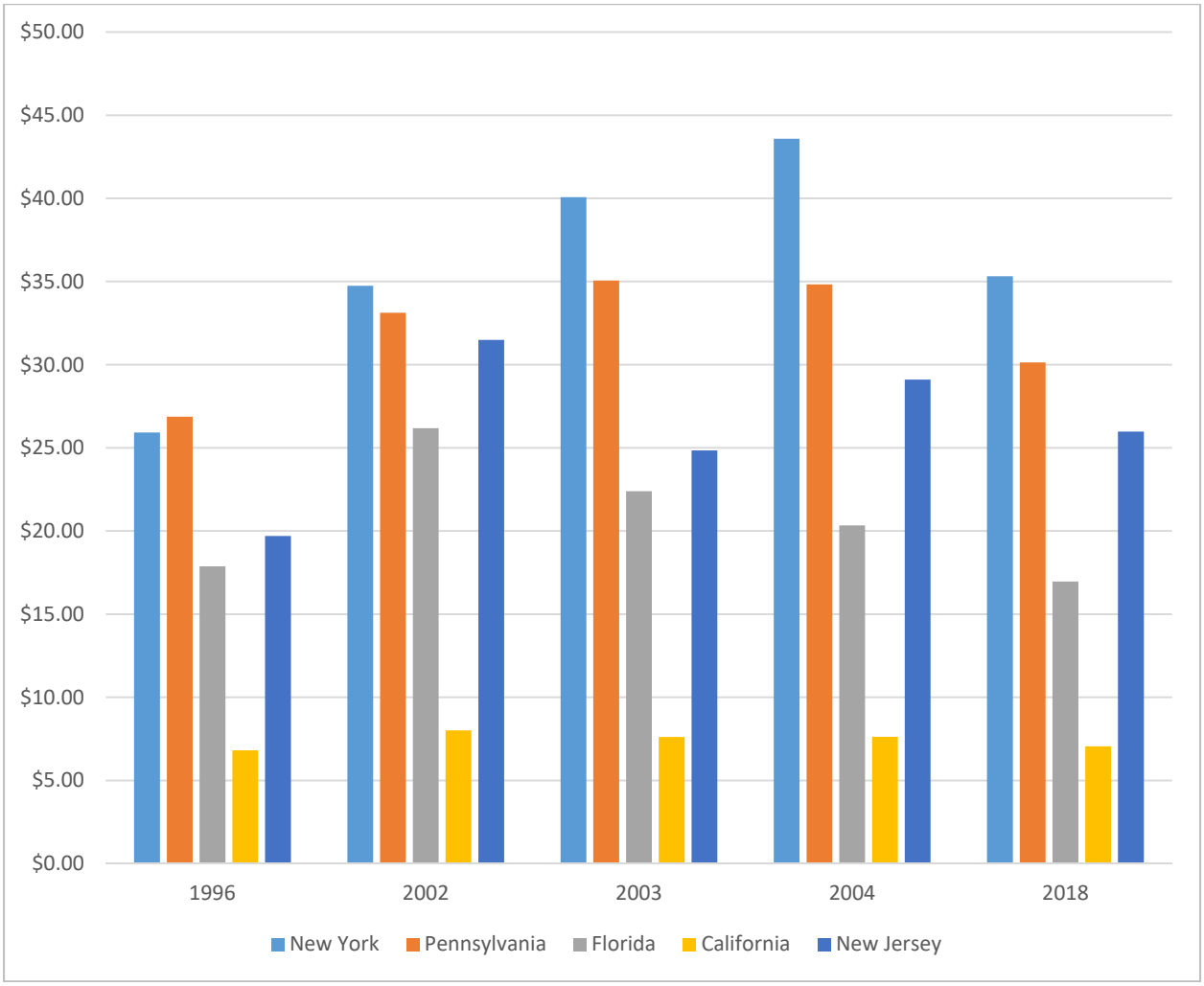
Value of Payment. All five highest payout states' value of payment increased from 1996 to 2018. Pennsylvania had the lowest percentage (17.5 percent) of increase in payouts verses the other states, followed by California (28.9 percent), Florida (39.9 percent), New Jersey (46.6 percent), and New York (46.7 percent). In regards to the total number (count) of medical malpractice payments, all five highest payout states decreased from 1996 to 2018. Pennsylvania had the 2nd highest decrease (43.5 percent) in the number (count) of medical malpractice payments.

California had the highest decrease (45.4 percent) in number (count) of medical malpractice payments.

Lastly, we analyzed the per capita cost of medical liability payouts by state. See Exhibit 51.

Exhibit 51

Cost Per Capita
Five Highest Payout States
As of December 31, 2018



Source: Developed by LBFC staff from information obtained from the National Practitioner Data Bank.

Per Capita Cost. As shown in Exhibit 51 the per capita cost in medical liability has increased in four out of five highest payout states from 1996

to 2018. Pennsylvania, had the 2nd lowest percentage (12.1 percent) of increase in per capita cost from $26.87 (1996) to $30.13 (2018). The remaining three states from highest to lowest percentage of increase in per capita cost are: New York (36.2 percent), New Jersey (31.8 percent), and California (3.6 percent). The state of Florida cost per capita decreased by 5.1 percent.

D. Prompt Determination and Fair Compensation: Proposed Rule Change

The number of medical malpractice filings and the number of jury awards have decreased since 2003. However, the available data does not support a conclusion on the effect of venue on changes in the number of filings and/or jury awards. The decrease in MCARE fund claims paid does show a similar trend as the number of filings and jury awards; but as MCARE stated it could be due to a delay in claims or other statutory changes that were enacted during tort reform. The most comprehensive source with available data on all medical malpractice payments made on behalf of a medical practitioner is the National Practitioner Databank (NPDB). The NPDB data showed that the severity of payments made on behalf of MD/DOs in Pennsylvania and nationwide from 1996 to 2018 has increased, while the number (count) of payments has decreased.

The data available does not allow for a review of the time between incident and payment, which therefore does not support a conclusion regarding the prompt determination of medical professional liability actions in Pennsylvania.

The effects of the proposed rule change on the number of medical malpractice filings and/or the value of medical malpractice payments in Pennsylvania could not be determined with any certainty.

Due to the multiple variables involved in medical malpractice cases, such as severity of injury, case flow management systems etc., we could not determine the effects, if any, the proposed rule change to venue would have on the prompt determination of, and fair compensation for injuries and death as a result of medical negligence by a health care provider.

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SECTION VII
AVAILABILITY, COST, AND AFFORDABILITY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE

Overview

Fast Facts...

- *The number of medical malpractice insurance companies writing $1 million or more in direct premiums increased from 39 in 2002 to 70 in 2017.*
- *Beginning in 2008, medical malpractice insurance rates began to decline across the specialty types we review. This seems to be closely tied to a national trend.*
- *Medical malpractice insurance rates increased as a percentage of the Philadelphia rate in most counties with hospital systems tied to Philadelphia.*

We were asked to determine the effects of the 2003 changes governing venue in medical professional liability actions on the availability, cost, and affordability of medical professional liability insurance in every geographic region of Pennsylvania. To accomplish this task, we reviewed the following information:

A. Medical professional liability rate information from the *Medical Liability Monitor Annual Rate Survey.*[120]
B. The number of insurance companies writing medical professional liability insurance policies, their market share, and premium amounts from the Pennsylvania Insurance Department (Department) *Annual Statistical Report*.
C. Pennsylvania Joint Underwriters Association (JUA) Underwriting Manuals.
D. Medical Care Availability and Reduction of Error (MCARE) Fund Assessment Manuals.

We reviewed the available data from 1996 to 2018 in the case of the *Medical Liability Monitor, JUA Underwriting Manuals,* and *MCARE Assessment Manuals,* and from 2002 to 2017 in the case of the Department's *Annual Statistical Report*.

We found:

1. 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.
2. The availability of medical professional liability insurance has increased since 2002:
   a. The number of insurance companies writing more than $1,000 in direct premiums increased from 89 in 2002 to 144 in 2017.

[120] The *Medical Liability Monitor Annual Rate Survey* surveys major writers of medical malpractice insurance for Internal Medicine, General Surgery, and Obstetrics/Gynecology. The *Survey* has been used by the United States Government Accountability Office, Department of Health and Human Services, and the Congressional Budget Office for various studies, research, and policymaking projects.

   b. The number of insurance companies writing more than $1 million in direct premiums increased from 39 in 2002 to 70 in 2017.
   c. The market share of the 10 largest medical professional liability insurers (as measured by direct written premium) decreased from 71.6 percent in 2002 to 49.4 percent in 2017.
3. The cost of medical professional liability insurance increased dramatically from 1996 through 2008 before declining. However, this change appears closely aligned to a national trend:
   a. Total direct premiums fluctuated over time, from a low of $499 million in 2002, peaking at $768 million in 2006, and declining to $646 million in 2017.
4. Since 2008, the cost of medical professional liability insurance decreased significantly, and therefore became more affordable, before leveling off in 2013. This change also appears closely aligned to a national trend:
   a. Whether insurance is more affordable varies by county.

Issue Areas

A. Availability, Cost, and Affordability of Medical Professional Liability Insurance

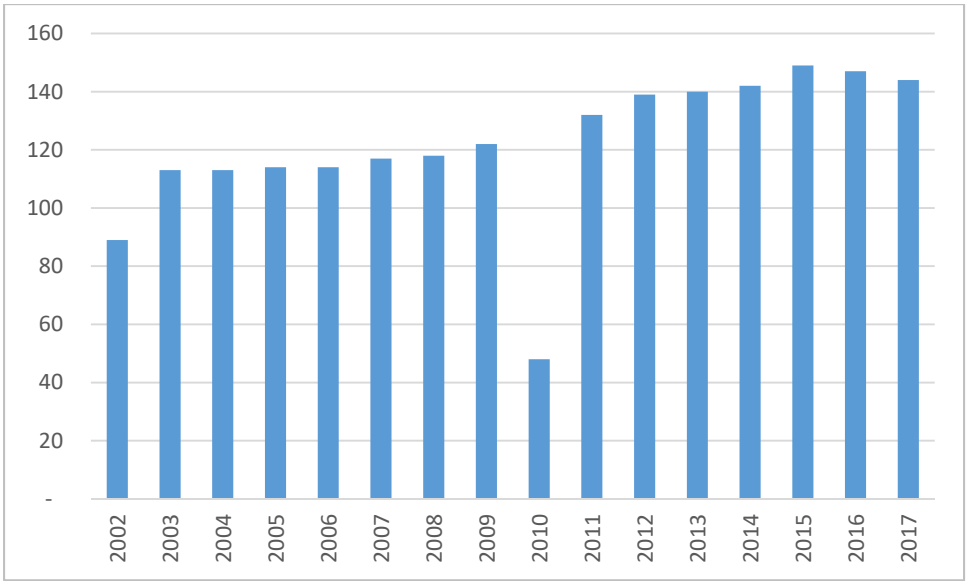
Availability of Medical Professional Liability Insurance

As mentioned above, we obtained data on the number of insurance companies writing medical professional liability insurance policies, their market share, and premium amounts from the Pennsylvania Insurance Department (Department) *Annual Statistical Report*.

The total number of companies writing $1,000 or more in premiums increased from 89 in 2002 to 144 in 2017, or 62 percent. The average annual increase was roughly 3 percent. See Exhibit 52.

Exhibit 52

Number of Insurers Writing $1,000 or More in Direct Premium[a/]



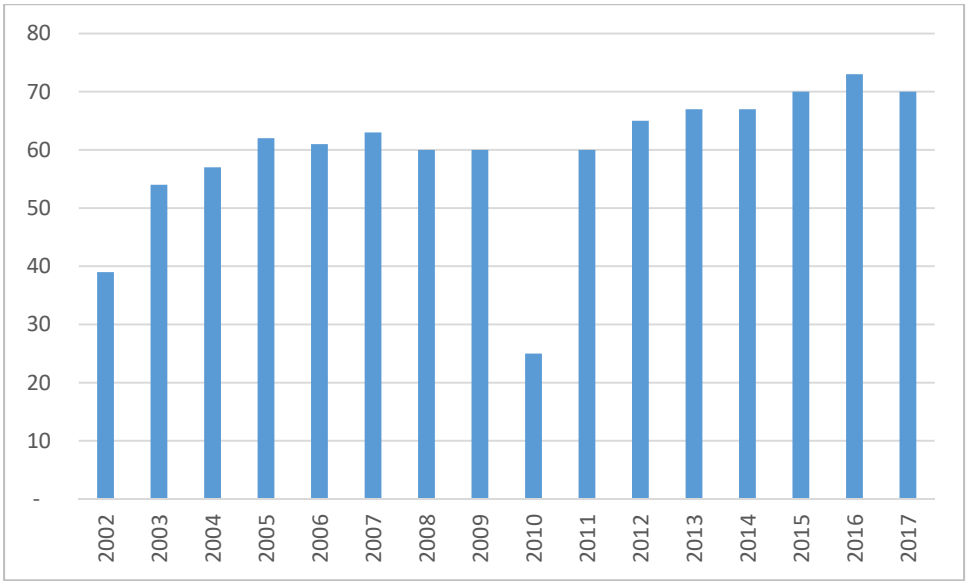
Note:
[a/]According to the Pennsylvania Department of Insurance, the 2010 data did not include information for Risk Retention Groups and Surplus Lines.

Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

The number of companies writing $1 million or more in direct premiums increased from 39 in 2002 to 70 in 2017. See Exhibit 53.

Exhibit 53

Number of Insurers Writing $1 Million or More in Direct Premium[a/]



Note:
[a/]According to the Pennsylvania Department of Insurance, the 2010 data did not include information for Risk Retention Groups and Surplus Lines.

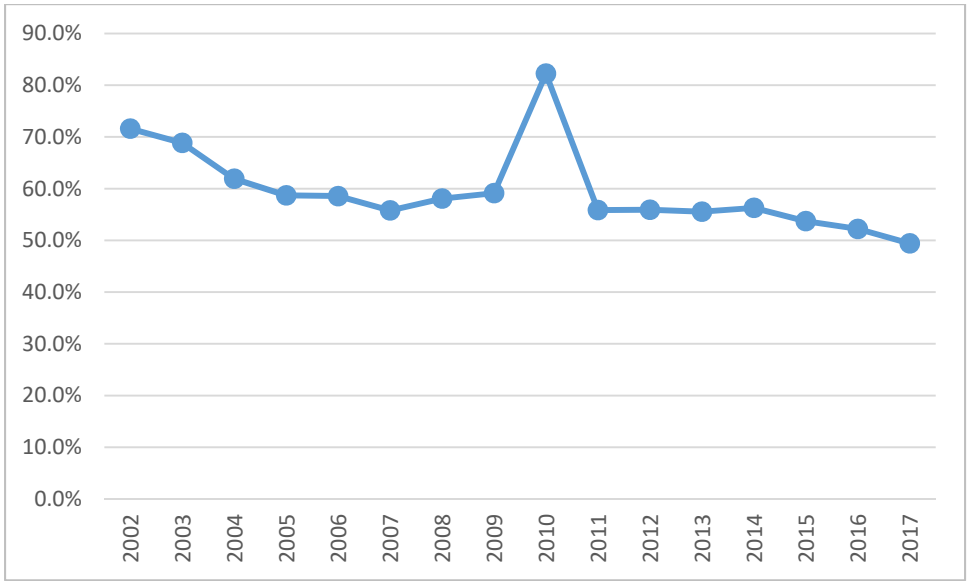
Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

The market share for the 10 largest insurance companies[121] that write medical professional liability insurance has steadily declined from a high of 71.6 percent in 2002 to 49.4 percent in 2017. See Exhibit 54.

[121] For our purposes, largest is defined as the dollar amount of direct premiums written for medical professional liability insurance.

Exhibit 54

Market Share of 10 Largest Insurers[a/]



Note:
[a/]According to the Pennsylvania Department of Insurance, the 2010 data did not include information for Risk Retention Groups and Surplus Lines.

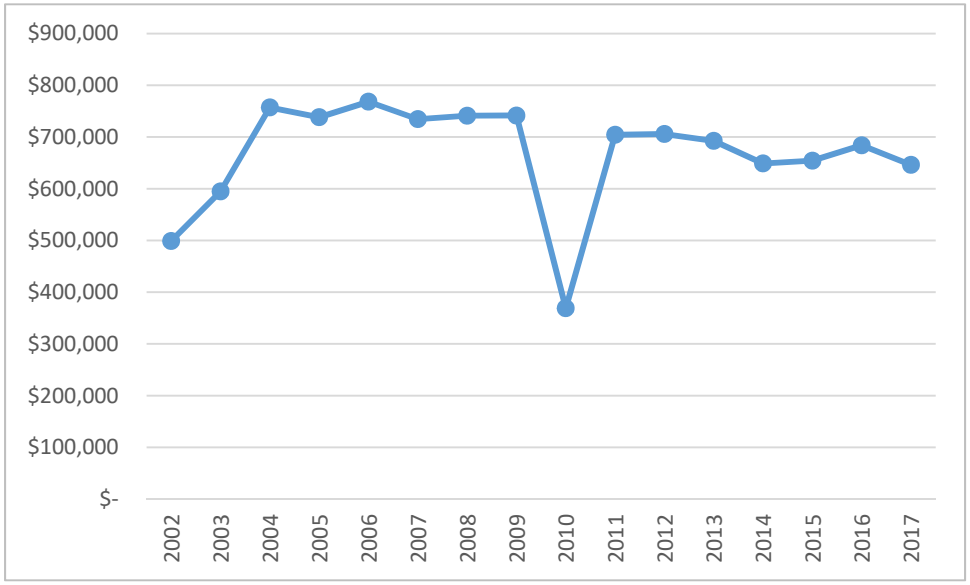
Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

The total amount of direct premiums written for medical liability insurance soared from 2002 to 2004 before entering a period of steady decline. In 2002, direct premiums written were almost $500 million. In 2004, that number peaked at $757 million, an increase of 51 percent. Beginning in 2004, direct premiums declined steadily to $654 million in 2017. See Exhibit 55.

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.

Exhibit 55

Total Direct Medical Liability Insurance Premiums[a/]



Note:
[a/]According to the Pennsylvania Department of Insurance, the 2010 data did not include information for Risk Retention Groups and Surplus Lines.

Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

Cost of Medical Professional Liability Insurance[122]

The cost of medical professional liability insurance in Pennsylvania as well as the nation as a whole, increased significantly from 1996 to its peak around 2007. Thereafter, rates decreased.

In Pennsylvania, medical professional liability insurance rates for internal medicine increased, on average by county, roughly 348 percent from 1996 to 2018. Eleven counties realized an increase of over 450 percent over the period. See Exhibit 56.

[122] Insurance 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.

Exhibit 56

Increase in Medical Professional Liability Insurance Rates by County
Internal Medicine
1996 to 2018

County	1996	2018	% Change
Adams	$2,446	$10,663	335.9%
Allegheny	2,611	10,663	308.4
Armstrong	2,446	10,663	335.9
Beaver	2,446	10,663	335.9
Bedford	2,446	10,663	335.9
Berks	2,446	10,663	335.9
Blair	2,446	10,663	335.9
Bradford	2,446	10,663	335.9
Bucks	4,506	12,424	175.7
Butler	2,446	10,663	335.9
Cambria	2,446	10,663	335.9
Cameron	2,446	10,663	335.9
Carbon	2,446	13,795	464.0
Centre	2,446	10,663	335.9
Chester	3,246	12,424	282.7
Clarion	2,446	10,663	335.9
Clearfield	2,446	10,663	335.9
Clinton	2,446	10,663	335.9
Columbia	2,446	13,795	464.0
Crawford	2,446	11,446	367.9
Cumberland	2,446	12,424	407.9
Dauphin	2,446	13,795	464.0
Delaware	5,002	14,982	199.5
Elk	2,446	10,663	335.9
Erie	2,446	11,446	367.9
Fayette	2,446	10,663	335.9
Forest	2,446	10,663	335.9
Franklin	2,446	12,424	407.9
Fulton	2,446	10,663	335.9
Greene	2,446	10,663	335.9
Huntingdon	2,446	10,663	335.9
Indiana	2,446	10,663	335.9
Jefferson	2,446	10,663	335.9
Juniata	2,446	10,663	335.9
Lackawanna	3,246	15,867	388.8

Exhibit 56 Continued

County	1996	2018	% Change
Lancaster	2,446	10,663	335.9
Lawrence	2,446	11,446	367.9
Lebanon	2,446	10,663	335.9
Lehigh	2,446	13,795	464.0
Luzerne	2,446	13,795	464.0
Lycoming	2,446	10,663	335.9
McKean	2,446	10,663	335.9
Mercer	3,246	11,446	252.6
Mifflin	2,446	10,663	335.9
Monroe	3,246	15,867	388.8
Montgomery	5,002	12,424	148.4
Montour	2,446	13,795	464.0
Northampton	2,446	13,795	464.0
Northumberland	2,446	13,795	464.0
Perry	2,446	10,663	335.9
Philadelphia	5,002	14,982	199.5
Pike	2,446	13,795	464.0
Potter	2,446	10,663	335.9
Schuylkill	4,506	15,867	252.1
Snyder	2,446	10,663	335.9
Somerset	2,446	10,663	335.9
Sullivan	2,446	10,663	335.9
Susquehanna	2,446	10,663	335.9
Tioga	2,446	10,663	335.9
Union	2,446	10,663	335.9
Venango	2,446	10,663	335.9
Warren	2,446	10,663	335.9
Washington	2,446	10,663	335.9
Wayne	2,446	13,795	464.0
Westmoreland	3,246	10,663	228.5
Wyoming	2,446	13,795	464.0
York	2,446	10,663	335.9

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Increases in medical professional liability insurance rates for general surgeons from 1996 to 2018 were less than those for internal medicine. The average general surgeon increase by county for the period was 251 percent. See Exhibit 57.

Exhibit 57

Increase in Medical Professional Liability Insurance Rates by County
General Surgeon
1996 to 2018

County	1996	2018	% Change
Adams	$11,151	$37,091	232.6%
Allegheny	11,901	37,091	211.7
Armstrong	11,151	37,091	232.6
Beaver	11,151	37,091	232.6
Bedford	11,151	37,091	232.6
Berks	11,151	37,091	232.6
Blair	11,151	37,091	232.6
Bradford	11,151	37,091	232.6
Bucks	20,541	45,460	121.3
Butler	11,151	37,091	232.6
Cambria	11,151	37,091	232.6
Cameron	11,151	37,091	232.6
Carbon	11,151	51,969	366.0
Centre	11,151	37,091	232.6
Chester	14,796	45,460	207.2
Clarion	11,151	37,091	232.6
Clearfield	11,151	37,091	232.6
Clinton	11,151	37,091	232.6
Columbia	11,151	51,969	366.0
Crawford	11,151	40,810	266.0
Cumberland	11,151	45,460	307.7
Dauphin	11,151	51,969	366.0
Delaware	22,798	57,610	152.7
Elk	11,151	37,091	232.6
Erie	11,151	40,810	266.0
Fayette	11,151	37,091	232.6
Forest	11,151	37,091	232.6
Franklin	11,151	45,460	307.7
Fulton	11,151	37,091	232.6
Greene	11,151	37,091	232.6
Huntingdon	11,151	37,091	232.6
Indiana	11,151	37,091	232.6
Jefferson	11,151	37,091	232.6
Juniata	11,151	37,091	232.6
Lackawanna	14,796	60,958	312.0

Exhibit 57 Continued

County	1996	2018	% Change
Lancaster	11,151	37,091	232.6
Lawrence	11,151	40,810	266.0
Lebanon	11,151	37,091	232.6
Lehigh	11,151	51,969	366.0
Luzerne	11,151	51,969	366.0
Lycoming	11,151	37,091	232.6
McKean	11,151	37,091	232.6
Mercer	14,796	40,810	175.8
Mifflin	11,151	37,091	232.6
Monroe	14,796	60,958	312.0
Montgomery	22,798	45,460	99.4
Montour	11,151	51,969	366.0
Northampton	11,151	51,969	366.0
Northumberland	11,151	51,969	366.0
Perry	11,151	37,091	232.6
Philadelphia	22,798	57,610	152.7
Pike	11,151	51,969	366.0
Potter	11,151	37,091	232.6
Schuylkill	20,541	60,958	196.8
Snyder	11,151	37,091	232.6
Somerset	11,151	37,091	232.6
Sullivan	11,151	37,091	232.6
Susquehanna	11,151	37,091	232.6
Tioga	11,151	37,091	232.6
Union	11,151	37,091	232.6
Venango	11,151	37,091	232.6
Warren	11,151	37,091	232.6
Washington	11,151	37,091	232.6
Wayne	11,151	51,969	366.0
Westmoreland	14,796	37,091	150.7
Wyoming	11,151	51,969	366.0
York	11,151	37,091	232.6

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Rate increases for OB/GYNS were higher than those for general surgeons. The average increase by county from 1996 to 2018 was 312 percent. See Exhibit 58.

Exhibit 58

Increase in Medical Professional Liability Insurance Rates by County
OB/GYN
1996 to 2018

County	1996	2018	% Change
Adams	$12,431	$ 48,367	289.1%
Allegheny	13,628	48,367	254.9
Armstrong	12,431	48,367	289.1
Beaver	12,431	48,367	289.1
Bedford	12,431	48,367	289.1
Berks	12,431	48,367	289.1
Blair	12,431	48,367	289.1
Bradford	12,431	48,367	289.1
Bucks	22,899	59,555	160.1
Butler	12,431	48,367	289.1
Cambria	12,431	48,367	289.1
Cameron	12,431	48,367	289.1
Carbon	12,431	68,256	449.1
Centre	12,431	48,367	289.1
Chester	16,495	59,555	261.0
Clarion	12,431	48,367	289.1
Clearfield	12,431	48,367	289.1
Clinton	12,431	48,367	289.1
Columbia	12,431	68,256	449.1
Crawford	12,431	53,339	329.1
Cumberland	12,431	59,555	379.1
Dauphin	12,431	68,256	449.1
Delaware	25,416	75,798	198.2
Elk	12,431	48,367	289.1
Erie	12,431	53,339	329.1
Fayette	12,431	48,367	289.1
Forest	12,431	48,367	289.1
Franklin	12,431	59,555	379.1
Fulton	12,431	48,367	289.1
Greene	12,431	48,367	289.1
Huntingdon	12,431	48,367	289.1
Indiana	12,431	48,367	289.1
Jefferson	12,431	48,367	289.1
Juniata	12,431	48,367	289.1
Lackawanna	16,495	80,273	386.7

Exhibit 58 Continued

County	1996	2018	% Change
Lancaster	12,431	48,367	289.1
Lawrence	12,431	53,339	329.1
Lebanon	12,431	48,367	289.1
Lehigh	12,431	68,256	449.1
Luzerne	12,431	68,256	449.1
Lycoming	12,431	48,367	289.1
McKean	12,431	48,367	289.1
Mercer	16,495	53,339	223.4
Mifflin	12,431	48,367	289.1
Monroe	16,495	80,273	386.7
Montgomery	25,416	59,555	134.3
Montour	12,431	68,256	449.1
Northampton	12,431	68,256	449.1
Northumberland	12,431	68,256	449.1
Perry	12,431	48,367	289.1
Philadelphia	25,416	75,798	198.2
Pike	12,431	68,256	449.1
Potter	12,431	48,367	289.1
Schuylkill	22,899	80,273	250.6
Snyder	12,431	48,367	289.1
Somerset	12,431	48,367	289.1
Sullivan	12,431	48,367	289.1
Susquehanna	12,431	48,367	289.1
Tioga	12,431	48,367	289.1
Union	12,431	48,367	289.1
Venango	12,431	48,367	289.1
Warren	12,431	48,367	289.1
Washington	12,431	48,367	289.1
Wayne	12,431	68,256	449.1
Westmoreland	16,495	48,367	193.2
Wyoming	12,431	68,256	449.1
York	12,431	48,367	289.1

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

From 1996, rates increased dramatically before peaking around 2007. OB/GYN rates increased the most – 462 percent over the period. See Exhibit 59, 60, and 61.

Exhibit 59

Increase in Medical Professional Liability Insurance Rates by County
Internal Medicine
1996 to 2007

County	1996	2007	% Change
Adams	$2,446	$11,923	387.4%
Allegheny	2,611	11,923	356.6
Armstrong	2,446	11,923	387.4
Beaver	2,446	11,923	387.4
Bedford	2,446	11,923	387.4
Berks	2,446	11,923	387.4
Blair	2,446	11,923	387.4
Bradford	2,446	11,923	387.4
Bucks	4,506	19,405	330.6
Butler	2,446	11,923	387.4
Cambria	2,446	11,923	387.4
Cameron	2,446	11,923	387.4
Carbon	2,446	15,664	540.4
Centre	2,446	11,923	387.4
Chester	3,246	19,405	497.8
Clarion	2,446	11,923	387.4
Clearfield	2,446	11,923	387.4
Clinton	2,446	11,923	387.4
Columbia	2,446	15,664	540.4
Crawford	2,446	11,923	387.4
Cumberland	2,446	14,729	502.2
Dauphin	2,446	14,729	502.2
Delaware	5,002	19,405	287.9
Elk	2,446	11,923	387.4
Erie	2,446	11,923	387.4
Fayette	2,446	11,923	387.4
Forest	2,446	11,923	387.4
Franklin	2,446	14,729	502.2
Fulton	2,446	11,923	387.4
Greene	2,446	11,923	387.4
Huntingdon	2,446	11,923	387.4
Indiana	2,446	11,923	387.4
Jefferson	2,446	11,923	387.4
Juniata	2,446	11,923	387.4
Lackawanna	3,246	18,470	469.0

Exhibit 59 Continued

County	1996	2007	% Change
Lancaster	2,446	11,923	387.4
Lawrence	2,446	11,923	387.4
Lebanon	2,446	11,923	387.4
Lehigh	2,446	15,664	540.4
Luzerne	2,446	15,664	540.4
Lycoming	2,446	11,923	387.4
McKean	2,446	11,923	387.4
Mercer	3,246	11,923	267.3
Mifflin	2,446	11,923	387.4
Monroe	3,246	18,470	469.0
Montgomery	5,002	19,405	287.9
Montour	2,446	15,664	540.4
Northampton	2,446	15,664	540.4
Northumberland	2,446	15,664	540.4
Perry	2,446	11,923	387.4
Philadelphia	5,002	19,405	287.9
Pike	2,446	15,664	540.4
Potter	2,446	11,923	387.4
Schuylkill	4,506	18,470	309.9
Snyder	2,446	11,923	387.4
Somerset	2,446	11,923	387.4
Sullivan	2,446	11,923	387.4
Susquehanna	2,446	11,923	387.4
Tioga	2,446	11,923	387.4
Union	2,446	11,923	387.4
Venango	2,446	11,923	387.4
Warren	2,446	11,923	387.4
Washington	2,446	11,923	387.4
Wayne	2,446	15,664	540.4
Westmoreland	3,246	11,923	267.3
Wyoming	2,446	15,664	540.4
York	2,446	11,923	387.4

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 60

Increase in Medical Professional Liability Insurance Rates by County
General Surgeon
1996 to 2007

County	1996	2007	% Change
Adams	$11,151	$51,443	361.3%
Allegheny	11,901	51,443	332.3
Armstrong	11,151	51,443	361.3
Beaver	11,151	51,443	361.3
Bedford	11,151	51,443	361.3
Berks	11,151	51,443	361.3
Blair	11,151	51,443	361.3
Bradford	11,151	51,443	361.3
Bucks	20,541	89,976	338.0
Butler	11,151	51,443	361.3
Cambria	11,151	51,443	361.3
Cameron	11,151	51,443	361.3
Carbon	11,151	70,710	534.1
Centre	11,151	51,443	361.3
Chester	14,796	89,976	508.1
Clarion	11,151	51,443	361.3
Clearfield	11,151	51,443	361.3
Clinton	11,151	51,443	361.3
Columbia	11,151	70,710	534.1
Crawford	11,151	51,443	361.3
Cumberland	11,151	65,894	490.9
Dauphin	11,151	65,894	490.9
Delaware	22,798	89,976	294.7
Elk	11,151	51,443	361.3
Erie	11,151	51,443	361.3
Fayette	11,151	51,443	361.3
Forest	11,151	51,443	361.3
Franklin	11,151	65,894	490.9
Fulton	11,151	51,443	361.3
Greene	11,151	51,443	361.3
Huntingdon	11,151	51,443	361.3
Indiana	11,151	51,443	361.3
Jefferson	11,151	51,443	361.3
Juniata	11,151	51,443	361.3
Lackawanna	14,796	85,161	475.6

Exhibit 60 Continued

County	1996	2007	% Change
Lancaster	11,151	51,443	361.3
Lawrence	11,151	51,443	361.3
Lebanon	11,151	51,443	361.3
Lehigh	11,151	70,710	534.1
Luzerne	11,151	70,710	534.1
Lycoming	11,151	51,443	361.3
McKean	11,151	51,443	361.3
Mercer	14,796	51,443	247.7
Mifflin	11,151	51,443	361.3
Monroe	14,796	85,161	475.6
Montgomery	22,798	89,976	294.7
Montour	11,151	70,710	534.1
Northampton	11,151	70,710	534.1
Northumberland	11,151	70,710	534.1
Perry	11,151	51,443	361.3
Philadelphia	22,798	89,976	294.7
Pike	11,151	70,710	534.1
Potter	11,151	51,443	361.3
Schuylkill	20,541	85,161	314.6
Snyder	11,151	51,443	361.3
Somerset	11,151	51,443	361.3
Sullivan	11,151	51,443	361.3
Susquehanna	11,151	51,443	361.3
Tioga	11,151	51,443	361.3
Union	11,151	51,443	361.3
Venango	11,151	51,443	361.3
Warren	11,151	51,443	361.3
Washington	11,151	51,443	361.3
Wayne	11,151	70,710	534.1
Westmoreland	14,796	51,443	247.7
Wyoming	11,151	70,710	534.1
York	11,151	51,443	361.3

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 61

Increase in Medical Professional Liability Insurance Rates by County
OB/GYN
1996 to 2007

County	1996	2007	% Change
Adams	$12,431	65,728	428.7%
Allegheny	13,628	65,728	382.3
Armstrong	12,431	65,728	428.7
Beaver	12,431	65,728	428.7
Bedford	12,431	65,728	428.7
Berks	12,431	65,728	428.7
Blair	12,431	65,728	428.7
Bradford	12,431	65,728	428.7
Bucks	22,899	115,483	404.3
Butler	12,431	65,728	428.7
Cambria	12,431	65,728	428.7
Cameron	12,431	65,728	428.7
Carbon	12,431	90,266	626.1
Centre	12,431	65,728	428.7
Chester	16,495	115,483	600.1
Clarion	12,431	65,728	428.7
Clearfield	12,431	65,728	428.7
Clinton	12,431	65,728	428.7
Columbia	12,431	90,266	626.1
Crawford	12,431	65,728	428.7
Cumberland	12,431	84,388	578.9
Dauphin	12,431	84,388	578.9
Delaware	25,416	115,483	354.4
Elk	12,431	65,728	428.7
Erie	12,431	65,728	428.7
Fayette	12,431	65,728	428.7
Forest	12,431	65,728	428.7
Franklin	12,431	84,388	578.9
Fulton	12,431	65,728	428.7
Greene	12,431	65,728	428.7
Huntingdon	12,431	65,728	428.7
Indiana	12,431	65,728	428.7
Jefferson	12,431	65,728	428.7
Juniata	12,431	65,728	428.7
Lackawanna	16,495	109,266	562.4

Exhibit 61 Continued

County	1996	2007	% Change
Lancaster	12,431	65,728	428.7
Lawrence	12,431	65,728	428.7
Lebanon	12,431	65,728	428.7
Lehigh	12,431	90,266	626.1
Luzerne	12,431	90,266	626.1
Lycoming	12,431	65,728	428.7
McKean	12,431	65,728	428.7
Mercer	16,495	65,728	298.5
Mifflin	12,431	65,728	428.7
Monroe	16,495	109,266	562.4
Montgomery	25,416	115,483	354.4
Montour	12,431	90,266	626.1
Northampton	12,431	90,266	626.1
Northumberland	12,431	90,266	626.1
Perry	12,431	65,728	428.7
Philadelphia	25,416	115,483	354.4
Pike	12,431	90,266	626.1
Potter	12,431	65,728	428.7
Schuylkill	22,899	109,266	377.2
Snyder	12,431	65,728	428.7
Somerset	12,431	65,728	428.7
Sullivan	12,431	65,728	428.7
Susquehanna	12,431	65,728	428.7
Tioga	12,431	65,728	428.7
Union	12,431	65,728	428.7
Venango	12,431	65,728	428.7
Warren	12,431	65,728	428.7
Washington	12,431	65,728	428.7
Wayne	12,431	90,266	626.1
Westmoreland	16,495	65,728	298.5
Wyoming	12,431	90,266	626.1
York	12,431	65,728	428.7

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Beginning in 2007, medical professional liability rates began to decline across the specialty types we reviewed. The average decline by county for general surgeons was the largest at 29. See Exhibit 62, 63, and 64.

Exhibit 62

Change in Medical Professional Liability Insurance Rates by County
Internal Medicine
2007 to 2018

County	2007	2018	% Change
Adams	$11,923	$10,663	-10.6%
Allegheny	11,923	10,663	-10.6
Armstrong	11,923	10,663	-10.6
Beaver	11,923	10,663	-10.6
Bedford	11,923	10,663	-10.6
Berks	11,923	10,663	-10.6
Blair	11,923	10,663	-10.6
Bradford	11,923	10,663	-10.6
Bucks	19,405	12,424	-36.0
Butler	11,923	10,663	-10.6
Cambria	11,923	10,663	-10.6
Cameron	11,923	10,663	-10.6
Carbon	15,664	13,795	-11.9
Centre	11,923	10,663	-10.6
Chester	19,405	12,424	-36.0
Clarion	11,923	10,663	-10.6
Clearfield	11,923	10,663	-10.6
Clinton	11,923	10,663	-10.6
Columbia	15,664	13,795	-11.9
Crawford	11,923	11,446	-4.0
Cumberland	14,729	12,424	-15.6
Dauphin	14,729	13,795	-6.3
Delaware	19,405	14,982	-22.8
Elk	11,923	10,663	-10.6
Erie	11,923	11,446	-4.0
Fayette	11,923	10,663	-10.6
Forest	11,923	10,663	-10.6
Franklin	14,729	12,424	-15.6
Fulton	11,923	10,663	-10.6%
Greene	11,923	10,663	-10.6
Huntingdon	11,923	10,663	-10.6
Indiana	11,923	10,663	-10.6
Jefferson	11,923	10,663	-10.6
Juniata	11,923	10,663	-10.6
Lackawanna	18,470	15,867	-14.1

Exhibit 62 Continued

County	2007	2018	% Change
Lancaster	$11,923	10,663	-10.6
Lawrence	11,923	11,446	-4.0
Lebanon	11,923	10,663	-10.6
Lehigh	15,664	13,795	-11.9
Luzerne	15,664	13,795	-11.9
Lycoming	11,923	10,663	-10.6
McKean	11,923	10,663	-10.6
Mercer	11,923	11,446	-4.0
Mifflin	11,923	10,663	-10.6
Monroe	18,470	15,867	-14.1
Montgomery	19,405	12,424	-36.0
Montour	15,664	13,795	-11.9
Northampton	15,664	13,795	-11.9
Northumberland	15,664	13,795	-11.9
Perry	11,923	10,663	-10.6
Philadelphia	19,405	14,982	-22.8
Pike	15,664	13,795	-11.9
Potter	11,923	10,663	-10.6
Schuylkill	18,470	15,867	-14.1
Snyder	11,923	10,663	-10.6
Somerset	11,923	10,663	-10.6
Sullivan	11,923	10,663	-10.6
Susquehanna	11,923	10,663	-10.6
Tioga	11,923	10,663	-10.6
Union	11,923	10,663	-10.6
Venango	11,923	10,663	-10.6
Warren	11,923	10,663	-10.6
Washington	11,923	10,663	-10.6
Wayne	15,664	13,795	-11.9
Westmoreland	11,923	10,663	-10.6
Wyoming	15,664	13,795	-11.9
York	11,923	10,663	-10.6

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 63

Change in Medical Professional Liability Insurance Rates by County
General Surgery
2007 to 2018

County	2007	2018	% Change
Adams	$51,443	$37,091	-27.9%
Allegheny	51,443	37,091	-27.9
Armstrong	51,443	37,091	-27.9
Beaver	51,443	37,091	-27.9
Bedford	51,443	37,091	-27.9
Berks	51,443	37,091	-27.9
Blair	51,443	37,091	-27.9
Bradford	51,443	37,091	-27.9
Bucks	89,976	45,460	-49.5
Butler	51,443	37,091	-27.9
Cambria	51,443	37,091	-27.9
Cameron	51,443	37,091	-27.9
Carbon	70,710	51,969	-26.5
Centre	51,443	37,091	-27.9
Chester	89,976	45,460	-49.5
Clarion	51,443	37,091	-27.9
Clearfield	51,443	37,091	-27.9
Clinton	51,443	37,091	-27.9
Columbia	70,710	51,969	-26.5
Crawford	51,443	40,810	-20.7
Cumberland	65,894	45,460	-31.0
Dauphin	65,894	51,969	-21.1
Delaware	89,976	57,610	-36.0
Elk	51,443	37,091	-27.9
Erie	51,443	40,810	-20.7
Fayette	51,443	37,091	-27.9
Forest	51,443	37,091	-27.9
Franklin	65,894	45,460	-31.0
Fulton	51,443	37,091	-27.9
Greene	51,443	37,091	-27.9
Huntingdon	51,443	37,091	-27.9
Indiana	51,443	37,091	-27.9
Jefferson	51,443	37,091	-27.9
Juniata	51,443	37,091	-27.9
Lackawanna	85,161	60,958	-28.4

Exhibit 63 Continued

County	2007	2018	% Change
Lancaster	$51,443	37,091	-27.9
Lawrence	51,443	40,810	-20.7
Lebanon	51,443	37,091	-27.9
Lehigh	70,710	51,969	-26.5
Luzerne	70,710	51,969	-26.5
Lycoming	51,443	37,091	-27.9
McKean	51,443	37,091	-27.9
Mercer	51,443	40,810	-20.7
Mifflin	51,443	37,091	-27.9
Monroe	85,161	60,958	-28.4
Montgomery	89,976	45,460	-49.5
Montour	70,710	51,969	-26.5
Northampton	70,710	51,969	-26.5
Northumberland	70,710	51,969	-26.5
Perry	51,443	37,091	-27.9
Philadelphia	89,976	57,610	-36.0
Pike	70,710	51,969	-26.5
Potter	51,443	37,091	-27.9
Schuylkill	85,161	60,958	-28.4
Snyder	51,443	37,091	-27.9
Somerset	51,443	37,091	-27.9
Sullivan	51,443	37,091	-27.9
Susquehanna	51,443	37,091	-27.9
Tioga	51,443	37,091	-27.9
Union	51,443	37,091	-27.9
Venango	51,443	37,091	-27.9
Warren	51,443	37,091	-27.9
Washington	51,443	37,091	-27.9
Wayne	70,710	51,969	-26.5
Westmoreland	51,443	37,091	-27.9
Wyoming	70,710	51,969	-26.5
York	51,443	37,091	-27.9

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 64

Change in Medical Professional Liability Insurance Rates by County
OB/GYN
2007 to 2018

County	2007	2018	% Change
Adams	$65,728	$48,367	-26.4%
Allegheny	65,728	48,367	-26.4
Armstrong	65,728	48,367	-26.4
Beaver	65,728	48,367	-26.4
Bedford	65,728	48,367	-26.4
Berks	65,728	48,367	-26.4
Blair	65,728	48,367	-26.4
Bradford	65,728	48,367	-26.4
Bucks	115,483	59,555	-48.4
Butler	65,728	48,367	-26.4
Cambria	65,728	48,367	-26.4
Cameron	65,728	48,367	-26.4
Carbon	90,266	68,256	-24.4
Centre	65,728	48,367	-26.4
Chester	115,483	59,555	-48.4
Clarion	65,728	48,367	-26.4
Clearfield	65,728	48,367	-26.4
Clinton	65,728	48,367	-26.4
Columbia	90,266	68,256	-24.4
Crawford	65,728	53,339	-18.8
Cumberland	84,388	59,555	-29.4
Dauphin	84,388	68,256	-19.1
Delaware	115,483	75,798	-34.4
Elk	65,728	48,367	-26.4
Erie	65,728	53,339	-18.8
Fayette	65,728	48,367	-26.4
Forest	65,728	48,367	-26.4
Franklin	84,388	59,555	-29.4
Fulton	65,728	48,367	-26.4
Greene	65,728	48,367	-26.4
Huntingdon	65,728	48,367	-26.4
Indiana	65,728	48,367	-26.4
Jefferson	65,728	48,367	-26.4
Juniata	65,728	48,367	-26.4
Lackawanna	109,266	80,273	-26.5

Exhibit 64 Continued

County	2007	2018	% Change
Lancaster	65,728	$48,367	-26.4
Lawrence	65,728	53,339	-18.8
Lebanon	65,728	48,367	-26.4
Lehigh	90,266	68,256	-24.4
Luzerne	90,266	68,256	-24.4
Lycoming	65,728	48,367	-26.4
McKean	65,728	48,367	-26.4
Mercer	65,728	53,339	-18.8
Mifflin	65,728	48,367	-26.4
Monroe	109,266	80,273	-26.5
Montgomery	115,483	59,555	-48.4
Montour	90,266	68,256	-24.4
Northampton	90,266	68,256	-24.4
Northumberland	90,266	68,256	-24.4
Perry	65,728	48,367	-26.4
Philadelphia	115,483	75,798	-34.4
Pike	90,266	68,256	-24.4
Potter	65,728	48,367	-26.4
Schuylkill	109,266	80,273	-26.5
Snyder	65,728	48,367	-26.4
Somerset	65,728	48,367	-26.4
Sullivan	65,728	48,367	-26.4
Susquehanna	65,728	48,367	-26.4
Tioga	65,728	48,367	-26.4
Union	65,728	48,367	-26.4
Venango	65,728	48,367	-26.4
Warren	65,728	48,367	-26.4
Washington	65,728	48,367	-26.4
Wayne	90,266	68,256	-24.4
Westmoreland	65,728	48,367	-26.4
Wyoming	90,266	68,256	-24.4
York	65,728	48,367	-26.4

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Significant changes to the law regulating medical professional liability insurance were enacted in 2003. However, rates continued to rise as shown by the smaller decline in rates over the full period of 2003 to 2018 than from 2007 to 2018. Rates for those doctors practicing internal medicine increased by 9 percent from 2003 to 2018. However, rates for

general surgeons and OB/GYNs declined by 15 percent and 13 percent respectively. See Exhibits 65, 66, and 67.

Exhibit 65

Change in Medical Professional Liability Insurance Rates by Specialty Internal Medicine 2003 to 2018

County	2003	2018	% Change
Adams	$9,542	$10,663	11.7%
Allegheny	9,542	10,663	11.7
Armstrong	9,542	10,663	11.7
Beaver	9,542	10,663	11.7
Bedford	9,542	10,663	11.7
Berks	9,542	10,663	11.7
Blair	9,542	10,663	11.7
Bradford	9,542	10,663	11.7
Bucks	15,903	12,424	-21.9
Butler	9,542	10,663	11.7
Cambria	9,542	10,663	11.7
Cameron	9,542	10,663	11.7
Carbon	12,722	13,795	8.4
Centre	9,542	10,663	11.7
Chester	15,903	12,424	-21.9
Clarion	9,542	10,663	11.7
Clearfield	9,542	10,663	11.7
Clinton	9,542	10,663	11.7
Columbia	12,722	13,795	8.4
Crawford	9,542	11,446	20.0
Cumberland	11,927	12,424	4.2
Dauphin	11,927	13,795	15.7
Delaware	15,903	14,982	-5.8
Elk	9,542	10,663	11.7
Erie	9,542	11,446	20.0
Fayette	9,542	10,663	11.7
Forest	9,542	10,663	11.7
Franklin	11,927	12,424	4.2
Fulton	9,542	10,663	11.7
Greene	9,542	10,663	11.7
Huntingdon	9,542	10,663	11.7
Indiana	9,542	10,663	11.7

Exhibit 65 Continued

County	2003	2018	% Change
Jefferson	$9,542	$10,663	11.7
Juniata	9,542	10,663	11.7
Lackawanna	15,108	15,867	5.0
Lancaster	9,542	10,663	11.7
Lawrence	9,542	11,446	20.0
Lebanon	9,542	10,663	11.7
Lehigh	12,722	13,795	8.4
Luzerne	12,722	13,795	8.4
Lycoming	9,542	10,663	11.7
McKean	9,542	10,663	11.7
Mercer	9,542	11,446	20.0
Mifflin	9,542	10,663	11.7
Monroe	15,108	15,867	5.0
Montgomery	15,903	12,424	-21.9
Montour	12,722	13,795	8.4
Northampton	12,722	13,795	8.4
Northumberland	12,722	13,795	8.4
Perry	9,542	10,663	11.7
Philadelphia	15,903	14,982	-5.8
Pike	12,722	13,795	8.4
Potter	9,542	10,663	11.7
Schuylkill	15,108	15,867	5.0
Snyder	9,542	10,663	11.7
Somerset	9,542	10,663	11.7
Sullivan	9,542	10,663	11.7
Susquehanna	9,542	10,663	11.7
Tioga	9,542	10,663	11.7
Union	9,542	10,663	11.7
Venango	9,542	10,663	11.7
Warren	9,542	10,663	11.7
Washington	9,542	10,663	11.7
Wayne	12,722	13,795	8.4
Westmoreland	9,542	10,663	11.7
Wyoming	12,722	13,795	8.4
York	9,542	10,663	11.7

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 66

Change in Medical Professional Liability Insurance Rates by Specialty
General Surgeon
2003 to 2018

County	2003	2018	% Change
Adams	$43,512	$37,091	-14.8%
Allegheny	43,512	37,091	-14.8
Armstrong	43,512	37,091	-14.8
Beaver	43,512	37,091	-14.8
Bedford	43,512	37,091	-14.8
Berks	43,512	37,091	-14.8
Blair	43,512	37,091	-14.8
Bradford	43,512	37,091	-14.8
Bucks	72,518	45,460	-37.3
Butler	43,512	37,091	-14.8
Cambria	43,512	37,091	-14.8
Cameron	43,512	37,091	-14.8
Carbon	58,012	51,969	-10.4
Centre	43,512	37,091	-14.8
Chester	72,518	45,460	-37.3
Clarion	43,512	37,091	-14.8
Clearfield	43,512	37,091	-14.8
Clinton	43,512	37,091	-14.8
Columbia	58,012	51,969	-10.4
Crawford	43,512	40,810	-6.2
Cumberland	54,387	45,460	-16.4
Dauphin	54,387	51,969	-4.4
Delaware	72,518	57,610	-20.6
Elk	43,512	37,091	-14.8
Erie	43,512	40,810	-6.2
Fayette	43,512	37,091	-14.8
Forest	43,512	37,091	-14.8
Franklin	54,387	45,460	-16.4
Fulton	43,512	37,091	-14.8
Greene	43,512	37,091	-14.8
Huntingdon	43,512	37,091	-14.8
Indiana	43,512	37,091	-14.8
Jefferson	43,512	37,091	-14.8
Juniata	43,512	37,091	-14.8
Lackawanna	68,892	60,958	-11.5

Exhibit 66 Continued

County	2003	2018	% Change
Lancaster	43,512	37,091	-14.8
Lawrence	43,512	40,810	-6.2
Lebanon	43,512	37,091	-14.8
Lehigh	58,012	51,969	-10.4
Luzerne	58,012	51,969	-10.4
Lycoming	43,512	37,091	-14.8
McKean	43,512	37,091	-14.8
Mercer	43,512	40,810	-6.2
Mifflin	43,512	37,091	-14.8
Monroe	68,892	60,958	-11.5
Montgomery	72,518	45,460	-37.3
Montour	58,012	51,969	-10.4
Northampton	58,012	51,969	-10.4
Northumberland	58,012	51,969	-10.4
Perry	43,512	37,091	-14.8
Philadelphia	72,518	57,610	-20.6
Pike	58,012	51,969	-10.4
Potter	43,512	37,091	-14.8
Schuylkill	68,892	60,958	-11.5
Snyder	43,512	37,091	-14.8
Somerset	43,512	37,091	-14.8
Sullivan	43,512	37,091	-14.8
Susquehanna	43,512	37,091	-14.8
Tioga	43,512	37,091	-14.8
Union	43,512	37,091	-14.8
Venango	43,512	37,091	-14.8
Warren	43,512	37,091	-14.8
Washington	43,512	37,091	-14.8
Wayne	58,012	51,969	-10.4
Westmoreland	43,512	37,091	-14.8
Wyoming	58,012	51,969	-10.4
York	43,512	37,091	-14.8

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 67

Change in Medical Professional Liability Insurance Rates by Specialty
OB/GYN
2003 to 2018

County	2003	2018	% Change
Adams	$55,821	$48,367	-13.4%
Allegheny	55,821	48,367	-13.4
Armstrong	55,821	48,367	-13.4
Beaver	55,821	48,367	-13.4
Bedford	55,821	48,367	-13.4
Berks	55,821	48,367	-13.4
Blair	55,821	48,367	-13.4
Bradford	55,821	48,367	-13.4
Bucks	93,033	59,555	-36.0
Butler	55,821	48,367	-13.4
Cambria	55,821	48,367	-13.4
Cameron	55,821	48,367	-13.4
Carbon	74,424	68,256	-8.3
Centre	55,821	48,367	-13.4
Chester	93,033	59,555	-36.0
Clarion	55,821	48,367	-13.4
Clearfield	55,821	48,367	-13.4
Clinton	55,821	48,367	-13.4
Columbia	74,424	68,256	-8.3
Crawford	55,821	53,339	-4.4
Cumberland	69,773	59,555	-14.6
Dauphin	69,773	68,256	-2.2
Delaware	93,033	75,798	-18.5
Elk	55,821	48,367	-13.4
Erie	55,821	53,339	-4.4
Fayette	55,821	48,367	-13.4
Forest	55,821	48,367	-13.4
Franklin	69,773	59,555	-14.6
Fulton	55,821	48,367	-13.4
Greene	55,821	48,367	-13.4
Huntingdon	55,821	48,367	-13.4
Indiana	55,821	48,367	-13.4
Jefferson	55,821	48,367	-13.4
Juniata	55,821	48,367	-13.4
Lackawanna	88,382	80,273	-9.2

Exhibit 67 Continued

County	2003	2018	% Change
Lancaster	55,821	48,367	-13.4
Lawrence	55,821	53,339	-4.4
Lebanon	55,821	48,367	-13.4
Lehigh	74,424	68,256	-8.3
Luzerne	74,424	68,256	-8.3
Lycoming	55,821	48,367	-13.4
McKean	55,821	48,367	-13.4
Mercer	55,821	53,339	-4.4
Mifflin	55,821	48,367	-13.4
Monroe	88,382	80,273	-9.2
Montgomery	93,033	59,555	-36.0
Montour	74,424	68,256	-8.3
Northampton	74,424	68,256	-8.3
Northumberland	74,424	68,256	-8.3
Perry	55,821	48,367	-13.4
Philadelphia	93,033	75,798	-18.5
Pike	74,424	68,256	-8.3
Potter	55,821	48,367	-13.4
Schuylkill	88,382	80,273	-9.2
Snyder	55,821	48,367	-13.4
Somerset	55,821	48,367	-13.4
Sullivan	55,821	48,367	-13.4
Susquehanna	55,821	48,367	-13.4
Tioga	55,821	48,367	-13.4
Union	55,821	48,367	-13.4
Venango	55,821	48,367	-13.4
Warren	55,821	48,367	-13.4
Washington	55,821	48,367	-13.4
Wayne	74,424	68,256	-8.3
Westmoreland	55,821	48,367	-13.4
Wyoming	74,424	68,256	-8.3
York	55,821	48,367	-13.4

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Affordability of Medical Professional Liability Insurance

Affordability is a difficult term to define. What one person finds to be an acceptable and affordable price for a good or service may not be considered acceptable and affordable to another. We chose two methods to deal with this issue. First, the data can show us whether or not the price for medical professional liability insurance increased or decreased over time. The second is to compare county and specialty rates to a particular benchmark. Because Philadelphia, Allegheny, and Lackawanna counties are of particular concern to policymakers, we use those counties as our benchmark by which to compare the rates of other counties later in our analysis.

The change in the affordability of medical professional liability insurance varied depending on county and practice specialty. For example, general surgeons in Montgomery County saw the smallest increase in medical professional liability insurance rates from 1996 to 2018 at 99 percent. Doctors practicing internal medicine in eleven counties experienced an overall rate increase of 464 percent from 1996 to 2018. See Exhibit 68.

Exhibit 68

Percent Change in Medical Malpractice Rates
High/Low Comparison
1996 to 2018

County	Specialty	Change
Montgomery (low)	Internal Medicine	148.4%
See List[a/] (high)	Internal Medicine	464.0
Montgomery (low)	General Surgeon	99.4
See List [a/] (high)	General Surgeon	366.0
Montgomery (low)	OB/GYN	134.3
See List [a/] (high)	OB/GYN	449.1

[a/] Carbon, Columbia, Dauphin, Lehigh, Luzerne, Montour, Northampton, Northumberland, Pike, Wayne, and Wyoming Counties.

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

As previously noted, the years 1996 to 2007 saw significant increases in medical professional lability insurance in Pennsylvania. The most dramatic increase was for Internal Medicine in ten counties where rates increased 626 percent over the period. The smallest increase in rates took place in Mercer and Westmorland Counties for general surgeons – 248 percent. See Exhibit 69.

Exhibit 69

Percent Change in Medical Malpractice Rates
High/Low Comparison
1996 to 2007

County	Specialty	Change
Mercer & Westmorland(low)	Internal Medicine	267.3%
See List [a/] (high)	Internal Medicine	540.4
Mercer & Westmorland(low)	General Surgeon	247.7
See List [a/] (high)	General Surgeon	534.1
Mercer & Westmorland (low)	OB/GYN	298.5
See List [a/] (high)	OB/GYN	626.1

[a/]Carbon, Columbia, Lehigh, Luzerne, Montour, Northampton, Northumberland, Pike, Wayne, and Wyoming Counties

Source: Developed by LBFC using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Post 2007, rates began to decline. However, as in previous periods, the rate of decline was not shared equally across Pennsylvania's counties or medical specialties. Bucks, Chester, and Montgomery Montgomery County general surgeons realized the largest decrease in rates (50 percent) while Crawford, Erie, Lawrence, and Mercer County doctors practicing internal medicine only saw declines of 4 percent over the period. See Exhibit 70.

Exhibit 70

Percent Change in Medical Malpractice Rates
High/Low Comparison
2007 to 2018

County	Specialty	Change
See List [a/] (low)	Internal Medicine	-36.0%
See List [b/] (high)	Internal Medicine	-4.0
See List [a/] (low)	General Surgeon	-49.5
See List [b/] (high)	General Surgeon	-20.7
See List [a/] (low)	OB/GYN	-30.5
See List [b/] (high)	OB/GYN	-48.4

[a/] Bucks, Chester, and Montgomery Counties.
[b/] Crawford, Erie, Lawrence, and Mercer Counties.

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

The time period from 2003, the year significant changes to Pennsylvania's laws regarding medical professional liability insurance were made, through 2018 also show a disparate impact among counties and physician specialties. For example, general surgeons in Bucks, Chester, and Montgomery Counties saw their rates decline by 37 percent during the period, while doctors practicing internal medicine in Crawford, Erie, Lawrence, and Mercer Counties saw their rates increase by 20 percent over the same period. See Exhibit 71.

Exhibit 71

Percent Change in Medical Malpractice Rates
High/Low Comparison
2003 to 2018

County	Specialty	Change
See List[a/] (low)	Internal Medicine	-21.9%
See List[b/] (high)	Internal Medicine	20.0
See List[a/] (low)	General Surgeon	-37.3
Dauphin (high)	General Surgeon	-4.4
See List[a/] (low)	OB/GYN	-36.0
Dauphin (high)	OB/GYN	-2.2

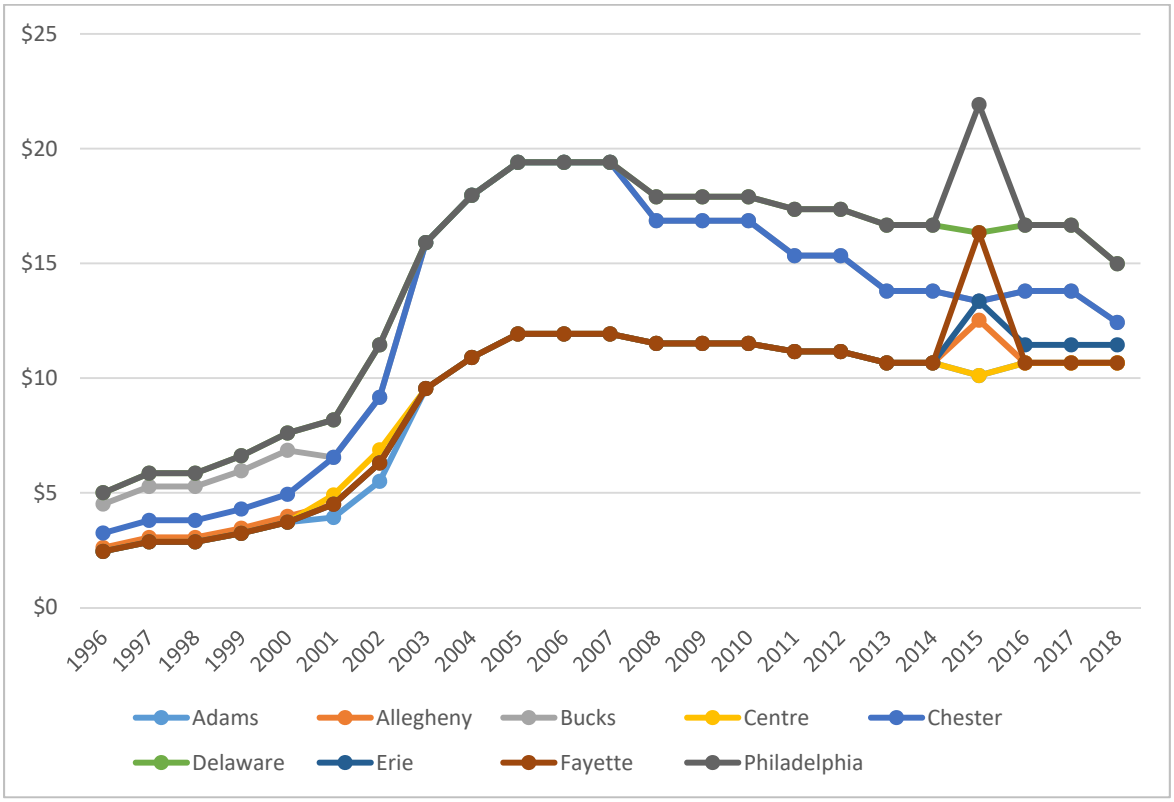
[a/] Bucks, Chester, and Montgomery Counties
[b/] Crawford, Erie, Lawrence, and Mercer Counties

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

As previously noted, the cost of medical professional liability insurance in Pennsylvania differs based on the risk profile of the county. See Exhibits 72, 73, and 74 for examples from various counties across the Commonwealth.

Exhibit 72

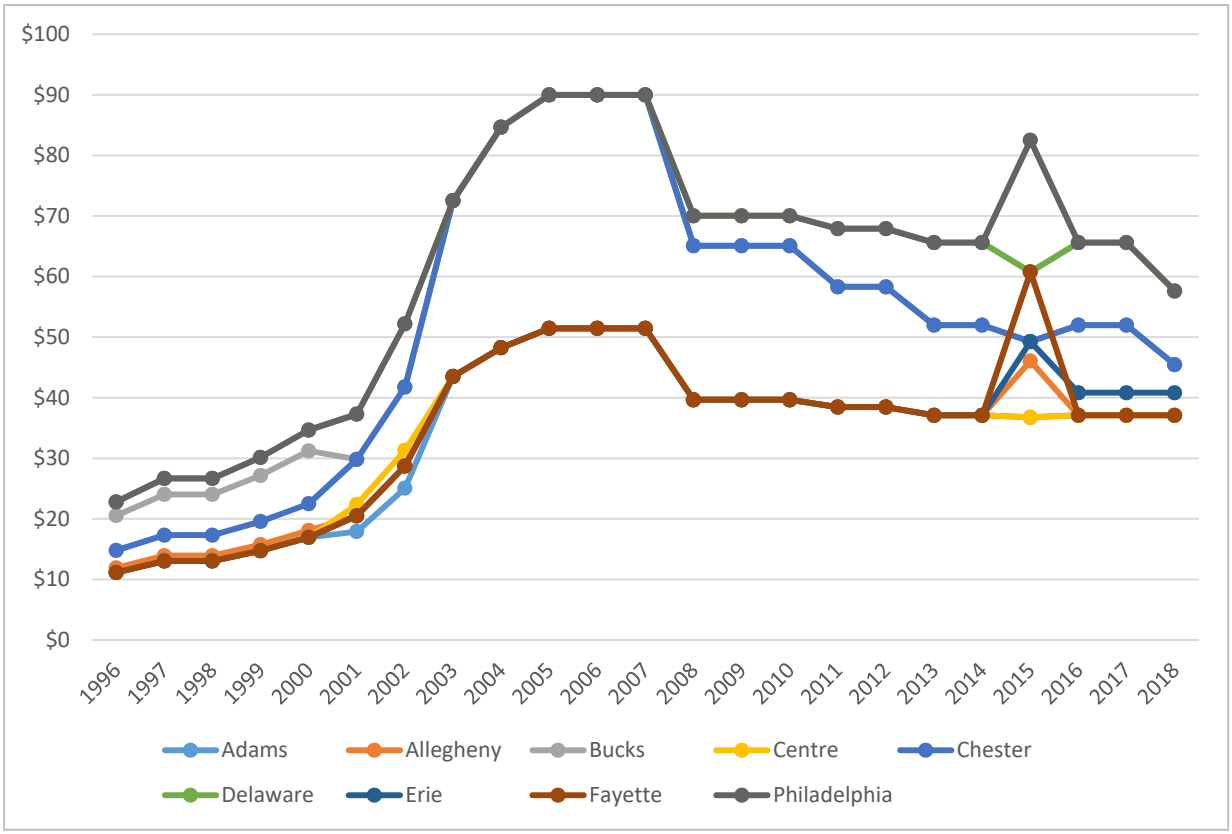
Insurance Rates for Selected Counties Internal Medicine
1996 to 2018
(000)



Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 73

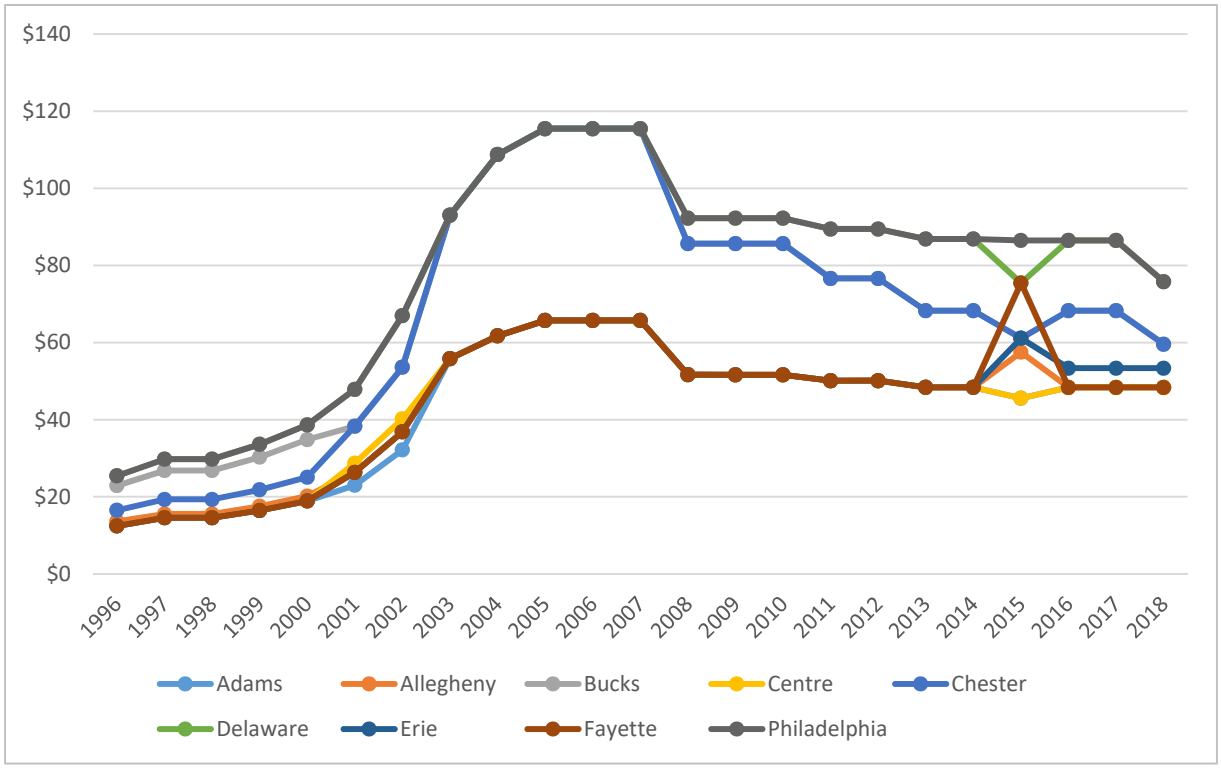
Insurance Rates for Selected Counties General Surgery
1996 to 2018
(000)



Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 74

Insurance Rates for Selected Counties OB/GYN
1996 to 2018
(000)



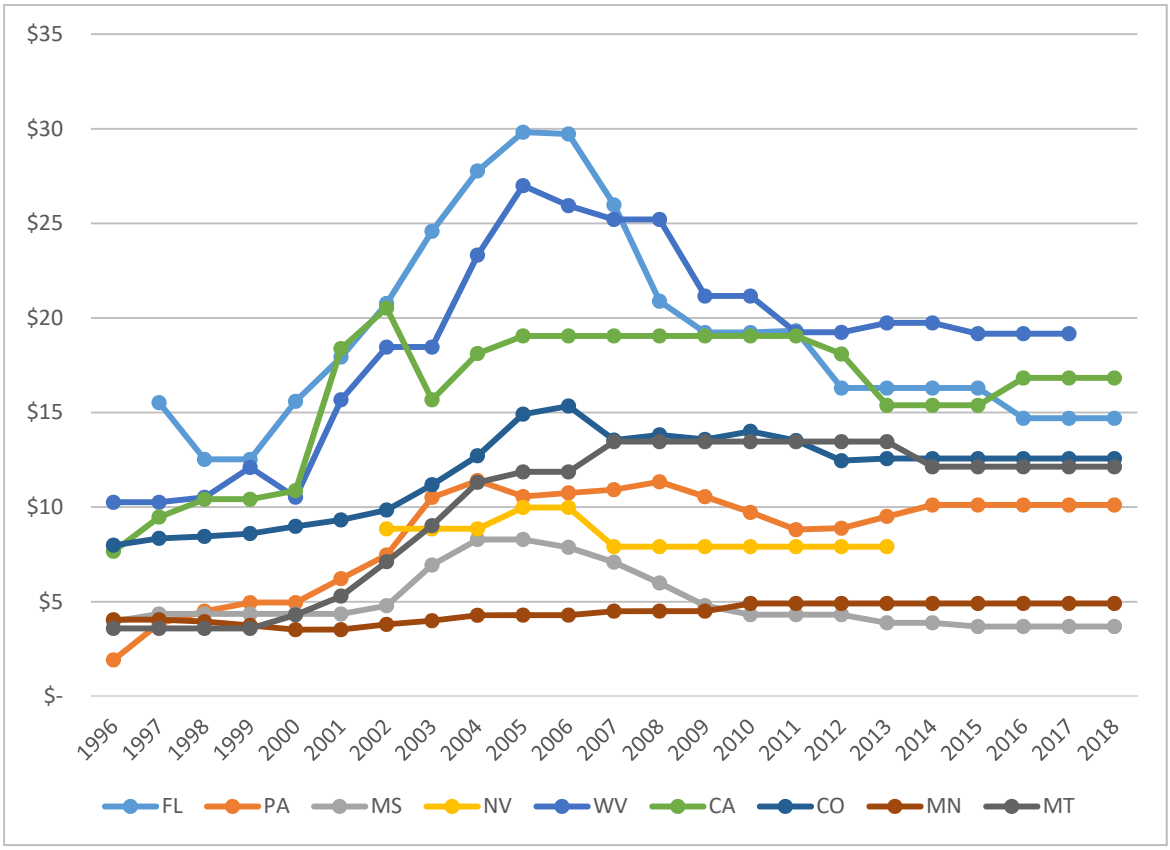
Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

As shown by the Exhibits, although the cost of insurance may differ from county to county and specialty to specialty, the general trend is remarkably similar. The same holds true for other states.

We also compared *Medical Liability Monitor* data from eight other states – Florida, Mississippi, Nevada, West Virginia, California, Colorado, Minnesota, and Montana. We chose these states based on a Federal Government Accountability Office study from 2003 entitled *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium* Rates. As shown on Exhibits 75, 76, and 77, the trend across the country is that rates increased fairly dramatically until 2005, 2006, or 2007 depending on the state, and then began to decline.

Exhibit 75

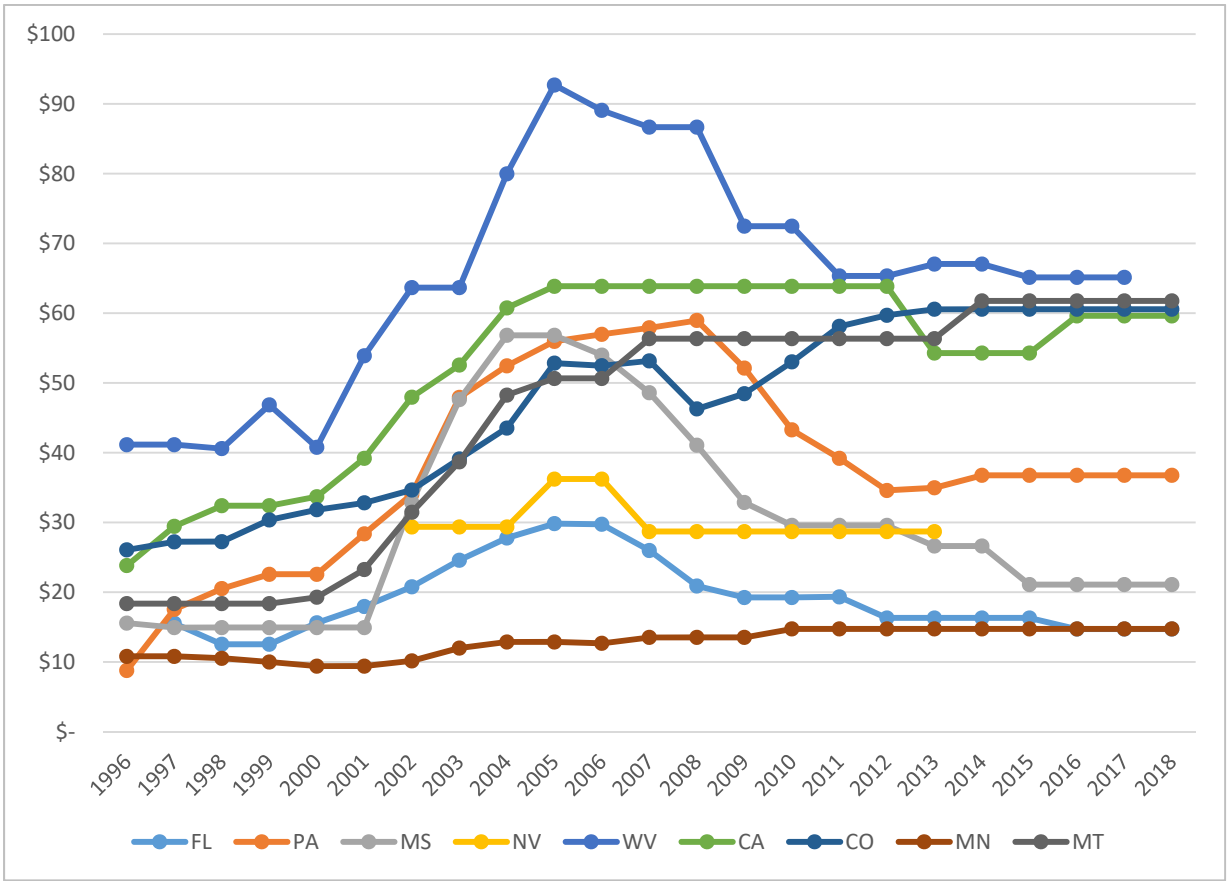
Trend in Insurance Rates for Selected States Internal Medicine
1996 to 2018
(000)



Source: Developed by LBFC staff from information provided by the *Medical Liability Monitor*.

Exhibit 76

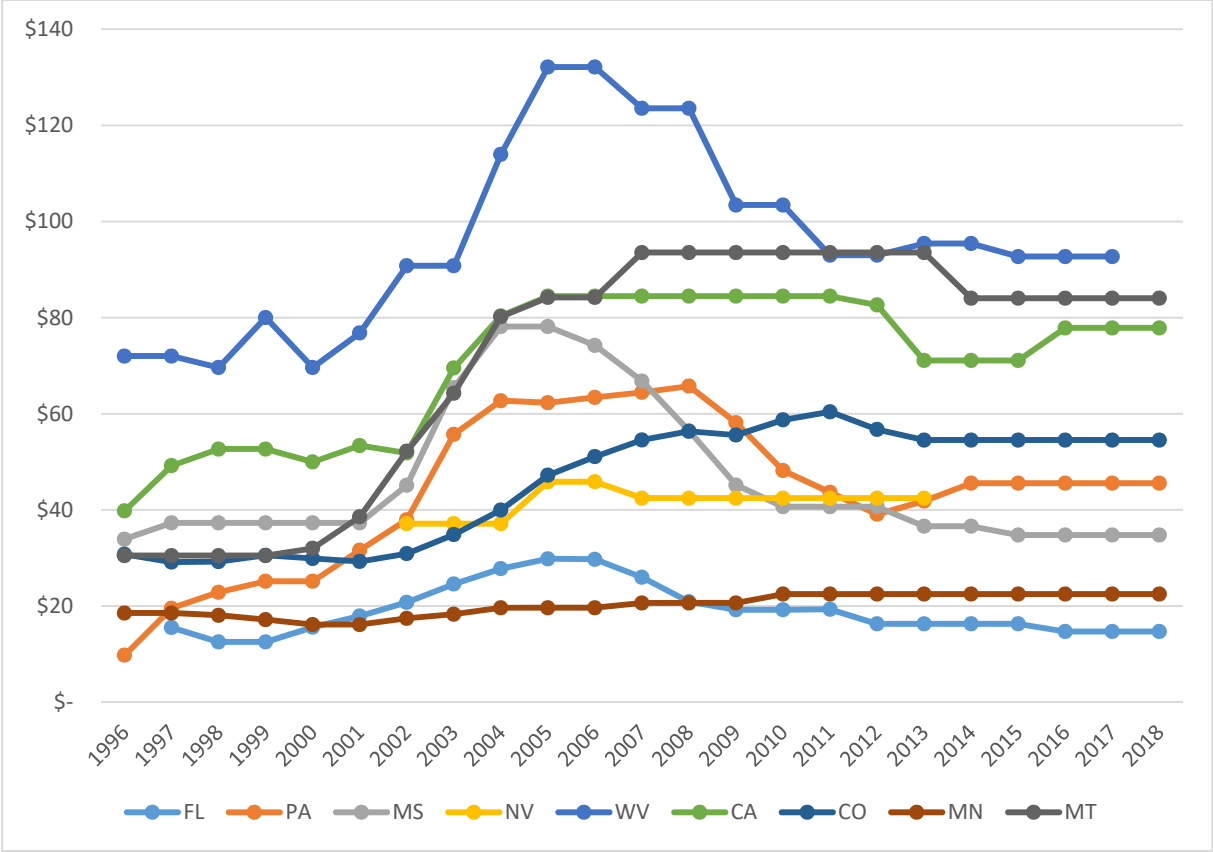
Trend in Insurance Rates for Selected States General Surgery
1996 to 2018
(000)



Source: Developed by LBFC staff from information provided by the *Medical Liability Monitor*.

Exhibit 77

Trend in Insurance Rates for Selected States OB/GYN
1996 to 2018
(000)



Source: Developed by LBFC staff from information provided by the *Medical Liability Monitor*.

Select County Rates Compared to Philadelphia, Allegheny, and Lackawanna Counties

As noted earlier, one way to measure the affordability of medical professional liability insurance is to measure the cost against a benchmark. We chose to compare the cost of insurance in certain counties to Philadelphia, Allegheny, and Lackawanna Counties. For example, in Adams County, medical professional liability insurance rates were 60 percent of the Philadelphia rate in 2003. By 2018, that increased to 64 percent. By that measure, only four counties saw their rates improve as a percentage of Philadelphia rates from 2003 to 2018 and 2008 to 2018 – Bucks, Chester, Delaware, and Montgomery. See Appendix G.

One concern of policymakers is that as medicine has become regionalized, doctors and hospitals will be drawn into the Philadelphia, Allegheny or Lackawanna court systems if a hospital system has a footprint in several counties.

For example, in 1996 hospital systems in Philadelphia had a presence in Clarion, Centre, Franklin, Lehigh, Montgomery, and Delaware Counties. Exhibit 78 shows three counties of concern to various stakeholders that had a hospital system with presence in other counties.

Exhibit 78

Select Counties with Hospital Systems in Multiple Counties
1996

Health System Headquarter Counties	Counties with Health Systems Tied to Headquarter County	
Philadelphia	Clarion	Centre
	Franklin	Lehigh
	Montgomery	Delaware
Allegheny	Beaver	Erie
	Blair	Centre
	Cumberland	York
Lackawanna	Luzerne	

Source: Developed by LBFC Staff

To determine the change in affordability of medical malpractice insurance and how closely tied these counties are to either Philadelphia, Allegheny, or Lackawanna counties, we calculated the OB/GYN premium for the counties shown in Exhibit 79 above as a percent of the premium for those counties of concern to policymakers. For example, in 1996, the Centre County medical malpractice premium for an OB/GYN was $12,431. The premium for an OB/GYN in Philadelphia was $25,416. Therefore, the Centre County premium in 1996 was 49 percent of the Philadelphia rate. The results of our calculations for 1996, 2003, and 2018 are in Exhibit 79.

The results show that for Centre, Clarion, Franklin, and Lehigh Counties, rates were less affordable as compared to Philadelphia in 2018 than they were in 1996 – although their rates did decline from 2003 to 2018.

That said, as a percentage of the Philadelphia rate, all four counties experienced premiums more closely tied to Philadelphia. In fact, four counties, Centre, Clarion, Franklin, and Lehigh saw their rates become more closely aligned with the Philadelphia rate post 2003. Montgomery

County experienced a small decoupling of rates, while Delaware County realized no change.

Exhibit 79

Select County Rates as a Percentage of Philadelphia Medical Malpractice Rate (OB/GYN)

County	1996	2003	2018
Centre	48.9%	60.0%	63.81%
Clarion	48.9	60.0	63.81
Delaware	100.0	100.0	100.0
Franklin	48.9	75.0	78.6
Lehigh	48.9	80.0	90.05
Montgomery	100.0	100.0	78.6

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

For counties that have medical systems tied to Allegheny County, the results are similar. For Beaver, Blair, Centre, Cumberland, Erie, and York Counties, OB/GYN rates either became more closely aligned to Allegheny County rates or exceeded them. See Exhibit 80.

Exhibit 80

Select County Rates as a Percentage of Allegheny Medical Malpractice Rate(OB/GYN)

County	1996	2003	2018
Beaver	91.22%	100.0%	100.0%
Blair	91.22	100.0	100.0
Centre	91.22	100.0	100.0
Cumberland	91.22	124.9	141.1
Erie	91.22	100.0	110.3
York	91.22	100.0	100.0

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Hospital systems in Lackawanna County were only present in one additional county in 1996 – Luzerne County. Again, OB/GYN rates in Luzerne County increased as a percentage of the Lackawanna County OB/GYN medical malpractice rate. See Exhibit 81

Exhibit 81

Select County Rates as a Percentage of Lackawanna Medical Malpractice Rate (OB/GYN)

County	1996	2003	2018
Luzerne	75.4%	84.2%	85.0%

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

By 2002, hospital systems in Philadelphia, Allegheny, and Lackawanna Counties had continued to expand into additional counties. For example, hospital systems in Philadelphia expanded to Lancaster, Berks, and Chester Counties. See Exhibit 82.

Exhibit 82

Additional Select Counties with Hospital Systems in Multiple Counties 2002

Health System Headquarter Counties	Counties with Health Systems Tied to Headquarter County	
Philadelphia	Lancaster	Berks
	Chester	
Allegheny	Berks	Bedford
	Cambria	Mercer
	Montour	Venango
	Washington	
Lackawanna	Cambria	Montour

Source: Developed by LBFC Staff.

In Berks and Lancaster Counties, rates increased as a percentage of the Philadelphia OB/GYN rate – showing that rates post 2003 became more closely aligned. Chester County experienced a decrease in the OB/GYN rate as compared to Philadelphia, indicating a decoupling. See Exhibit 83.

Exhibit 83

Select County Rates as a Percentage of Philadelphia Medical Malpractice Rate

County	2003	2018
Berks	60.0%	63.8%
Chester	100.0	78.6
Lancaster	60.0	63.8

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

Exhibit 84 shows those counties with hospital systems in Allegheny County as well. Two counties experienced rate increases as compared to Allegheny County – Mercer and Montour – in the period after the 2003 changes. All others remained exactly aligned with the Allegheny County OB/GYN rate.

Exhibit 84

Select County Rates as a Percentage of Allegheny Medical Malpractice Rate

County	2003	2018
Berks	100.0%	100.0%
Bedford	100.0	100.0
Cambria	100.0	100.0
Mercer	100.0	110.3
Montour	133.3	141.1
Venango	100.0	100.0
Washington	100.0	100.0

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

A hospital system in Lackawanna County expanded into two additional counties by 2002. In 2003, the Cambria and Montour County OB/GYN medical malpractice rates as a percentage of the Lackawanna County rate were 63 and 84 percent respectively. By 2018, the Cambria County rate decreased as a percentage of the Lackawanna County rate and the Montour County rate increased. See Exhibit 85.

Exhibit 85

Select County Rates as a Percentage of Lackawanna Medical Malpractice Rate

County	2003	2018
Cambria	63.2%	60.3%
Montour	84.2	85.0

Source: Developed by LBFC staff using PMSLIC/NORCAL rates provided by the *Medical Liability Monitor*.

B. The Impact of the Proposed Venue Rule on the Availability, Cost, and Affordability of Medical Professional Liability Insurance

Availability

The MCARE Act requires the JUA to offer medical professional liability insurance to health care providers who cannot conveniently obtain medical professional liability insurance through ordinary methods. Therefore, regardless of whether the proposed venue rule change comes to fruition, medical professional liability insurance in Pennsylvania will continue to be offered by the JUA.

The question then becomes, will other insurance companies continue to make medical professional liability insurance available in Pennsylvania if the venue rule changes? As a practical matter, the trend in the number of insurance companies offering more than $1 million in total coverage began prior to the effects of the MCARE act being realized. Additionally, as noted earlier, isolating the effects caused by the change in the venue rule from the other changes made in the MCARE act is problematic given the number of changes made at the same time. Finally, the change in cost of medical professional liability insurance in Pennsylvania seems to follow the trend in other states indicating that national factors play a significant role.

Cost

As noted earlier, the cost of medical professional liability insurance increased significantly from 1996 to 2007. However, this is a trend that is also clearly established in other states. While it is possible that the changes in the MCARE act had an effect on the cost of insurance, given the many changes to the law, regulations, and court rules that occurred

at the same time, 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 in the same way. This is not an assumption we are comfortable making.[123]

Affordability

Affordability is a difficult term to define. As noted earlier, what two people, equally situated, are willing to pay for the same thing may differ greatly. However, we did show that medical professional liability insurance has become less expensive since 2008 – depending on the county in Pennsylvania. As noted above, the benefits of the reduction in rates were not realized equally across the state.

Also noted above, only three counties, Bucks, Delaware, and Montgomery, saw their rates improve as a percentage of the rate in Philadelphia. For example, Dauphin County premium rates for OB/GYNs were 49 percent of the Philadelphia rate in 1996. By 2018, rates were 90 percent of the Philadelphia rate. Put another way, the affordability of rates in 64 of Pennsylvania's counties improved less than the affordability in three Pennsylvania counties. By that measure, rates are less affordable as compared to Philadelphia than they were in 1996.

Additionally, those counties tied to Philadelphia, Allegheny, and Lackawanna Counties because of hospital system expansion saw their OB/GYN medical malpractice rates increase as a percentage of their respective county rates. This indicates that rather than a decoupling of rates, they became more closely aligned over time.

[123] See section I for further explanation.

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SECTION VIII
JUA CLAIMS AND PAYMENTS

Fast Facts...

- *JUA direct premiums declined by 92 percent from 2003 to 2017.*
- *JUA payments made to claimants decreased by 90 percent during the same period.*

Overview

We were asked to provide a history of premiums earned, and losses incurred, by the Pennsylvania Professional Liability Joint Underwriting Association (JUA) from 2003 through the present. The JUA is a non-profit association established in the Medical Care Availability and Reduction of Error Act (MCARE) to offer medical professional liability insurance covering the provision of health care services in Pennsylvania.

To accomplish this task, we reviewed the following:

A. Information regarding the market share, premium amounts, and claims paid by the JUA from the Pennsylvania Insurance Department (Department) *Annual Statistical Report*.

We found:

A. Premiums earned by the JUA decreased significantly from 2003 to 2017.
B. Payments made to claimants declined from $21 million to $2 million over the same period.

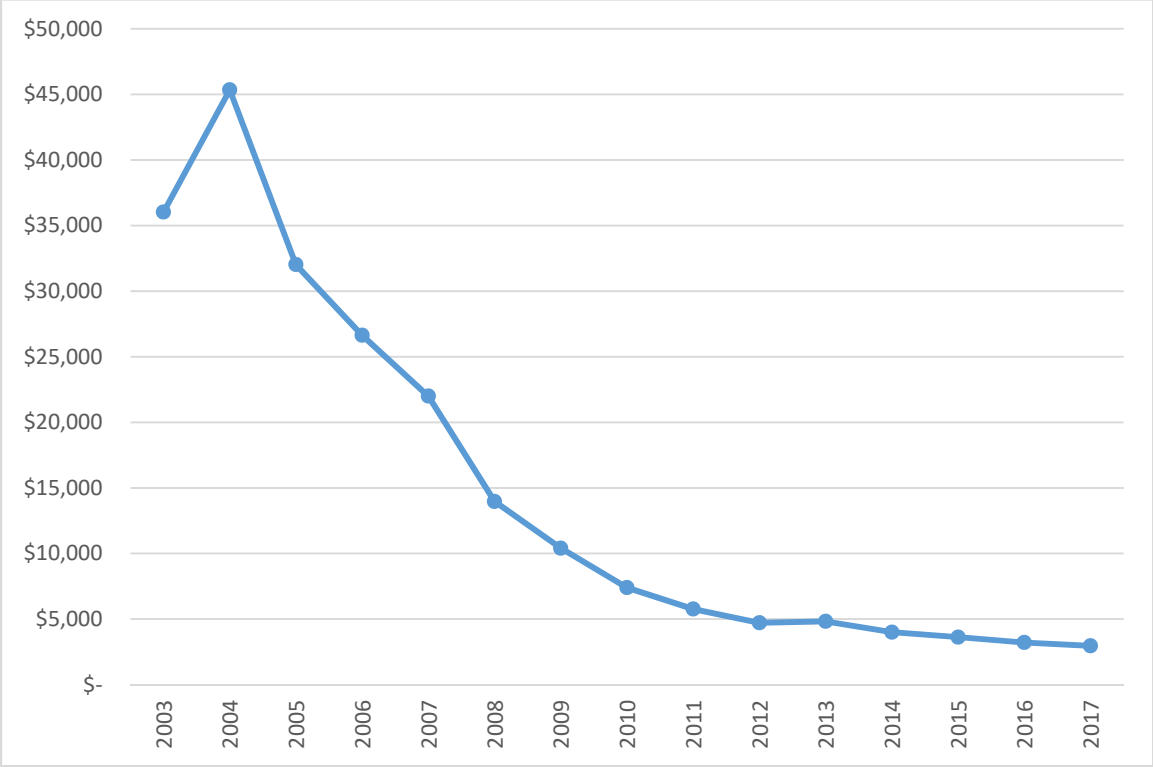
Issue Areas

A. JUA Premiums

The Pennsylvania Professional Liability Joint Underwriting Association saw a decrease in premiums earned from 2003 to 2017. In 2003, the direct premiums earned by the JUA totaled $38.6 million. By 2017, that number declined to $3 million. See Exhibit 86.

Exhibit 86

JUA Direct Premiums
2003 to 2017



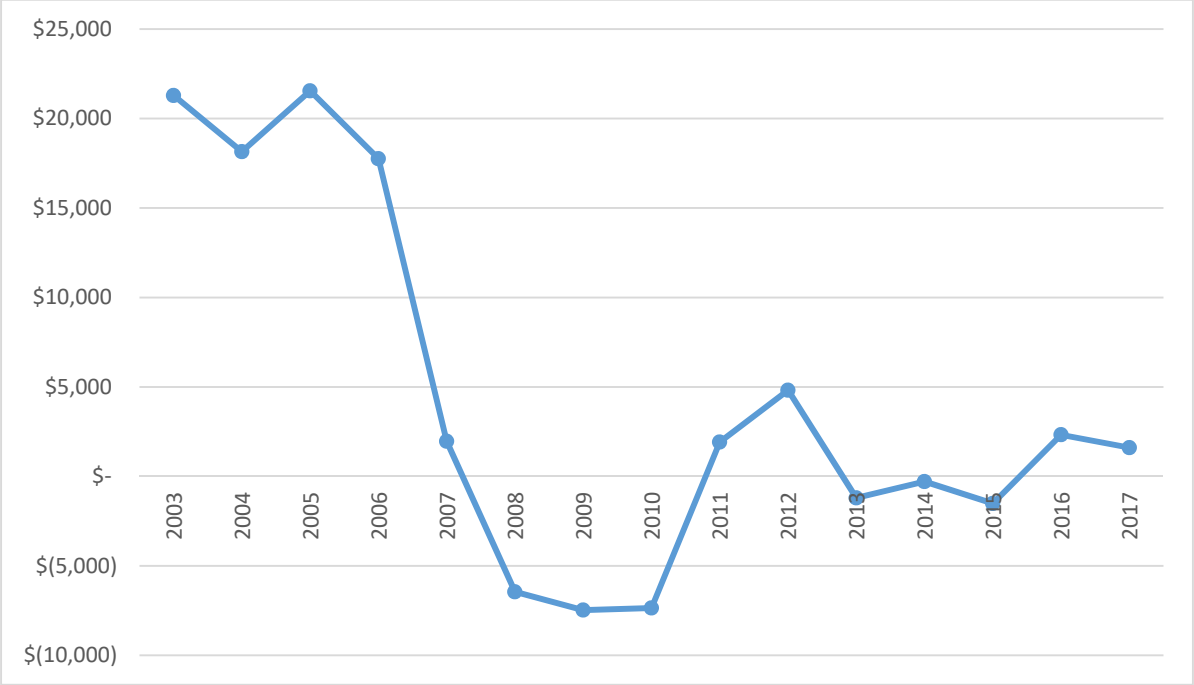
Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

B. JUA Losses (Payments Made to Claimants)

The losses (payments made to claimants) incurred by the JUA declined from $21 million in 2000 to $2 million in 2017. See Exhibit 87.

Exhibit 87

JUA Direct Losses[a/]
2003 to 2017



[a/]Direct losses incurred are at times negative. This is because the number includes the incurred losses from the present year and the reserves for losses from previous years. If the claims results from previous years are sufficiently good, companies reduces the reserves they carry for the previous years. In some cases, this reduction can be more than the incurred losses for the current year resulting in a negative number on an annual basis.

Source: Developed by LBFC staff from information provided by the Pennsylvania Department of Insurance.

The data does not lead to a conclusion regarding the affect the venue change in isolation had or will have on rates.

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SECTION IX
APPENDICES

Appendix A – Senate Resolution 2019-20

PRINTER'S NO. 155

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 20 Session of 2019

INTRODUCED BY BAKER, SCARNATI, CORMAN, LANGERHOLC, HUTCHINSON, MENSCH, J. WARD, REGAN, YAW, MARTIN, BARTOLOTTA, ALLOWAY, DiSANTO, FOLMER, WHITE, LAUGHLIN, BROOKS, AUMENT AND KILLION, FEBRUARY 1, 2019

REFERRED TO JUDICIARY, FEBRUARY 1, 2019

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study of the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth and requesting that the Pennsylvania Supreme Court delay action on the proposed amendment to Pa.R.C.P. No. 1006.

WHEREAS, The Commonwealth faced a medical malpractice crisis in 2002; and

WHEREAS, The Project on Medical Liability in Pennsylvania {project}, funded by The Pew Charitable Trusts, reported in 2003 that Philadelphia County and Allegheny County ranked high in malpractice filings per population among 45 large counties across the United States as surveyed by Federal officials in 1992 and 1996; and

WHEREAS, The rate in Allegheny County, which includes the City of Pittsburgh, was more than 50% above the national median; and

WHEREAS, The rate in Philadelphia County, which includes the City of Philadelphia, was more than double the national median;

and

WHEREAS, Payouts in Pennsylvania were higher than in any neighboring state; and

WHEREAS, Payouts in Pennsylvania were nearly one-third above the national average; and

WHEREAS, In contrast, payouts in California were more than one-third below the national average; and

WHEREAS, The rising cost of legal claims was the greatest component affecting affordability of liability coverage; and

WHEREAS, The project further reported that Pennsylvania exceeded the national average for legal costs because of high claims rates and payouts; and

WHEREAS, Plaintiffs were twice as likely to win jury trials in the City of Philadelphia as in the rest of the country, and a substantial percentage of cases there resulted in verdicts greater than $1 million; and

WHEREAS, A 2003 Pennsylvania Medical Society report on the Pennsylvania medical liability crisis found that practitioners were leaving the State or retiring early due to availability and affordability issues when obtaining medical liability coverage; and

WHEREAS, The report further stated that new practitioners were choosing to practice elsewhere when faced with the same conditions; and

WHEREAS, Pennsylvania was on a precipice of adverse events in patient care as physicians scaled back their practices to exclude obstetric deliveries and surgeries and as the number of specialists in general surgery, neurosurgery, orthopedic surgery and obstetrics decreased; and

WHEREAS, To address the medical malpractice crisis, the

General Assembly passed Act 13 of 2002, known as the Medical Care Availability and Reduction of Error (Mcare) Act (Act 13); and

WHEREAS, Section 102 of Act 13 sets forth the following:

The General Assembly finds and declares as follows:

(1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania;

and

WHEREAS, Section 514(a) of Act 13 sets forth the following:

(a) Declaration of policy.--The General Assembly further recognizes that recent changes in the health care delivery system have necessitated a revamping of the corporate structure for various medical facilities and hospitals across this

Commonwealth. This has unduly expanded the reach and scope of existing venue rules. Training of new physicians in many geographic regions has also been severely restricted by the resultant expansion of venue applicability rules. These physicians and health care institutions are essential to maintaining the high quality of health care that our citizens have come to expect;

and

WHEREAS, Section 514(b) of Act 13 established the Interbranch Commission on Venue {Commission} for actions relating to medical professional liability; and

WHEREAS, Under Act 13, the Commission consists of representatives of the executive, judicial and legislative branches of State government; and

WHEREAS, Act 13 charged the Commission with reviewing and analyzing the issue of venue as it relates to medical professional liability actions filed in this Commonwealth; and

WHEREAS, Act 13 further charged the Commission with reporting its findings and recommendations for legislative action or promulgation of court rules on venue to the General Assembly and the Pennsylvania Supreme Court; and

WHEREAS, The Commission issued its report on August 8, 2002; and

WHEREAS, A majority of Commission members recommended "that venue be limited in medical professional liability actions to a county where a cause of action arose or where a transaction or occurrence took place out of which a cause of action arose";

and

WHEREAS, The General Assembly, in keeping with the Commission's report, passed Act 127 of 2002 {Act 127}; and

WHEREAS, Act 127 provided that, as a matter of public policy, there existed a need to change venue requirements for medical professional liability actions; and

WHEREAS, Act 127 added 42 Pa.C.S. § 5101.1, providing in part:

(b) General rule.--Notwithstanding any other provision to the contrary, a medical professional liability action may be brought against a health care provider for a medical professional liability claim only in the county in which the cause of action arose;

and

WHEREAS, On January 27, 2003, the Pennsylvania Supreme Court modified Pa.R.C.P. No. 1006, relating to venue, by adding the following subdivision:

(a.1) Except as otherwise provided by subdivision (c), a medical professional liability action may be brought against a health care provider for a medical professional liability claim only in a county in which the cause of action arose. This provision does not apply to a cause of action that arises outside the Commonwealth;

and

WHEREAS, Changes governing venue in medical professional liability actions have been in place, largely without further modification, for more than 15 years; and

WHEREAS, The medical malpractice crisis which existed in Pennsylvania in 2002 has abated; and

WHEREAS, On December 22, 2018, the Civil Procedural Rules Committee published notice in the Pennsylvania Bulletin that it intends to propose to the Pennsylvania Supreme Court a change to Pa.R.C.P. No. 1006 eliminating the provision for venue in

medical malpractice liability actions as that provision "no longer appears warranted"; and

WHEREAS, The Senate notes that it is important to determine the extent to which venue provisions adopted more than 15 years ago have alleviated Pennsylvania's medical malpractice crisis; and

WHEREAS, The Senate further notes that it is important to determine the effects of rescinding the venue provisions; therefore be it

RESOLVED, That the Senate direct the Legislative Budget and Finance Committee to conduct a study of the impact of venue for medical professional liability actions on access to medical care and maintenance of health care systems in this Commonwealth; and be it further

RESOLVED, That the study include an assessment the effects of the 2003 changes governing venue in medical professional liability actions on the following:

(1) availability of medical care in this Commonwealth;

(2) availability of, and access to, a full spectrum of hospital services and highly trained physicians in all specialties across this Commonwealth;

(3) availability, cost and affordability of medical professional liability insurance in every geographic region of this Commonwealth;

(4) prompt determination of, and fair compensation for, injuries and death resulting from medical negligence by health care providers in Pennsylvania;

and be it further

RESOLVED, That the study include an assessment of the likely impact of the Civil Procedural Rules Committee proposed

amendment to Pa.R.C.P. No. 1006 on the matters enumerated above; and be it further

RESOLVED, That the study include a history of claims made to, and payouts made by, the Pennsylvania Professional Liability Joint Underwriting Association from 2003 through the present; and be it further

RESOLVED, That the Legislative Budget and Finance Committee hold at least one public hearing prior to preparing its report and accept testimony from affected parties, including, but not limited to, representatives of the health care industry, the insurance industry and the legal community; and be it further

RESOLVED, That the Legislative Budget and Finance Committee report its findings to the General Assembly no later than January 1, 2020; and be it further

RESOLVED, That the Senate request that the Pennsylvania Supreme Court delay action on the proposed amendment to Pa.R.C.P. No. 1006 until the Legislative Budget and Finance Committee submits its report to the General Assembly; and be it further

RESOLVED, That the Secretary of the Senate transmit duly certified copies of this resolution to the Justices of the Pennsylvania Supreme Court and the members of the Civil Procedural Rules Committee.

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December 1, 2017

David Kwass, Esquire
Chair, Civil Procedure Rules Committee
Pennsylvania Judicial Center
601 Commonwealth Avenue
Suite 6200
Harrisburg, PA 17106

Dear Mr. Qwass:

I write to respectfully request that the Rules Committee consider a rule change to return the venue rules to their pre-2003 status when medical malpractice defendants were subject to the exact same venue rules as all other non-governmental defendants. This rule change would be accomplished by eliminating Pa. R.C.P. 1006(a.1).

A Brief History of the Impetus Behind Special Venue Privileges for Malpractice Defendants

As the Rules Committee may be aware, circa 2000, there were significant lobbying efforts by various special interest groups to enact wide-ranging "tort reform" measures to combat an alleged medical malpractice "crisis." Without regard to the validity of the "crisis," various legislative and judicial reforms were enacted, including the passage of Act 13 of 2002 (MCARE Act). These changes included the reduction in the amount of coverage required by physicians from 1.2 million to 1 million dollars, the elimination of the collateral source rule, abrogation of joint liability, reduction to present worth for future earnings losses, and periodic payments of future medical and personal care expenses that are extinguished upon the death of the malpractice victim. As you no doubt appreciate, these changes, by design, significantly reduced the financial exposure of malpractice defendants. Additionally, in 2003, the Pennsylvania Supreme Court adopted rule changes that placed limitations on the plaintiff's choice of venue by requiring that medical malpractice cases be filed in the county where the alleged malpractice arose, and 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. In short, various legislative and judicial reform measures were enacted that created special rules for medical malpractice defendants that treated them more favorably (i.e. privileged) than other civil defendants.

Empirical Data Refutes Any Suggestion That Special Venue Rules Are Necessary for Medical Malpractice Defendants

While there may have been "room for debate" concerning the need for special venue rules for medical malpractice defendants in the early 2000s, there is absolutely no room for debate now, and hasn't been for quite some time. For example, in 2011, no less an authority than then-Chief Justice Ronald Castille laid to rest any such notion when he publicly declared the following:

> Pennsylvania's judiciary collaboratively addressed a complex medical malpractice litigation crisis, and the latest 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. **The crisis is over.**[1]

Again, Chief Justice Castille's comment was from 2011. Since then, a brief review of the data compiled by the Pennsylvania Supreme Court makes it more irrefutable that special venue rules are no longer necessary.

Overall, there has been a 43.6% decrease in medical malpractice filings in the past 15 years, down from 2,733 in 2000-2002 to 1,541 in 2016.[2] In Philadelphia County alone, Pennsylvania's largest county, there has been a 68.6% decrease in medical malpractice filings over that same time period, from 1,204 to 378.[3] Allegheny County, Pennsylvania's second-largest county, witnessed a decrease of 31.6% over that same period, from 396 to 271 filings.[4] Likewise, payouts by MCARE, the excess insurer for all Pennsylvania physicians and hospitals, have decreased by 54% from $378,720,772 in 2003 to $173,955,487 in 2016.[5]

Moreover, the data further reveals that very few cases that go to trial are decided in the plaintiff's favor. Statewide, in 2016, 110 medical malpractice cases were tried to verdict, and 84.5% were defense verdicts;[6] in 2015, 78.4% of the 102 medical malpractice cases tried to verdict

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[1] Jeff Blumenthal, *Medical malpractice filings lowest in a decade in Phila.*, PHILADELPHIA BUSINESS JOURNAL (May 18, 2011) (emphasis added).
[2] Pennsylvania Medical Malpractice Case Filings, http://www.pacourts.us/assets/files/setting-2929/file-6330.pdf?cb=5faa44.
[3] Id.
[4] Id.
[5] Pennsylvania Insurance Department, *Medical Care Availability and Reduction of Error Fund 2016 Annual Report*, http://www.insurance.pa.gov/Mcare%20Documents/2016%20Report.pdf.
[6] Pennsylvania Medical Malpractice Statistics, http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics.

were defense verdicts;[7] in 2014, 82% were defense verdicts; and in 2013, 77.3% of such cases were defense verdicts.[8]

Even without traditional damage caps in place in Pennsylvania, statutory and rule changes in 2002 and 2003 have combined to have a significant chilling effect on medical malpractice claims and payments. One significant impediment to pursuing viable medical malpractice claims occurs because of the special venue rules currently in place. As you no doubt can appreciate, in some counties in Pennsylvania, there is a significant hardship in requiring a plaintiff to sue a malpractice defendant only where the cause of action arose when the malpractice defendant transacts business in other counties. For example, in many counties, the hospital or healthcare system may be the county's largest employer. Therefore, it becomes difficult, if not impossible, to seat an impartial jury in these counties as some jurors invariably depend on the hospital for healthcare or employment, and/or have close relationships with those that do.

For example, while Pittsburgh is certainly no haven for malpractice victims, as only 5 out of 55, or 9% of plaintiffs won their malpractice case in Allegheny county between 2012 and 2016, plaintiffs fare even worse in the surrounding counties.[9] In Armstrong, Beaver, Butler, Fayette, Washington and Westmoreland counties, plaintiffs won only 2 out of 30 cases, an abysmal 6.6%, over that same timeframe.[10] Thus, over the course of five years in western Pennsylvania, patients only won 7 out of 85 cases, a "batting average" of .082. In essence, malpractice defendants have pitched the litigation equivalent of a "no hitter" over the past five years in western Pennsylvania.

There has also been a national decrease in claims paid by or on behalf of physicians. From the years 1992-1996 to 2009-2014, the most recent data available indicates that the rate of paid claims decreased by 55.7% nationally.[11] According to one study, the number of paid claims per physician career has dropped from 1.05 in 1992 to 0.45 in 2012.[12] Thus, the average physician will never be involved in a medical malpractice claim that results in the payment of money.

Unfortunately, the decreases in medical malpractice claims, payments and insurance rates cannot be attributed to higher-quality health care.[13] A recent study from researchers at Johns Hopkins estimates that 251,454 deaths stem from preventable medical errors each year, or 9.5% of all annual deaths in the US, making preventable medical errors the 3rd leading cause of death in

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[7] Id.
[8] Id.
[9] Pennsylvania Medical Malpractice Statistics, http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics.
[10] Id.
[11] Adam Schaffer, *Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014*, JAMA INTERNAL MEDICINE, May 2017 at 713.
[12] Myungho Paik, Bernard S. Black, David A. Hyman, *The Receding Tide of Medical Malpractice Litigation Part 1: National Trends*, 10 JOURNAL OF EMPIRICAL STUDIES, 2013, at p. 617.
[13] Adam Schaffer, *Rates and Characteristics of Paid Malpractice Claims* at 714.

the country.[14] While insurance companies suggest that damage caps and other tort reform measures reduce the cost of health care, empirical studies reveal the opposite -- that these practices have little to no effect on healthcare costs.[15,16] The entire cost of the malpractice system is estimated to be less than 1% of total healthcare costs nationwide,[17] with some studies indicating that medical malpractice payments are as low as 0.1% of total healthcare costs.

If medical malpractice defendants played by the same venue rules as other non-governmental defendants, it would be possible to sue a malpractice defendant in other counties in which one or more of the malpractice defendants regularly conducts business. Also, under the current rules, any defendant, including a medical malpractice defendant, has a remedy available if that defendant believes that the venue (county) in which the defendant has been sued is inconvenient and another more appropriate forum exists. Thus, a special venue rule for malpractice defendants necessarily implies that the current rules regarding forum non-conveniens are deficient. Yet, they work well for every other class of defendant.

Special Rules for Malpractice Defendants Result in a Transfer Tax to Pennsylvania Taxpayers

The combined cumulative effect of these changes has resulted in an approximate 50% decrease in the number of lawsuits filed and a 50% decrease in the amount of claim payments. But, every action has an equal and opposite reaction. To wit, the decrease in claims filed and payouts made results in far fewer fairly compensated victims of medical negligence. For each uncompensated or undercompensated victim of medical negligence, a societal "transfer tax" occurs which results in the transfer of the costs of medical negligence from the legally responsible parties (malpractice defendants) to the taxpayers of Pennsylvania. Importantly, when a victim of medical negligence is uncompensated or undercompensated, the cost for providing care and treatment to that victim in the future is not extinguished. Rather, those costs are borne by various governmental benefit programs, all of which are ultimately paid for and subsidized by Pennsylvania taxpayers.

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[14] Michael Daniel, *Study Suggests Medical Errors Now Third Leading Cause of Death in the U.S.*, JOHNS HOPKINS MEDICINE (May 3, 2016) (although estimates vary, this study indicates that 251,454 deaths stem from medical error annually, 9.5% of all annual deaths in the U.S.).
[15] Adam Schaffer, *Rates and Characteristics of Paid Malpractice Claims* at 714.
[16] Myungho Paik, Bernard Black, David A. Hyman, *Damage caps and defensive medicine, revisited*, J. of Health Econ. 2017, (finding that tort reform has no impact on Medicare Part A reimbursement costs, and may in fact *increase* Medicare Part B costs).
[17] Andrew Friedson, *Medical Malpractice Damage Caps and Provider Reimbursement*, HEALTH ECON, 2017.

Special Rules Privileging Medical Malpractice Defendants are Repugnant to Equality Under Law

As a society, we are all bound on equal terms by a common set of rules. One of the bedrock principles of our justice system is equality under the law. Our founding fathers recognized that the very legitimacy of our constitutional democracy demands the veneration of this principle and requires that all people, especially the financially and politically powerful, be bound by it. This core concept has been enshrined and revered throughout the development of American jurisprudence. Our progress as a society, in our continuing effort to perfect our imperfect union, has often been measured by our adherence to it. Special rules privileging medical malpractice defendants are repugnant to equality under the law.

The Pennsylvania Rules of Civil Procedure should create "fairness of process" and be "agnostic to outcome." Special venue rules for malpractice defendants are corrosive to this principle. They were adopted because of perceived inequalities in outcomes for one class of defendants, and their continued existence is antithetical to "fairness of process." Thus, to the extent that adherence to equality under the law is a barometer of progress, Rule 1006(a.1) is a significant step backwards. Fear of "venue shopping," or other similar "abuse of the rules," is a poor excuse to continue to condone special venue rules benefitting a special class of litigants.

For all these reasons, the Pennsylvania Supreme Court should amend the venue rules that were enacted in 2003 concerning medical malpractice defendants. Malpractice victims and malpractice defendants should play by the same rules as all other tort victims and defendants. Medical malpractice cases should be permitted to be filed in a county in which one or more of the defendants regularly conducts business. That's the rule for every other civil defendant, including motor vehicle defendants, premises liability defendants, contractual and commercial defendants, and in virtually all other civil cases. Respectfully, it is difficult to imagine any legitimate basis for the continuation of Rule 1006(a.1) as there is simply no empirical data which supports the need for special rules for medical malpractice defendants

In closing, I thank the Committee for consideration of this important issue.

Very truly yours,

MATZUS LAW, LLC

Jason E. Matzus

JEM/tll

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Appendix C – Public Hearing Participants

The following stakeholders provided testimony at the LBFC public hearings:

June 25, 2019
Patients • Patient Safety Authority
Providers • Hospital and Healthsystem Association of Pennsylvania • Pennsylvania Medical Society
Attorneys • Pennsylvania Association for Justice • Pennsylvania Bar Association
June 26, 2019
Insurers • Insurance Federation of Pennsylvania
Medical Colleges • University of Pennsylvania • Lake Erie College of Medicine • Pennsylvania State University, College of Medicine

Source: LBFC public hearings held June 25 and 26, 2019.

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Appendix D – General Acute Care Hospitals: Total Number of the 49 Selected Services Available by Facility and County from the *Annual Hospital Questionnaires*

Alleghany	FY 1996-97	FY 2003-04	CY 2018
Alleghany General Hospital	41	39	25
Alleghany Valley Hospital	15	14	22
Forbes Hospital	26	29	27
Heritage Valley--Sewickley	30	30	32
Jefferson Hospital	26	29	31
Ohio Valley General Hospital	19	20	25
St Clair Memorial Hospital	26	29	31
UPMC East	-	-	24
UPMC McKeesport	20	27	29
UPMC Mercy	32	31	33
UPMC Passavant	25	32	30
UPMC Presbyterian-Shadyside	-	43	43
UPMC ST Margaret	24	27	26
West Penn Hospital	28	31	34
Berks			
Reading Hospital	34	35	39
St Joseph Medical Center	29	30	30
Blair			
Nanson Hospital	20	21	20
Tyrone Hospital	21	19	15
UPMC Altoona	32	32	32
Bucks			
Doylestown Hospital	28	30	27
Grandview Hospital	23	24	30
Lower Bucks Hospital	24	24	21
ST Luke's Quakertown Hospital	16	24	27
ST Mary Medical Center	28	28	27

Appendix D Continued

Cambria	**FY 1996-97**	**FY 2003-04**	**CY 2018**
Conemaugh Memorial Medical Center	29	28	32
Conemaugh Medical Center	26	26	26
Carbon			
Blue Mountain Hospital	21	23	28
Centre			
Mount Nittany Medical Center	26	27	28
Clinton			
Bucktail Medical Center	11	17	7
UPMC Susquehanna-Lock Haven	19	18	18
Dauphin			
Milton S. Hershey Medical Center	40	37	38
UPMC Pinnacle Hospital	34	36	29
Delaware			
Crozer-Chester Medical Center	35	32	35
Delaware County Memorial Hospital	26	30	23
Mercy Fitzgerald Hospital	29	31	25
Riddle Memorial Hospital	22	23	30
Elk			
Penn Highlands Elk	16	19	21
Erie			
Corry Memorial Hospital	18	21	18
Millcreek Community Hospital	18	20	22
Saint Vincent Health Center	31	31	29
UPMC Hamot	32	27	34
Fayette			
Highlands Hospital	21	19	21
Uniontown Hospital	22	25	25
Lackawanna			
Geisinger-Community Medical Center	31	30	22
Moses Taylor Hospital	23	26	20
Regional Hospital of Scranton	26	29	21

Appendix D Continued

Lackawanna	**FY 1996-97**	**FY 2003-04**	**CY 2018**
Ephrata Community Hospital	26	26	27
Lancaster General Hospital	34	33	32
UPMC Pinnacle Lancaster	-	25	23
UPMC Pinnacle Lititz	26	20	29
Lawrence			
Ellwood City Medical Center	27	18	26
UPMC Jameson	27	31	26
Lehigh			
Lehigh Valley Hospital	38	39	40
ST. Luke's Hospital Bethlehem	35	36	37
ST. Luke's Hospital Sacred Heart Campus	32	29	24
Surgical Specialty Hospital-Coordinated Health	-	-	13
Luzerne			
Geisinger Wyoming Valley Medical Center	22	27	26
Lehigh Valley Hospital-Hazelton Campus	20	20	21
Wilkes-Barre General Hospital	28	29	30
Lycoming			
Geisinger Jersey Shore Hospital	13	17	17
Muncy Valley Hospital	19	19	15
Williamsport Regional Medical Center	24	23	33
Mercer			
Edgewood Surgical Hospital	-	6	10
Grove City Medical Center	20	21	20
Sharon Regional Health System	32	31	31
UPMC Horizon	27	25	27
Monroe			
Lehigh Valley Hospital-Pocono	21	19	32
ST. Luke's Hospital -Monroe Campus	-	-	19
Northampton			
Easton Hospital	24	28	30

Appendix D Continued

Philadelphia	**FY 1996-97**	**FY 2003-04**	**CY 2018**
Albert Einstein Medical Center	25	36	38
Chestnut Hill Hospital	19	23	22
Eastern Regional Medical Center	-	-	23
Hahnemann University Hospital	37	37	36
Hospital of the University of PA	39	37	37
Jeanes Hospital	20	22	24
Jefferson Health Northeast	26	34	30
Kensington Hospital	11	9	17
Mercy Philadelphia Hospital	25	26	26
Nazareth Hospital	25	26	27
Penn Presbyterian Medical Center	27	25	32
Pennsylvania Hospital of Univ. of PA Hlth System	33	32	24
Roxborough Memorial Hospital	22	23	19
Temple University Hospital	39	38	40
Thomas Jefferson University Hospital	36	38	39
Schuylkill			
Lehigh Valley Hospital Schuylkill	-	-	21
ST. Luke's Miners Memorial Hospital	23	23	24
Westmoreland			
Excela Health Frick Hospital	24	21	20
Excela Health Latrobe Hospital	29	29	25
Excela Health Westmoreland Regional Hospital	31	31	29

Source: Developed by LBFC staff from information obtained from PDH *Annual Hospital Questionnaire.*

Appendix E –Five Highest Medical Malpractice Payout States: Medical Malpractice, Statutory Provisions[a/]

State	Damage Award/Limit or Cap	Limits on Attorney Fees	Periodic Payments	Patient Compensation or Injury Fund	Medical or Peer Review Panels
New York[b/]	No applicable statute.	Jud. 30 §474-a.	Civil Practice Law and Rules §5031 *et seq*.	Public Health §2999-G *et seq*.	No statute provided specific to medical liability/malpractice cases.
Pennsylvania[c/]	No limitations.	Limits declared unconstitutional by state Supreme Court (see Heller v. Frankston, 475 A.2d 1291 (Pa. 1984).	Title 40 §1303.501 *et seq*.	Title 40 §1303.712. Medical Care Availability and Reduction of Error Fund.	63 §425.1 *et seq*. Peer review protection
Florida[d/]	Title XLV Torts. §766.118.; §768.73.	Fla. Atty. Conduct Reg. §4-1.5	Title XLV Torts. §768.77; §768.78.	Title XLV Torts. §766.105.; §766.301 *et seq*.	Title XXIX Public Health. §395.0193.; Title XLV Torts. Peer review; §766.101.
California[e/]	Civil Code §3333.2	Business and Professions §6146.	Civil Procedure §667.7.	None provided.	Business & Professions Code §805 *et seq*. ; Evidence Code §1157 et seq.
New Jersey[f/]	Title 2A §2A:15-5.14.	Court Rules §1:21-7.	No applicable statute.	None provided.	Title 2A §2A:84A-22.10. Professional review committees

Note:
a/ "Medical Liability/Medical Malpractice Laws *(*incorporates 2011 enactments*)." National Conference of State Legislatures*. *(*Last Updated: August 15, 2011). http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx.
b/ https://www.nysenate.gov/legislation
c/ https://ldpc6.legis.state.pa.us/LDPNet/Legislation/ and http://www.pacodeandbulletin.gov/
d/ http://www.leg.state.fl.us
e/ https://leginfo.legislature.ca.gov/faces/home.xhtml
f/ https://www.njleg.state.nj.us/

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Appendix F – National Practitioner Data Bank (NPDB)—Median and Mean Medical Malpractice Payment Delay, in Years, Between Incidents and Payment, by Jurisdiction, 2003 to 2012 a/

State	Median Rank		Median Delay		Mean Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
Alabama	17	17	4.1	4.1	5	4.5
Alaska	14	36	4.4	3.6	4.4	5.3
Arizona	25	33	3.9	3.7	4	4
Arkansas	23	35	4	3.7	5.4	4.2
California	50	51	2.8	2.7	3.3	3.2
Colorado	49	50	3.2	3.1	3.3	3.5
Connecticut	8	7	5.5	5.1	5.9	5.4
Delaware	45	26	3.3	3.8	3.5	4.3
District of Columbia	20	23	4	3.9	5.5	4.5
Florida	47	32	3.2	3.7	3.7	4.1
Georgia	33	28	3.7	3.8	4	4.3
Hawaii	3	15	5.9	4.2	5.6	4.3
Idaho	43	31	3.3	3.7	3.8	4.2
Illinois	7	5	5.6	5.3	6	5.8
Indiana	5	1	5.8	6	6	6.3
Iowa	39	45	3.4	3.4	3.6	3.8
Kansas	32	40	3.7	3.5	4.6	3.9
Kentucky	44	24	3.3	3.9	4.1	4.5
Louisiana	2	4	5.9	5.3	7	6
Maine	37	13	3.6	4.2	4	4.8
Maryland	16	18	4.1	4.1	4.3	4.3
Massachusetts	6	2	5.7	6	6	6.1
Michigan	31	25	3.7	3.9	4.3	4.3
Minnesota	24	47	4	3.4	4.1	3.8
Mississippi	1	12	6.1	4.3	7.6	5.2
Missouri	34	22	3.7	3.9	5	4.4
Montana	42	38	3.3	3.6	6.2	4.1
Nebraska	21	19	4	4	3.9	4.3
Nevada	22	10	4	4.5	4.3	4.7
New Hampshire	36	16	3.7	4.1	3.8	4.4
New Jersey	10	8	5	5.1	5.5	5.9
New Mexico	12	21	4.5	3.9	4.4	4
New York	9	6	5.4	5.2	6	5.8

Appendix F Continued

State	Median Rank		Median Delay		Mean Delay	
	2012	2003-2012	2012	2003-2012	2012	2003-2012
North Carolina	18	27	4.1	3.8	4.5	4.3
North Dakota	27	43	3.9	3.5	3.6	3.6
Ohio	46	37	3.2	3.6	4.1	4.4
Oklahoma	18	34	4.1	3.7	4.8	4.2
Oregon	47	49	3.2	3.2	3.9	3.5
Pennsylvania	**11**	**9**	**4.7**	**4.8**	**5.4**	**5.6**
Rhode Island	3	3	5.9	5.8	5.9	6
South Carolina	13	11	4.4	4.4	4.8	4.8
South Dakota	51	48	2.5	3.2	3.2	3.7
Tennessee	26	29	3.9	3.8	4.4	4.3
Texas	38	46	3.4	3.4	3.9	3.8
Utah	30	30	3.7	3.7	4.3	4.1
Vermont	29	20	3.8	4	3.5	4.5
Virginia	15	44	4.3	3.4	6.6	4.3
Washington	28	38	3.8	3.6	4.2	3.9
West Virginia	41	41	3.4	3.5	3.7	4
Wisconsin	40	14	3.4	4.2	3.9	4.5
Wyoming	35	42	3.7	3.5	4.2	3.7

Note:
a/National Practitioner Data Bank*, 2012 Annual Report***,** February 2014. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks. Mean delay in years. Median and Mean Medical Malpractice Payment Delay, in Years, Between Incident and Payment, by Jurisdiction, 2003 to 2012.

Source: Developed by LBFC staff from information obtained from NPDB.

Appendix G – County Rates Compared to Philadelphia

County	2003	2008	2018	2003 to 2008	2008 to 2018
Adams	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Allegheny	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Armstrong	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Beaver	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Bedford	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Berks	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Blair	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Bradford	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Bucks	93,033	85,642	59,555		
Philadelphia	93,033	92,261	75,798		
	100.00%	92.83%	78.57%	-21.43%	-14.26%
Butler	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Cambria	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Cameron	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%

Appendix G Continued

County	2003	2008	2018	2003 to 2008	2008 to 2018
Carbon	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Centre	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Chester	93,033	85,642	59,555		
Philadelphia	93,033	92,261	75,798		
	100.00%	92.83%	78.57%	-21.43%	-14.26%
Clarion	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Clearfield	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Clinton	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Columbia	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Crawford	55,821	51,662	53,339		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	70.37%	10.37%	14.37%
Cumberland	69,773	63,577	59,555		
Philadelphia	93,033	92,261	75,798		
	75.00%	68.91%	78.57%	3.57%	9.66%
Dauphin	69,773	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	75.00%	78.95%	90.05%	15.05%	11.10%
Delaware	93,033	92,261	75,798		
Philadelphia	93,033	92,261	75,798		
	100.00%	100.00%	100.00%	0.00%	0.00%
Elk	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Erie	55,821	51,662	53,339		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	70.37%	10.37%	14.37%

Appendix G Continued

County	2003	2008	2018	2003 to 2008	2008 to 2018
Fayette	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Forest	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Franklin	69,773	63,577	59,555		
Philadelphia	93,033	92,261	75,798		
	75.00%	68.91%	78.57%	3.57%	9.66%
Fulton	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Greene	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Huntingdon	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Indiana	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Jefferson	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Juniata	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Lackawanna	88,382	85,642	80,273		
Philadelphia	93,033	92,261	75,798		
	95.00%	92.83%	105.90%	10.90%	13.08%
Lancaster	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Lawrence	55,821	51,662	53,339		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	70.37%	10.37%	14.37%
Lebanon	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%

Appendix G Continued

County	2003	2008	2018	2003 to 2008	2008 to 2018
Lehigh	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Luzerne	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Lycoming	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
McKean	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Mercer	55,821	51,662	53,339		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	70.37%	10.37%	14.37%
Mifflin	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Monroe	88,382	85,642	80,273		
Philadelphia	93,033	92,261	75,798		
	95.00%	92.83%	105.90%	10.90%	13.08%
Montgomery	93,033	85,642	59,555		
Philadelphia	93,033	92,261	75,798		
	100.00%	92.83%	78.57%	-21.43%	-14.26%
Montour	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Northampton	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Northumber-land	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Perry	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Pike	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%

Appendix G Continued

County	2003	2008	2018	2003 to 2008	2008 to 2018
Potter	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Schuylkill	88,382	85,642	80,273		
Philadelphia	93,033	92,261	75,798		
	95.00%	92.83%	105.90%	10.90%	13.08%
Snyder	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Somerset	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Sullivan	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Susquehanna	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Tioga	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Union	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Venango	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Warren	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Washington	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%
Wayne	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
Westmoreland	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%

Appendix G Continued

County	2003	2008	2018	2003 to 2008	2008 to 2018
Wyoming	74,424	72,844	68,256		
Philadelphia	93,033	92,261	75,798		
	80.00%	78.95%	90.05%	10.05%	11.10%
York	55,821	51,662	48,367		
Philadelphia	93,033	92,261	75,798		
	60.00%	56.00%	63.81%	3.81%	7.81%

Source: Developed by LBFC staff from information provided by the *Medical Liability Monitor*.