EXECUTIVE SUMMARY

MCARE COMMISSION

TESTIMONY OF
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November 2, 2006

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I appreciated the opportunity of delivering these remarks to the Pennsylvania Insurance Commissioner Diane Koken, Actuary Timothy Landick and employee of Pricewaterhouse, Peter Adams from the Mcare Fund and the other members of the Commission as the only non-medical person. Both Tim Landick and Peter Adams have done an enormous amount of work to provide data to the Commissioners and advisors. I have enjoyed serving as an advisor to the Commission.

I. INTRODUCTION

The question we have been charged with is what to do about the Mcare Fund? However, the mandate from the legislature does not require abolishment of the Fund.

The truth is that it makes no sense to abolish the Mcare Fund because there is no sensible replacement for it. The private industry is not able to do the job. Why do so many hospitals today self-insure? Discussions with hospital heads show that they self insure because it is a less costly alternative than private insurance companies, because they can control their risks better by getting rid of bad doctors and because they can handle their own claims which they will know the most about.

II. HISTORY

The Mcare Fund used to be called the CAT Fund and was created as a pay as you go system by Lycoming County Pennsylvania Senator Henry "Merc" Hager.

The CAT Fund had to be created because of the small, homogenous medical malpractice insurance market. Today that market is even smaller because of self-insurance and therefore is more homogenous.

We now have proof positive that the medical malpractice insurance market fluctuates dramatically not because of claims payouts but because of the insurance cycle which is affected by interest rates, natural disasters, events like 9/11 and the simple profit motive. This was first explored by Hofflander & Nye in 1987 as a result of a jointly funded study promoted by the Pennsylvania Medical Society, the Trial Lawyer and the Pennsylvania legislature. The Pricewaterhouse work performed in 2006 reaffirmed the excellent work originally done by Hofflander & Nye. The insurance cycle, it is agreed by everyone, must be tamed.

III. FACTS

I am a member of the Patient Safety Authority and I recall when patient safety burst on the scene in 1999 due to an Institute of Medicine report entitled, "To Err is Human." We learned that the equivalent of two 747's go down every month which represents the number of preventable medical errors in hospitals alone. The report was

authored by doctors and scientists and shocked the medical community and the population at large.

It's hard to factor in the affect of the patient safety movement on medical malpractice premiums, but it is wrong to ignore it.

Empirical data has now proven beyond any doubt that lawsuits are not a problem to be solved but rather patient errors are. The Pew Foundation in a highly celebrated study determined that in fact not enough people are compensated given the number of medical errors which occur.

A recent article in the Annals of Internal Medicine investigated a large number of closed medical malpractice files. The investigation was performed by doctors alone. The study concluded that most of the cases were well founded. They did not find frivolous cases.

The big change since 2000 is that the medical profession now understands and realizes the importance of patient safety and has embraced the movement. This is a good development and one where both the trial bar and the medical profession can be partners.

Another very important point to appreciate is that private insurance companies dominated by one industry can be a disaster. PHICO was the insurance company controlled by hospitals. The insurance commission will remember that PHICO funneled its profits to hospital heads via offshore companies instead of building up a reserve. When claims came in, there was no money to pay the claims. This and other such disasters demonstrated the need for stiffer insurance disclosure and regulation which we still do not have in Pennsylvania.

Finally the question of doctors in the state has arisen. According to statistics kept by the Pennsylvania Insurance Commission, the proportion of doctors has actually increased in Pennsylvania in every year since 1976 given the population decline in the state. The problem of professionals leaving the state because of lack of economic growth is endemic to all professions in the state and is not peculiar to physicians. Pennsylvania has one of the oldest populations in the country.

IV. PROPOSALS

The Pennsylvania Trial Lawyers Association has endorsed a proposal that would keep the Mcare Fund. The so-called "unfunded liability" is really no such thing but rather is a prediction of future claims which have been dropping dramatically in the last few years.

Permanent public funding is absolutely necessary to flatten out the insurance cycle. It is now provided by cigarette taxes and the auto CAT Fund. This abatement program is demanded by the medical profession and hospitals and should be continued.

Legislation is necessary to allow the insurance commissioner to authorize primary insurance carriers individually to write more or less insurance coverage, rather than just phasing out the Mcare Fund.

Tort changes creating barriers to recovery or lowering limits, not enhance patient safety. This only hurts those already hurt.

I appreciate the opportunity of addressing the Commission in further detail.

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I. INTRODUCTION

The Pennsylvania Medical Society and other medical groups will recommend, on July 27, 2006, retirement of the Mcare Fund and related proposals. The recommendations contain a preamble suggesting that doctors are leaving the state and inferring that medical malpractice premiums have been high because of claims. The claim does not represent the best data available to date.

II. History of Medical Malpractice Premiums

Most of us are familiar with the first so-called medical malpractice premium crisis in the early '70s. The legislature, thanks to the efforts of Henry "Merc" Hager, created the system known as the CAT Fund. The CAT Fund was a "pay-as-you-go" system, similar to Social Security, where the bulk of coverage required by doctors and hospitals would be supplied by a "paid-into" fund that would receive money from assessments on health care providers as needed. The problem with the Fund was that it did not make provision for future claims. As a result, this "tail" began to grow as claims came in. Assessments could be kept low in their earlier years because there simply were no claims. When claims began to mature, the funds on hand simply were not adequate and a so-called "unfunded liability" was created.

The unfunded liability is an accounting creature, and is not necessarily money owed. The so-called unfunded future claims could vary, based upon the investment climate, the number of claims made, and payouts.

There have been at least two other medical malpractice insurance premium crises since the CAT Fund was created in 1976. The second major one was in the late '80s, and the third one in the late '90s. Both of these crises were predictable on the basis of interest rates alone. In the late '80s, specifically 1987, the legislature, with funding from itself as well as doctor and lawyer groups, hired Hufflander & Nye from California to study the Pennsylvania catastrophe loss system. The professors concluded that there would be a cyclical crisis of medical malpractice insurance premiums approximately every 10 years for the obvious reason that when interest rates and investment returns were high, primary insurance companies would charge too little, and when interest rates were low, usually as a result of a prior recession, the primary insurance companies would have to boost their premiums to make up for the shortfall. The CAT Fund would be required to follow suit.

In 2001-2002, the legislature decided to lower the amount of insurance doctors and hospitals had to carry, and to increase the amount of insurance written by primary carriers. In a rising interest rate environment, this would not be a difficult task to accomplish. The problem is that it does not provide for future stability. The Mcare Commission was created to assist in determining the future of the Catastrophe Loss Fund, now named the Mcare Fund.

It would be a mistake to try to solve the medical malpractice insurance premium instability problem either by arbitrarily cutting claims payments through tort reform or by simply eliminating the Mcare Fund. What needs to be done is to stabilize the primary insurance market regardless of economic conditions and to make sure the Mcare Fund has sufficient money for claims payouts without the need to resort to significant increases in assessments.

The medical society has circulated its proposal for essentially shutting down the Mcare Fund over a relatively short period of years and creating an emergency reserve type of fund. While the proposal deserves careful consideration, it is based upon some erroneous assumptions and is not sufficiently specific to guarantee stability in the insurance market.

A number of factual items must be kept in mind.

III. Factual Prerequisites

1. According to statistics kept by the CAT Fund, assessment data from the Mcare Fund and Licensure Board information, the number of physicians in Pennsylvania has increased in every year since 1977. As the population of the Commonwealth has dropped, the ratio between doctors and patients has actually improved substantially so that Pennsylvania has one of the higher rates of doctor-patient contact in the entire country.

2. Patient safety is now on the front burner as a major driving force behind rising costs in health care. The Health Care Quality Containment Council has estimated that infections alone cost the Commonwealth $1 billion a year because of the high expense of pharmaceutical and sequelae from serious infections.

3. The Patient Safety Authority has reported approximately 170,000 serious events and incidents in 2005 alone. These are not all necessarily indications of neglect, but according to the Patient Safety Authority represent "underreporting." In the same time period the Pennsylvania Supreme Court reveals that approximately 1,500 lawsuits have been filed.

4. The Mcare Commission itself has revealed statistics showing somewhere between 25 percent and a one-third drop in claims payouts, much larger than expected by any predictor of events.

5. Health Grades Quality Study, Third Annual Patient Safety in America Hospitals Report in April 2006, identified the performance of hospitals according to a best-practice benchmark. Health Grades stated: "However, despite what we have learned from this research, recent studies assessing the state of hospital patient safety conclude that current progress is slow, results in general are at best modest, and the gap between the best possible care and actual care remains large."

6. The Institute of Medicine's 1999 study, "To Err is Human," shows that the rate of preventable deaths in American hospitals is equivalent to two 747's going down each month. The Pew Foundation commissioned Professor Mehlman to look at the medical malpractice system, and he finds that, if anything, there is more medical malpractice than is identified by litigation. Obstacles to success in litigation actually keep claims payments artificially low. Those obstacles are many, but include difficulty in obtaining medical expert witnesses to testify against other doctors and the cost of so doing.

7. A surge in medical malpractice claims payouts in the 1999-2000 time frame in Pennsylvania was due to a new system in Philadelphia which eliminated an 11-year backlog and resulted in Philadelphia becoming one of the most efficient places to try medical malpractice cases in the country. Unfortunately, this did create a bulge in justified payouts.

8. A host of tort reform, such as where cases could be brought and matters relating to expert witnesses, has further depressed claims payouts. A good case can be made for the fact that many of the reforms are extremely unfair and have created artificial barriers while doing nothing to reduce problems of patient safety.

9. A recent study published in the Annals of Internal Medicine with respect to closed medical malpractice claims demonstrates that most of the claims were meritorious. The belief and argument that medical malpractice claims are frivolous because plaintiffs and claimants have difficulties prevailing in a court of law could not be more erroneous. Most of the difficulty in proving a medical malpractice claim relates to secretive peer review and a reluctance that doctors have in testifying against other doctors.

10. According to statistics available to the Pennsylvania Department of Insurance the number of doctors relative to the population in Pennsylvania has increased every year since 1976. This is due not only to the increasing number of physicians but also due to the declining population in Pennsylvania. While there may be rural regional shortages of some specialists, that has not generally been a problem in any other part of the Commonwealth.

11. The graying of Pennsylvania, which renders it one of the oldest populations in the country, affects every field of endeavor whether medicine, law, the computer industry, paraprofessionals and the like. The Governor's office and private groups have documented Pennsylvania's slow growth prior to 2002. While other "rust-belt" states developed hi-tech industries, Pennsylvania remained economically more abound during the last decade of growth.

12. Everyone in the medical malpractice debate agrees that reimbursement for healthcare providers in Pennsylvania has been inexcusably low. The trial bar has attempted to work with the medical profession to solve this problem.

13. Information submitted by Pricewaterhouse to the Mcare Commission shows the following:

13.1 Mcare's claim payments have declined each year since 2003;
13.2 Mcare's assessment rate has declined each year since 2001;
13.3 Total Mcare assessments paid by providers (net of abatements) have declined each year since 2001.

14. The history of Mcare payments shows a general downward trend from 2000 when it was $341 million to 2006 where it stood at the level of $210 million. This is an astounding drop which was not predicted and still has not been factored into Mcare Fund future scenarios.

15. The count of paid cases and claims also shows a dramatic drop. "Claims" are against individual providers that result in Mcare payments. A "case" encompass all claims paid to one plaintiff. Claims were 699 in 2000 and 424 in 2006. Cases were 544 in 2000 and 322 in 2006. This trend also needs to be factored into future long-term planning for the Mcare Fund.

16. Another dramatic change in the way medical malpractice cases are handled concerns alternative dispute resolution procedures. This has been embraced by both the medical profession and the trial bar. Mediation was used in 114 cases between September 1, 2005, and August 31, 2006, 46% increase when compared to 78 for the previous year. Arbitration was used in an additional 21 cases in 2006. Trials with pre-determined award ranges (high/low) were used in 4 cases. ADR techniques were used in a total of 139 cases in the 2006 Mcare claim year.

17. According to the Administrative Office of the Pennsylvania Courts, there were 2,632 case filings in the year 2000 and 1,698 in 2005 with a 41.5% decline in case filing since 2002.

18. The unfunded liability is the amount of money Mcare is projected to pay for claims reported to date as well as claims occurred but are unreported. The Pricewaterhouse representative has concurred in the statement that unfunded liability is nothing more than a future projection of claims payment and is not a debt owed. The drop in filings and payouts show that predictions of the so-called "unfunded liability" may be very high. Between 2000 and 2006 the unfunded liabilities were amazingly consistent. Because of the tail of effect on medical malpractice claims, the drop in both claims and payouts is not yet reflected in the future prediction of liabilities.

It must be remembered that from an actuarial point of view claims payouts are driven by claims and it must be understood from a patient safety point of view that claims are driven by medical errors which should not occur. The patient safety movement has taken off since 1999 and the results are dramatic. The number of claims and payouts in the last two years alone have dropped by more

than one-third. In some counties, which were expected to see an increase in filings because of venue changes making it impossible to file cases in Philadelphia, the number has actually dropped by one-half. Dauphin County would be one example of that.

IV. The Solution

The jurisdiction of the Mcare Commission is limited. The Mcare Commission is not in a position to address such matters as patient safety, the need for alternative dispute resolution, or other questionable approaches suggested by medical and hospital groups. The Mcare Commission can, however, contribute to the stability in the boutique medical malpractice insurance market.

It is the purpose of this paper to examine current proposals, based upon available legislation, for the Mcare Fund and to devise an approach which will be fair to the victims of medical malpractice as well as to providers who must pay for coverage when medical malpractice does occur.

Why do hospitals like self insurance and risk retention groups? A discussion with representatives of the Jefferson Health Care System, the Geisinger System and the Pittsburgh Medical Consortium demonstrates that self insurance and RRG's have the following attractions:

1) Less expensive;
2) Risk control;
3) Hands on handling of claims.

It is necessary legislatively to support the movement towards self insurance and risk retention groups. This concept has been embraced by hospitals because it works. Most of the hospital self insured entities would have no problem picking up the share of coverage now covered by the Mcare Fund.

V. Specific Concerns

1. No suitable replacement for the Mcare Fund has been suggested which would not be subject to the vagaries of interest rates and the reinsurance business. Therefore, it would be far too risky to assign no new claims to the Mcare Fund after December 31, 2008.

2. We agree that the current Mcare abatement program should continue and be institutionalized. The program should continue on a permanent basis with the same source of funding.

3. We agree that current coverage limits for primary coverage and the Mcare Fund should remain in place for policies, but not merely those that incept or

renew in 2007 and 2008. To suggest or infer any change in coverage limits would introduce instability and lack of predictability. Lack of predictability is one of the main sources of fluctuating medical malpractice insurance premiums. To the extent that primary coverage limits change, the Fund would have to be in place capable of providing the remaining coverage. This is a crucial aspect which cannot be left in the background.

4. We agree that all revenues from the cigarette tax and auto CAT Fund surcharges should be retained and placed in a proper fund for payment of future Mcare Fund claims and expenses.

5. We do not agree that primary limits should be increased absent availability of sufficient carriers, sufficient competition, and fair rates. Therefore, we believe that while primary carriers should be entitled to write more than $500,000 per occurrence if they wish, they should not be required so to do. Arbitrarily increasing primary limits is a recipe for the same disaster that has occurred at least three times in the last 30 years. It would represent a return to the "bad old days" of primary carriers being at the mercy of changing economic conditions. The current Mcare legislation addressing change in primary limits based upon "availability" and "affordability" of coverage is a crucial component to the stability of the medical malpractice insurance market.

6. Under this scenario, no Mcare assessments may be necessary, although that possibility should certainly be kept available.

7. Under the scenario we have suggested, a Health Care Provider Rate Stabilization Fund would not be necessary, although a name change for the Mcare Fund is not out of the question. The Mcare Fund could continue to provide coverage not provided by the primary market right down to dollar one, if necessary. The Fund would be "stabilized" by virtue of the cigarette tax and auto CAT Fund surcharges referenced above.

VI. Discussion

It would be irresponsible to decide at the current time that the Mcare Fund should be eliminated without very specific knowledge that the number of carriers available to write primary coverage and their rate structure would be fair. The Pennsylvania insurance market for medical malpractice is relatively small, and therefore the fluctuations great. In 1987, Hofflander and Nye, at the request of the Medical Society, the Pennsylvania legislature, and the trial lawyers, examined the medical malpractice insurance rate cycle in Pennsylvania. The predictability of that cycle has been born out and was reaffirmed by the updating of the Hofflander and Nye study in 2001/2002.

What is needed is a stable source of revenue for the Mcare Fund, together with appropriate risk management. While that risk management has begun, thanks to the

Pennsylvania Patient Safety Authority, the Health Care Quality Containment Council, the Governor's Office of Health Care Reform and the Pennsylvania Department of Health, those efforts have not been clearly tied into claims payout features.

It is beyond the scope of the Mcare Commission to integrate the issues of primary insurance levels, excess insurance levels, patient safety, reimbursement levels and physician access at the same time.

The evidence is convincing that the largest components of medical malpractice insurance costs are interest rates, the investment climate, and payouts due to insufficient patient safety measures. The Health Care Quality Containment Council of Pennsylvania has estimated that infections alone cost the Pennsylvania health care system $1 billion per year because of the high cost of pharmaceuticals.

While the proposals of the Medical Society and its allies do provide for an interesting dialogue, they are not supported on a long-term basis by the available data and would risk an insurability crisis caused by even a modest change in interest rates.

Perhaps the greatest reason for primary insurance coverage in Pennsylvania today is the fact that interest rates have risen dramatically. Even so, only three carriers in Pennsylvania write the majority of primary coverage in the Commonwealth. To eliminate the Mcare system, based upon available knowledge, invites uncertainty in the market and could lead to catastrophe for health care providers.

VII. Proposal

A more modest proposal, which seems to be supported by the current data, is as follows:

1. Keep the Mcare Fund in existence as provided for by statute, subject to bi-yearly scrutiny as to whether primary insurance coverage is "available and affordable." In other words, utilize the current statutory schematic.

2. Permanently fund Mcare with cigarette tax and the auto CAT Fund legislatively.

3. Study whether the current legislation would permit the Insurance Department to allow primary carriers to write more than $500,000 of primary coverage, if they wish, without requiring more coverage to be written by the primary carriers. A study should be conducted by the Legislative Finance and Budget Committee on the relationship between interest rates, medical payments reimbursement, and medical malpractice insurance rates.

4. On a long-term basis, consider whether legislation would be necessary for the insurance commissioner to permit primary carriers to write less than $500,000 of primary coverage, and for the Mcare Fund to pick up the remainder when conditions require.

In order to utilize this alternative model, some further underwriting and financial models will have to be developed.

VIII. MCARE COMMISSION ACTUARIAL DATA

Tim Landick from Pricewaterhouse Coopers has worked hard on behalf of the Mcare Commission to examine data and create models. Those models all have their limitations both because of the relatively short period of time to study alternatives and because of the limited jurisdiction of the Mcare Commission.

The following information has been provided by the Mcare Commission:

1. The value of the stream of cigarette tax surcharges through 2025 is $3.1 billion from the HAP proposal presented October 5, 2006.

2. The value of the Auto Cat Fund surcharges through 2013 is $0.3 billion from the HAP proposal presented October 5, 2006.

3. The value of Mcare assessments under Act 13 with no change in limits through 2025 is $4.3 billion from Attachment C of the HAP proposal presented October 5, 2006.

4. The value of projected Mcare claim payments through 2025 is $12.0 billion from slide 39 in Tim Landick's September 14, 2006, presentation.

5. The value of Mcare Fund operating expenses through 2025 is $0.2 billion from Attachment C of the HAP proposal presented October 5, 2006.

6. The value of Mcare claim payments for incidents through 12/31/05 is $2.3 billion from Tim Landick's June 15, 2006, presentation on unfunded liabilities.

7. Tim Landick has stated at Commission meetings that he expects Mcare's unfunded liabilities will increase by approximately $0.1 billion in CY2006 (this is not on the website).

8. The value of primary premiums annually through 2025 for $500,000/$1,500,000 of coverage is $4.0 billion (PV) from slide 20 from the October 5, 2006, meeting.

9. The value of claim payments through 2025 in excess of $500,000/$1,500,000 of coverage is $4.0 billion (PV) from slide 20 from the October 5, 2006, meeting.

The assumptions of the numbers provided, in many cases, are just as important as the numbers themselves. What is the basis upon which we can predict greater payouts or expenses than are currently the case? What is the data which supports drop in claims based upon enhanced patient safety? Perhaps even more fundamental is the question as to what facts to take into account in projecting future liabilities, referred to as "unfunded liabilities."

The crucial problem is that by shifting future guestimates of liability of the Mcare Commission to the private insurance industry, there is not going to be any reduction in cost of medical malpractice insurance. Transfer to the private insurance industry of all responsibility for medical malpractice insurance will actually increase administrative costs because of the need by the primary insurance carriers to make a profit. That is understandable but represents a cost increase nevertheless.

The work conducted by the accounting firm demonstrates that whether the Mcare Commission exists or not, there are going to be increases in medical malpractice premiums just by virtue of inflation. The accounting firm has not taken into account any permanent reduction in claims due to patient safety initiatives which have taken hold over the last two years.

Therefore, regardless of whether there is an Mcare Fund or not the following endemic problems exist in the medical malpractice insurance industry:

1. The number of purchasers of medical malpractice insurance is small, especially as more hospitals insure.

2. The medical malpractice insurance market is very homogeneous with most of the carriers writing only medical malpractice insurance.

3. The Pew Foundation and others have pointed out that not nearly all the people are compensated for medical errors who should be compensated although some of the payouts that are large receive much publicity.

4. Nobody has devised a good way of predicting the cost savings of patient safety initiatives although the Health Care Quality Containment Counsel and other groups have come out with some very large projected cost savings as a result of enhancements in patient safety.

5. If the cost of medical malpractice insurance is going to stay level, drop or not exceed inflation there are a limited number of alternatives as follows:

5.1 Public funding from Auto CAT Fund and cigarette tax must continue;
5.2 Other public funding should be considered tied to patient safety initiatives;
5.3 Mcare Fund should be able to receive public funding in years where rates may rise dramatically due to the well known insurance cycle;
5.4 Regulation of the insurance industry must be considered including but not limited to requiring insurance companies that do business in Pennsylvania to write some portion of their business in medical malpractice;
5.5 Consideration should be given to creating a private consortium or pool of insurance carriers that may not otherwise be writing medical malpractice insurance in Pennsylvania in order to handle the primary requirements;
5.6 Requiring binding arbitration between primary insurance carrier and the Mcare Fund when there are disputes about payment. This would have to be legislatively created;
5.7 Reconsidering the role of the Joint Underwriting Authority;
5.8 Investigate permitting self insurance for the full amount of acquired liability limits. In other words, should hospitals and risk retention groups be able to "opt out" of the Mcare Fund subject to other appropriate regulation and proof of sufficient financial security? Is there a hybrid approach where the Mcare Fund would continue to exist for those who are not in self insured pools or risk retention groups?
5.9 The insurance commissioner should legislatively be given authority to consider "affordability" along with availability of insurance and to either permit the primary carriers to write more or less coverage. Additional flexibility is needed in the system to flatten out the sometimes dramatic and unpredictable insurance cycle.
5.10 It is imperative to have aggressive risk control and compliance and to reward patient safety with lower rates while making sure that unsafe practitioners or institutions receive remedial assistance and pay higher rates.
5.11 Extending the life of the Mcare Commission and enhancing its jurisdiction to consider other legislative alternatives such as those discussed herein.

IX. POSITION OF THE PENNSYLVANIA TRIAL LAWYERS ASSOCIATION

The undersigned author asked the Pennsylvania Trial Lawyers Association for an official position on the Mcare Fund.

The Pennsylvania Trial Lawyers Association voted at its recent quarterly meeting to recommend continuation of the Mcare Fund. The Pennsylvania Trial Lawyers

Association will continue to work with the legislature and interested medical groups to stabilize the medical malpractice insurance industry while enhancing claims management and risk reduction through patient safety.

The Pennsylvania Trial Lawyers Association supports continued public funding of the Mcare fund until and unless reasonable alternatives are developed such as those suggested here or which may be developed which will have the affect of stabilizing the medical malpractice insurance industry and flattening the dramatic insurance cycle which can disrupt the ability of doctors and hospitals to obtain medical malpractice insurance at reasonable cost.

The Pennsylvania Trial Lawyers Association continues to support patient safety initiatives along with an understanding that fair and prompt compensation is an instrumental part of our system of laws as well as a reasonable expectation of unnecessarily injured patients.