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February 20, 2019

Karla M. Shultz, Counsel
Civil Procedural Rules Committee
Supreme Court of Pennsylvania
Pennsylvania Judicial Center
PO Box 62635
Harrisburg, PA 17106-2635

Dear Ms. Shultz:

The Pennsylvania Medical Society (PAMED) respectfully submits its objections to the Civil Procedural Rules Committee's proposed amendment of Pa. R.C.P. Nos. 1006, 2130, 2156, and 2179 governing venue in medical professional liability (MPL) actions.

In the early 2000s, Pennsylvania was losing the national competition for quality physicians due to the MPL crisis the state was experiencing at that time. And, as a result of the adverse practice climate, health care in the Commonwealth suffered. Fortunately, due to the 2003 MPL venue reform and a series of other legislative efforts, Pennsylvania recovered from the crisis and is once again a leader in the health care arena.

Regrettably, the proposed changes to the venue rule threaten to undo the positive gains the Commonwealth has made since the early 2000s by resurrecting forum shopping in MPL cases. This could result in a domino-effect of negative implications for the MPL insurance market and access to quality patient care for all Pennsylvanians—particularly in the state's rural areas.

The attached documents support PAMED's opposition to the proposed amendment by:

- Demonstrating the positive impact the current rule had on eliminating forum shopping in the Commonwealth;
- Underscoring the importance of the current rule in maintaining the stability of Pennsylvania's health care system; and
- Offering an analysis of the estimated impact of the proposed rule changes on MPL costs and insurance rates.

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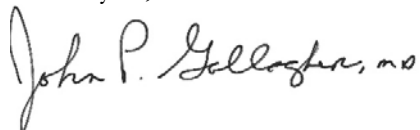
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PAMED's comments also advocate for collaboration between Pennsylvania's legislative and judicial branches, as well as an open public process in the development of any new rule.

Pennsylvanians cannot afford to allow the gains realized by the 2003 MPL venue reforms to be undone by the Committee's proposed changes. Accordingly, PAMED recognizes the great importance of this issue and appreciates the opportunity to comment on the proposed amendments.

Thank you,

A handwritten signature in black ink that reads "John P. Gallagher, MD". The signature is written in a cursive, flowing style.

John P. Gallagher, MD

**The Pennsylvania Medical Society's
Objections
to the Civil Procedural Rules Committee's
Proposed
Rule 1006 MPL Venue Rule Rollback**

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I. Introduction and Summary

The Pennsylvania Medical Society, on behalf of its member physicians (Medical Society),¹ objects to the Civil Procedural Rules Committee’s proposed amendment of Pa. R.C.P. Nos. 1006, 2130, 2156, and 2179 governing venue in medical professional liability (MPL) actions.² The proposed amendment would resurrect forum shopping in MPL cases, threaten patient care—particularly in rural Pennsylvania, and provoke a turf war with the legislature over a policy issue that, if pursued, cries out for interbranch collaboration, not confrontation.

Forum shopping redux: The Committee proposes to roll back a 2003 MPL venue reform that limits MPL venue to the “county in which the cause of action arose.” The limitation is premised on an express legislative finding that forum shopping—the then-prevalent practice of haling MPL defendants into high verdict counties such as Philadelphia even though the alleged injury did not occur there—is an opportunistic manipulation of the system. The General Assembly found that the problem was getting worse in 2002 because “existing venue rules” permitted suit in counties where a defendant had a business presence, and recent consolidations in the health care delivery system had thus multiplied the venues where plaintiffs could sue MPL defendants.

The Committee’s observation that the 2003 MPL venue reform “no longer appears warranted” is confounding. The facts show that the reform worked as intended, and continues to

¹ Founded in 1848, the Medical Society is presently the largest physician organization in Pennsylvania, comprised of over 16,000 physicians and medical students, and governed by physician members, including a Board of Trustees. Among its services, and a top priority, is advocacy for physicians at the state government level on matters involving medical professional liability (“MPL”) insurance and advocacy for physicians and Commonwealth residents, patients, in advancing public policy and public health measures.

² 48 Pa.B. 7744 (Dec. 22, 2018).

be needed, perhaps now even more than in 2003. The Committee’s rationale perversely implies that the very success of the 2003 MPL venue reform— “a significant reduction” in MPL filings in the past 15 years—somehow justifies abandoning the reform and reinstating forum shopping. But the data show that while Pennsylvania continues to rank near the top of states nationwide for MPL case filings³ and size of payouts,⁴ the “significant reduction” in MPL case filings that the 2003 MPL venue reform brought about was in *Philadelphia* MPL filings.⁵ That means the 2003 MPL venue reform had its intended effect: Philadelphia, the county of choice for forum shopping plaintiffs, experienced a spike in MPL filings in 2002 as plaintiffs rushed to file before the rule went into effect, and then a precipitous drop in filings (much greater on a percentage basis than in other counties) after the MPL venue reform went into effect in 2003. While MPL filings in Philadelphia plummeted, filings in nearby Montgomery and Bucks Counties increased; Montgomery County MPL filings jumped by 316 percent.⁶ There is no basis for believing that a rollback of the reform will do anything other than spur a significant resurgence in MPL filings in Philadelphia, back to pre-2003 levels, or higher, as claims based on care provided in counties outside of Philadelphia are permitted to return to Philadelphia courtrooms.

It is likely, moreover, that rollback will make the problem worse than before.

Consolidation in the health care delivery system since 2003 has not reversed—it has grown exponentially.⁷ Today, many more physicians are associated with health systems and other large providers that have a business presence in counties throughout the state. A rollback of the 2003 MPL venue reform would precipitate an influx of MPL cases to Philadelphia and other high

³ Figures 14 and 15.

⁴ Figure 12.

⁵ Figure 1.

⁶ Figure 2.

⁷ Figures 16 and 17.

verdict counties that have no connection to the county in which the alleged injury occurred.

Global actuarial firm Milliman conservatively estimates the rollback will increase MPL costs and insurance rates by 15 percent statewide, with an additional 17 percent increase for physicians in high-risk specialties.⁸

Threat to Rural Patient Care: There is no doubt that rolling back the 2003 MPL venue reform will revive forum shopping in Philadelphia and other high verdict counties. Forum shopping's burden will fall on physicians who have chosen to practice in rural Pennsylvania but who are forced to defend MPL actions in high MPL payout counties far from where they live and practice. In addition to inconvenience and time away from patients, the data show that in Philadelphia they face a higher likelihood of plaintiff verdicts,⁹ higher verdict and settlement amounts,¹⁰ and resulting higher reported MPL insurance rates and MCARE assessments.¹¹ Pennsylvania faces a serious shortage of physicians in rural areas, documented in recent years by government and non-governmental organizations. Forty-eight (48) of Pennsylvania's 67 counties, home to 3.4 million residents, are designated as rural,¹² and twenty-two percent of Pennsylvania's citizens live in areas that are plagued by health care provider shortages.¹³ It is hard enough to get physicians to locate in Pennsylvania's rural areas now; if we revert to the old venue rule, we risk losing the ones who already live and work there, and discouraging others from choosing to care for patients in rural areas.

⁸ See Appendix C.

⁹ Figure 4.

¹⁰ Figures 5-7.

¹¹ Figures 8-9.

¹² Figure 19.

¹³ Figure 20.

Health Care Policy Turf War: The 2003 MPL venue reform the Committee is proposing to roll back was integral to the General Assembly’s effort in 2001 and 2002 that produced the MCARE Act—social legislation designed to abate the MPL crisis that threatened patient access to quality health care. The 2003 MPL venue reform in Rule 1006 began as a section of the legislation that became the MCARE Act, was enacted as a separate statute after representatives from all three governmental branches reported back to the legislature to recommend its adoption, and then was “incorporated” by the Supreme Court into Rule 1006.

Implicit in the proposed rollback is a recognition that rollback will result in a direct conflict between the parallel statute and Rule 1006 as amended. To effectuate the amendment, the Supreme Court will need to invoke its exclusive power under Pennsylvania’s Constitution to promulgate procedural rules, and to suspend the statute as inconsistent with Rule 1006 as amended. Confrontation of this sort is neither necessary nor wise. Both the legislature and the Court have in the past recognized MPL venue as part of a larger debate that involves substantive public policy: how best to assure quality health care for Pennsylvanians. Interbranch collaboration remains the good government path. If after reviewing the comments it has solicited the Committee still believes the proper choice is to roll back the 2003 MPL venue reform, it should recommend that the Court work cooperatively with the General Assembly to find a path forward. The existing rule was born of cooperation and compromise. Changes to it should be handled in the same spirit. Unilateral action by the Court in a matter that so clearly affects substantive public policy is the type of action that has in the past, and could here, provoke legislative attempts to curb the Court’s Constitutional powers.¹⁴

¹⁴ See, e.g., Daniel A. Durst, *Pennsylvania Judicial Rulemaking: Steps Toward Increased Public Participation*, 86 Pa. B.A. Q. 47, 57 (2015) (“In the past, judicial rulemaking suspensions without notice have created tension with the legislature. For example, the Court exercised its

The Committee’s proposed amendment already has attracted legislative scrutiny, prompted a legislative fact finding plan, and initiated an unusual formal dialogue by the General Assembly with the Supreme Court. On February 5, 2019 the Senate adopted Senate Resolution No. 20 of 2019 directing the Senate 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” including “an assessment of the likely impact of the Civil Procedural Rules Committee proposed amendment to Pa. R.C.P. No. 1006” on “availability of medical care,” access to “the full spectrum of hospital services and highly trained physicians in all specialties,” access to affordable MPL insurance “in every geographic region” of the state, and the “prompt determination of and fair compensation for, injuries and death” resulting from medical errors. The Committee is directed to hold “at least one public hearing” on the issue and “report its findings to the General Assembly no later than January 1, 2020.”¹⁵ The resolution expressly requests the Pennsylvania Supreme Court “to delay action on the amendment to Pa.R.C.P. No. 1006” pending submission of the Committee’s report and directed the Secretary of the Senate to transmit certified copies of the resolution to the Justices, which was effected as of February 7, 2019. On February 14, 2019, the Court agreed to do so.¹⁶

rulemaking authority to suspend the Capital Unitary Review Act without prior notice, which ignited another round of proposed resolutions to amend the Constitution to fetter the Court’s rulemaking power. One such proposed constitutional amendment would have required a notice and comment period, as provided by the General Assembly, prior to the adoption of judicial rules by the Court.”) (footnotes omitted).

¹⁵ See *History of S. Res. 20*, P.N. 155, 203rd Gen. Assem., Reg. Sess. (Pa. 2019) https://www.legis.state.pa.us/cfdocs/billInfo/bill_history.cfm?year=2019&sind=0&body=S&type=R&bn=20

¹⁶ *Id.*

1. The 2003 MPL Venue Reform Derives From, and Mirrors, Contemporaneous Remedial Legislation Enacted to Provide Pennsylvania Patients With Access to Quality Medical Care

Rule 1006's 2003 MPL venue reform grew out of 2001 legislative efforts to enact the MCARE Act to address a medical professional liability crisis so serious that it threatened Pennsylvanians' access to health care.¹⁷ Originally part of the draft legislation that became the MCARE Act,¹⁸ a legislative compromise removed the MPL venue requirement and replaced it with Section 514—an express legislative finding that existing venue rules were part of the health care access problem.¹⁹ Section 514 also mandated the creation of a Joint Interbranch Commission populated by appointees from each branch of government²⁰ “to review and analyze

¹⁷ As the Pennsylvania Supreme Court has explained: “The MCARE Act is unusual in that it amounts to something very similar to a government-run supplemental insurance program. It was enacted to abate a malpractice insurance exigency serious enough to require legislative intervention. As such, MCARE comprises social legislation specifically designed (among other things) to ensure that Pennsylvania citizens have access to the care they need by incentivizing health care professionals to stay in Pennsylvania, or move to Pennsylvania, and fulfill those needs. *See, e.g.*, 40 P.S. §§ 1303.102 (“It is the purpose of th[e MCARE] act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.”); 1303.502 (“Ensuring the future availability of and access to quality health care is a fundamental responsibility that the General Assembly must fulfill as a promise to our children, our parents and our grandparents.”); 1303.514.” *Hospital and Healthsystem Assoc. of Pa. v. Com.*, 77 A.3d 587, 603 (Pa. 2013).

¹⁸ H.R. 1802, P.N. 2788, 186th Gen. Assem., Reg. Sess. (Pa. 2001) (final passage in Pa. House of Representatives January 29, 2002, H.J. p. 139).

¹⁹ 40 P.S. § 1303.514(a) (“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.”).

²⁰ 40 P.S. § 1303.514(b)(1).

the issue of venue as it relates to medical professional liability actions filed in this Commonwealth”²¹ and make recommendations.²² After deliberation a majority of the Joint Interbranch Commission recommended that “venue be limited in medical professional liability actions to a county where the cause of action arose or where a transaction or occurrence took place out of which a cause of action arose.”²³

²¹ 40 P.S. § 1303.514(b)(2).

²² As Senator Dent described it in comments offered at final passage in the General Assembly, the venue issue was integral to the legislative solution to the crisis and the compromise of chartering the Joint Interbranch Commission was critical:

There are things in this legislation I like very much, and there are some things I wish would be in this legislation that are not here. One of those things in particular deals with the matter of venue. All of us know that too many of our hospitals and our physicians have been dragged into courtrooms in communities far removed from where they actually live or where the alleged malpractice events may have occurred. We know that particularly in the city of Philadelphia we have a problem with venue, that many plaintiffs want to take those cases into Philadelphia courtrooms. We know that, we also know why, because the average jury awards in the city of Philadelphia in medical malpractice cases are more than twice that of just about anywhere else in Pennsylvania, \$970,000, to be exact. This legislation contains language that deals with a venue commission, and I think that is positive for us, and I think that we need to send a message to our friends at the State Supreme Court that venue is very important to all of us. I wish we had retained the original House language on venue that said that the malpractice case would be heard in the county where the alleged malpractice occurred. I would have liked to have legislated that, but I realize this legislation is the result of compromise and negotiation, and on that issue we were unsuccessful. Regardless, we hope through the venue commission the court will hopefully deal with this issue and adopt the changes that were originally recommended by the House.

H.R. 1802, P.N. 3420, 186th Gen. Assem., Reg. Sess. (Pa. 2001) (final passage in the Senate of Pa., March 13, 2002, Leg. J. p. 1454).

²³ *Report of the Pennsylvania Interbranch Commission on Venue* (Aug. 8, 2002) at 14. The Committee, chaired by Hon. R. Stanton Wettick, included members Edward J. Balzarini, Michael J. Foley, Edwin L. Klett, William H. Lamb, Donald E. Matusow, Gerald J. Pappert, Hon. Curt Schroeder, James J. Sheehan, Hon. Rea Boylan Thomas, and Hon. Mary Jo White. Six of the eleven members supported limiting venue in medical professional liability cases as described.

Two months later, in October 2002, relying on the Joint Interbranch Commission Report,²⁴ the legislature added Section 5101.1 to the Judicial Code,²⁵ limiting venue in MPL actions to the county in which the cause of action arose:

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.²⁶

Remarks offered in the House and Senate in support of the legislation confirm that the MPL venue rule was an essential component of the legislative solution to the crisis affecting access to

²⁴ 42 Pa. C.S. § 5101.1(a) (prefacing the MPL venue rule stated in 42 Pa. C.S. § 5101.1(b) with a declaration of public policy that referred expressly to Section 514 of the MCARE Act's creation of the Joint Interbranch Commission: "In accordance with section 514(a) of the act of March 20, 2002 (P.L. 154, No. 13),¹ known as the Medical Care Availability and Reduction of Error (Mcare) Act, and as a matter of public policy, the General Assembly further declares the need to change the venue requirements for medical professional liability actions.")

²⁵ Act of October 17, 2002, P.L. 880 (Act 127 of 2002) § 3.

²⁶ 42 Pa. C.S. § 5101.1(b).

health care in Pennsylvania.²⁷ The legislation was approved overwhelmingly in the House²⁸ and unanimously in the Senate.²⁹

On January 27, 2003, the Pennsylvania Supreme Court amended Rule 1006 to add to its civil suit venue rule the MPL venue requirement enacted by the legislature three months before, using language essentially identical to that enacted by the legislature. In the explanatory comment to the rule amendment, the Supreme Court cited to and quoted 42 Pa. C.S. § 5101.1(b), stating that the statutory provision “has been incorporated into Rule of Civil Procedure 1006 governing venue as new subdivision (a.1). The new subdivision uses the terminology of the legislation.”³⁰

²⁷ **See, e.g., remarks of Representative Gannon**, October 7, 2002, L.J. p. 1815: “The venue commission studied this issue long and hard, and essentially what the venue commission did was paved the road so that the legislature could take action on this important proposal to move Pennsylvania in the right direction to solve our medical malpractice insurance crisis. One hundred and fifty years ago we did not have that, Mr. Speaker, and that is why we need this change today, to bring things back into focus, to bring them into context, to level the playing field, if you will. This is an opportunity that we should not let pass to make this correction, not to deny any plaintiff the access to the courts which they rightfully have, not to deny a plaintiff the opportunity for a trial before a jury of his or her peers, but to provide that forum which is appropriate, and that forum is the forum where the cause of action arose and not another jurisdiction where the relationship is so tenuous that it is often difficult for the most reasonable person to see it.”; **Remarks of Senator White**, October 9, 2002, L.J. p. 2216: “I suggest that forum shopping is not a constitutional right. Neither the 14th amendment of the Federal Constitution nor the Pennsylvania Constitution prohibits us from classifying persons differently or treating classes in different ways so long as that classification is rational and connected to some public policy that is justifiable. In the findings of fact in our MCARE Act, this General Assembly found as a declaration of policy 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 recent scope of existing venue rules.”

²⁸ Final Passage in the House (186-12), October 7, 2002 L.J. p. 1819.

²⁹ Final Passage in the Senate (49-0), October 9, 2002 L.J. pp. 2217-2218.

³⁰ 33 Pa.B. 751 (Feb. 7, 2003).

Separately, the North-Central Pennsylvania Trial Lawyers Association challenged the constitutionality of 42 Pa. C.S. § 5101.1(b)'s MPL venue requirement in November 2002, shortly after it was enacted, and before the Supreme Court's incorporation of it into Rule 1006, arguing that venue is a procedural rule, and that Article V, Section 10(c) of the Pennsylvania Constitution confers exclusive power on the Supreme Court to promulgate procedural rules. The plaintiffs filed in Commonwealth Court, but also asked the Supreme Court to take extraordinary jurisdiction of the case. The Supreme Court took no immediate action and the case proceeded in the Commonwealth Court. In the context of overruling preliminary objections filed by the Commonwealth defendants, the Commonwealth Court agreed that the statute is unconstitutional, and invited motions for summary disposition on the issue.³¹ Those motions were filed, briefed and argued, but never decided. Instead, on November 19, 2003, the Supreme Court granted the plaintiff's petition to exercise extraordinary jurisdiction, removed the case from the Commonwealth Court, and declared the constitutional issue moot as "a result of the promulgation of the amendments to Pa. R. Civ. P. 1006 by Order of January 27, 2003."³²

As this recap of the genesis of the MPL venue requirement reveals, the underlying issue is and has for at least the past two decades been a critical facet of a public policy concern that is the province of the legislative branch—Pennsylvanian's access to quality medical care. In this factual context, MPL venue is much more than a mere procedural issue. It directly affects the substantive rights of Pennsylvania's physicians, and indirectly affects the substantive rights of every citizen of Pennsylvania. The Pennsylvania Supreme Court wisely declined to interfere

³¹ *North-Central Pa. Trial Lawyers Assn. v. Weaver*, 827 A. 2d 550 (Pa. Cmwlth. 2003) (en banc).

³² *North-Central Pa. Trial Lawyers Assn. v. Weaver*, 260 MM 2002 (Pa. Nov. 19, 2003). <https://ujportal.pacourts.us/DocketSheets/AppellateCourtReport.ashx?docketNumber=260+MM+2002&dnh=xIBaqtPe99v3pbX6sneTcg%3d%3d>

with the legislature’s choice based on a simplistic separation of powers theory in 2003.³³ Today, and for the same reasons, the Committee should discontinue its proposed rollback of the MPL venue requirement. Any proposed review of the wisdom of the existing MPL venue requirement should involve, at a minimum, the type of legislative fact-finding that preceded its adoption in 2002 and 2003.³⁴

2. The 2003 MPL Venue Reform Has Curbed Forum Shopping With No Harm To Plaintiffs

The 2003 MPL venue reform had the intended effect of curbing forum shopping—the opportunistic importing of MPL cases into Philadelphia and other high MPL payout counties that are not the site of the alleged medical error. In Philadelphia, the effect was a decrease in MPL filings from an outsized 44 percent of statewide filings before the reform to an average of 29 percent since. The reform did not prevent plaintiffs from seeking compensation, but merely required plaintiffs to bring their claim in the county where they received treatment.³⁵ Figure 1

³³ See, e.g., Daniel A. Durst and Karla M. Shultz, *Wielding and Yielding: Pennsylvania Judicial Procedural Rulemaking Authority and the Preemption Doctrine*, 26 Widener L.J. 45, 53 (2017) (Observing that the Supreme Court could have suspended Section 5101.1 in 2003 when it promulgated the 2003 MPL reform as part of Rule 1006, but chose not to do so: “The supreme court’s rulemaking authority is not without limit. As it relates to the court’s procedural rulemaking authority, a line of arguable discernment has been drawn: procedural statutes intrude upon the supreme court’s exclusive rulemaking authority; whereas substantive statutes are within the General Assembly’s legislative authority. ...[V]enue is an area in which the lines between statutory procedure and judicial procedural rules have been blurred.”) (footnotes omitted).

³⁴ Legislative fact finding on the MPL venue issue already is underway as the result of Senate Resolution No. 20 of 2019, adopted February 5, 2019 and certified to the Justices of the Pennsylvania Supreme Court on February 7, 2019. The Court has advised that it will await the legislative committee’s report in 2020 before proceeding to consider any amendments to the MPL venue rules. See *supra* n.15.

³⁵ Contrary to the Committee’s suggestion (“it has been reported to the committee that [the significant reduction in MPL filings] has resulted in a decrease in the amount of claim payments resulting in far fewer compensated victims”), the overall drop in MPL filings *statewide* is attributable not to the 2003 MPL venue reform but rather other MPL reforms, including one adopted by the Supreme Court on the same day – the certificate of merit requirement in Pa. R.C.P. No. 1042.3. (33 Pa.B. 748 (Feb. 8, 2003)). Requiring an “appropriate licensed

depicts the sudden spike in MPL filings in Philadelphia when the reform was being considered (an additional 200 cases in 2002), and then the precipitous drop in Philadelphia filings versus the rest of the state after it went into effect:

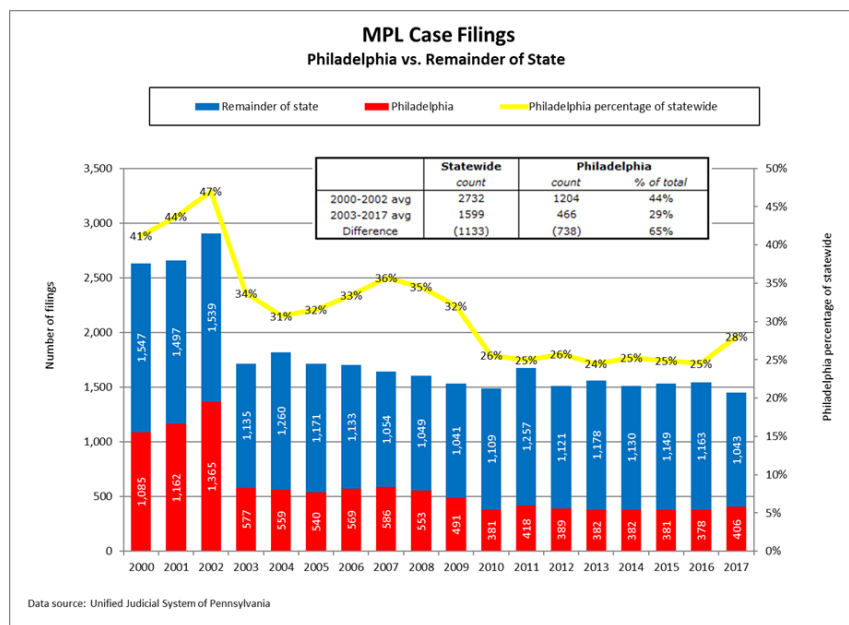


Figure 1

At the same time, MPL filings in Montgomery and Bucks Counties to the north and east of Philadelphia surged, as cases that otherwise would have been resolved in Philadelphia instead were litigated in the surrounding counties where the alleged medical error actually occurred, shown on Figure 2:

professional” to opine that there is a reasonable probability that the alleged deviation from an acceptable professional standard was a cause in bringing about the alleged harm had the effect of discouraging the filing of marginal MPL cases.

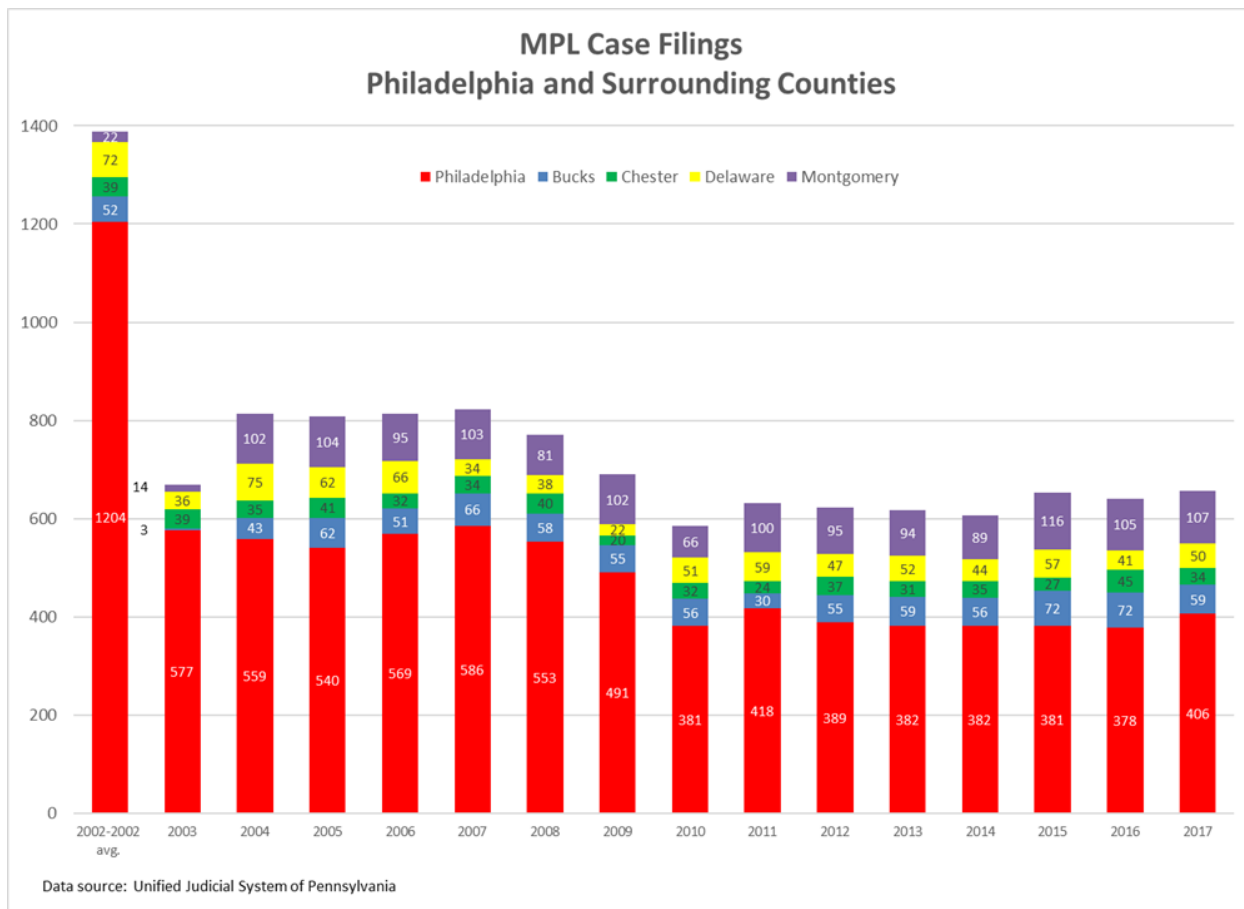


Figure 2

Philadelphia has long been a plaintiff-friendly, high-verdict MPL venue. In the decade before the MPL venue reform was adopted, Philadelphia’s median MPL verdict was \$972,909—almost twice that of Allegheny County, and more than twice the statewide median excluding Philadelphia County.³⁶ *The 2003 MPL venue reform was not designed to change that, and did not.* Philadelphia continues to rank as one of the highest venues in the nation for loss severity—that is, MPL payouts. Figure 3 compares Philadelphia to other high-severity venues in the country and reveals that in most recent years it was the worst:

³⁶ Jury Verdict Research based on data from 1994-August 2001.

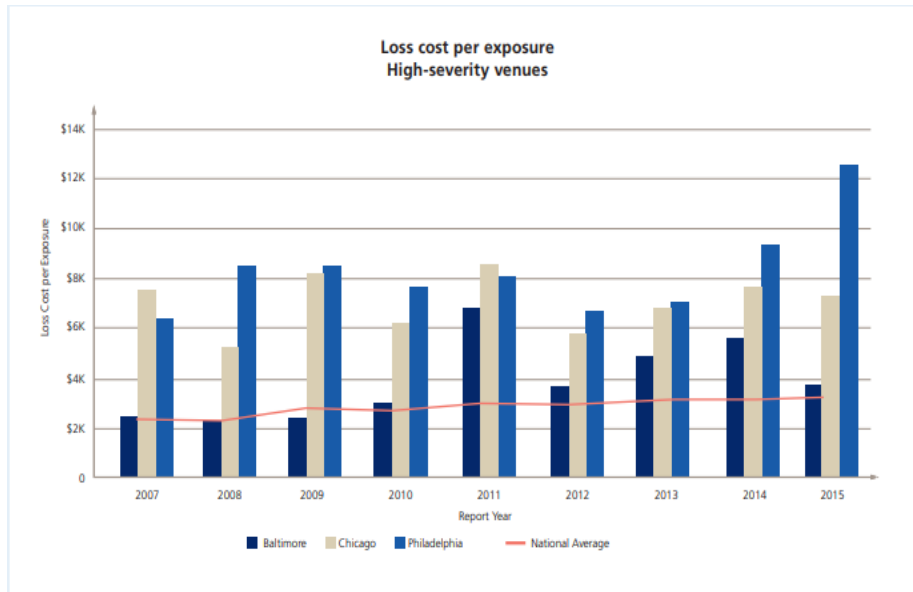


Figure 3

Source: Zurich, *2018 Benchmark Study of Healthcare Professional Liability Claims* p. 18. The full Zurich report is available on its website (https://www.zurichna.com/_/media/dbe/zna/docs/kh/hc/2018-zurich-benchmark-study-of-hpl-claims.pdf).

As shown in Figure 4, an MPL plaintiff's chance of success with a Philadelphia jury is about twice that of MPL plaintiffs in any other Pennsylvania county.

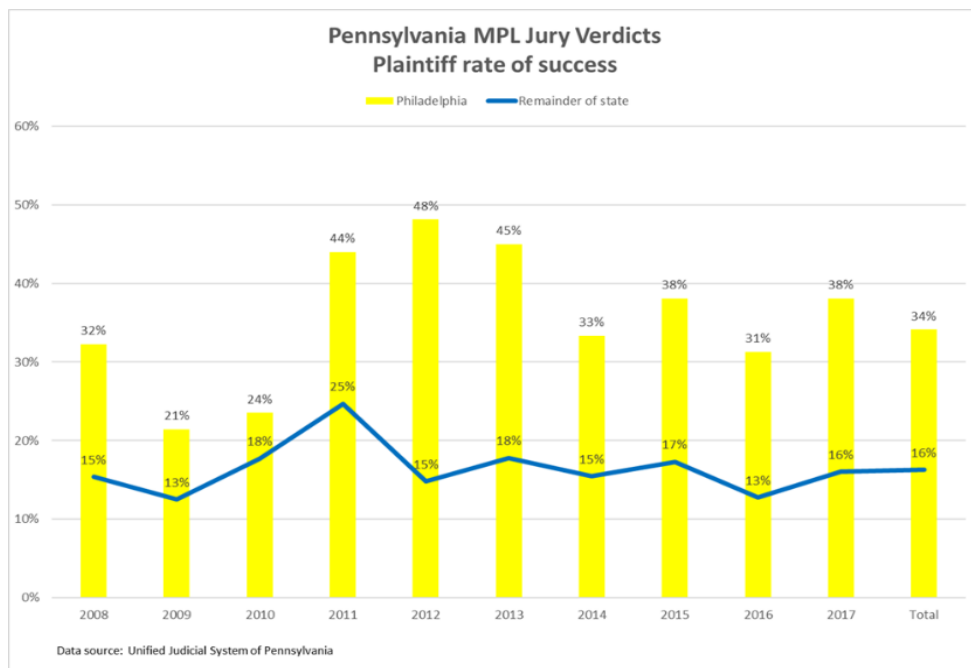


Figure 4

Philadelphia's position as a high MPL payout county is confirmed by data available from MCARE. In Pennsylvania, private MPL insurance provides a physician's first layer of required coverage, and MCARE provides the second layer. As shown in Figure 5, Philadelphia plaintiffs receive a disproportionate one-third of MPL payments that MCARE pays out statewide. This demonstrates either a higher frequency of Philadelphia claims that reach the MCARE layer, or higher payments in such cases, or both.

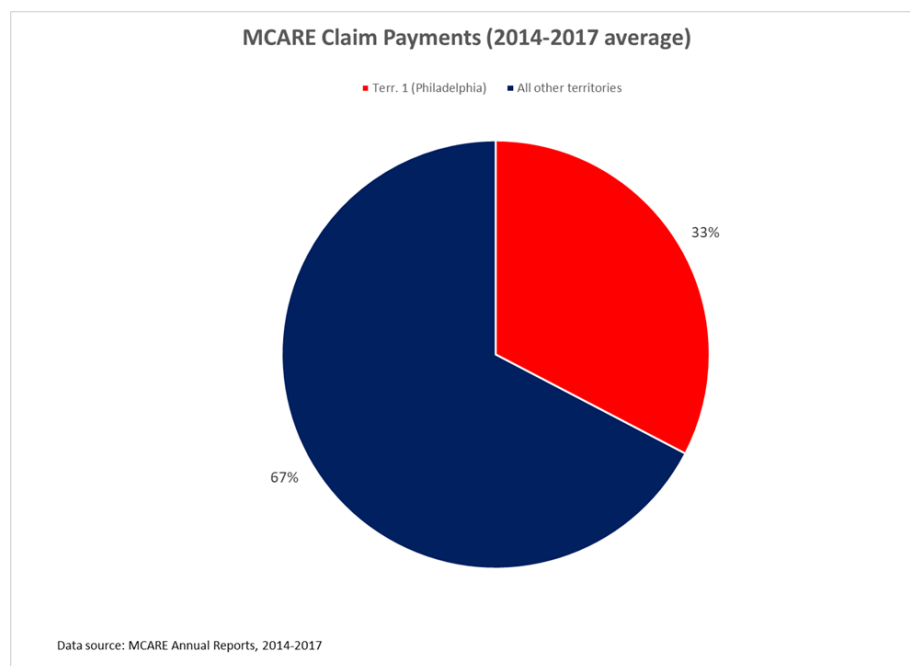


Figure 5

The same conclusion emerges from a look at MCARE payments per capita, which reveals that Philadelphia's rate is almost three times the statewide rate, shown in Figure 6:

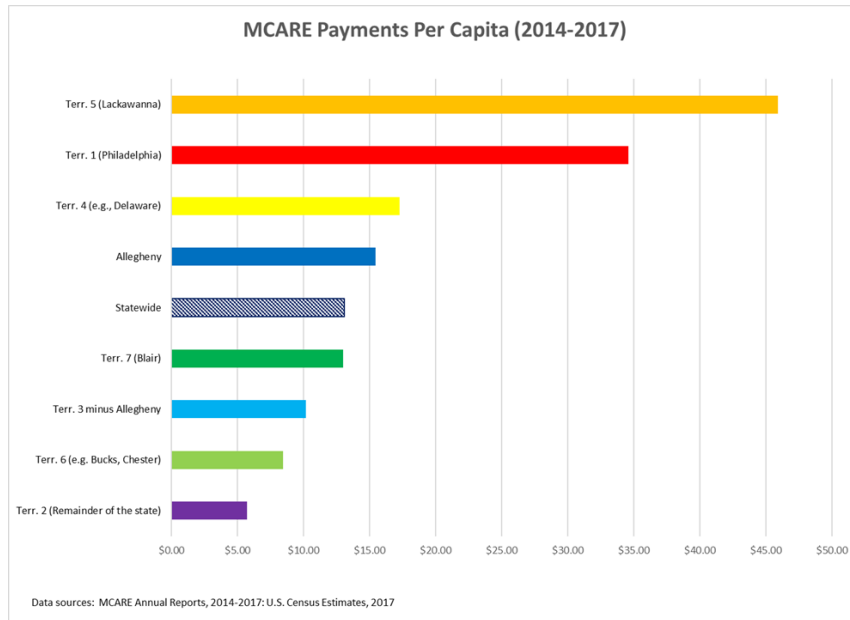


Figure 6

And, as shown in Figure 7 below, MCARE payments per hospital admission in Philadelphia are almost two times the statewide rate:

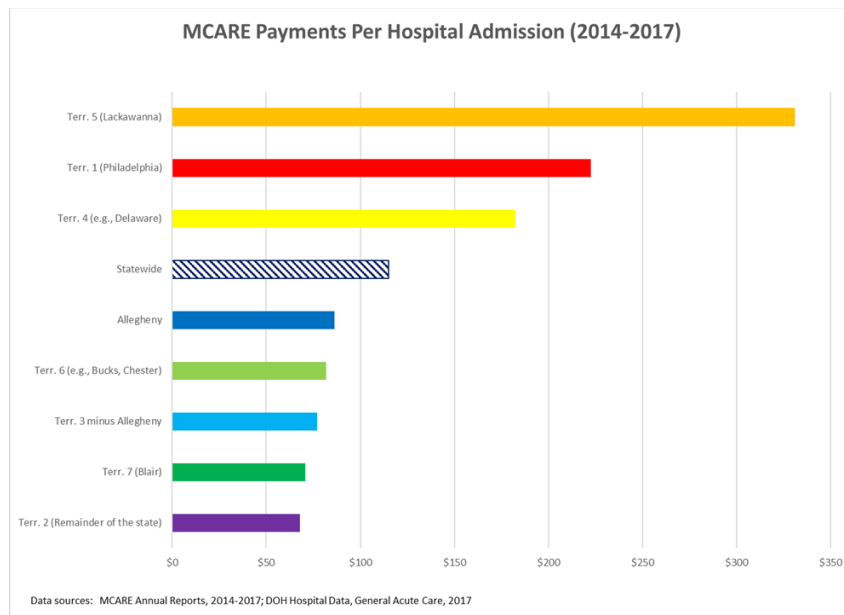
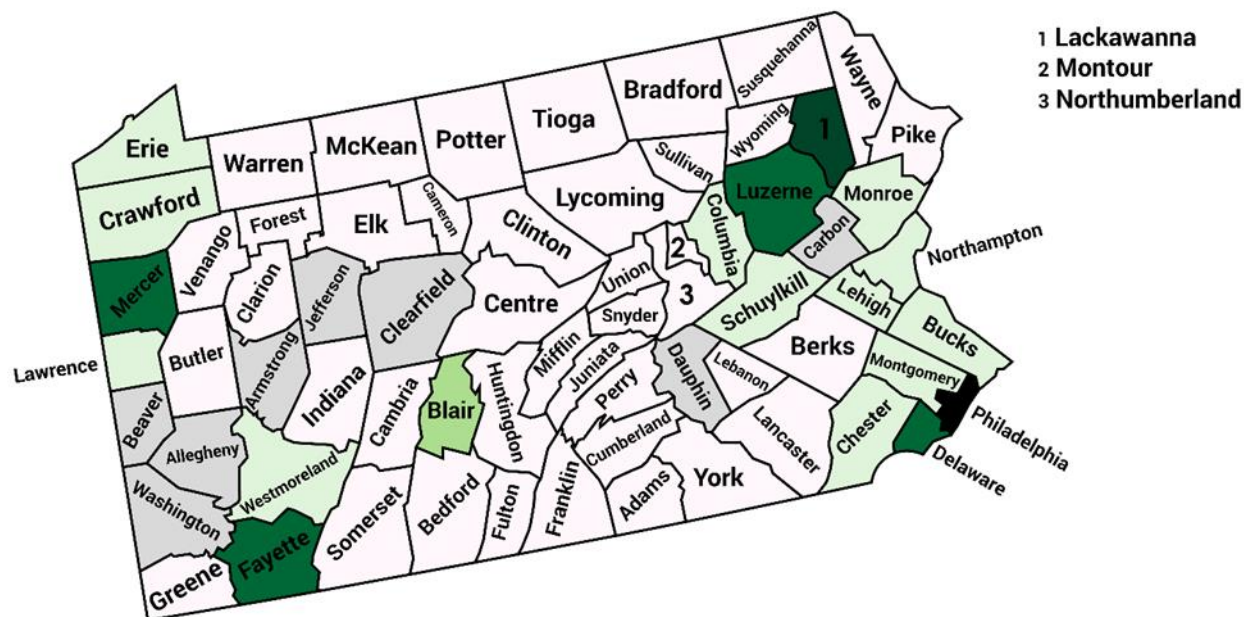


Figure 7

These indicators that Philadelphia is a plaintiff-friendly high MPL payout county are reflected in MCARE assessments physicians are required to pay. The Pennsylvania Professional Liability Joint Underwriting Association (JUA) assures that physicians are able to obtain the first layer of required private insurer MPL coverage. The second layer is MCARE, which is paid for through an assessment on each physician. The Insurance Department sets each physician's MCARE assessment using a percentage of the applicable JUA rate for the physician's territory within Pennsylvania and specialty. Philadelphia is its own territory for this purpose. It's MCARE assessment rating is more than double that of the rest of the state, based on the higher MPL payouts experienced in Philadelphia by comparison to other Pennsylvania venues.³⁷

Figure 8 below maps the relativities by territory and county:

³⁷ Lackawanna County also ranks high in MCARE payouts in the 2014-2017 period, but that the data reflect significant spikes in 2016 and 2017 payouts, and earlier MCARE reports do not break payout data out at the county level. *See* Appendix A at 12-17.



Key	Territory	Counties	Relativity
	1	Philadelphia	1.000
	5	Lackawanna	0.806
	4	Delaware, Fayette, Luzerne, Mercer	0.734
	7	Blair	0.701
	6	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland	0.593
	3	Allegheny, Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington	0.554
	2	Remainder of State	0.440

Data sources: Pennsylvania Professional Liability Joint Underwriting Association, Rate filings and Manuals. Manuals are available on JUA website (<http://www.pajua.com/juamannual.html>). Rate filings are available on NAIC SERFF Filing Access site (<https://filingaccess.serff.com/sfa/home/PA>). (Relationship of actual rates differs slightly apparently due to standard administrative fee.)

Figure 8

Actual MPL rates, including MCARE assessments, that physicians in various Pennsylvania counties are required to pay in order to serve patients is further indication of Philadelphia's outlier status. Figure 9 shows that an obstetrician-gynecologist in Philadelphia

faces an annual MPL insurance bill of \$130,000, almost double the \$70,000 reported rate in Lancaster County.

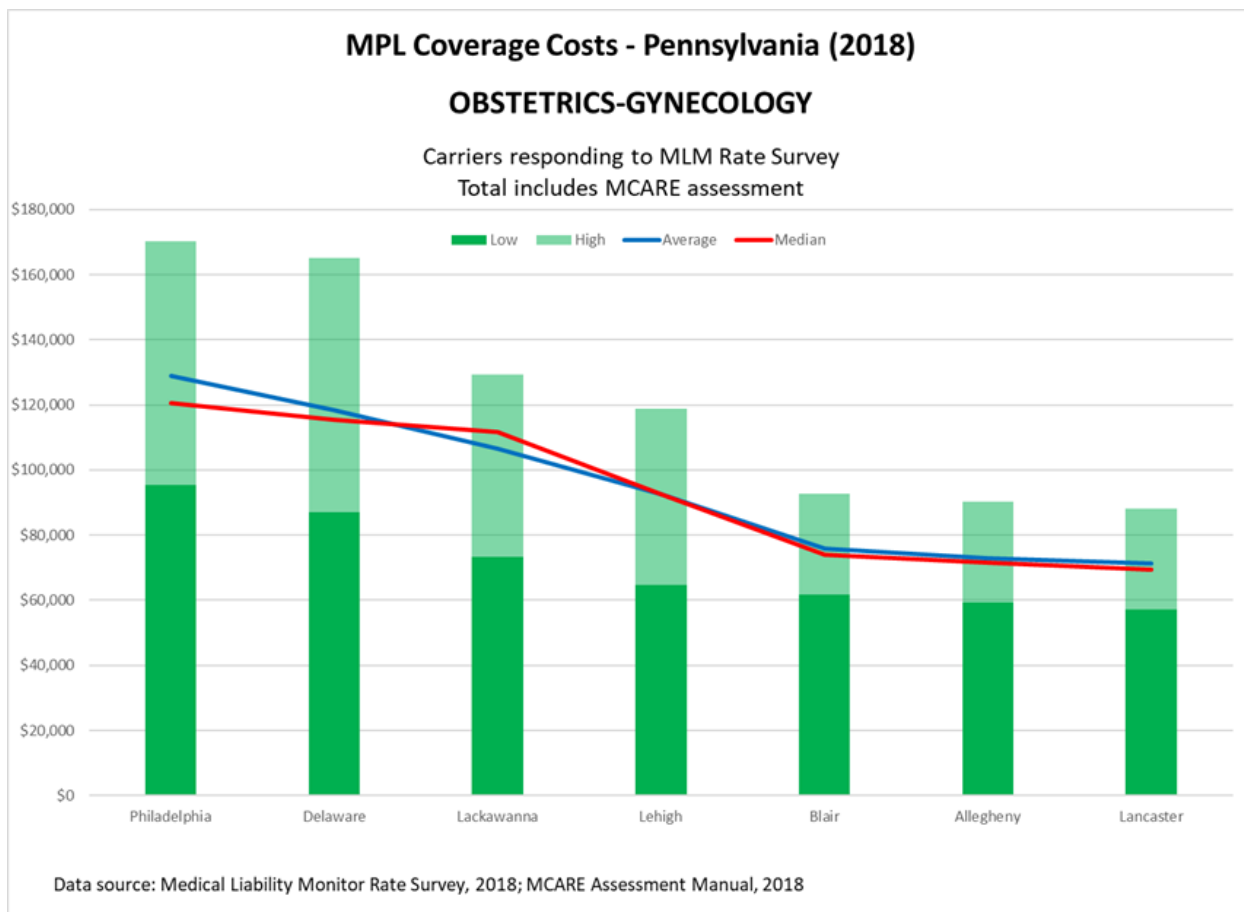


Figure 9

This MPL cost disparity between Philadelphia and other Pennsylvania venues carries through to other specialties, from internal medicine to general surgery.³⁸ National data reveal that MPL insurance costs for physicians practicing in Philadelphia are among the highest in the country, further proof that Philadelphia is among the most plaintiff-friendly venues in America. Again, looking at comparative rates for an obstetrician-gynecologist, Figure 10 shows that Philadelphia

³⁸ See Appendix A at 18-19.

is among the top ten venues nationwide:

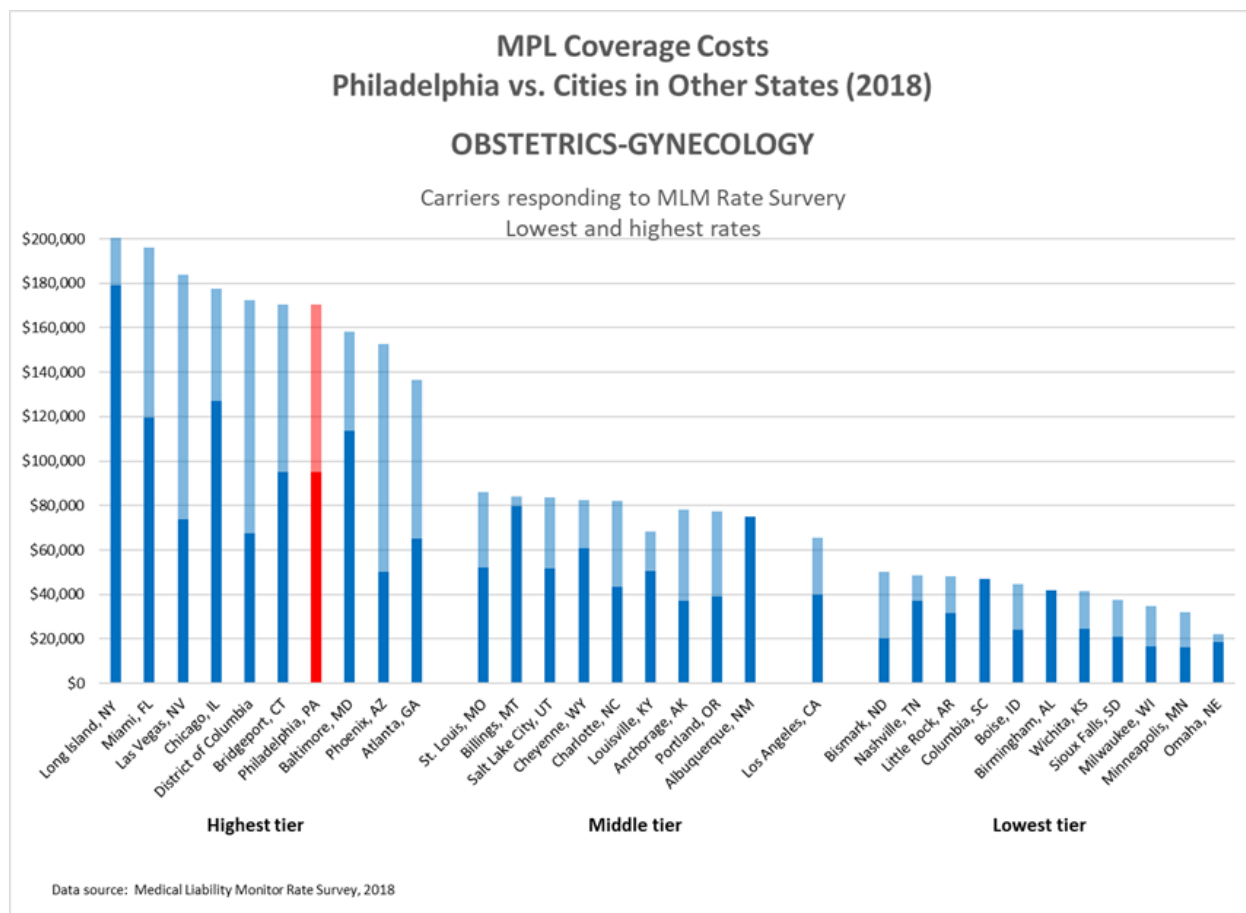


Figure 10

And again, this MPL cost disparity between Philadelphia and other venues across the country carries through to other specialties, from internal medicine to general surgery.³⁹ It thus is no surprise that the American Tort Reform Association has labelled the Philadelphia Court of Common Pleas as number 6 on its list of “judicial hellholes.”⁴⁰

The 2003 venue reform obviously did nothing to address the problem of runaway jury verdicts in Philadelphia, although there is ample reason for the General Assembly to attempt to

³⁹ See Appendix A at 20-21.

⁴⁰ <https://www.judicialhellholes.org/>

take steps to correct that problem. Instead, by requiring MPL plaintiffs to bring their claims in the county where they received treatment, the reform shifted many of the cases that previously would have been filed in Philadelphia to other venues—venues whose juries, like Philadelphia juries, reflect the values of the citizens who actually reside in the county where the care was rendered. In other words, the 2003 MPL venue reform did not attempt to impose the will of the legislature on juries, but instead elected to accept the judgment of juries in each county to determine liability and compensation for medical errors alleged to have been committed in that county. Under the 2003 venue reform, Philadelphia juries decide cases that arise from care provided in their county. These juries are twice as likely to find liability in cases and tend to render verdicts that are among the highest in the country. Cases arising from care rendered in other Pennsylvania counties are likewise decided by juries in those counties—these juries tend to find general liability less often and verdicts tend to be lower than in Philadelphia. While the Medical Society would have preferred that the General Assembly cap MPL jury verdicts, as some other populous states have done, the “local jury rule” venue reform chosen in 2003 certainly cannot be said to treat MPL plaintiffs who received care outside of Philadelphia unfairly.

The consequence of the 2003 MPL venue reform is that fewer cases are filed in Philadelphia and total statewide MPL payments since 2003 have decreased. However, as shown in Figure 11 for both physicians and other health care practitioners, that decrease is modest:

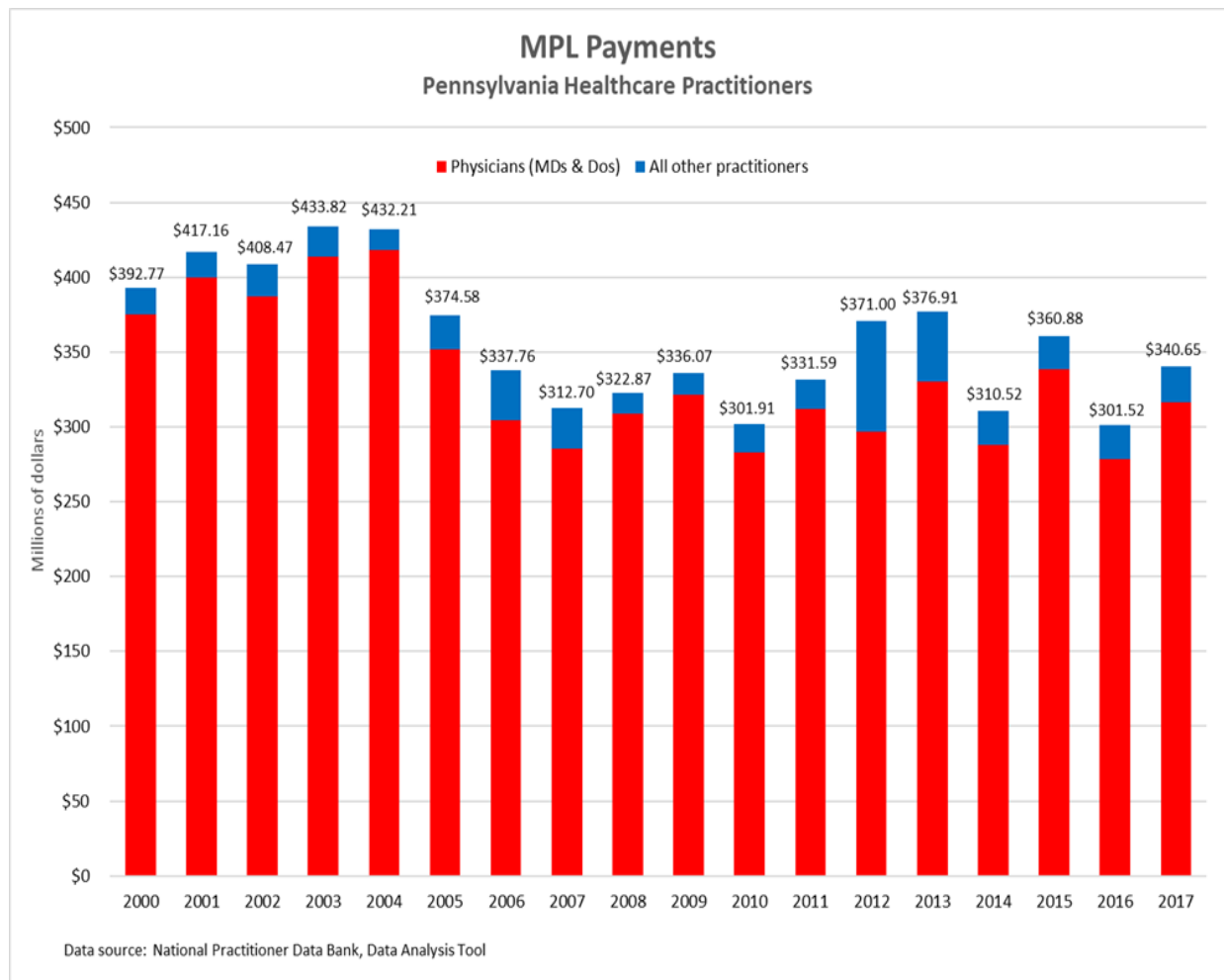


Figure 11

Indeed, as shown in Figure 12, Pennsylvania still ranks fourth in the United States overall in MPL payouts on a per capita basis, with payouts well more than double the national average:

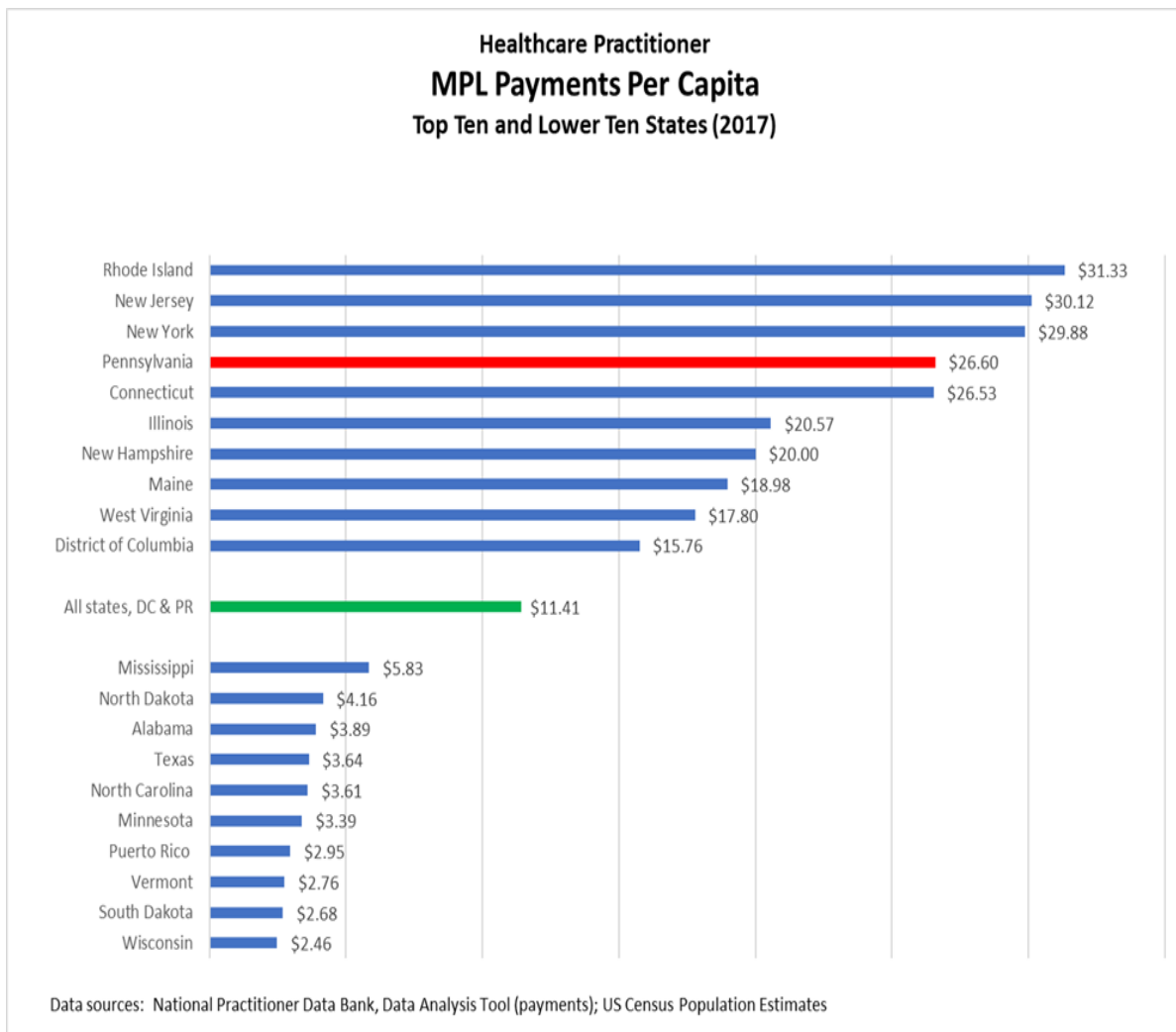
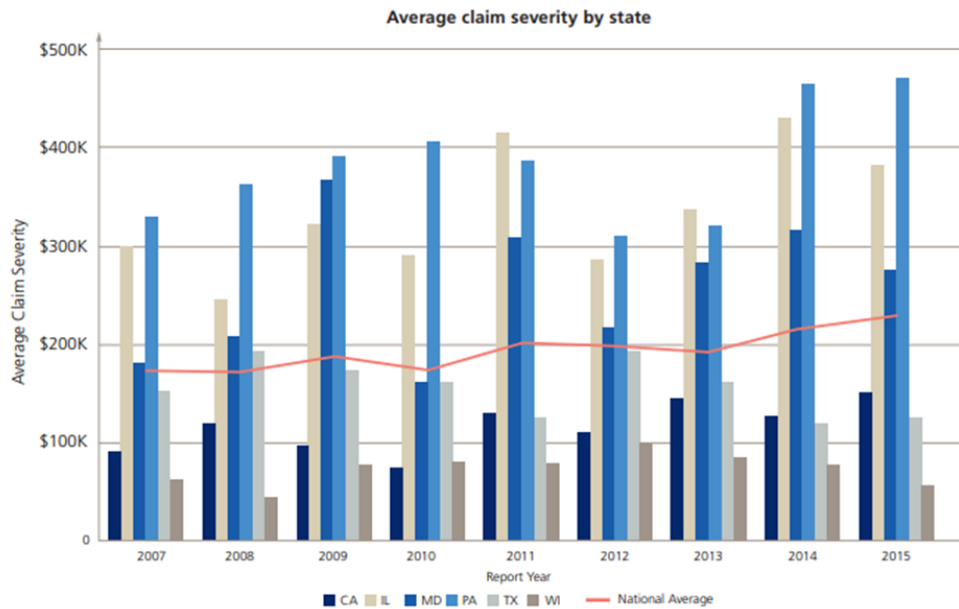


Figure 12

Nor can it be argued that the 2003 MPL venue reform adversely affected the ability of Pennsylvania plaintiffs to secure just compensation—Pennsylvania has consistently experienced one of the highest average claim severity levels in the country, and more than double the national average, as shown below in Figure 13:



Source: Zurich, 2018 Benchmark Study of Healthcare Professional Liability Claims p.7.

Figure 13

Moreover, while Pennsylvania MPL filings have dropped since 2003, MPL filings per capita in Pennsylvania are still among the highest in the country. Figure 14 below displays data collected by the National Center for State Courts, Court Statistics Project.

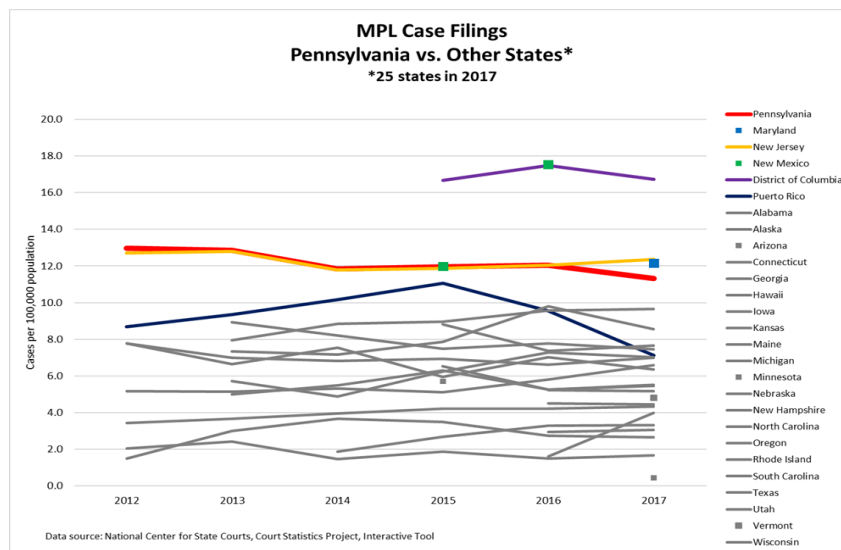


Figure 14

Figure 14 shows that of the jurisdictions reporting, only the District of Columbia, New Mexico, New Jersey and Maryland experience a higher number of MPL filings adjusted for population:

The same result holds even when MPL filings in Philadelphia are separated from the rest of Pennsylvania, as shown on Figure 15:

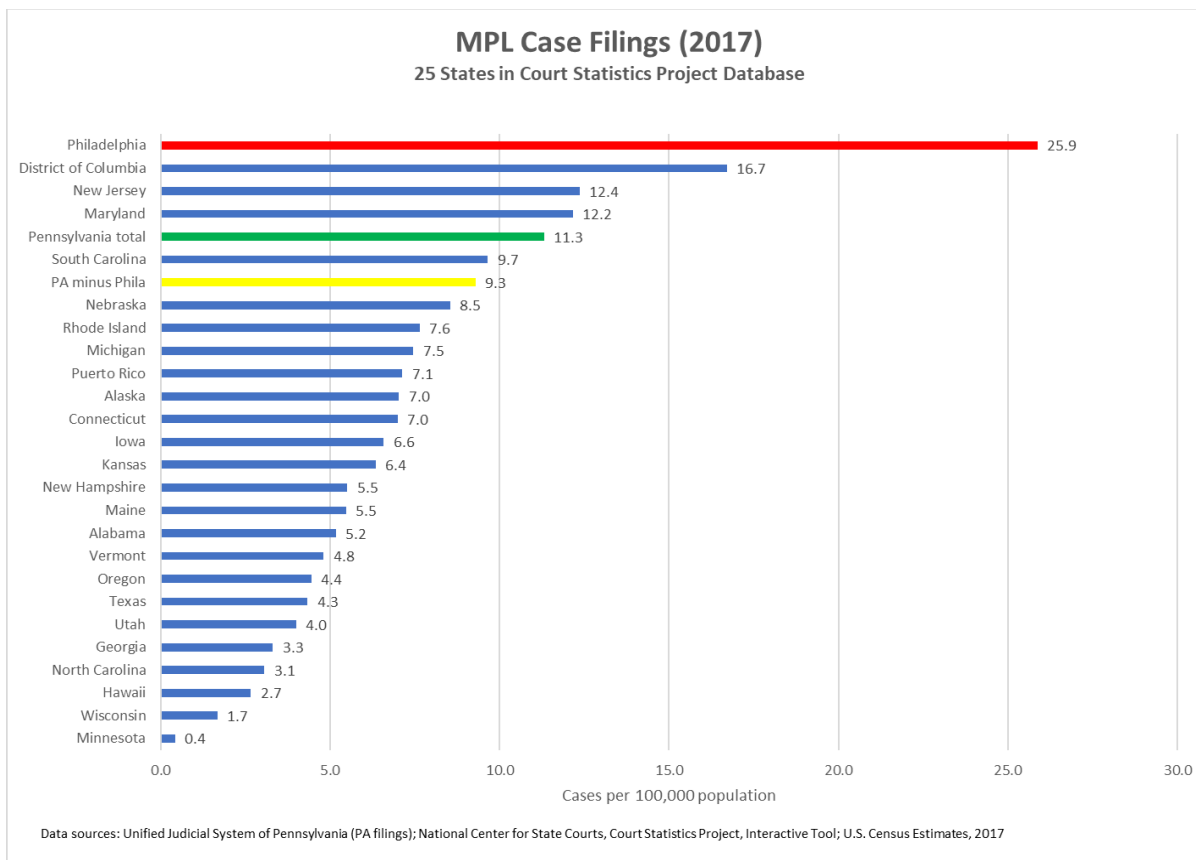


Figure 15

The data driven facts thus demonstrate that the Committee is simply wrong in assuming that the reduction in MPL filings since 2003 signals that MPL plaintiffs are not being fairly compensated, either from the perspective of Pennsylvania standing alone or by comparison with the rest of the country. The 2003 MPL venue reform was designed to reduce the number of plaintiffs filing suit in Philadelphia and other high-verdict counties by limiting venue in MPL

cases to the county in which the alleged medical error occurred. The reform was necessary to stop forum shopping. It has worked as intended. Since 2003, 65 percent of the decrease in statewide MPL filings is attributable to Philadelphia.⁴¹ Nothing prevents plaintiffs who seek compensation to file their MPL action in the county where the care was rendered—and they continue to do so. Pennsylvania remains among the leading states for number of MPL actions filed per capita, payouts to plaintiffs, and claim severity. In short, the 2003 MPL venue reform eliminated forum shopping, but it did not prejudice MPL plaintiffs.

3. The 2003 MPL Venue Reform is Needed Today More Than Ever

Contrary to the Committee’s assertion that the 2003 MPL venue reform “no longer appears warranted,” the historical facts about the General Assembly’s reason for limiting venue to the “county where the cause of action arose,” coupled with current facts concerning the state of health care delivery in Pennsylvania, show that adding back the “county where [the defendant] regularly does business” venue option would be disastrous. Pennsylvania needs the 2003 MPL venue reform as much today as it did in 2003. If anything, two developments make it even more necessary.

The first development relates to continuing consolidation within the health care delivery system. Consolidation was the General Assembly’s stated reason in 2002 for altering venue rules as they relate to MPL actions. As stated in Section 514 of the MCARE Act, which created the Joint Interbranch Commission to study the problem further:

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.

⁴¹ See Appendix A at 2.

40 P.S. § 1303.514(a).

As Judge Wettick observed in the *Report of the Pennsylvania Interbranch Commission on Venue*, “[t]he General Assembly’s legislative finding may ... be based on a concern that a venue rule which permits a lawsuit in any county in which a hospital does business creates a reach and scope that is unduly expansive.” *Id.* at Attachment 14 p. 3. He reasoned that if this was the General Assembly’s concern, the General Assembly should enact a statute providing that in MPL actions “the lawsuit may be brought only in a county where, as to at least one of the defendants, the cause of action arose.” *Id.* at 5. The General Assembly did just that in Section 5101.1 of the Judicial Code, which the Supreme Court thereafter “incorporated” into Rule 1006.

The “unduly expansive” reach and scope of venue for MPL cases the General Assembly was concerned about in 2002 arose because at that time, more and more physicians were becoming employees of hospitals and health care systems, and more and more hospitals and health care systems were merging with one another, enlarging substantially the number of counties in which an MPL defendant could be considered to be “doing business.” As a result, Rule 1006’s “county where [the defendant] regularly does business” venue option created the possibility that an MPL plaintiff could bring suit in a multiplicity of counties that had no connection to the alleged medical error, including the high verdict counties where the Rule permitted venue.

The revamping of health care system corporate structures through mergers has only accelerated since 2002. The number of hospitals in health systems has almost doubled, while the

number of independent hospitals continues to shrink, as displayed on Figure 16, prepared by the Hospital and Healthsystem Association of Pennsylvania based on Department of Health data:⁴²

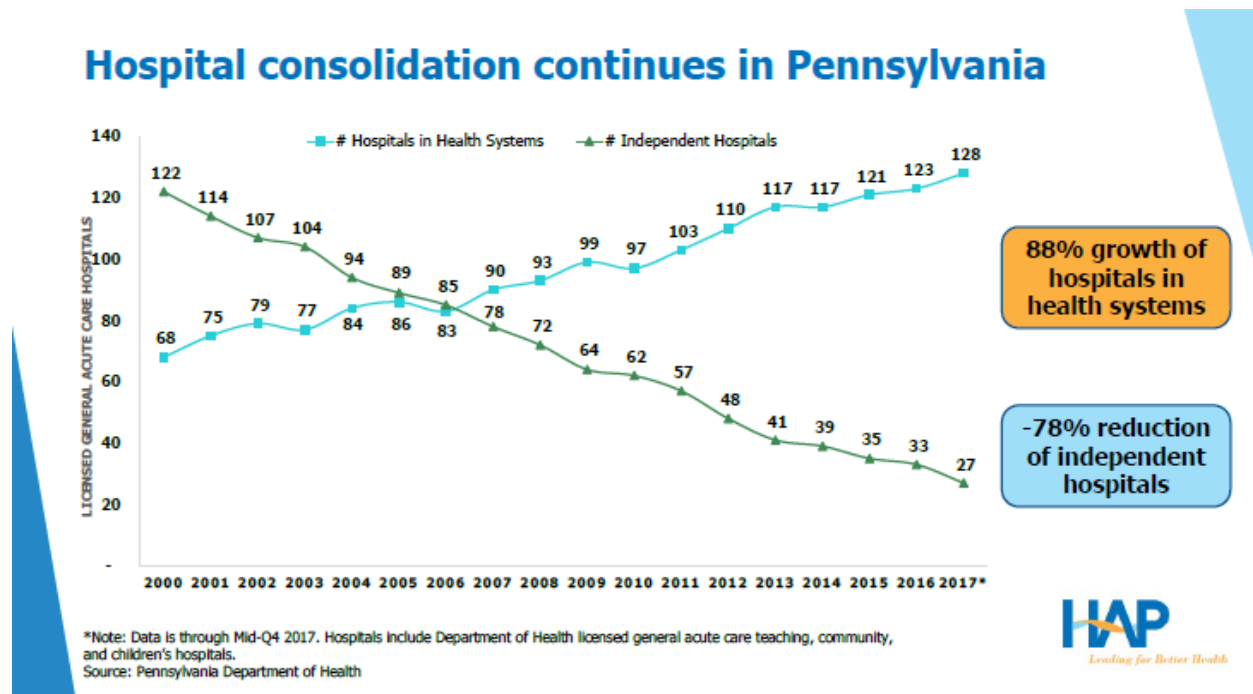
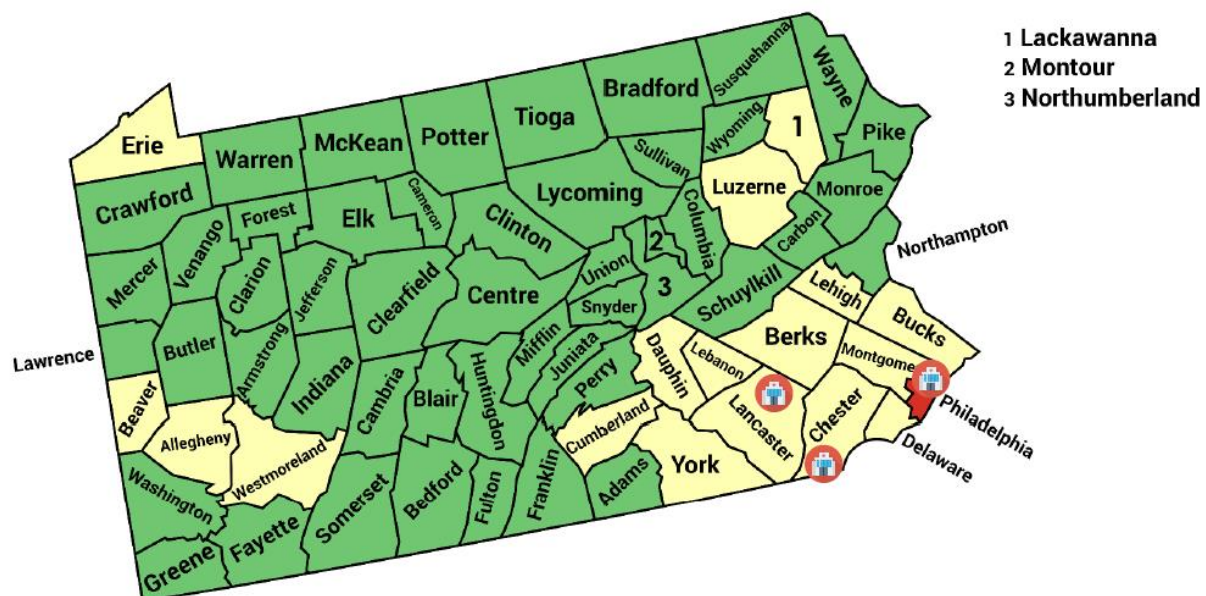


Figure 16

The continued pace of consolidation is obvious even to the casual observer. UPMC has facilities in counties throughout the state. The University of Pennsylvania operates throughout eastern Pennsylvania, including Lancaster. Reading Health System (now Tower Health) just acquired 5 hospitals in the Philadelphia area, including Chestnut Hill Hospital in Philadelphia County. And the list goes on. Figure 17 is a map that depicts the University of Pennsylvania Health System. It shows that as a result of Penn’s addition of hospitals in Lancaster and Chester Counties, a return to a venue rule that permits MPL suits in the “county where [the defendant] regularly does business” will mean that a physician joined as a defendant in a case with

⁴² Hospital Consolidation: Longitudinal Trends of Pennsylvania’s Independent and System-Affiliated General Acute Care Licensed Hospitals.” The Hospital and Healthsystem Association of Pennsylvania, 2018. Data source: Pennsylvania Department of Health, Division of Health Informatics. Annual Hospital Survey, 2000 through mid-Q4 2017.

Lancaster General or Penn Medicine Chester now risks suit in Philadelphia, because Penn “does business” in Philadelphia, even though the care in question was rendered in Lancaster County or Chester County:



UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM	County
Hospital of the University of Pennsylvania	Philadelphia
Lancaster General Hospital	Lancaster
Lancaster Rehabilitation Hospital	Lancaster
Penn Medicine Chester County Hospital	Chester
Penn Presbyterian Medical Center	Philadelphia
Pennsylvania Hospital	Philadelphia

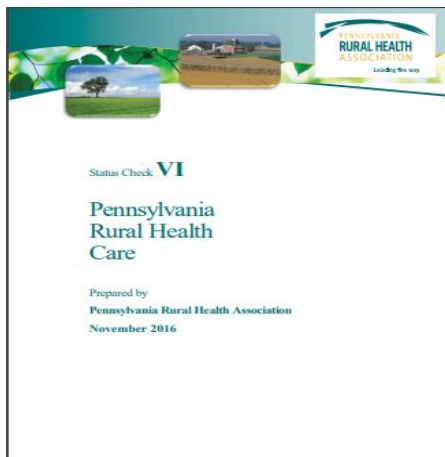
Key	
	System hospital(s) in county
	Rural county
	Urban county
	Likely forum target county

Figure 17

The same combination of continuing health system expansion and a rollback of venue reform would have a similar impact on physicians who are joined as defendants with UPMC or Geisinger for care rendered exclusively in rural counties—they can be haled into court in high-verdict counties such as Allegheny or Mercer in the case of UPMC, or Lackawanna in the case of

Geisinger.⁴³ For this reason alone, the Committee should abandon its proposal to roll back the 2003 MPL venue reform. The structural problem the reform was meant to address still exists. Indeed, it is getting worse.

The second development that makes the 2003 MPL venue reform all the more necessary today is the shortage of rural physicians and the negative impact that rolling back the reform will have on recruitment and retention of physicians in the many underserved rural areas of Pennsylvania. As Pennsylvania is home to a number of world class research and teaching hospitals, it is sometimes easy to forget that most Pennsylvania counties—48 of 67—are considered to be rural, that more than a quarter of Pennsylvania’s 12.8 million people live in rural areas, and that many of those rural areas are underserved from a health care provider perspective. The Pennsylvania Rural Health Association tracks such issues. Its 2016 report⁴⁴ explains the basic demographics:



“Twenty-seven percent of the state’s population live in areas that are designated as rural and, except for Philadelphia, every county in Pennsylvania has areas classified as rural. Forty-eight (48) of Pennsylvania’s 67 counties are considered to be rural based on population density and four counties are 100 percent rural.”

Figure 18

⁴³ See Appendix A at 27-28.

⁴⁴ The Pennsylvania Rural Health Association, *Status Check VI: Pennsylvania Rural Health Care*, November 2016 <http://www.paruralhealth.org/Status-Check-VI.Final.pdf>.

The 48 rural counties occupy most of the state except Southeastern Pennsylvania as shown in Figure 19 below:

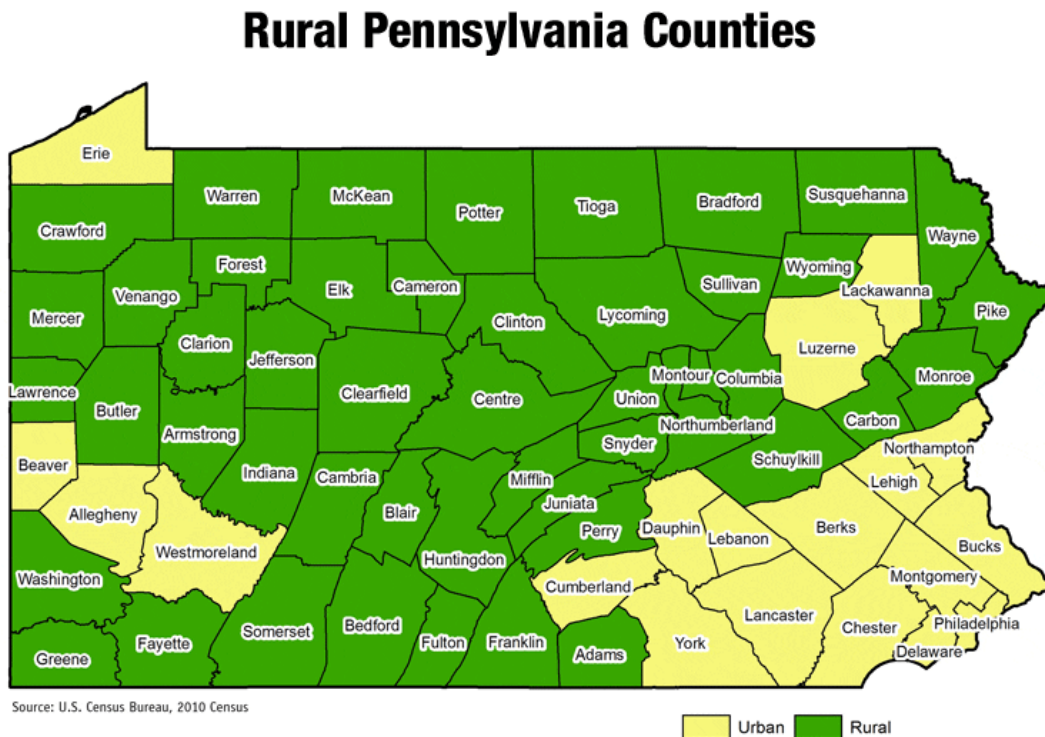
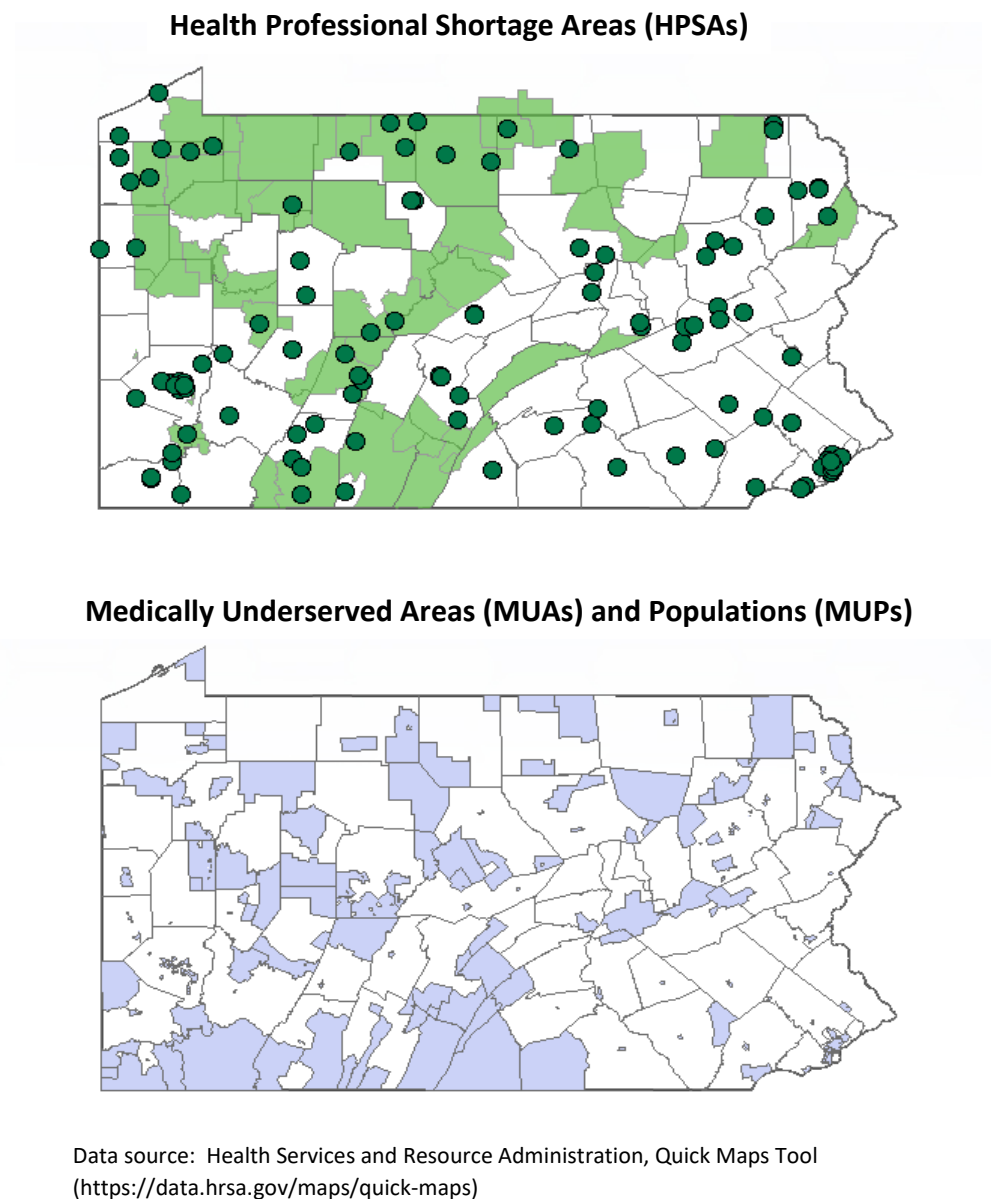


Figure 19

Source: The Center for Rural Pennsylvania
(<http://www.rural.palegislature.us/ruralcounties.html>)

The Pennsylvania Rural Health Association's 2016 report also explains how the determination is made that an area is experiencing a health care professional shortage. The federal government has developed definitions to classify the problem. One is Health Professional Shortage Area (HPSA). The other is Medically Underserved Area or Population (MUA or MUP).

Pennsylvania has more than its share of each. Fourteen percent of Pennsylvania's population reside in an area designated as a HPSA, and fourteen percent reside in an area designated as an MUA,⁴⁵ as shown in Figure 20 below:



Data source: Health Services and Resource Administration, Quick Maps Tool
(<https://data.hrsa.gov/maps/quick-maps>)

Figure 20

⁴⁵ <http://www.paruralhealth.org/Status-Check-VI.Final.pdf> at 12.

Twenty-two percent of Pennsylvania’s residents live in areas designated as either a HPSA or a MUA.⁴⁶ “Residents of an area of underservice are more likely to be rural, of minority status, poorly educated, living in poverty, and have limited access to transportation.”⁴⁷

As the Association explains, while some of the underserved areas are urban, most are rural:

Primary care access and provider shortages in the state have been well documented. In fact, based on 2015 estimates, portions of 65 of the state’s 67 counties, both rural and urban, are designated as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) or both. According to federal 2010 data, HPSAs are home to 26 percent of the rural population, or 913,000 rural residents, while more than 1.1 million, or 32 percent of rural residents, live in MUAs. These far exceed the number of urban residents who live in HPSAs or MUAs, at 1.7 percent and 16 percent, respectively.

Id. at 16.

The American Medical Association Journal of Ethics also notes that physician shortages are aggravated in rural areas, with the majority (65 percent) of primary care health professional shortages occurring in this area.⁴⁸ The Journal also highlights that primary care physicians nearing retirement (age 56 or older) make up nearly one-third of the clinician workforce in rural (27.5 percent) and remote rural (28.9 percent) locations.⁴⁹ In Pennsylvania, 30 percent of physicians practicing in rural counties anticipate leaving direct patient care in Pennsylvania in less than 6 years and, among them, 43 percent cite retirement as the reason for their departure.⁵⁰

⁴⁶ *Id.* at 12.

⁴⁷ *Id.*

⁴⁸ Daniel G. Mareck, MD, *Federal and State Initiatives to Recruit Physicians to Rural Areas*, <https://journalofethics.ama-assn.org/article/federal-and-state-initiatives-recruit-physicians-rural-areas/2011-05> (May 2011).

⁴⁹ *Id.*

⁵⁰ Joint State Government Commission, *The Physician Shortage in Pennsylvania*, <http://jsg.legis.state.pa.us/publications.cfm> (April 2015).

The rural physician shortage problem links directly to and is exacerbated by the MPL insurance issue, as the Pennsylvania Rural Health Association’s report points out—affordable MPL insurance is a major factor in a physician’s decision to locate his or her practice:

Although state medical liability issues, which severely impacted physician recruitment and retention in the early 1990s, have greatly improved, Pennsylvania’s liability climate continues to be challenging. *Affordable malpractice insurance coverage strongly influences where a physician may decide to practice* and may discourage physicians from choosing training and practice sites in Pennsylvania. This is especially disturbing when we consider the fact that most physicians choose to practice within a 20-mile radius of where they completed their residency training.

Id. at 16 (emphasis added).

Under the 2003 MPL venue reform, a physician who chooses to practice in a rural area can expect that if he is sued for an alleged medical error, he will be able to defend in his rural county and submit to the liability and compensation judgments of the citizens of that county. If the venue reform is rolled back, however, it is more likely than not that the MPL plaintiff will seek to sue in Philadelphia or some other high plaintiff success rate/high verdict county. There the rural physician will face, in addition to inconvenience and time away from patients, a higher likelihood of plaintiff verdicts,⁵¹ a higher verdict or settlement amount,⁵² and a resulting higher MPL insurance rate and MCARE assessment.⁵³

Moreover, like the original reason for the reform, the shortage of rural physicians is a legislative issue. The General Assembly took it up as recently as 2014, directing the Joint State Government Commission to examine the problem and report back.⁵⁴ It is a matter of public

⁵¹ Figure 4.

⁵² Figures 5-7.

⁵³ Figures 8-9.

⁵⁴ <http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2015-411-physician%20shortage%20report%204-20-2015.pdf>

policy, part of the overall legislative effort to assure the availability of quality health care for all Pennsylvanians.

Finally, the Committee’s assertion that the 2003 MPL venue reform “no longer appears warranted,” is illogical. The reform was intended to curb forum shopping, and it worked. But like the finger in the dike or the universal vaccination for measles, it will continue to work only if it remains in place—take it away, and we will be right back where we started, only worse off than we were.

4. The Committee Should Discontinue Its Proposal To Recommend Unilateral Rollback of the MPL Venue Reform Via Rule Amendment

From the outset, the Supreme Court has treated the MPL venue requirement as the serious public policy issue it is, because it reaches beyond usual court procedural rulemaking. Rather than suspend Section 5101.1 of the Judicial Code by invoking its exclusive rulemaking powers under Article V, Section 10(c) of the Pennsylvania Constitution, the Court adopted an amendment to Rule 1006 that “incorporated” Section 5101.1’s MPL venue requirement. Rather than permit the Commonwealth Court to issue a judgment declaring Section 5101.1 unconstitutional in *Weaver*, the Supreme Court assumed extraordinary jurisdiction of the case and then declared the issue moot in light of the Court’s previous incorporation of Section 5101.1’s MPL venue requirement into Rule 1006. In so doing, the Court acted with appropriate circumspection,⁵⁵ aware of its power under Article V, Section 10(c), but recognizing that the

⁵⁵ *Villani v. Seibert*, 159 A. 3d 478 (Pa. 2017) (In the context of constitutional challenge to the Dragonetti Act’s authorization of a cause of action for wrongful use of civil proceedings against the attorney for the plaintiff who brings the wrongful lawsuit, as infringing the Supreme Court’s exclusive power, the Court reasoned: “We begin with the notion that the powers accorded to this Court under Article V, Section 10(c) are exclusive. *There are several reasons why this assertion must be considered with great circumspection.* For example, this Court promulgated and maintains a set of evidence rules per its rulemaking authority under Article V, Section 10(c), *see* Pa.R.E. 101(b), while also expressly recognizing that some of the law of

MPL venue requirement presents one of the relatively rare circumstances in which what ordinarily would be considered a purely procedural matter within the Court’s exclusive power—a venue rule—takes on substantive aspects that fall within the purview of the political branch.⁵⁶

To be sure, a superficial argument can be made that the Supreme Court has exclusive power to amend its own procedural rule and simultaneously suspend a statute that conflicts with it.⁵⁷ But the truth is that MPL venue, under the facts and circumstances that existed in 2003 and continue today, affects substantive rights that fall within the realm of legislative policymaking based on legislative findings. Absent legislative movement to roll back the MPL venue requirement, the Committee should recommend to the Court that the Committee’s proposed rule change be abandoned. The history reveals that the MPL venue requirement is based on legislative findings that were fully supported. The current facts reveal that the requirement remains necessary today. The General Assembly has already initiated legislative fact finding concerning the MPL venue issue in light of the Committee’s proposed rollback of the 2003 MPL venue reform, and a report is due in January 2020.⁵⁸ The Court has advised that it will await the

evidence is appropriately governed by statute. *See id.*, comment; *see also Commonwealth v. Olivo*, 633 Pa. 617, 127 A.3d 769, 780 (2015). Furthermore, this Court enforces procedural provisions of statutes, such as the Post Conviction Relief Act. *See* 42 Pa.C.S. § 9545. The Court also has acknowledged that many subjects of legislation and/or judicial rulemaking possess both attributes implicating this Court’s rulemaking power *and* substantive-law characteristics which are suited to the province of the political branch.”) (emphasis added) (footnote omitted).

⁵⁶ *See* n. 33 *supra*, citing Daniel A. Durst and Karla M. Shultz, *Wielding and Yielding: Pennsylvania Judicial Procedural Rulemaking Authority and the Preemption Doctrine*, 26 Widener L.J. 45 at 53 (2017),

⁵⁷ *North-Central Pa. Trial Lawyers Assn. v. Weaver*, 827 A. 2d 550 (Pa. Cmwlth. 2003) (en banc) (relying on from *McGinley v. Scott*, 401 Pa. 310, 317, 164 A.2d 424, 428 (1960) for the generic proposition that venue is an incident of procedure and on that basis striking down Section 5101.1 of the Judicial Code as an invasion of the Supreme Court’s exclusive power under Article V, Section 10(c) of the Pennsylvania Constitution).

⁵⁸ Senate Resolution No. 20 of 2019; *see supra* nn. 15 and 34.

legislative committee's report before proceeding to consider any amendments to the MPL venue rules. The Committee should stand down on this pending further action by the General Assembly.

5. In The Alternative, The Committee Should Open the Process, Convene Public Hearings, and Invite Legislative Involvement

In the alternative, if the Committee chooses to move forward with its deliberations notwithstanding the General Assembly's ongoing study of the issue, the Committee should open its process. Nothing prevents the Committee from holding public hearings,⁵⁹ and it should do so here, where the matter is so clearly legislative in nature and the subject of public interest well beyond the usual "inside baseball" of civil procedural rulemaking.

Recognizing it would need Court authority to do so,⁶⁰ the Committee should also make all comments received public. The issue involved has always been, and now is once again, one of intense political lobbying from all sides of the MPL community; if the Committee is committed to venturing into what is essentially a legislative matter, the public deserves to hear and actively participate in the arguments being offered to Committee and Court decisionmakers. The Committee should seek authority from the Court to make the process transparent by disclosing publicly all comments received.

Finally, the Committee should invite legislative involvement in the process. The Court is well aware that the General Assembly wrote the 2003 MPL venue reform that the Committee

⁵⁹ Daniel A. Durst, *Pennsylvania Judicial Rulemaking: Steps Toward Increased Public Participation*, 86 Pa. B. A. Q. 47 at 54 nn. 48-50.

⁶⁰ *Id.* at 54 (2015) ("Judicial rulemaking in Pennsylvania has... adopted a "closed comment" approach wherein written comments received in response to a proposal are not made public by the committees. This approach is intended to encourage candid participation by not publically attributing written comments to individual commentators; the release of comments with attribution may have a chilling effect on participation.").

now is proposing to rescind; the Court merely incorporated what the General Assembly already had decided into the Court's venue rule. The Court has already indicated that it will await the legislative committee's report before proceeding to consider any amendments to the MPL venue rules. The Court has wisely proceeded in this fashion in the past – and indeed, on this identical issue. The Committee should proceed in that spirit now.

II. Conclusion

The Pennsylvania Medical Society objects to the Civil Procedural Rules Committee's proposed amendment of Pa. R.C.P. Nos. 1006, 2130, 2156, and 2179 governing venue in medical professional liability actions. The Committee's proposal to roll back a 2003 MPL venue reform that limits MPL venue to the "county in which the cause of action arose" will re-enable forum shopping to the detriment of Pennsylvania patients' – particularly rural patients' -- access to health care. The data show that Pennsylvania continues to rank near the top of states nationwide for MPL case filings and size of payouts. The "significant reduction" in MPL case filings the Committee references was a reduction in *Philadelphia* MPL filings that involved alleged medical errors that occurred in counties other than Philadelphia and were imported into Philadelphia under the old "county where [the defendant] regularly does business" venue option.

The issue here goes far beyond typical court procedural rulemaking and verges into the legislative branch's domain, as the current rule's pedigree readily reveals. The 2003 MPL venue reform should not be rolled back, but if roll back is to be considered, the debate should be public, and the legislature should be involved. Pennsylvania's patients deserve no less.

APPENDIX A

APPENDIX A

The Data Case Against Rollback of the 2003 MPL Venue Reform

Effective January of 2003, the Pennsylvania Supreme Court adopted a venue reform for medical professional liability (MPL) cases.

The purpose of the reform was to address rampant forum shopping, i.e., the practice of plaintiff attorneys to file cases where they were most likely to obtain a favorable resolution even when the alleged negligence occurred elsewhere.

Abuses of the prior rule allowed plaintiff attorneys to exploit biases against health care provider defendants in certain forums, particularly Philadelphia, which was notorious for speculative and jackpot jury verdicts.

Physicians could be haled into Philadelphia courts to defend care provided outside Philadelphia, despite the physician's lack of ties to Philadelphia, simply by adding a corporate defendant with Philadelphia connections, e.g., one that regularly "did business" in Philadelphia.

The reform implemented a commonsense standard. It requires MPL actions to be filed only in the county where the cause of action occurred, i.e., where the allegedly negligent care was provided.

The court's action mirrored and effectively sanctioned 2002 legislation, which was enacted as part of a package of reforms designed to address a MPL crisis that threatened access to care in the Commonwealth.

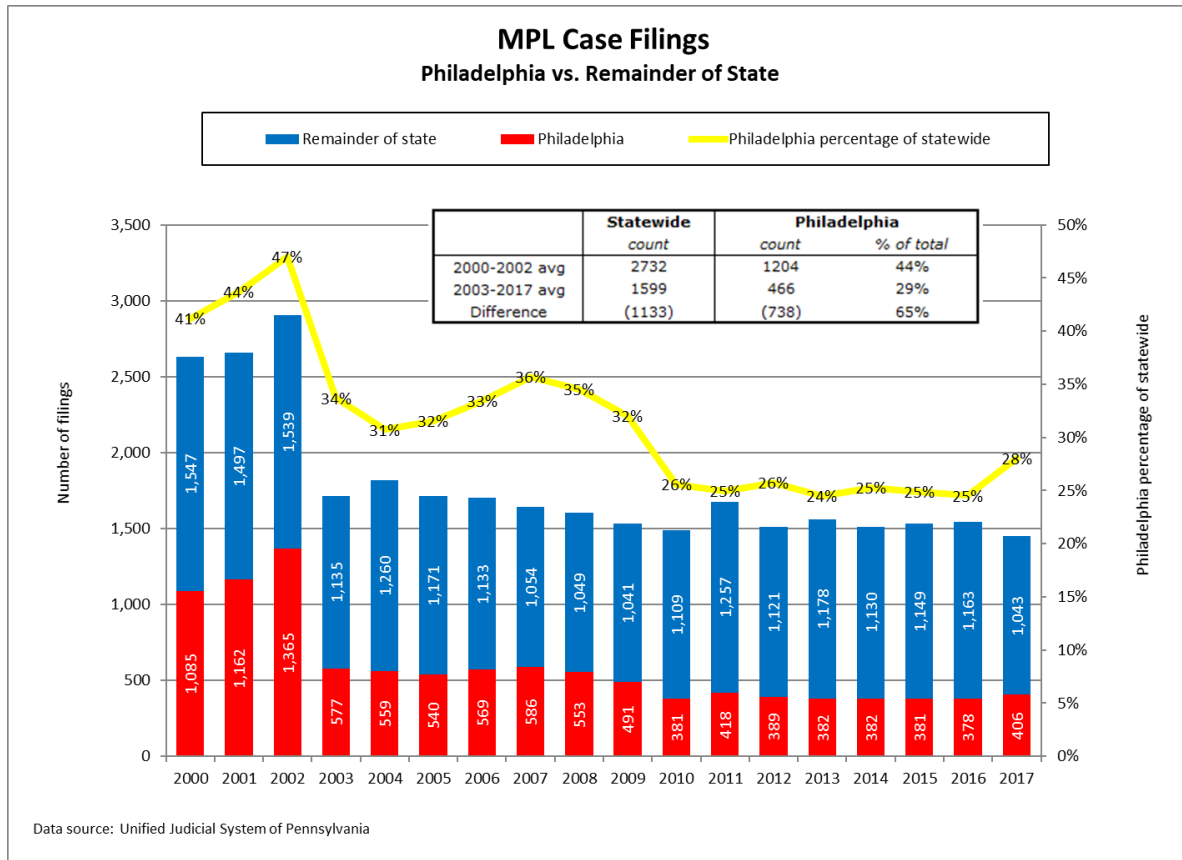
The Civil Procedural Rules Committee for the Pennsylvania Supreme Court now proposes a rollback of the court's venue reform to the previous rule that permits forum shopping.

The Pennsylvania Medical Society (Medical Society) opposes the proposed rollback, as it would unfairly subject physicians to a foreign forum, expose them to higher risk and attendant liability coverage costs, and jeopardize access to care, particularly in rural Pennsylvania.

The Medical Society further believes that any changes in the venue rules for MPL cases would be best resolved by the legislature, in consultation with the Supreme Court, following public hearings on the myriad of complex issues at play.

This Appendix illustrates the compelling data in support of the Medical Society's position.

Impact of Venue Reform on Forum Shopping



Data on case filings is available on the Unified Judicial System of PA website (<http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics>). Currently, the site only includes an average for filings in Philadelphia from 2000-2002. Figures in the chart for those years in Philadelphia were obtained from previously released data.

Pennsylvania Supreme Court data on MPL case filings demonstrates that venue reform has made inroads in controlling forum shopping.

In 2002, when it became apparent that venue reform would soon be adopted, court data reflects a “run to the court house” before the reform took effect.

The spike was especially evident in Philadelphia, the forum where plaintiff attorneys knew success and even a jackpot verdict in a marginal case was a realistic plaintiff outcome.

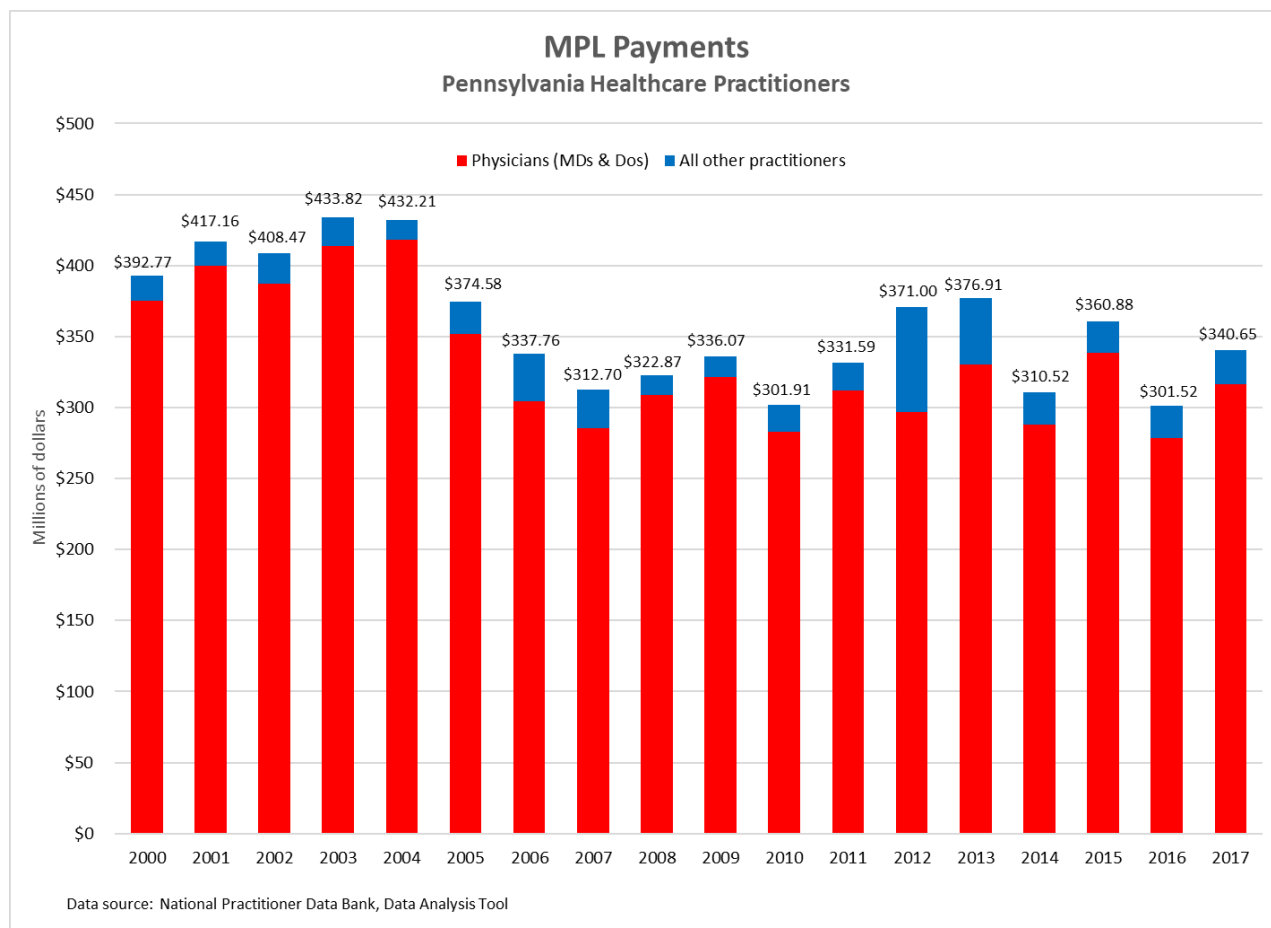
Post venue reform, there was an immediate and substantial decrease in case filings.

Statewide filings dropped over 40%, comparing the three years prior to venue reform and the 15 years after the reform.

Again, Philadelphia case filings drove the change in the filing rate. 65% of the decrease in statewide filings resulted from a steep reduction in Philadelphia.

The Philadelphia percentage of filings went from an average of 44% to an average of 29%.

Impact of Venue Reform on Forum Shopping



The NPDB Data Analysis Tool is available on its website (<https://www.npdb.hrsa.gov/analysistool/>).

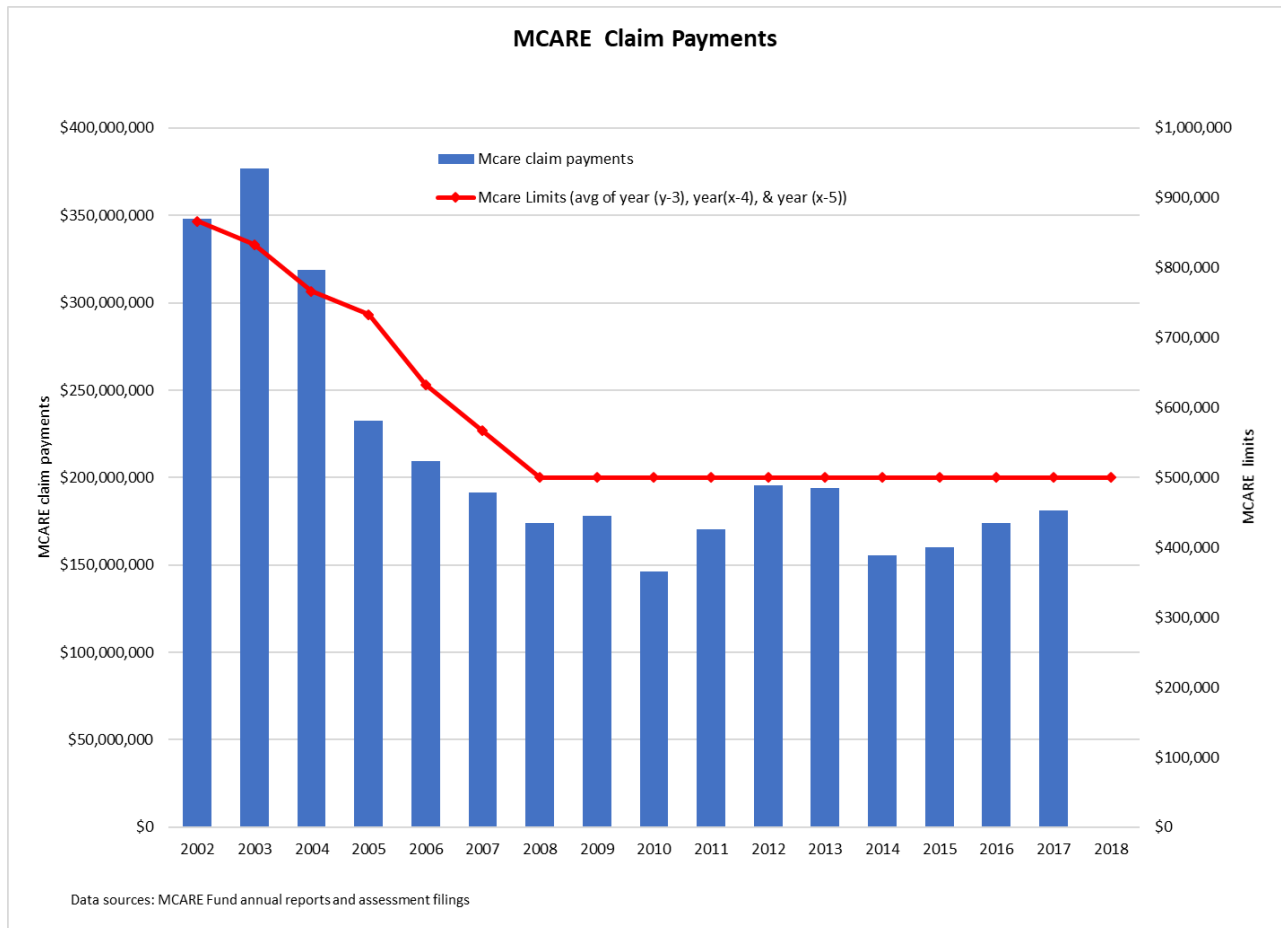
The available evidence* from the National Practitioner Data Bank also suggests that overall payouts have declined post venue reform – although likely not to the extent implied by plaintiff attorneys.

Payouts for healthcare practitioners began to fall in 2005, when resolution of cases filed under the reform began to be finalized.

These payouts have stayed below the highs in 2003 and 2004, but there are signs of an upward trend in recent years.

*There is no combination of public databases from which payouts for all health care providers, including hospitals and nursing homes, can be ascertained.

Impact of Venue Reform on Forum Shopping



MCARE Annual Reports and Assessment filings are available on its website (<https://www.insurance.pa.gov/SpecialFunds/MCARE/Pages/MCARE.aspx>).

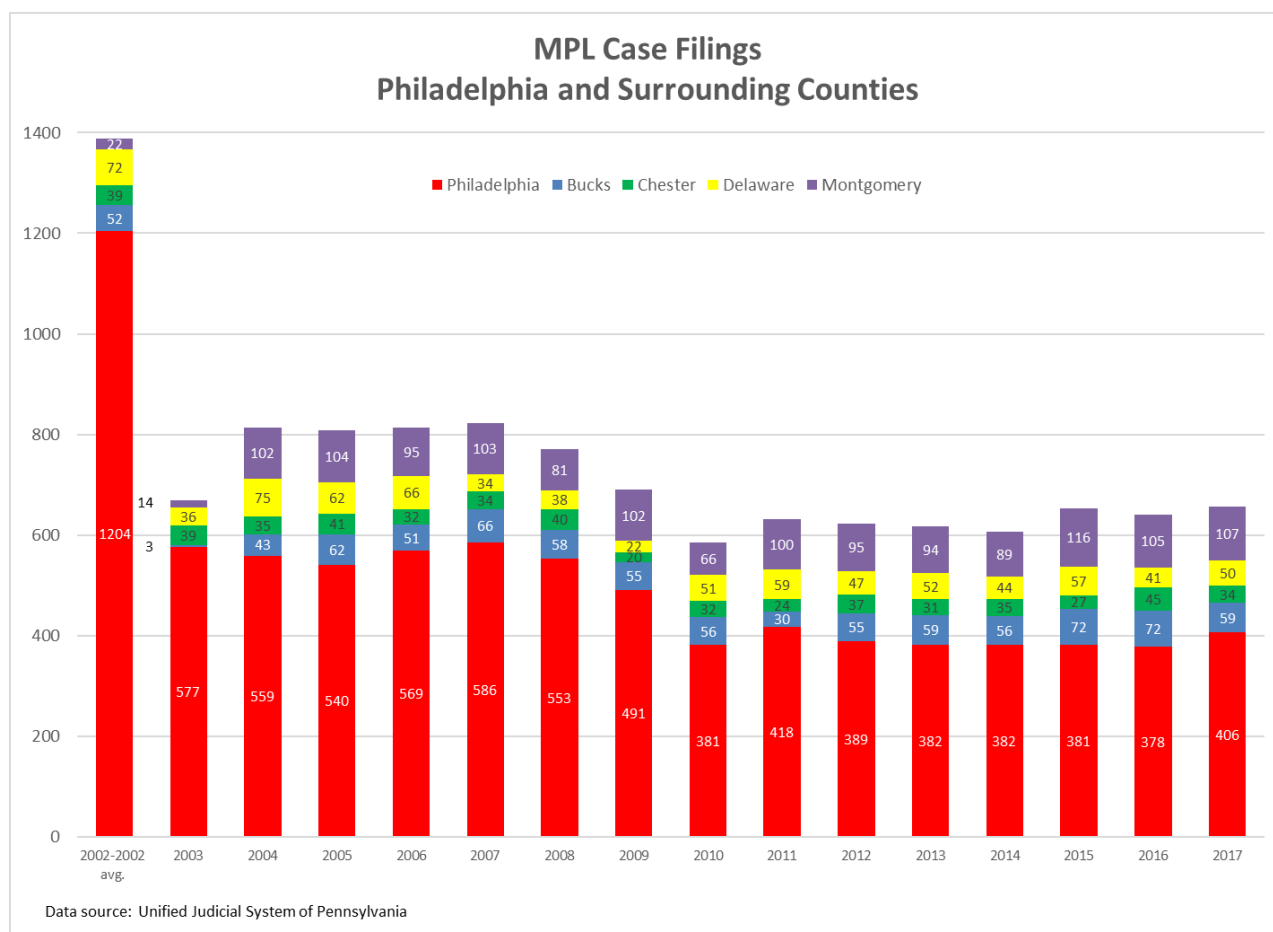
Payments by the MCARE Fund, which provides “excess” coverage above the primary payer, also have decreased – although again this decrease is misleading.

The decrease has largely been driven by a reduction in the MCARE limits, as part of a phase-out plan that transferred coverage from MCARE to the primary layer in steps and an overall reduction in the mandated limits.

MCARE limits were decreased from \$1 million to \$500,000 while primary coverage limits increased to \$500,000.

	Primary	Mcare	Total
1996 & prior	200,000	1,000,000	1,200,000
1997	300,000	900,000	1,200,000
1998	300,000	900,000	1,200,000
1999	400,000	800,000	1,200,000
2000	400,000	800,000	1,200,000
2001	500,000	700,000	1,200,000
2002	500,000	700,000	1,200,000
2003 & after	500,000	500,000	1,000,000

Impact of Venue Reform on Forum Shopping



It is difficult to measure the precise magnitude of venue reform's impact on MPL case filings and payouts, as it was implemented at the same time as other reforms designed to attract and retain physicians in Pennsylvania.

The certificate of merit rule, in particular, also likely helped weed out meritless MPL case filings that would not otherwise have been brought but for the prior availability of the Philadelphia forum.

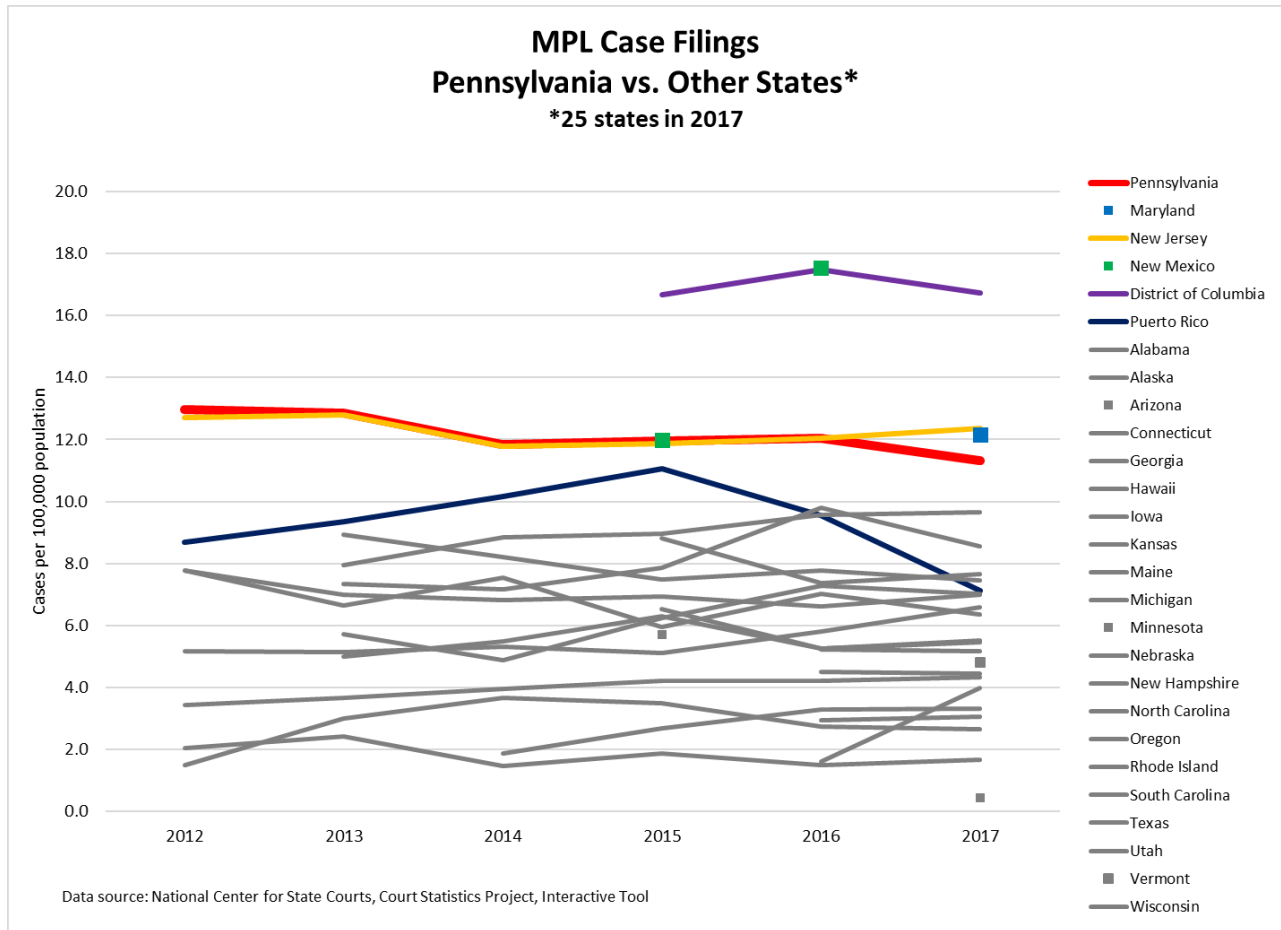
However, it is clear from an examination of Supreme Court data on filings in the five-county southeastern Pennsylvania region that venue reform played a substantial role.

While case filings in Philadelphia dramatically fell post venue reform, filings in Bucks and Montgomery Counties increased.

The movement was most dramatic in Montgomery County, which experienced a 316% increase, comparing the average from 2000-2002 to the average over the next 15 years.

In essence, cases involving alleged negligence in those counties, previously forum shopped to Philadelphia, are now being appropriately litigated where the cause of action arose.

Compensation for Alleged Medical Negligence



The NCSC, CSP Interactive Tool is available on the CSP website (<http://www.courtstatistics.org/>).

Plaintiff attorneys speculate, with no evidence whatsoever, that venue reform has resulted in victims of medical negligence not receiving appropriate compensation.

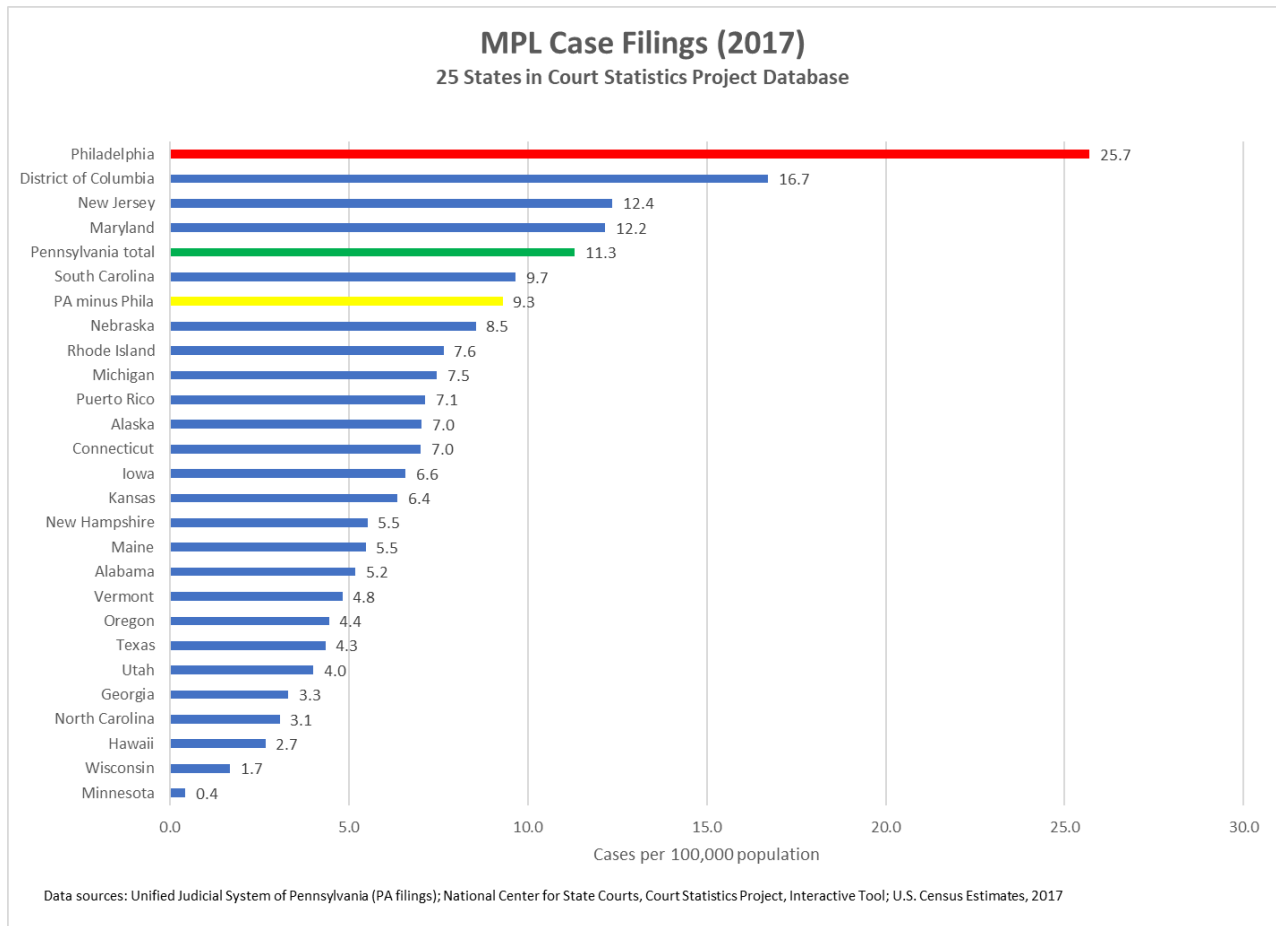
The evidence from the National Center for State Court's Court Statistics Project proves otherwise.

Although Pennsylvania case filings decreased post venue reform, Pennsylvania filing rates remain high.

The rate at which cases are filed remains much higher in Pennsylvania than most other states, when compared based on filings per 100,000 population.

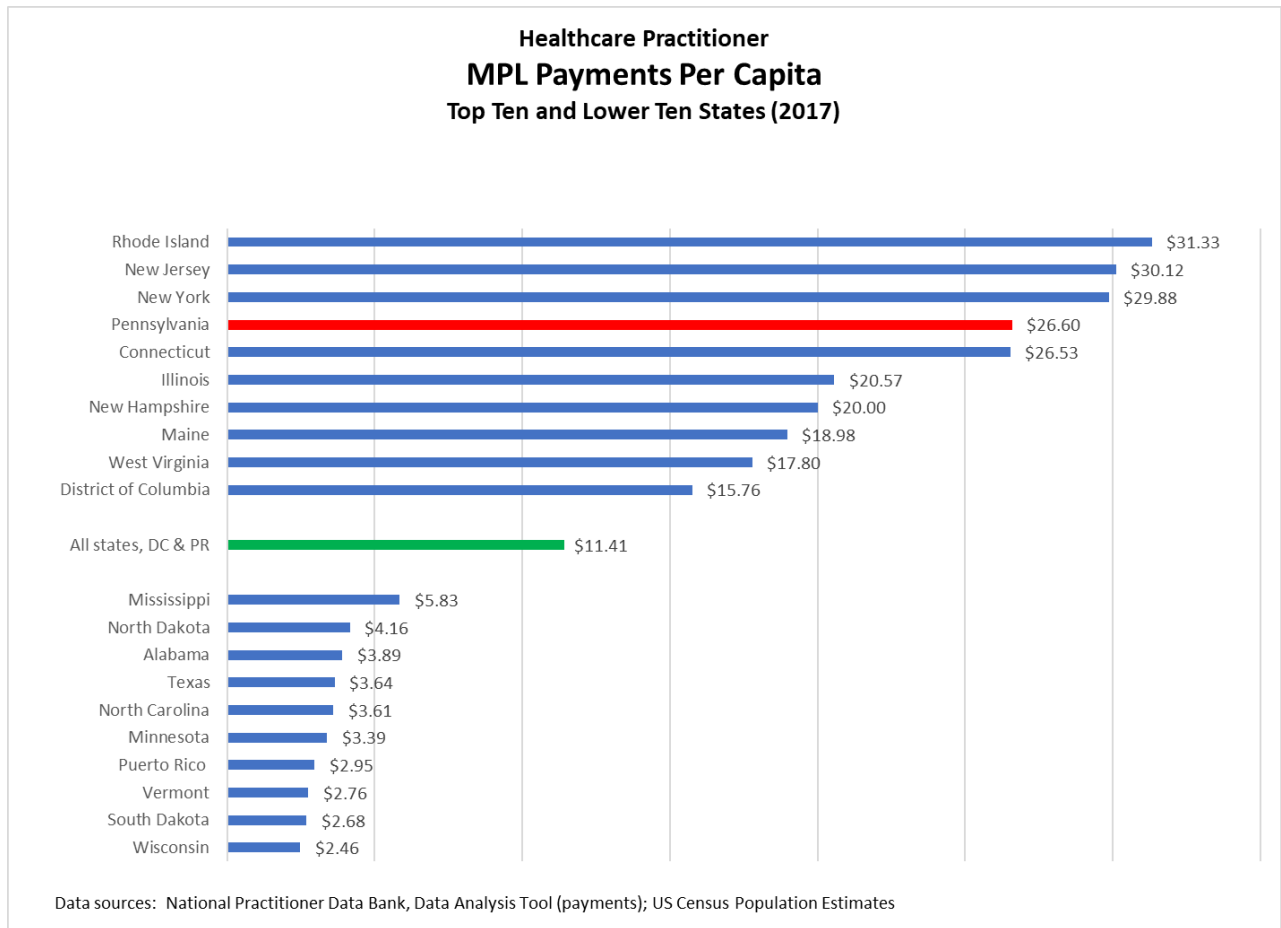
Most recently, from 2012-2017, Pennsylvania filings per 100,000 was around 12, while most states in the Court Statistic Project database had rates in the 2-10 range.

Compensation for Alleged Medical Negligence



Even when Philadelphia case filings are separately counted, the filing rate for the remainder of the state remains at the high end of the states in the Court Statistics Project database.

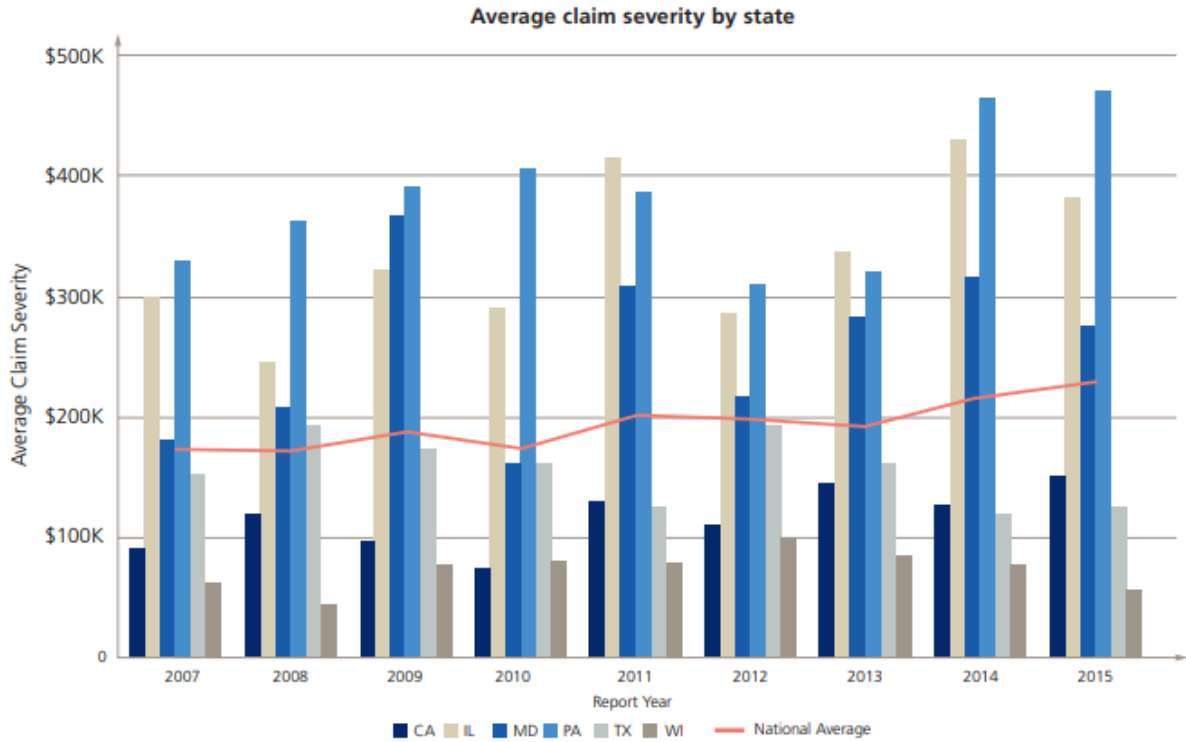
Compensation for Alleged Medical Negligence



National Practitioner Data Bank data, adjusted for population, show that aggregate payments in MPL cases for health care practitioners is much higher in Pennsylvania than most of the rest of the country.*

* Diederich Healthcare has slightly different results in its report, *2018 Medical Malpractice Payout Analysis* (<https://www.diederichhealthcare.com/the-standard/2018-medical-malpractice-payout-analysis/>). The report ranks Pennsylvania fifth in the northeast, behind Connecticut.

Compensation for Alleged Medical Negligence

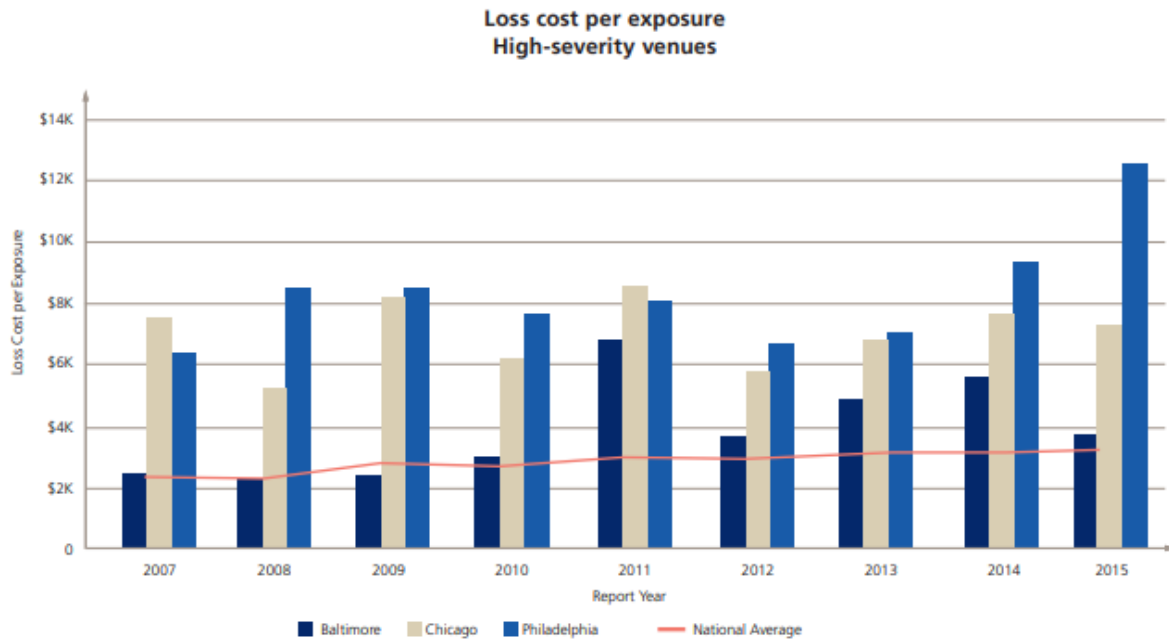


Source: Zurich, *2018 Benchmark Study of Healthcare Professional Liability Claims*

The full Zurich report is available on its website (https://www.zurichna.com/_/media/dbe/zna/docs/kh/hc/2018-zurich-benchmark-study-of-hpl-claims.pdf).

According to the Zurich *2018 Benchmark Study of Healthcare Professional Liability Claims*, the average claim severity for Pennsylvania is well above the national average.

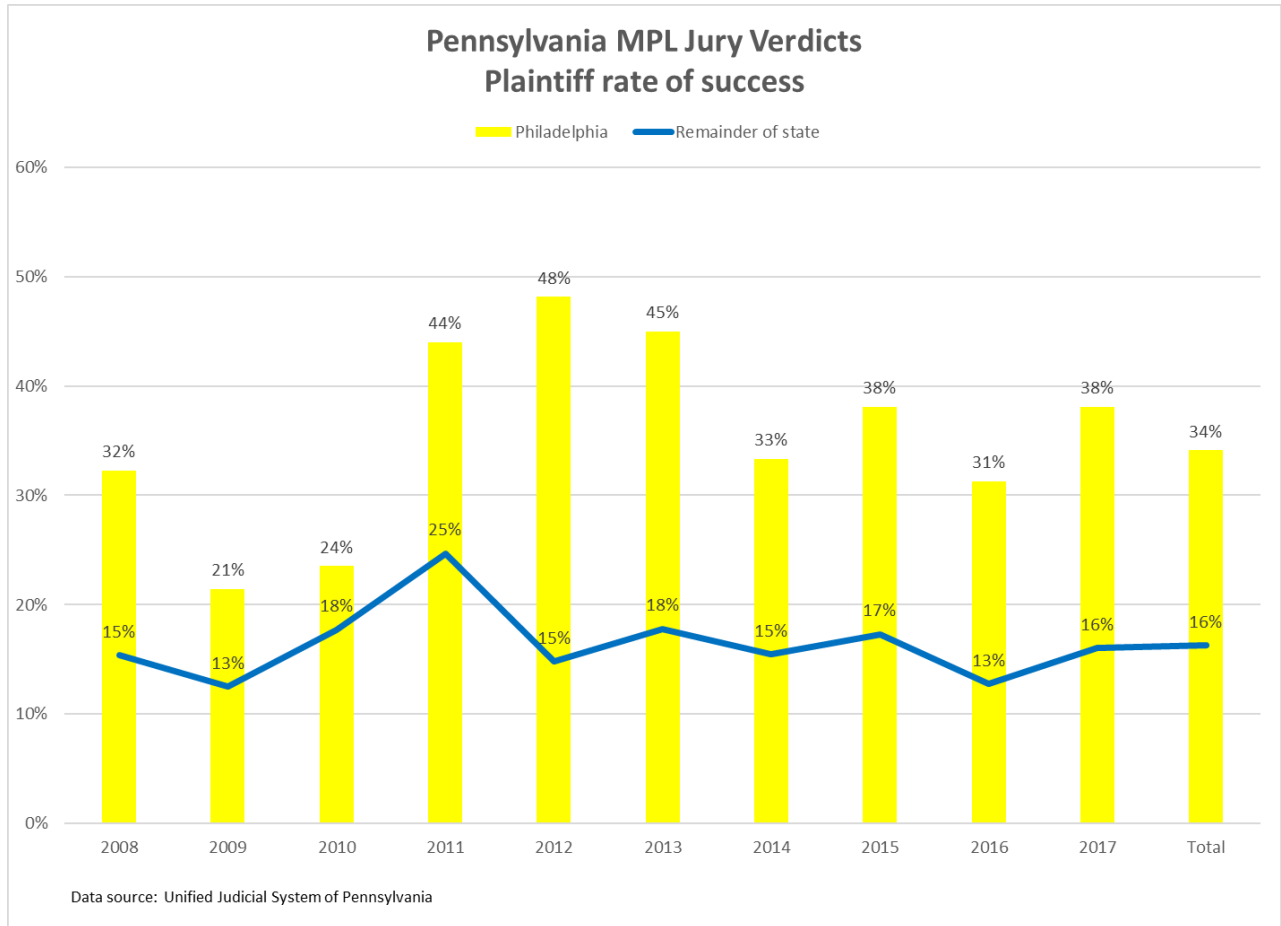
Compensation for Alleged Medical Negligence



Source: Zurich, 2018 *Benchmark Study of Healthcare Professional Liability Claims*

The Zurich Study further identifies Philadelphia, in particular, as a high severity venue, due to its substantially higher loss cost per exposure.

Philadelphia and Other Forum Shopping Venues

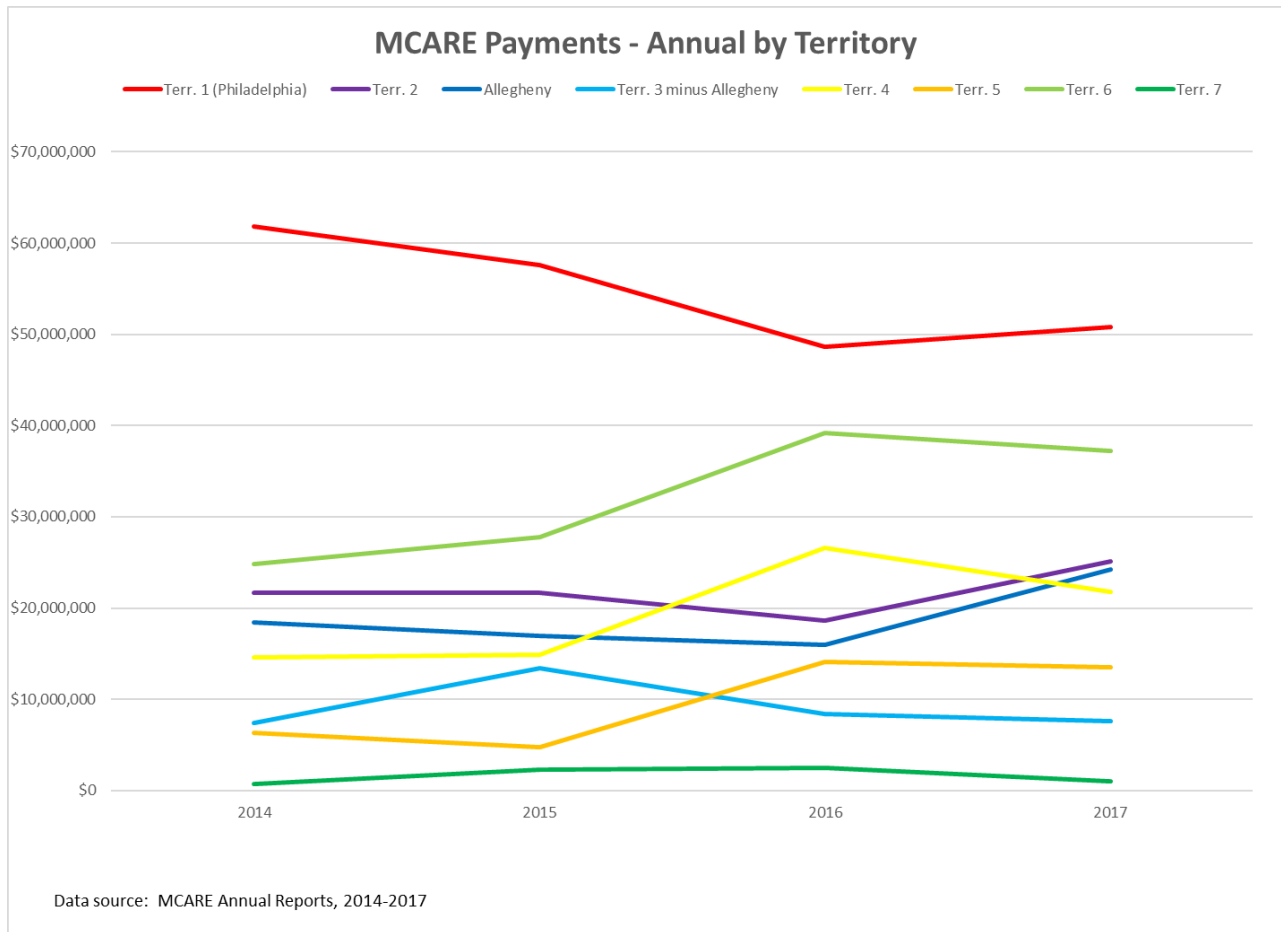


Data on verdict outcomes is available on the Unified Judicial System of PA website (<http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics>).

As in the past, Philadelphia continues to be a forum that provides a distinct advantage to plaintiff attorneys.

The success rate for plaintiffs in Philadelphia in jury trials is more than two times the success rate in the remainder of the state.

Philadelphia and Other Forum Shopping Venues



MCARE Annual Reports are available on its website (<https://www.insurance.pa.gov/SpecialFunds/MCARE/Pages/MCARE.aspx>).

The above chart shows MCARE claim payments by territory (with Allegheny separate from the remainder of Territory 3).

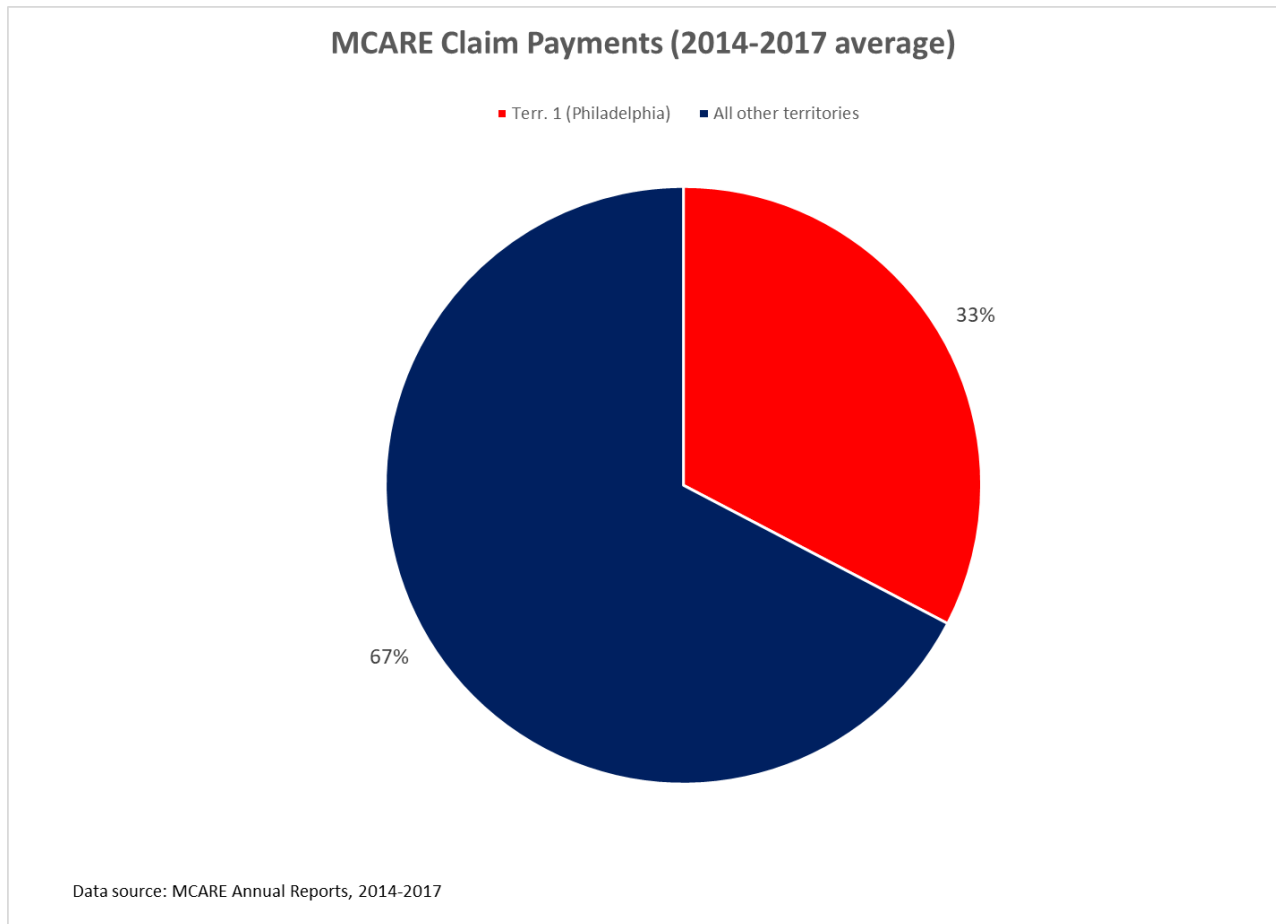
According to the 2016 report, the territory assignment is based upon the venue of the litigation.*

Territory 1 (red) is Philadelphia. A map of all territories is shown on page 17.

MCARE has cautioned that its territory data has limitations, including volatility in county payments from year to year. However, in general terms, this data is helpful in identifying high payout territories.

*In 2015 and 2016, a small percentage of payments were made for litigation outside of Pennsylvania.

Philadelphia and Other Forum Shopping Venues



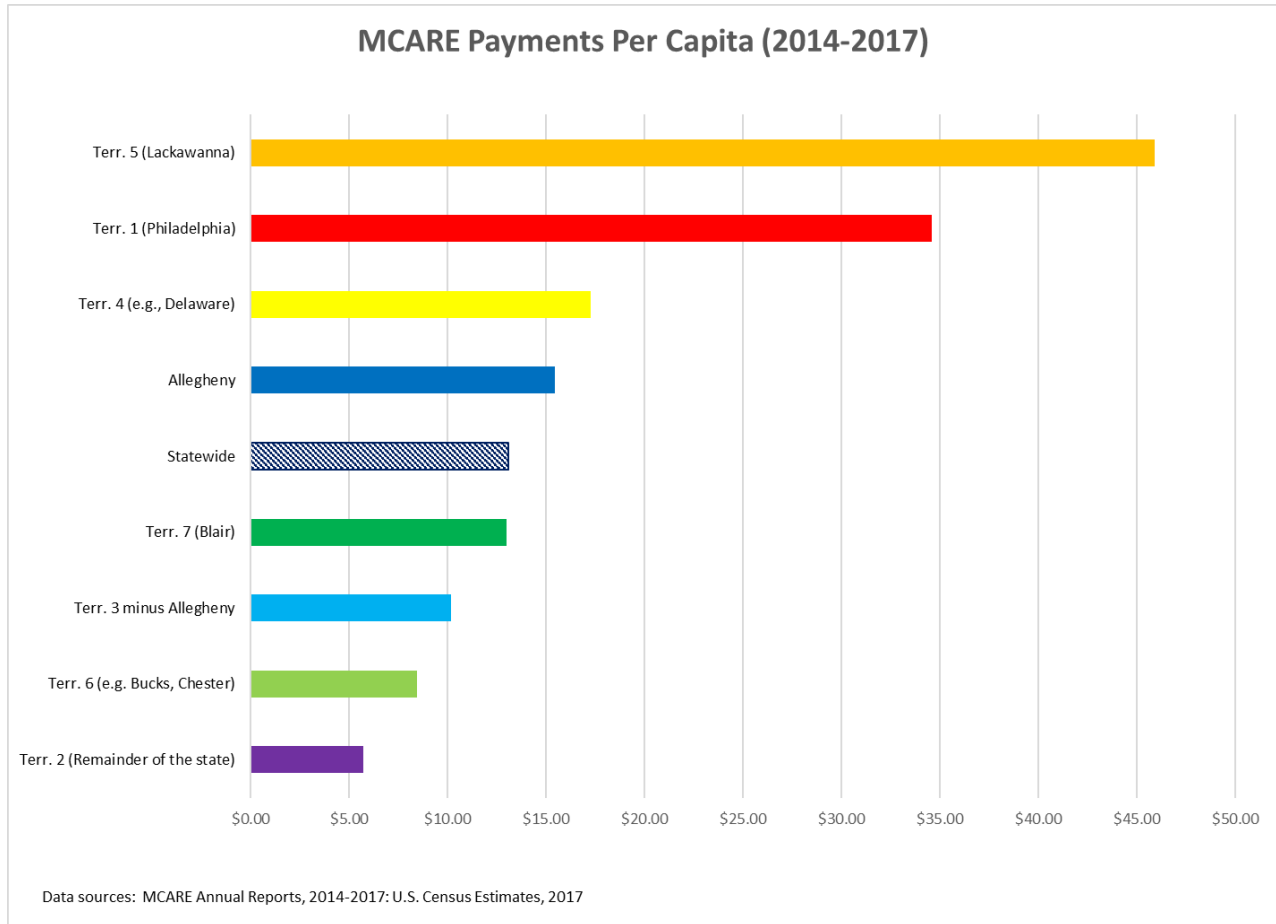
MCARE payments for litigation in Philadelphia are consistently a substantial portion of the statewide payments.

The Philadelphia average MCARE payments from 2014-2017 was one-third of the total statewide average MCARE payments for that period – ranging from 28% to 40%.

This suggests either higher frequency of claims reaching the MCARE “excess” layer, higher payments in those cases, or both.

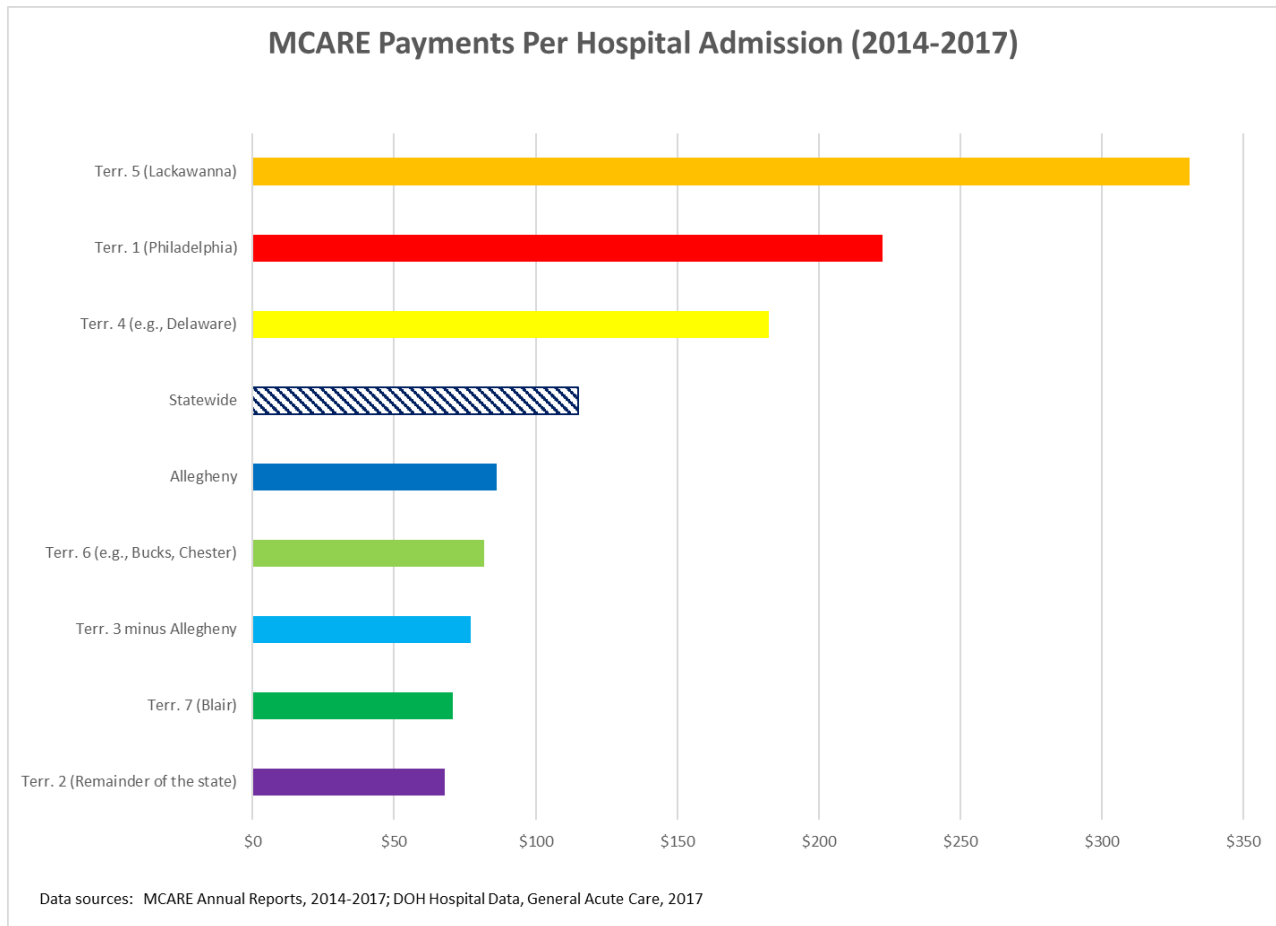
While Philadelphia has higher population and is a center of care, the disproportionate amount of MCARE payments for Philadelphia remains evident, even when adjustments are made for those factors.

Philadelphia and Other Forum Shopping Venues



For the period from 2014-2017, MCARE payments per capita in Philadelphia were almost three times the state rate.

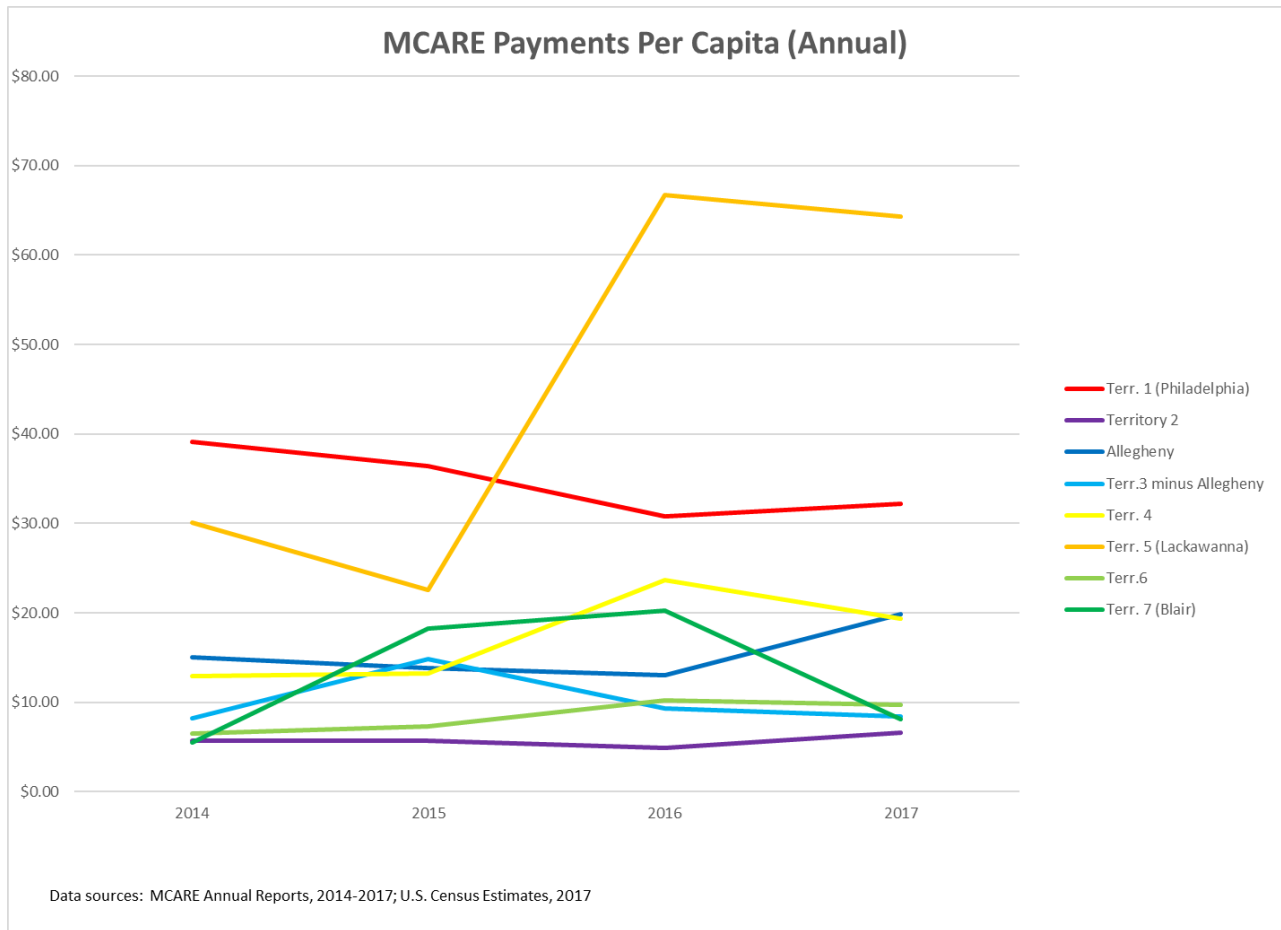
Philadelphia and Other Forum Shopping Venues



Data on admissions to General Acute Care Hospitals is available on the DOH website (<https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/Pages/hospital-reports.aspx>).

For the period from 2014-2017, MCARE payments per hospital admission in Philadelphia were almost two times the state rate.

Philadelphia and Other Forum Shopping Venues

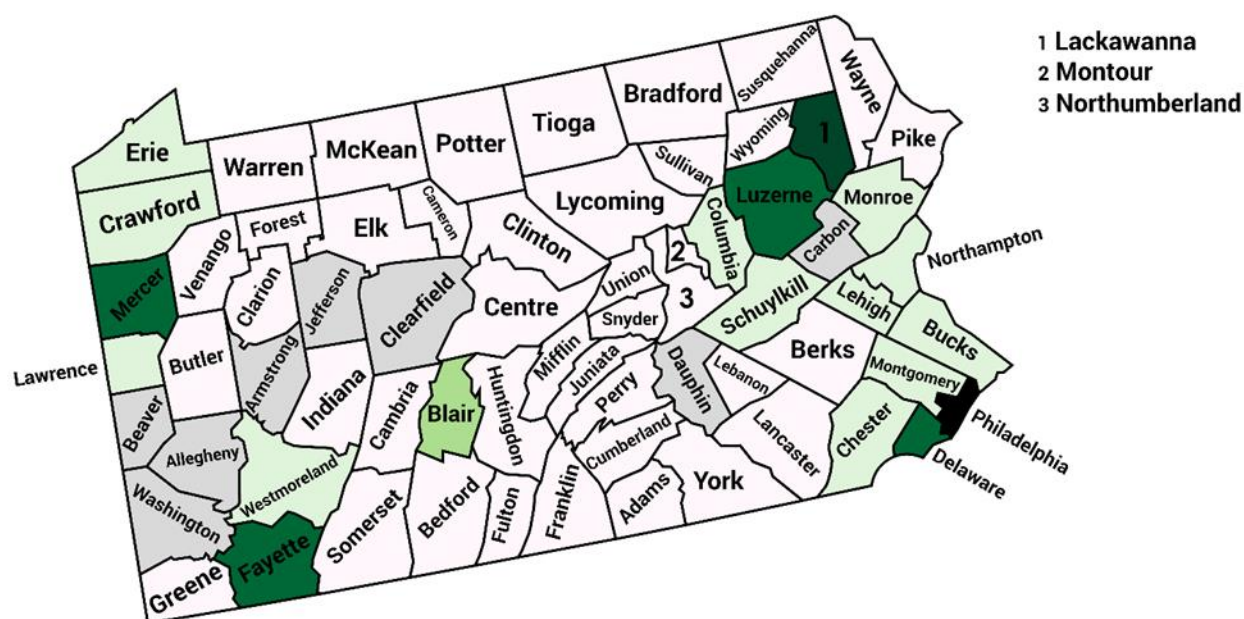


As evident from this chart and the previous charts, Lackawanna County (Territory 5) also ranks high at the MCARE payment level.

However, its 2014-2017 average was influenced by significant spikes in 2016 and 2017, and the data covers a limited time period.*

* Prior to 2014, the MCARE annual reports only showed payments by region – east, west, and central. According to the 2016 report, payments in the central region were higher than the historical average due to a greater number of dated matters coming to fruition. Lackawanna County is in the central region. Although the report does not specifically address whether that statement applies to Lackawanna.

MPL Coverage Costs in Pennsylvania



Key	Territory	Counties	Relativity
	1	Philadelphia	1.000
	5	Lackawanna	0.806
	4	Delaware, Fayette, Luzerne, Mercer	0.734
	7	Blair	0.701
	6	Bucks, Chester, Columbia, Crawford, Erie, Lawrence, Lehigh, Monroe, Montgomery, Northampton, Schuylkill, Westmoreland	0.593
	3	Allegheny, Armstrong, Beaver, Carbon, Clearfield, Dauphin, Jefferson, Washington	0.554
	2	Remainder of State	0.440

Data sources: Pennsylvania Professional Liability Joint Underwriting Association, Rate filings and Manuals. Manuals are available on JUA website (<http://www.pajua.com/juamannual.html>). Rate filings are available on NAIC SERFF Filing Access site (<https://filingaccess.serff.com/sfa/home/PA>). (Relationship of actual rates differs slightly apparently due to JUA's standard administrative fee.)

The Pennsylvania Professional Liability Joint Underwriting Association (JUA) was created pursuant to the MCARE Act to ensure that mandated primary coverage is available to physicians and other health care providers subject to the mandate.

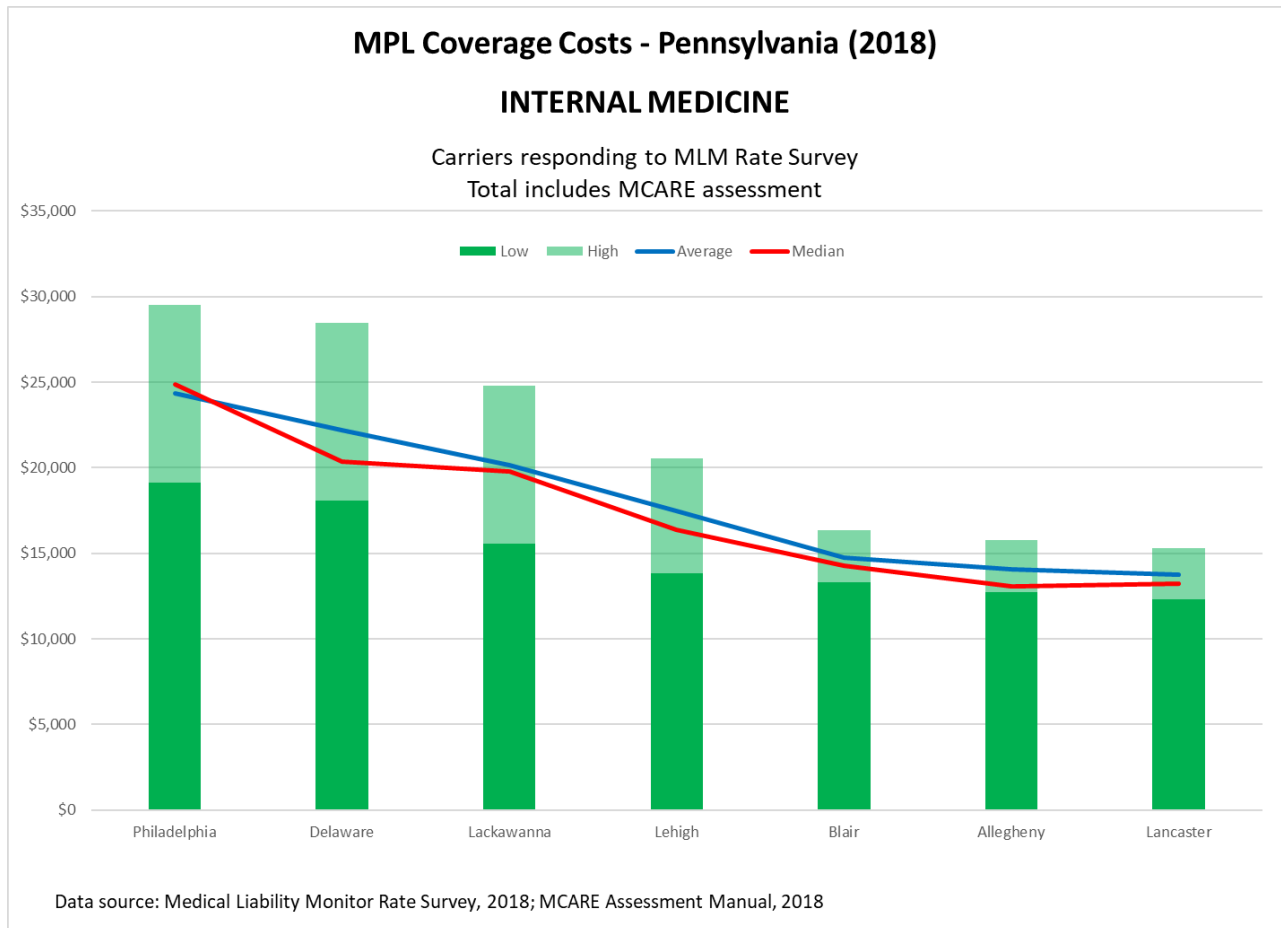
JUA's breakdown of how its rates for a physician vary by the location of the physician's practice (territory) is shown on the above map.

MCARE assessments are set at a percentage of the applicable JUA rate for their territory and specialty. As a result, MCARE assessments likewise vary by territory on the same basis.

The JUA must make an annual rate filing to the Insurance Department justifying its rates.

It is not surprising, given the preceding charts, that Philadelphia County and Lackawanna County are two of the highest territories for JUA rates and MCARE assessments.

MPL Coverage Costs in Pennsylvania



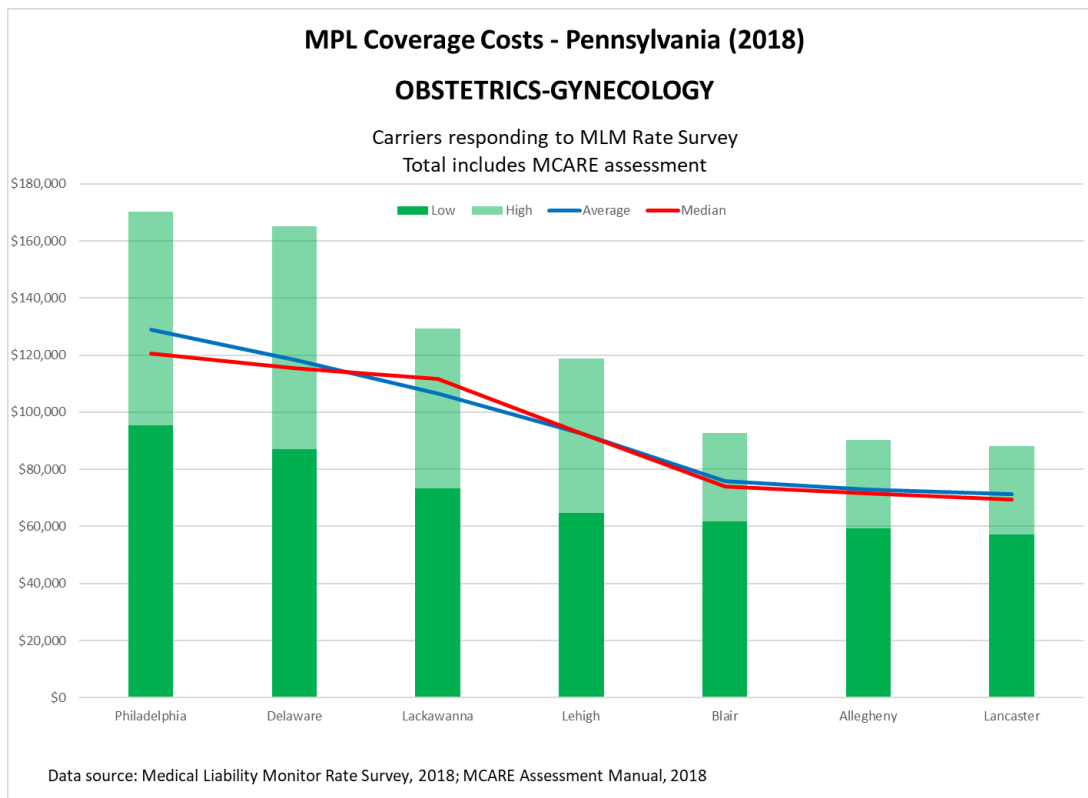
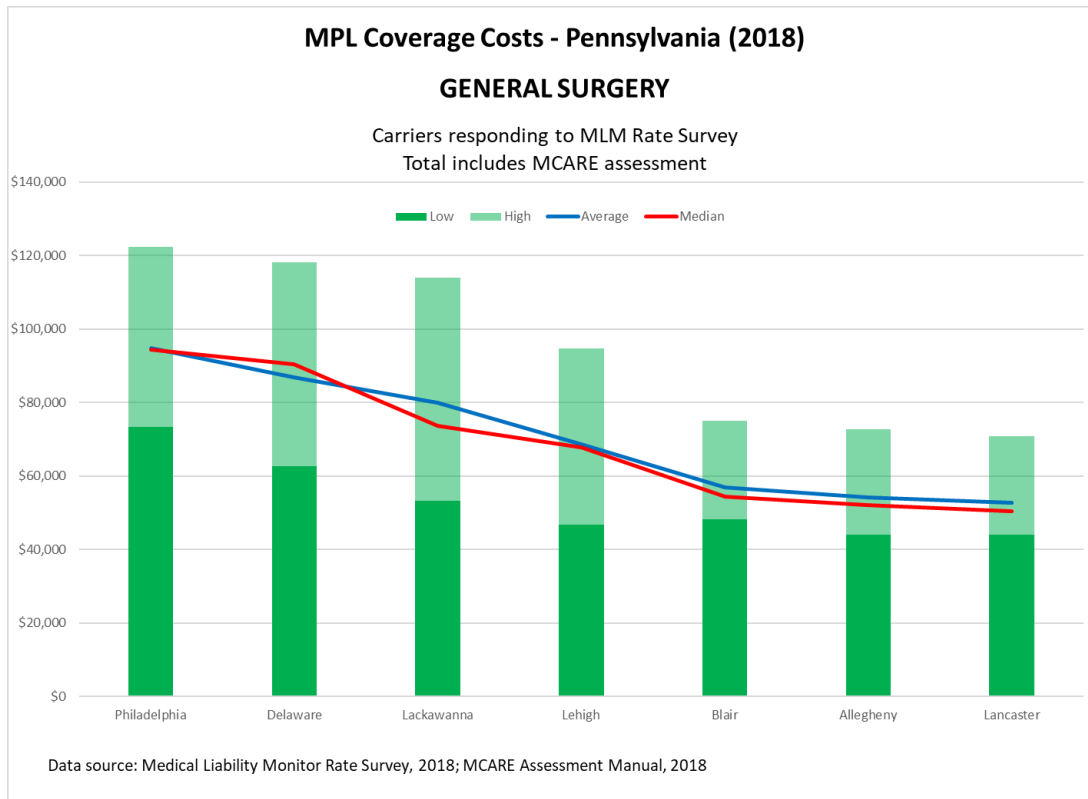
MCARE Assessment Manuals are available on its website (<https://www.insurance.pa.gov/SpecialFunds/MCARE/Pages/Mcare-Coverage.aspx>).

As result of Philadelphia's high losses, the total cost of coverage is considerably higher in Philadelphia relative to the remainder of the state.

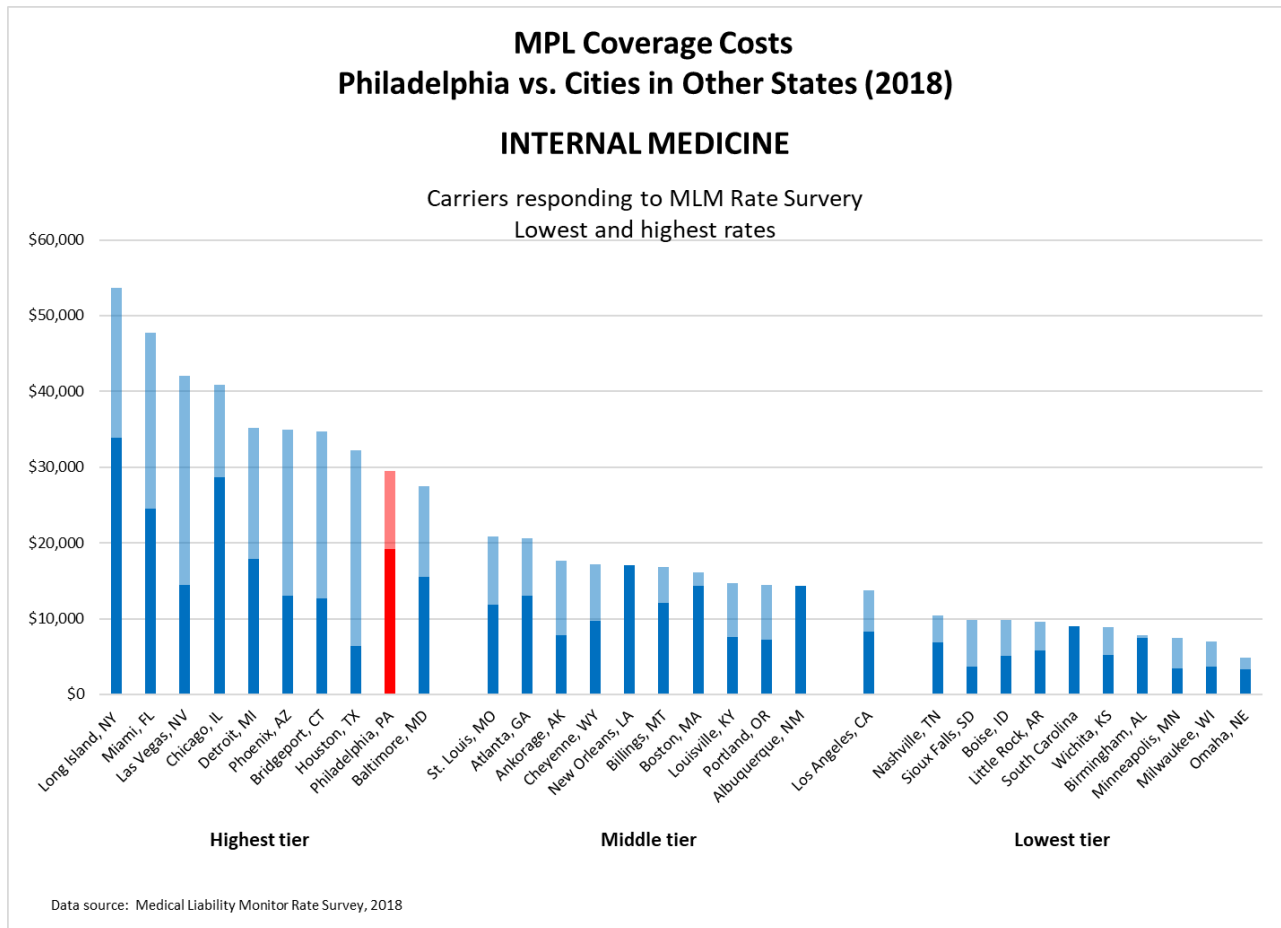
Medical Liability Monitor Rate Survey Data – for internal medicine, general surgery, and obstetrics-gynecology – is shown on this and the next two charts.

For all three specialties, the reported rates for Philadelphia are about 180% of the rates for Lancaster and most rural counties in the state.

MPL Coverage Costs in Pennsylvania



MPL Coverage Costs in Pennsylvania

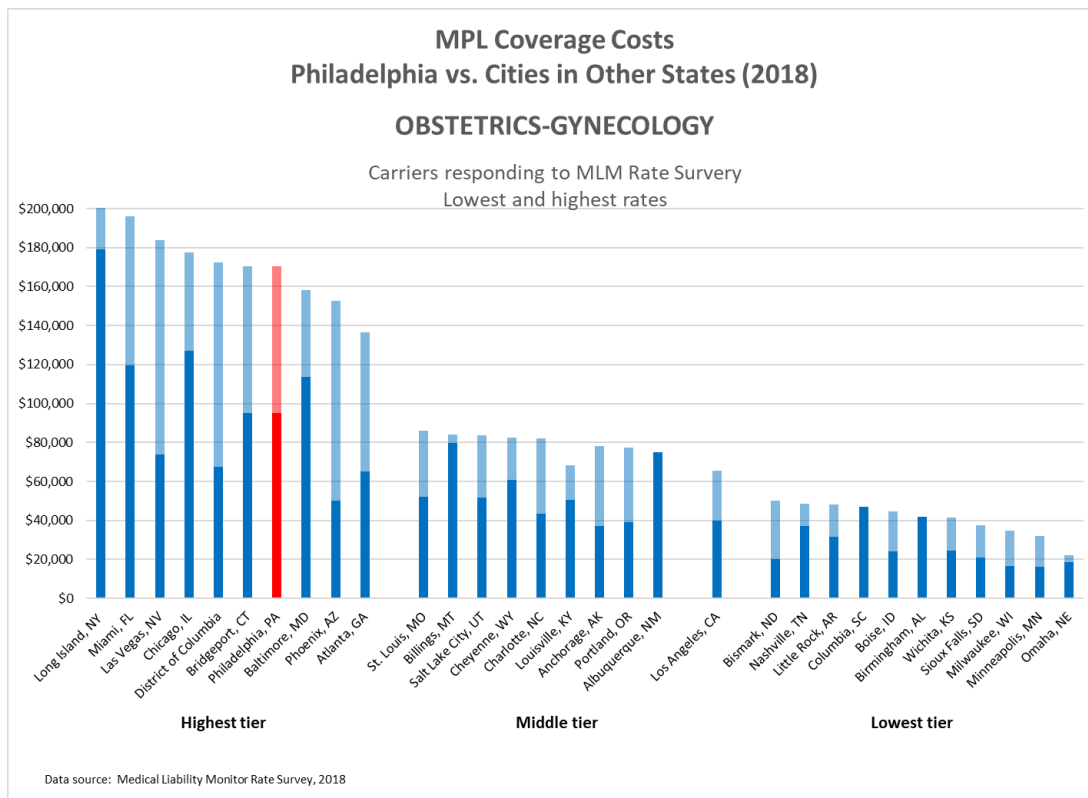
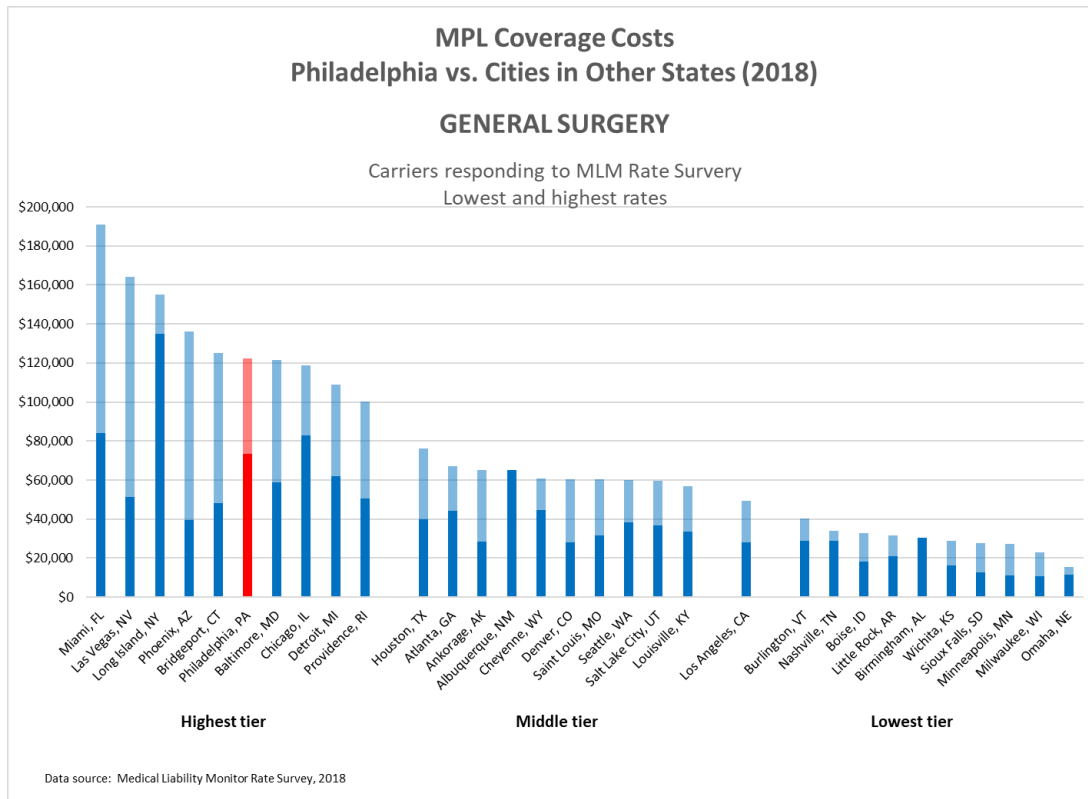


The total cost of coverage for Philadelphia (primary and MCARE) is in the highest tier nationwide.

This and the next two charts compare Medical Liability Monitor Rate Survey Data for Philadelphia and a major city in each state – for internal medicine, general surgery, and obstetrics-gynecology.

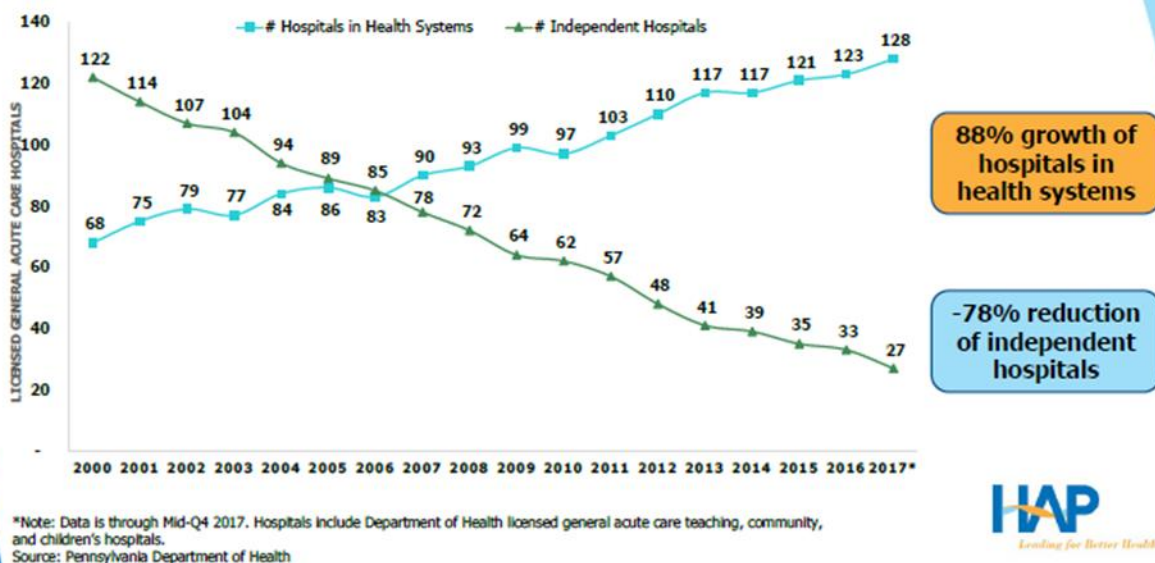
In the case of each specialty, Philadelphia is in the top 10 nationwide.

MPL Coverage Costs in Pennsylvania



Consequences of Venue Reform Rollback

Hospital consolidation continues in Pennsylvania



Source: Hospital Consolidation: Longitudinal Trends of Pennsylvania's Independent and System-Affiliated General Acute Care Licensed Hospitals." The Hospital and Healthsystem Association of Pennsylvania, 2018 (based upon data obtained from Pennsylvania Department of Health, Division of Health Informatics. Annual Hospital Survey, 2000 through mid-Q4 2017)

If venue reform is rolled back to the prior rule, the end-result will be higher liability costs for Pennsylvania physicians.

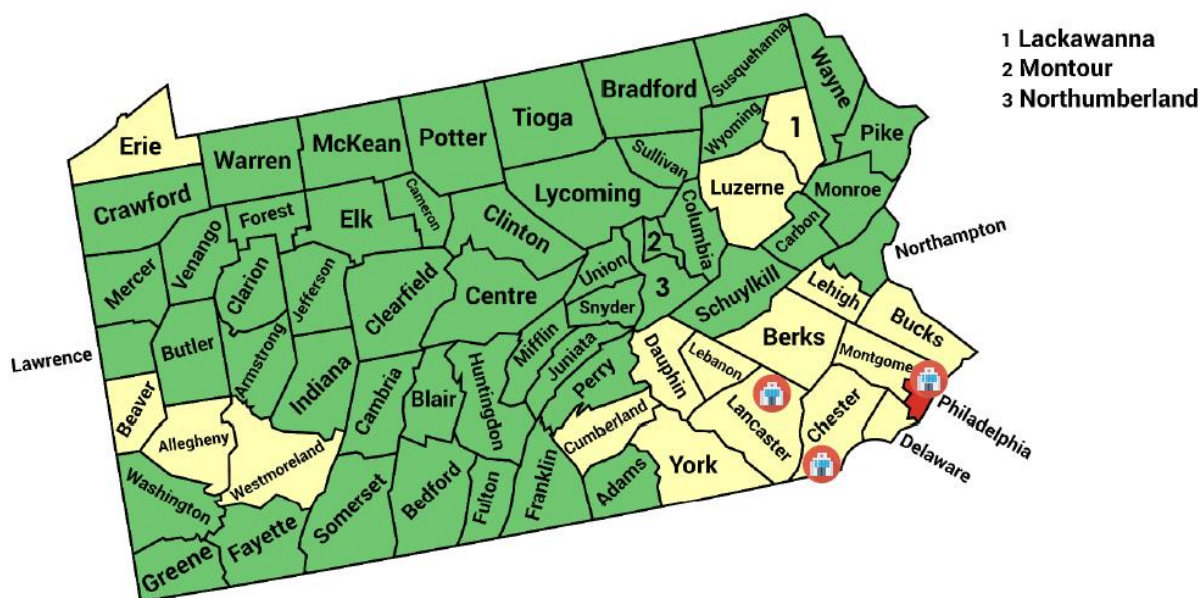
Plaintiff attorneys will once again be free to forum shop cases against individual physicians based upon the connections of corporate defendants.

This will be permitted even though the alleged negligence did not occur in the plaintiff's chosen forum and the physician has no connection to that forum.

Physicians who practice in areas with lower MPL risk will be exposed to higher risk and the attendant higher costs of coverage.

The consequences will be much more widespread than before, as a result of the considerable health care consolidation across the state in recent years.

Consequences of Venue Reform Rollback



UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM		County
Hospital of the University of Pennsylvania		Philadelphia
Lancaster General Hospital		Lancaster
Lancaster Rehabilitation Hospital		Lancaster
Penn Medicine Chester County Hospital		Chester
Penn Presbyterian Medical Center		Philadelphia
Pennsylvania Hospital		Philadelphia

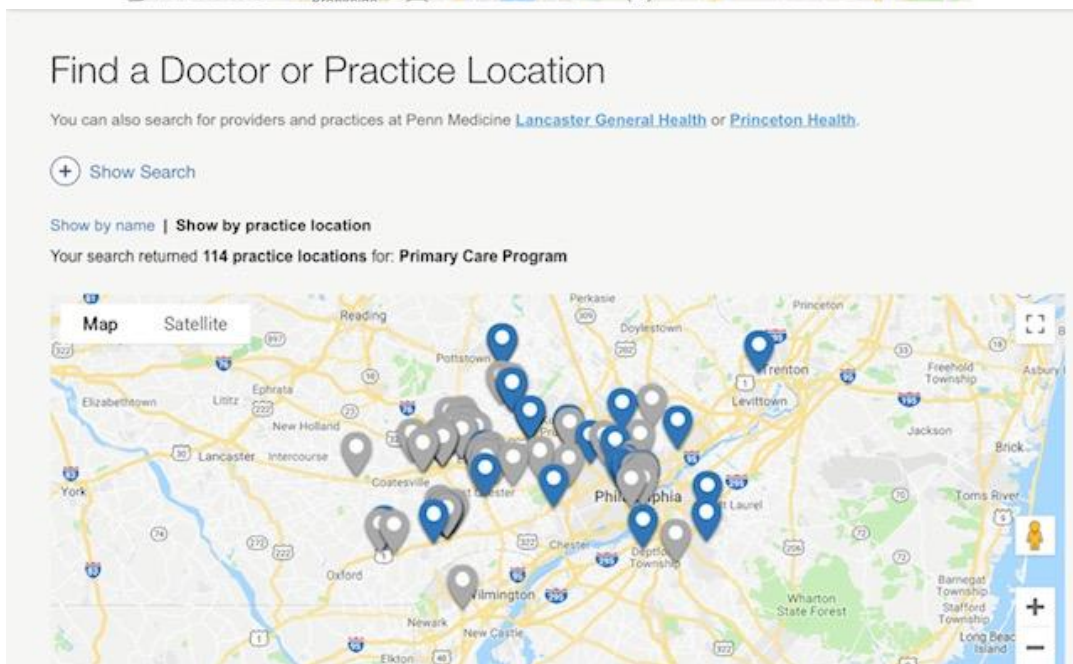
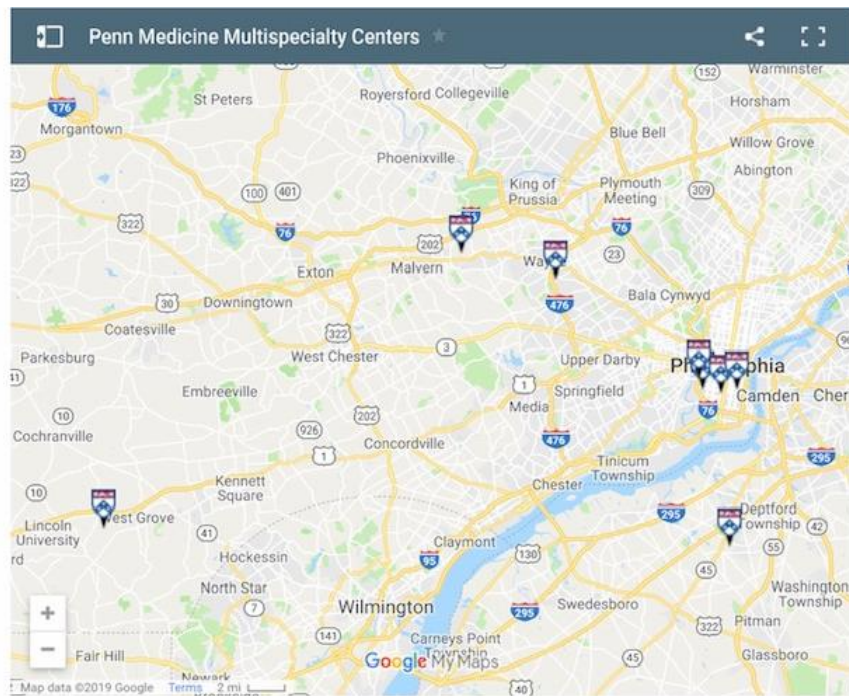
Key	
	System hospital(s) in county
	Rural county
	Urban county
	Likely forum target county

Data source: Hospital and Healthsystem Association of Pennsylvania

While earlier, physicians in counties surrounding Philadelphia were the primary victims, the number of physicians affiliated with corporate providers with Philadelphia connections has substantially increased.

For example, as a result of the merger of Lancaster General Health System with the University of Pennsylvania Health System (Penn Medicine), a physician joined in a case with Lancaster General would now risk suit in Philadelphia, even though all the care was rendered in Lancaster.

Consequences of Venue Reform Rollback

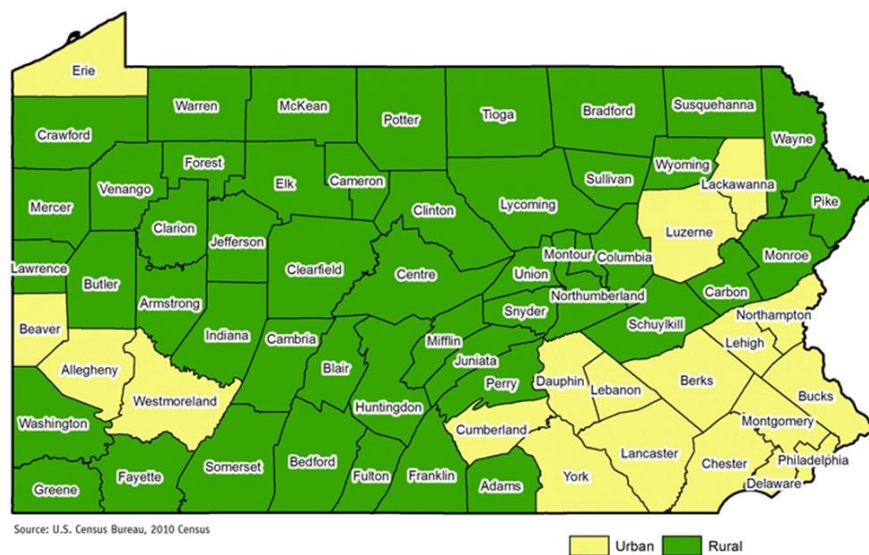


Source: Penn Medicine website (<https://www.pennmedicine.org/>)

The full extent of Penn Medicine's footprint in southeastern Pennsylvania is evident when you add maps of its multi specialty centers and primary care practices.

Consequences of Venue Reform Rollback

Rural Pennsylvania Counties



Source: The Center for Rural Pennsylvania
(<http://www.rural.palegislature.us/ruralcounties.html>)

The potential for expanded forum shopping and the attendant increase in MPL coverage cost is of heightened concern for the rural areas of the state, which are expansive.

27% of Pennsylvania's population live in areas that are designated as rural.

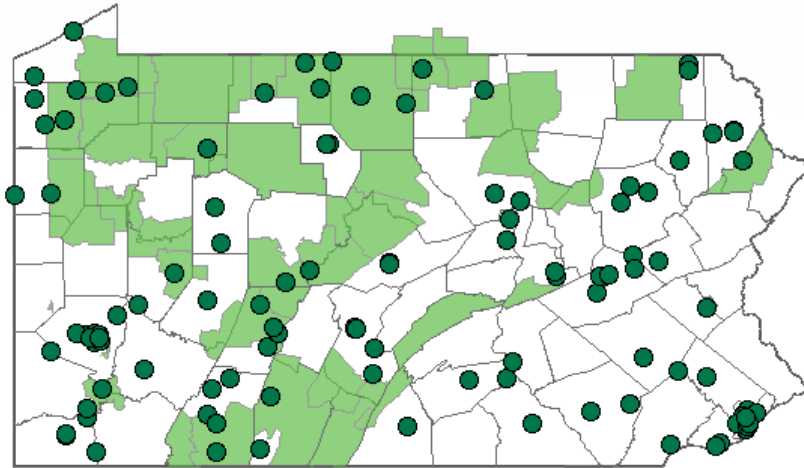
Except for Philadelphia, every county in the state has areas classified as rural.

48 of Pennsylvania's 67 counties are considered rural based upon population density and four counties are 100% rural.

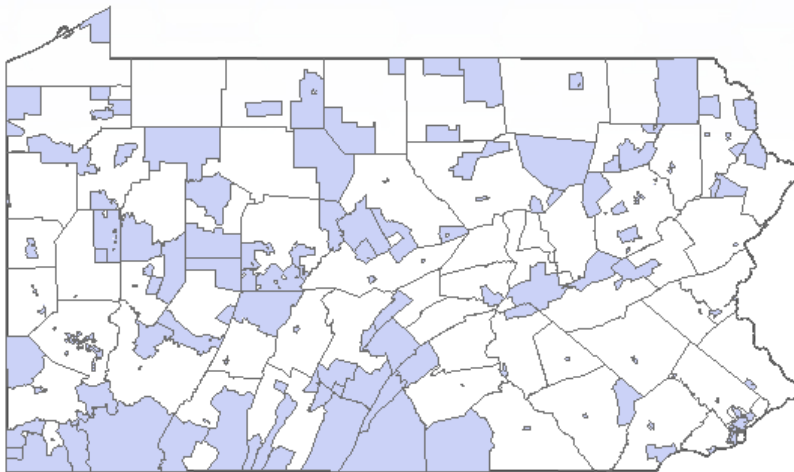
Data source: Pennsylvania Rural Health Association, *Status Check VI, Pennsylvania Rural Health Care*
(<http://www.paruralhealth.org/Status-Check-VI.Final.pdf>)

Consequences of Venue Reform Rollback

Health Professional Shortage Areas (HPSAs)



Medically Underserved Areas (MUAs) and Populations (MUPs)



Data source: Health Services and Resource Administration, Quick Maps Tool
(<https://data.hrsa.gov/maps/quick-maps>)

According to the Pennsylvania Rural Health Association, “[m]any rural and inner city areas have been and continue to be medically underserved.”

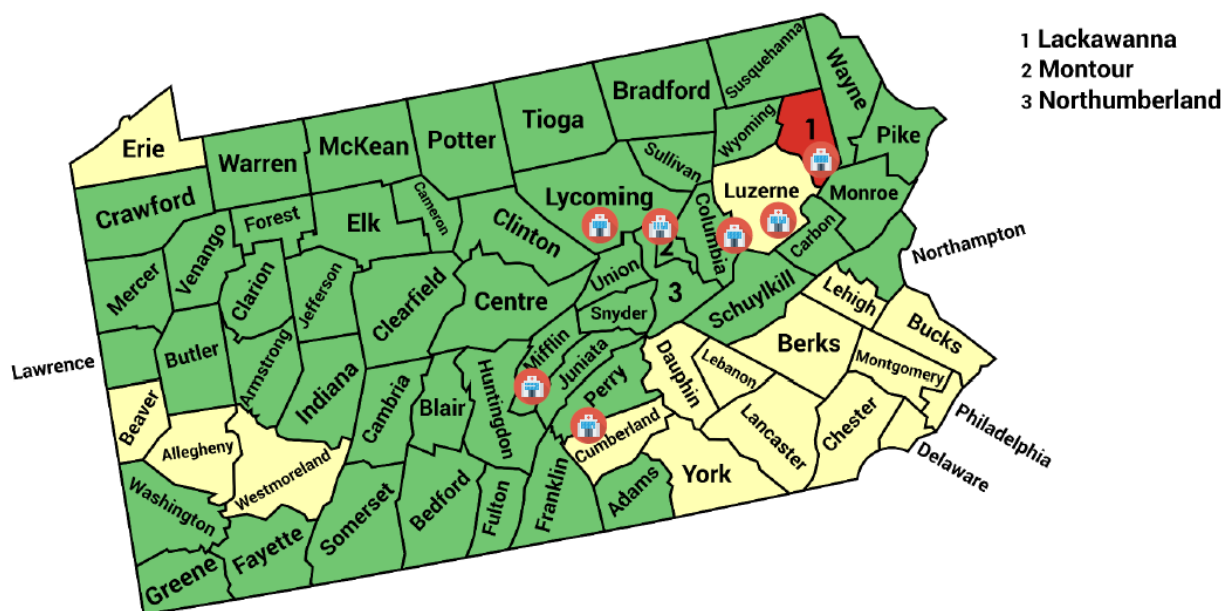
Two designations are used for programs to address these issues: Health Professional Shortage Area (HPSA) and Medically Underserved Area or Population (MUA and MUP).

14% of Pennsylvania’s population reside in an area designated as a HPSA and 14% of the state’s population reside in areas designated as a MUA.

22% of the state’s population live in areas designated as either a HPSA or a MUA.

Data source: Pennsylvania Rural Health Association, *Status Check VI, Pennsylvania Rural Health Care*
(<http://www.paruralhealth.org/Status-Check-VI.Final.pdf>)

Consequences of Venue Reform Rollback



GEISINGER HEALTH SYSTEM	County
Geisinger Community Medical Center	Lackawanna
Geisinger Holy Spirit	Cumberland
Geisinger Jersey Shore Hospital	Lycoming
Geisinger Medical Center	Montour
Geisinger Wyoming Valley Medical Center	Luzerne
Geisinger-Bloomsburg Hospital	Columbia
Geisinger-Lewistown Hospital	Mifflin

Key	
	System hospital(s) in county
	Rural county
	Urban county
	Likely forum target county

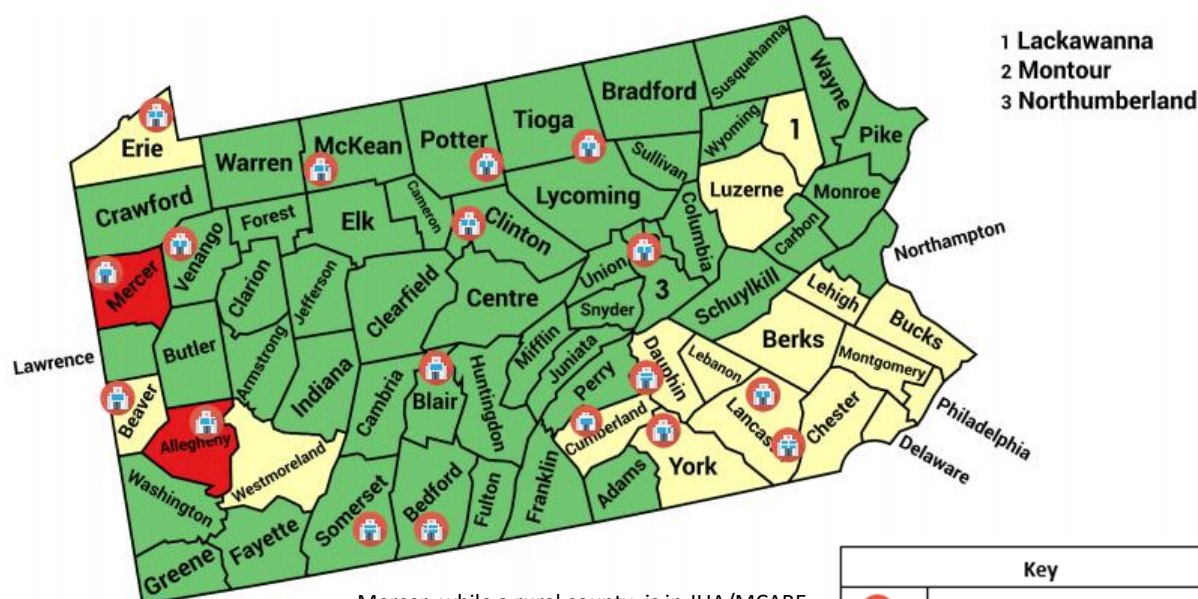
Data source: Hospital and Healthsystem Association of Pennsylvania

Many physicians in rural areas now have – or in the future could have – affiliations with corporate providers that have connections to Philadelphia and other high-risk forums, such as Lackawanna County.

Examples include physicians who are employed by or are otherwise affiliated with the Geisinger Health System and the University of Pittsburgh Medical Center Health System (UPMC).

As shown above and on the next page, both systems have hospitals located in rural areas as well as counties that are likely forum shopping targets.

Consequences of Venue Reform Rollback

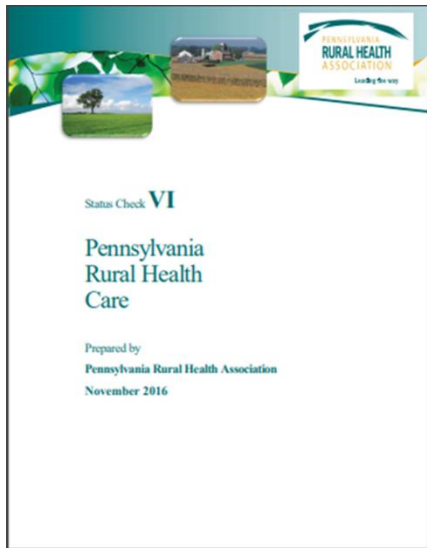


Mercer, while a rural county, is in JUA/MCARE Territory 4, rated as higher cost. Allegheny is in Territory 3, which is lower rated; but when separated, appears to have higher MCARE payouts than other counties in the territory and is above most rural counties.

UPMC HEALTH SYSTEM	County	UPMC HEALTH SYSTEM	County
UPMC Children's Hospital of Pittsburgh	Allegheny	UPMC Pinnacle Lancaster	Lancaster
UPMC East	Allegheny	UPMC Pinnacle Lititz	Lancaster
UPMC Magee-Womens Hospital	Allegheny	UPMC Jameson	Lawrence
UPMC McKeesport	Allegheny	UPMC Susquehanna Divine Providence Hospital	Lycoming
UPMC Mercy	Allegheny	UPMC Muncy Valley Hospital	Lycoming
UMPC Passavant	Allegheny	UPMC Susquehanna Williamsport	Lycoming
UPMC Presbyterian	Allegheny	UPMC Kane	McKean
UPMC St. Margaret	Allegheny	UPMC Horizon	Mercer
UPMC Bedford Memorial	Bedford	UPMC Susquehanna Sunbury	Northumberland
UPMC Altoona	Blair	UPMC Cole	Potter
UPMC Susquehanna Lock Haven	Clinton	UPMC Susquehanna Soldiers and Sailors	Tioga
UPMC Pinnacle Carlisle	Cumberland	UPMC Northwest	Venango
UPMC Pinnacle	Dauphin	UPMC Pinnacle Hanover	York
UPMC Hamot	Erie	UPMC Pinnacle Memorial	York

Data source: Hospital and Healthsystem Association of Pennsylvania

Consequences of Venue Reform Rollback



“Several inter-related factors pose challenges to physician recruitment and retention and to access to the services that they provide. These factors include professional isolation, reduced options for practice coverage, challenges with technology and trained personnel, barriers to continuing medical education, and spousal and family considerations. Although state medical liability issues, which severely impacted physician recruitment and retention in the early 1990s, have greatly improved, Pennsylvania’s liability climate continues to be challenging. Affordable malpractice insurance coverage strongly influences where a physician may decide to practice and may discourage physicians from choosing training and practice sites in Pennsylvania.”

Source: Pennsylvania Rural Health Association
(<http://www.paruralhealth.org/Status-Check-VI.Final.pdf>)

Exposing physicians who practice in rural areas to forum shopping and the attendant risk of higher liability costs will exacerbate the already difficult task of recruitment and retention in these areas and jeopardize access to care.

As poignantly observed by the Pennsylvania Rural Health Association:

“Affordable malpractice insurance coverage strongly influences where a physician may decide to practice and may discourage physicians from choosing training and practice sites in Pennsylvania.”

Consequences of Venue Reform Rollback

Milliman, Inc. a global actuarial consulting firm, was engaged to provide an analysis of the estimated impact on MPL costs and insurance rates of a rollback of MPL venue reform. They estimate the impact to be as follows:

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

They further observe that the above estimated increases are likely low, as their analysis did not account for the following items that could also increase MPL costs and rates:

- The impact of health care provider consolidation in recent years allowing easier access to any venue
- An increased incentive to bring smaller borderline claims
- A knock-on effect of potential higher verdicts and settlements on all areas of the state
- Higher defense costs as a result of venue change
- Potential increases to the MCARE assessments
- Higher rates due to uncertainty in pricing

Source: Milliman, *Review of Proposed Amendment of Pennsylvania Rules of Civil Procedure Nos. 1006, 2130, 2156, and 2179: Governing Venue in Medical Professional Liability Actions in Pennsylvania*, February 20, 2019. A full copy of the report is available in Appendix C.

APPENDIX B

APPENDIX B

Responses to Arguments Made By Proponents of Rollback

"The deck is stacked in favor of doctors.... Administrative Office of the Pennsylvania Courts data [show] that 18 percent of the previous year's 1,400 malpractice suits resulted in plaintiff verdicts. At the same time, the Pennsylvania Patient Safety Authority reports Incidents of Serious Events at about 330,000 per year."

The statement implies that physicians are harming patients at an alarming rate, only a small fraction of those patients harmed seek justice, and the majority of patients who seek justice are unsuccessful due to a biased court system. The statement is inaccurate and misleading.

In 2018, the Patient Safety Authority (PSA) released its most [recent report](#) on Pennsylvania's patient safety track record.¹ The report indicates that, between Jan. 1 – Dec. 31, 2017, there were **271,872** total reports in the acute care setting, which includes "Incidents" **and** "Serious Events". Only **7,881** of those reports in the acute care setting were considered "Serious Events."² And, in nursing homes, there were **30,624** reports of hospital acquired infections (HAI), which are all considered Serious Events. So, contrary to the implied assertion, the data show that only a fraction of the reports received by the PSA are considered Serious Events.

It is also important to note the definition of a Serious Event. As defined by Pennsylvania law, a Serious Event is *"an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient."*

A Serious Event, therefore, **is not** an indication of medical negligence as suggested. A Serious Event may include **any event**, regardless of physician fault, that results in death or unanticipated injury requiring additional patient care. "Injury to the patient" may encompass a wide range of issues, many of which may be temporary and/or not severe. While those events need to be addressed and prevented from a patient safety standpoint, they may not involve significant patient losses that would justify a legal action to recover damages for the injury.

In smaller, more rural counties, the local hospital or health system is often the main employer, with an outsized proportion of the jury pool working for the local system or having a personal connection.

This statement may be true, but the same can be said for Philadelphia and other urban counties, so the fact that hospitals may be leading employers is not a predictor of jury sympathies. Data from Pennsylvania's Department of Labor and Industry show that a high percentage of urban counties identify

¹ Patient Safety Authority. Patient Safety Authority: Annual Report 2017, https://thinkgraphtech.com/digital_media/Patient_Safety_Authority/2017AnnualReport/index.html. Accessed Feb. 9, 2019.

² The remaining were 263,991 were Incidents. An Incident is "an event, occurrence or situation involving the clinical care of a patient in a medical facility *which could have* injured the patient *but did not* either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a Serious Event." 40 Pa. Stat. Ann. § 1303.302 (West).

APPENDIX B

general medical and surgical hospitals among the top businesses established in the county. In addition, hospitals are among the top employers for the majority of urban counties.³

- 79% (15 out of 19) of Pennsylvania's urban counties have general medical and surgical hospitals among the top 5 businesses established in the county.
 - Among the state's urban counties, 89% of counties (17 out of 19) have at least one hospital among the top 5 employers.
 - In Allegheny County, 14 out of the top 50 employers are hospitals, with UPMC (#1) and West Penn Allegheny (#5) among the top 10 employers in the county.
 - In Philadelphia County, 11 out of the top 50 employers are hospitals, with CHOP (#5) and Thomas Jefferson Hospital (#7) among the top 10 employers in the county.
- 27 out of 48 (56%) of Pennsylvania's rural counties have general medical and surgical hospitals among the top 5 businesses established in the county.
 - 69% (33 out of 48) of the state's rural counties have at least one hospital among the top 5 employers.
 - In Bradford County, 6 out of the top 50 employers are hospitals, with 3 hospitals among the top 10 employers in the county: Robert Packer Hospital (#1), Guthrie Medical Group PC (#3), and Memorial Hospital Inc. (#10).

Any inequity can be redressed through a *forum non conveniens* motion.

This is not always true. Plaintiffs have long been provided with the initial choice of the court in which to bring an action, if that court has jurisdiction.⁴ It is well established in Pennsylvania jurisprudence that the plaintiff's choice of forum, although not absolute or unassailable, is given great weight. The burden is on the party challenging the plaintiff's choice of forum to show it was improper.⁵ Mere inconvenience to the defendant is not a proper reason to have the venue transferred.⁶ In order to prevail, the defendant has the heavy burden of proving, with detailed information on the record, that the forum chosen by the plaintiff is either vexatious or oppressive.⁷

In order to be considered vexatious, the defendant must prove with facts on the record that the plaintiff's choice of forum was designed to harass the defendant, even at some inconvenience to the plaintiff himself.⁸ Alternatively, to prove that the plaintiff's choice of forum is oppressive, the defendant may meet the burden by proving on the record that, for example, that trial in another county would provide easier access to witnesses or other sources of proof, or to the ability to conduct a view of premises involved in

³ Pennsylvania Department of Labor and Industry, Pennsylvania Top 50 Employers and Industries, <https://www.workstats.dli.pa.gov/Products/Top50/Pages/default.aspx>. Accessed Feb. 9, 2019.

⁴ Finch v. Am. Premier Underwriters, Inc., No. 1416 EDA 2015, 2016 WL 5852447, at *2 (Pa. Super. Ct. Sept. 30, 2016).

⁵ Moody v. Lehigh Valley Hosp.-Cedar Crest, 2018 PA Super 6, 179 A.3d 496, 502, reargument denied (Mar. 22, 2018), appeal denied, 194 A.3d 116 (Pa. 2018), and appeal denied, 194 A.3d 117 (Pa. 2018).

⁶ Moody v. Lehigh Valley Hosp.-Cedar Crest, 2018 PA Super 6, 179 A.3d 496, 502.

⁷ Bratic v. Rubendall, 626 Pa. 550, 562, 99 A.3d 1, 8 (2014).

⁸ Cheeseman v. Lethal Exterminator, Inc., 549 Pa. 200, 213, 701 A.2d 156, 162 (1997).

APPENDIX B

the dispute.⁹ In sum: although physicians defending themselves in medical professional liability cases can try to move the case back to the county where the care was provided, the motion is time consuming and costly, and the burden proof is great.

⁹ *Id.*

APPENDIX C

Review of Proposed Amendment of Pennsylvania Rules of Civil Procedure Nos. 1006, 2130, 2156, and 2179: Governing Venue in Medical Professional Liability Actions in Pennsylvania

February 20, 2019

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Executive Summary

In 2002-2003, a series of reform packages were enacted in Pennsylvania in order to address a growing crisis in medical malpractice (or medical professional liability (MPL)) insurance. These changes included changes in damage calculations, required safety committee/programs, a collateral source rule and venue reform, among others. The Supreme Court of Pennsylvania (“SCPA”) reformed the venue standard for MPL claims requiring claims be brought only in the county where the cause of action arose.

The Civil Procedural Rules Committee of the SCPA is considering a repeal of the current venue rule (known as the proposed amendment of Pennsylvania Rules of Civil Procedure (Pa.R.C.P.) Nos. 1006, 2130, 2156, and 2179). This amendment would reinstate the venue options available prior to the reforms.

Milliman, Inc., a global actuarial consulting firm, has been engaged to provide an analysis of the estimated impact on MPL costs and insurance rates of the proposed rule changes. Based on our review of publicly available documents such as physician insurance rate filings and data available from the SCPA, we estimate the impact of the proposed change to the venue rules for MPL claims to be as follows:

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

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

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

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

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

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

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

Scope and General Background

The following organizations are sponsors of our research and have requested that Milliman provide an analysis of the effect of repealing the venue reform, specifically the potential impact on MPL insurance rates on a statewide, county, and specialty basis:

- The Hospital and Healthsystem Association of Pennsylvania (“HAP”),
- Insurance Federation of Pennsylvania (“IFPenn”),
- Medical Mutual Insurance Company of North Carolina (“Medical Mutual”),
- the Pennsylvania Medical Society (“PAMED”),
- the Pennsylvania Coalition for Civil Justice Reform (“PCCJR”),
- the Pennsylvania Health Care Association (“PHCA”), and
- The Doctors Company (“TDC”).

This report includes the following:

- Discussion of the current venue rules for MPL, the reasons for the prior changes and the proposed changes;
- A quantitative analysis that evaluates the impact of the proposed change on MPL costs in Pennsylvania. The analysis includes a view on the impact on individual counties and physician specialties as well as the potential overall impact on the resulting insurance rates. (Note that for this report we have assumed that insurance rate changes correlate with the underlying costs of MPL liabilities.)

Current Pennsylvania Venue Rules and Proposed Change

The Civil Procedure Rules Committee of the SCPA is reviewing a proposed amendment of Pa. R.C.P. No. 1006, 2130, 2156, and 2179 governing venue in medical professional liability actions. The proposed wording of the change to Rule 1006 is as follows:

- (a) Except as otherwise provided by subdivisions (b) and (c) of this rule, an action against an individual may be brought in and only in a county where:
- 1) The individual may be served;
 - 2) The cause of action arose;
 - 3) A transaction or occurrence took place out of which the cause of action arose;
 - 4) Venue is authorized by law; or
 - 5) The property or a part of the property, which is the subject of the matter of the action is located provided that equitable relief is sought with response to property.

The proposed amendment removes the following rule for MPL actions:

- 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 current venue rule for MPL claims that took effect in January 2003 and was part of a series of legislative and civil rules changes enacted to address the affordability and availability crisis for MPL insurance for healthcare providers in Pennsylvania peaking in 2001-2002.

Summary of Findings

Impact of Prior Change to Venue Rule – General Discussion

Prior to the reforms made in 2002-2003, the Pennsylvania MPL environment was one of crisis. Reforms were put into place both through legislation (e.g., Act 13 of 2002, MCare Act) and rule changes in the judiciary. Of all the changes enacted, venue change has been cited as having one of the more material impacts on cost. Because of the changes made in 2002-2003, there are some indisputable facts concerning the MPL insurance markets in Pennsylvania:

- Shift in Number of MPL Claim Filings by County – According to the data available from the SCPA website, for the time period between 2000 and 2002, the average annual number of MPL claim filings in Philadelphia County was over 1,200 while the average annual number of filings in Montgomery County was just over 20. The total number of MPL claim filings

in Philadelphia dropped to 577 in 2003 – after the venue rule change went into effect in January 2003 – while by 2004 the number of claims filed in Montgomery increased to over 100.

- Lower Physician MPL Insurance Rates – According the Medical Liability Monitor, which provides an annual survey of MPL insurance rates by state, average physician rates in Pennsylvania have dropped by approximately 29% from 2004/2005 through 2018.
- Greater Availability of Insurance – The number and diversity of writers in the current Pennsylvania MPL insurance market have increased since 2002, with over 90 groups now providing coverage and no single writer with a market share over 12%, representing a stable and competitive market.

Potential Impact of the Proposed Change in Venue Rules

To estimate the potential increase in MPL costs and insurance rates related to “undoing” the venue reform enacted in 2003, we reviewed the decreases in these same costs and rates resulting from the original venue reform. This approach assumes, as we believe to be true, that the proposed change will return the venue rules for MPL claims to the same as those in place prior to 2003.

Our work therefore assumed that the venue reform (as opposed to the other reforms enacted in 2002-2003) extended only to the distribution of claims among counties, not to aggregate changes in the number of claims. We believe this to be a conservative approach. It is more likely that rescinding these venue reforms will have an impact beyond returning to the previous distribution of claims by county and could impact the total number of claims and amount of costs due, for example, to the following:

- Impact of Consolidation – Our analysis is primarily based on estimating the benefits of the initial venue reform in 2003 and assuming they would be reversed as the reform is undone (i.e., the observed cost decreases would become increases). However, the healthcare provider environment has changed significantly since the time period of the initial venue rule change in 2003. Individual practitioners have joined physician groups, groups have been purchased by hospitals, and hospitals have merged into hospital systems. As a result of the greater interconnectedness of healthcare providers, there are fewer degrees of separation today than in 2002 from nearly any venue location. As a result, the impact of the change in venue rules could result in a much greater shift of claims to selected jurisdictions with higher costs resulting in a greater amount of cost increase from changing the venue rules than the decrease observed from the original change starting in 2003.

- **Increased Incentives to Bring Borderline Claims** - The determination to file a claim can sometimes result from an economic calculation of the potential payoff based on the probability of receiving a favorable verdict and the potential size of the verdict award. If, as a result of the proposed venue rule change, claims can be more easily shifted to venues where claims are more likely to receive a successful verdict and/or result in a higher award amount, it is likely that smaller, borderline claims not previously brought will be pursued, increasing the total number of claims and costs within the system.
- **Knock-on Effect due to Precedents/Settlements** - If, as a result of the proposed venue change, claims are shifted to areas where there is a higher probability of a favorable verdict for plaintiffs and for a higher award, there is the possibility of a knock-on effect on other counties due to the established precedents and settlements in the higher cost counties. This increase could impact all counties in the state.
- **Higher Defense Costs** - As claims shift to higher cost venues, the amounts spent in defense of these claims may be expected to rise. Costs could also increase due to travel and lodging costs for out of county witnesses and defendants.
- **Potential Increases to the MCare Assessment** – The potential higher probability of a favorable verdict for plaintiffs and for higher awards could result in an increase to MCare payouts and the corresponding assessments needed to fund the increased payouts.
- **Higher Rates due to Uncertainty in Pricing** – If the venue rules are changed, there will be uncertainty as to the impact of the change on statewide costs and rates and, in particular, on the territory differentials used for pricing. Insurers may add a margin to their rates to compensate for the additional risk they are taking on due to the uncertainty in determining adequate rates.

Due to the limitation on time and data available to prepare this report for presentation to the SCPA, these items, all of which would increase costs, were not accounted for in our indications. Therefore, our results may be viewed as being conservative or on the low end of the range of possible increases.

We developed a range of results to provide a sense of the uncertainty surrounding some of our assumptions and the sensitivity of the results to reasonable, alternative data sources, methods and assumptions. Our ranges, for statewide rates, county rates and specialty are provided in the tables below.

Table 1
Milliman Estimated Impact of Venue Changes on Average
Statewide and Area MPL Rates

Method	Indicated Average Statewide Rate Change	Indicated Area Rate Change
1	15.3%	1% - 47%
2	23.2%	—
Average	19.2%	1% - 47%
Selected	15.0%	5% - 45%

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

State/Region	Average Change in Relativity to Internal Medicine	
	OB/GYN	Gen Surgery
Maryland	92%	100%
New York	105%	133%
New Jersey	92%	117%
Ohio	94%	88%
Non PA Average	95%	110%
PA-Philadelphia	85%	83%
PA - Remainder of State	79%	83%
PA Average	82%	83%
Potential Increase	17%	32%

Explanation of Methods and Assumptions – Statewide and County Impact

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

- Physician Rate Filings for the Pennsylvania Professional Liability Joint Underwriting Association (PAJUA); and
- Medical Malpractice claim filings data from the SCPA.

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

Method 1 – PAJUA Rate Filing Information

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

In order to increase the credibility of our indications, we aggregated the rate information into seven areas defined as follows and shown on Exhibit 1:

1. Philadelphia County
2. Counties Surrounding Philadelphia County
3. Allegheny County
4. Counties Surrounding Allegheny County
5. Lackawanna County
6. Counties Surrounding Lackawanna County
7. All Other

We determined territory relativities (representing the relative costs of each area to the base area (Philadelphia County)) by area at varying points of time prior to and after the venue reform and compared them to the latest relativities. We determined an overall average weighted relativity using a distribution of physician counts by area based on information provided by PAMED. The movement in the overall relativity by year is one possible indication of the change in the overall average statewide rate resulting from the change in venue rules.

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

Method 2 – PA Supreme Court Data

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

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

Jury verdicts by award bucket grouped by area are provided on Exhibit 3, Sheet 3. We have summed the data provided for 2000 and 2017 in order to increase the credibility and stability of the information. As we did not have access to the actual severity of the claims in each award buckets, we made assumptions regarding the average awards within each bucket as shown in row (13). Based on the distribution of claims by bucket and the average award assumptions, we estimated the average award by area as shown in column (8). We then developed a weighted average of the awards based on the claim filing distribution from Exhibit 3, Sheet 1 as shown in columns (9) through (12). Using an assumed trend of 3%, we calculated average awards, row (14) and compared them as shown in row (15). The implied impact on the statewide severity due to the venue reform was a decrease of over 18% between the 2000-2002 average and 2017 (\$722,150 / \$889,508). This implies that if the venue rules were removed, average awards and their resulting costs and rates will likely increase by as much as 23% (\$889,508/\$722,150).

Explanation of Methods and Assumptions – Physician Specialty Impact

To estimate the potential impact of the venue rule change on physician specialty, we examined the rates and relativities between the rates for the following specialties:

- Internal Medicine
- OB/Gyn
- General Surgery

We compared the rates for two of the higher risk physician specialties (OB/Gyn and General Surgery) since the initial venue reform in 2003 to the rates for Internal Medicine physicians in the same period. As there may have been improvements in risk management that impacted some specialties more than others across practices in the observed time period, we calculated this same relativity in neighboring states to Pennsylvania to observe if the change in relativity differed by state in this same time period. As provided in Table 2 above and Exhibit 4, Sheets 1 and 2, the rates for OB/Gyn physicians have decreased relative to the rates for Internal Medicine physicians by an average of 5% in many of the neighboring states while the relative decrease in Pennsylvania was 18%. This would indicate an additional 14% relative rate benefit from the 2002 changes featuring venue reform than experienced by other practitioners in neighboring states. Similarly, the relative rates for General Surgeons decreased by 17% in Pennsylvania as compared to an increase of 10% in neighboring states. This would indicate a potential additional rate benefit of 33% to General Surgeons from venue reform when compared to similar practitioners in neighboring states (the difference between a 10% increase compared to a 17% decrease). Conversely, it is implied that if the current venue rules were changed to those prior to the reform efforts, costs and rates for both O/B/Gyns and General Surgeons will likely experience additional increases of 17% or greater.

Potential Unintended Consequences of Change to Venue Rules in Pennsylvania

In addition to the increased MPL costs expected to be incurred if the proposed venue change rules are enacted, there could be other potential unintended consequences. These include the following:

Reduced Availability of Insurance Coverage

During the pre-reform crisis, many insurers left the market or reduced the amount of insurance they would provide in the state. Since the venue change in 2003, the MPL insurance market has somewhat stabilized. As noted previously, the proposed venue rule change would add additional uncertainty in the pricing of MPL insurance, particularly in regards to rates set by geographic territory. Besides increasing rates judgmentally until new territory differentials can be established, the increased uncertainty in pricing could result in insurers limiting future writings in the state or exiting the market entirely.

Adverse Impact of Self-Insured Health Care Entities

If the change in venue rules impacts MPL claim costs as estimated in this report, this could affect any self-insured hospitals or other facilities to which costs accrue directly. These entities have benefited in recent years from the cost declines related to the tort reforms from 2003 while dealing with changes and decreases

in healthcare reimbursements. A sudden surge in unbudgeted MPL costs could affect the financial performance of these entities.

Statement of Qualifications

Tom Ryan FCAS, MAAA of Milliman meets the actuarial qualification standards to provide this analysis.

Limitations

Data

In performing this analysis, we relied on publicly available data and other information. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. In that event, the results of our analysis may not be suitable for the intended purpose.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Uncertainty

During the course of our review, we applied generally accepted actuarial procedures. However, due to the uncertainty involved in projecting future events, it is likely that actual results will vary from our projections, perhaps materially.

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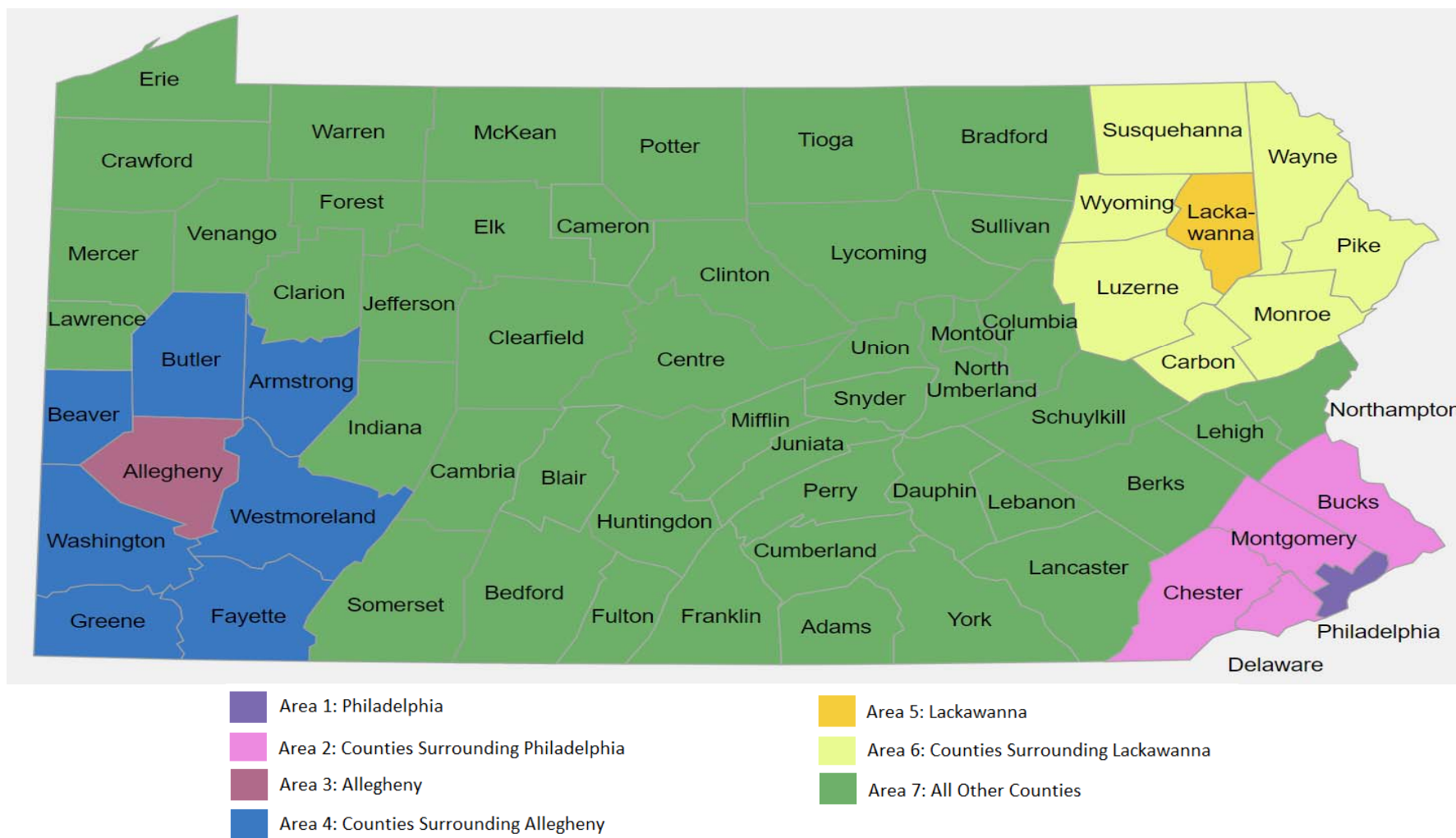
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Area Definitions

Exhibit 1



Calculation of Effect on Territory Relativities with Elimination of Venue Rule Change Based on PAJUA Rate Filing Information

Exhibit 2

Implied Territory Relativities

Based on PAJUA Rate Filing Information

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13a) (11) ÷ (6) - 1.0	(13b) (6) ÷ (11) - 1.0
Area	Territory Relativity (Relative to Area 1 - Philadelphia)										2016 Phys Count	Terr Rel Decrease 04-14	Implied Terr Rel Increase 04-14
	1/1/2001	1/1/2002	9/1/2002	9/1/2003	9/1/2004	1/1/2006	1/1/2008	1/1/2009	1/1/2010	1/1/2014			
1	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	6,807		
2	0.899	0.835	0.842	0.882	0.914	0.871	0.765	0.704	0.639	0.623	8,848	-32%	47%
3	0.522	0.522	0.550	0.600	0.600	0.600	0.506	0.480	0.480	0.554	5,846	-8%	8%
4	0.499	0.499	0.534	0.575	0.581	0.589	0.512	0.481	0.467	0.555	2,124	-5%	5%
5	0.750	0.750	0.800	0.850	0.900	0.850	0.598	0.598	0.580	0.806	537	-10%	12%
6	0.537	0.537	0.618	0.637	0.668	0.668	0.572	0.565	0.546	0.660	1,224	-1%	1%
7	0.496	0.494	0.562	0.584	0.593	0.593	0.519	0.498	0.477	0.509	12,450	-14%	16%
(14) Overall Wtd Avg Relativity:				0.736	0.748	0.738				0.643			
(15) Indicated Statewide Change Should Pre-2003 Venue Rule Environment return				0.145	0.164	0.149							
				Average:		0.153							

(1)	Area	Description
	1	Philadelphia
	2	Counties surrounding Philadelphia
	3	Allegheny
	4	Counties surrounding Allegheny
	5	Lackawanna
	6	Counties surrounding Lackawanna
	7	All Other
(2) - (11)	Relationship of (Rate for Area x) ÷ (Rate for Area 1)	
(12)	Physician counts by county from PAMED 2016 Licensed Active Physician list.	
(14)	Weighted average of territory relativities with (12) used as weights.	
(15)	= [(14) for Year XX] ÷ [(14) for 1/1/2014] - 1.0	

Calculation of Effect on Average Statewide Claim Severity with Elimination of Venue Rule Change
Based on PA Supreme Court Data

Exhibit 3
Page 1

PA Supreme Court Filings

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
	Filings																		
Area	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	
1	1,085	1,162	1,365	577	559	540	569	586	553	491	381	418	389	382	382	381	378	406	
2	200	176	176	92	255	269	246	238	217	199	205	213	234	236	224	272	263	250	
3	390	372	426	272	297	324	301	262	275	263	326	293	281	296	278	245	271	224	
4	149	149	149	110	113	126	107	88	86	82	105	210	133	130	112	125	110	105	
5	71	69	55	34	31	35	35	30	36	33	37	36	30	27	22	47	34	29	
6	56	61	53	60	96	54	59	64	73	69	52	81	45	76	64	66	68	65	
7	681	670	680	567	468	363	387	373	362	395	384	424	398	413	430	394	417	370	
Total	2,632	2,659	2,904	1,712	1,819	1,711	1,704	1,641	1,602	1,532	1,490	1,675	1,510	1,560	1,512	1,530	1,541	1,449	
(1)	<div>Area Description</div> <div>1 Philadelphia</div> <div>2 Counties surrounding Philadelphia</div> <div>3 Allegheny</div> <div>4 Counties surrounding Allegheny</div> <div>5 Lackawanna</div> <div>6 Counties surrounding Lackawanna</div> <div>7 All Other</div>																		
(2) - (19)	Based on PA Supreme Court data. A filing refers to the commencement of a civil action by complaint or praecipe for writ of summons.																		

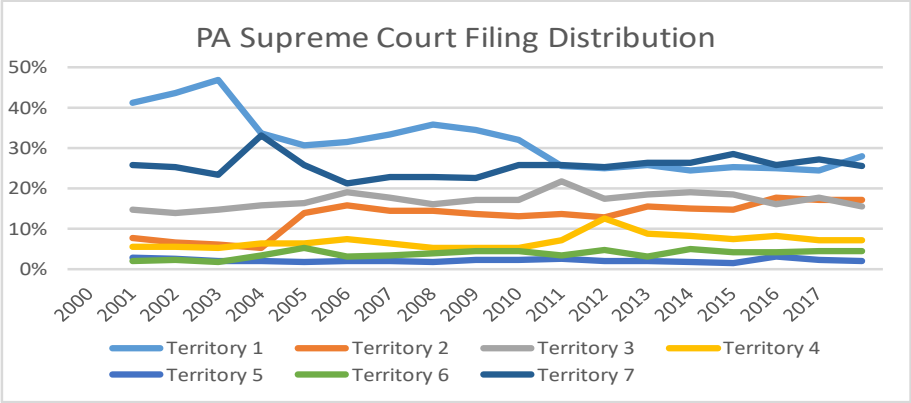
Calculation of Effect on Average Statewide Claim Severity with Elimination of Venue Rule Change
Based on PA Supreme Court Data

Exhibit 3
Page 2

PA Supreme Court Filing Distribution

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
	Filing Distribution																		
Area	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	
1	41.2%	43.7%	47.0%	33.7%	30.7%	31.6%	33.4%	35.7%	34.5%	32.0%	25.6%	25.0%	25.8%	24.5%	25.3%	24.9%	24.5%	28.0%	
2	7.6%	6.6%	6.1%	5.4%	14.0%	15.7%	14.4%	14.5%	13.5%	13.0%	13.8%	12.7%	15.5%	15.1%	14.8%	17.8%	17.1%	17.3%	
3	14.8%	14.0%	14.7%	15.9%	16.3%	18.9%	17.7%	16.0%	17.2%	17.2%	21.9%	17.5%	18.6%	19.0%	18.4%	16.0%	17.6%	15.5%	
4	5.7%	5.6%	5.1%	6.4%	6.2%	7.4%	6.3%	5.4%	5.4%	5.4%	7.0%	12.5%	8.8%	8.3%	7.4%	8.2%	7.1%	7.2%	
5	2.7%	2.6%	1.9%	2.0%	1.7%	2.0%	2.1%	1.8%	2.2%	2.2%	2.5%	2.1%	2.0%	1.7%	1.5%	3.1%	2.2%	2.0%	
6	2.1%	2.3%	1.8%	3.5%	5.3%	3.2%	3.5%	3.9%	4.6%	4.5%	3.5%	4.8%	3.0%	4.9%	4.2%	4.3%	4.4%	4.5%	
7	25.9%	25.2%	23.4%	33.1%	25.7%	21.2%	22.7%	22.7%	22.6%	25.8%	25.8%	25.3%	26.4%	26.5%	28.4%	25.8%	27.1%	25.5%	

(1)	<div>Area</div> <div>Description</div> <div>1 Philadelphia</div> <div>2 Counties surrounding Philadelphia</div> <div>3 Allegheny</div> <div>4 Counties surrounding Allegheny</div> <div>5 Lackawanna</div> <div>6 Counties surrounding Lackawanna</div> <div>7 All Other</div>
(2) - (19)	Based on PA Supreme Court data. A filing refers to the commencement of a civil action by complaint or praecipe for writ of summons.



Calculation of Effect on Average Statewide Claim Severity with Elimination of Venue Rule Change

Based on PA Supreme Court Data

Exhibit 3

Page 3

Average Jury Verdict by Area

Based on 2000 - 2017 PA Supreme Court Data

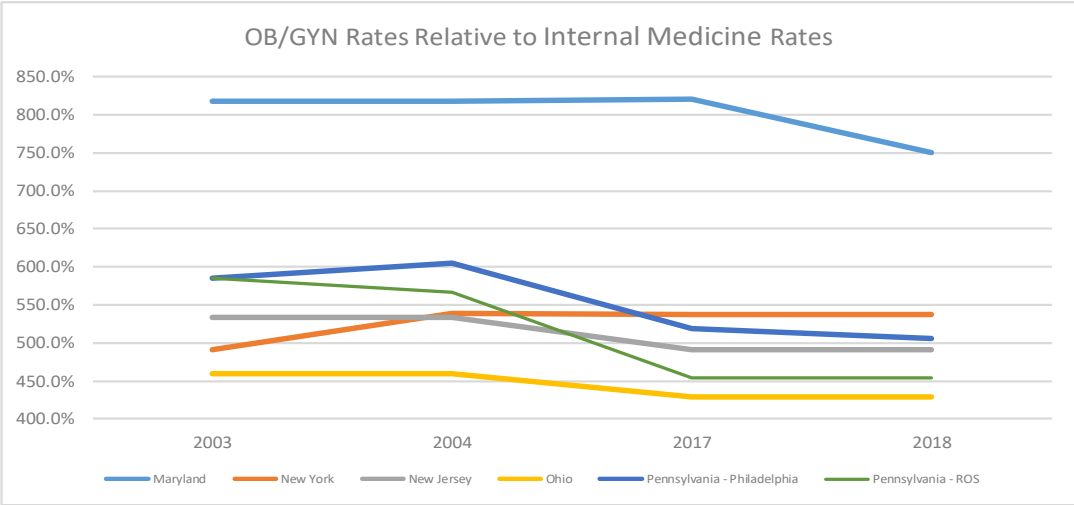
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Area	Award Bucket						Average Award by Area	Filing Distribution			
	Defense Verdicts	<\$500K	>\$500K,<\$1M	>\$1M,<\$5M	>\$5M,<\$10M	>\$10M		2000	2001	2002	2017
1	627	118	60	124	29	24	\$1,445,562	41.2%	43.7%	47.0%	28.0%
2	598	43	19	32	4	4	383,904	7.6%	6.6%	6.1%	17.3%
3	318	28	20	17	7	0	443,819	14.8%	14.0%	14.7%	15.5%
4	188	22	7	7	2	1	373,484	5.7%	5.6%	5.1%	7.2%
5	70	5	4	7	0	1	598,947	2.7%	2.6%	1.9%	2.0%
6	122	14	5	6	4	0	459,741	2.1%	2.3%	1.8%	4.5%
7	809	77	27	34	7	11	480,101	25.9%	25.2%	23.4%	25.5%
(13) Average Award	\$0	\$250,000	\$750,000	\$3,000,000	\$7,500,000	\$15,000,000					
(14)	Average Claim Severity: (Including 3.0% annual trend):							\$862,148	\$887,213	\$919,164	\$722,150
	Average:								\$889,508		
(15)	Indicated Statewide Severity Change Should Pre-2003 Venue Rule Environment return:							0.194	0.229	0.273	
	Average:									0.232	

(1)	Area	Description
	1	Philadelphia
	2	Counties surrounding Philadelphia
	3	Allegheny
	4	Counties surrounding Allegheny
	5	Lackawanna
	6	Counties surrounding Lackawanna
	7	All Other
(2) - (7)	Based on PA Supreme Court Filing data.	
(8)	Weighted average of Row (13) using Columns (2) through (7), by area, as weights.	
(9) - (12)	Based on PA Supreme Court Filing data in Exhibit 3, Page 1.	
(13)	Judgmentally assigned.	
(14)	Weighted average of (8) using distribution percentages in Columns (9) through (12).	
(15)	= [(14) using 20xx distribution] ÷ [(14) using 2017 distribution] - 1.0	

Change in OB/GYN Relative to Internal Medicine Pre & Post 2003 Venue Rule Change Based on Medical Liability Monitor Annual Rate Survey Data

Relationship of OB/GYN Rates to Internal Medicine Rates

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
State	2003	2004	2017	2018	Relationship between: 2003 & 2018 2004 & 2018		Average
Maryland	818.0%	818.0%	820.0%	750.0%	91.7%	91.7%	91.7%
New York	491.3%	538.7%	537.2%	537.2%	109.3%	99.7%	104.5%
New Jersey	533.4%	533.2%	491.3%	491.3%	92.1%	92.1%	92.1%
Ohio	459.1%	459.1%	429.5%	429.5%	93.6%	93.6%	93.6%
Pennsylvania - Philadelphia	585.0%	605.3%	519.0%	505.9%	86.5%	83.6%	85.0%
Pennsylvania - ROS	585.0%	566.5%	453.6%	453.6%	77.5%	80.1%	78.8%



- (1)

Rates were pulled from one writer by state as listed below:

Maryland:

Medical Mutual Liability Insurance Society of MD

New Jersey:

Princeton

New York:

MLMIC

Ohio:

Medical Assurance (ProAssurance)

Pennsylvania:

Norcal (PMSLIC) - Excl MCARE premium
- (2) - (5)

Relationship between OB/GYN Rates and Internal Medicine Rates
- (6)

= (5) ÷ (2)
- (7)

= (5) ÷ (3)
- (8)

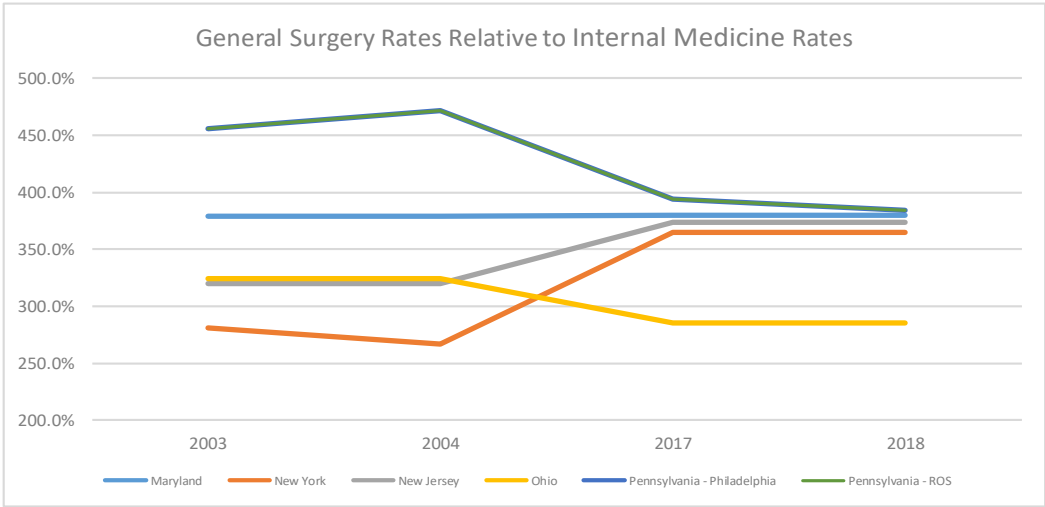
= Average of (6) and (7)

Change in General Surgery Relative to Internal Medicine Pre & Post 2003 Venue Rule Change

Based on Medical Liability Monitor Annual Rate Survey Data

Relationship of General Surgery Rates to Internal Medicine Rates

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
State	2003	2004	2017	2018	Relationship between:		Average
					2003 & 2018	2004 & 2018	
Maryland	379.0%	379.0%	380.0%	380.0%	100.3%	100.3%	100.3%
New York	281.4%	266.6%	365.0%	365.0%	129.7%	136.9%	133.3%
New Jersey	319.5%	319.5%	373.9%	373.9%	117.0%	117.0%	117.0%
Ohio	324.4%	324.4%	285.3%	285.3%	88.0%	88.0%	88.0%
Pennsylvania - Philadelphia	456.0%	471.1%	393.7%	384.5%	84.3%	81.6%	83.0%
Pennsylvania - ROS	456.0%	471.1%	393.7%	384.5%	84.3%	81.6%	83.0%



- (1)

Rates were pulled from one writer by state as listed below:

Maryland:

Medical Mutual Liability Insurance Society of MD

New Jersey:

Princeton

New York:

MLMIC

Ohio:

Medical Assurance (ProAssurance)

Pennsylvania:

Norcal (PMSLIC) - Excl MCARE premium
- (2) - (5)

Relationship between OB/GYN Rates and Internal Medicine Rates
- (6)

= (5) ÷ (2)
- (7)

= (5) ÷ (3)
- (8)

= Average of (6) and (7)

APPENDIX D

APPENDIX D: LIST OF CO-SPONSORING ENTITIES

TO THE PENNSYLVANIA MEDICAL SOCIETY’S OBJECTIONS TO PROPOSED AMENDMENTS TO Pa. R.C.P. Nos. 1006, 2130, 2156, and 2179

The Pennsylvania Medical Society (PAMED) and the following signatories to PAMED’s comments collectively advocate on behalf of patients, physicians, and other health care providers in the Commonwealth. Like PAMED, these organizations oppose the proposed amendment of Pa. R.C.P. Nos. 1006, 2130, 2156, and 2179 governing venue in medical professional liability (MPL) actions. The organizations support PAMED’s belief that the proposed amendments will result in a domino-effect of negative implications for the MPL insurance market and access to quality patient care for all Pennsylvanians—particularly in the state’s rural areas.

The Bucks County Medical Society (BCMS)

The Bucks County Medical Society (BCMS) advocates for physicians, patients, and the health of our community. BCMS opposes the state Supreme Court's Civil Procedural Rules Committee's proposed change to the MPL venue rules since this would resurrect forum shopping in medical professional liability cases. It would thereby threaten the viability of physician practices and jeopardize access to care for patients in the region.

Cardiology Consultants of Philadelphia (CCP)

Cardiology Consultants of Philadelphia (CCP) covers all five counties in southeastern Pennsylvania, has 37 offices, and rounds at 18 hospitals. The Mission of CCP is to improve the health of its patients through the provision of the most comprehensive cardiovascular care, research, and education possible. CCP strives to continuously advance its relevant knowledge in order to improve the service it provides to its patients, referring physicians and community. CCP is committed to forging longstanding relationships with its patients, referring physicians, shareholders and employees. CCP adheres to prudent business practices to ensure the long-term fiscal health of its organization.

Clarion County Medical Society (CCMS)

The Clarion County Medical Society (CCMS) represents the physicians of Clarion County. CCMS opposes the state Supreme Court’s Civil Procedural Rules Committee’s proposed change to the MPL venue rules. The proposed rule change will negatively impact physicians, medical training programs, and patient care—particularly in rural Pennsylvania—by resurrecting forum shopping in medical professional liability cases.

Lancaster City & County Medical Society (LCCMS)

Lancaster City & County Medical Society (LCCMS) is a Pennsylvania non-profit corporation that promotes and protects the practice of medicine for the physicians of Lancaster County so they may provide the highest quality patient-centered care in an increasingly complex environment. The Medical Society opposes the state Supreme Court's Civil Procedural Rules Committee's proposed change to the MPL venue rules. The proposed rule change will negatively impact physicians and affect patient care by allowing claimants to shop for verdict-friendly venues in which to file their suits. It will lead to higher medical professional liability insurance premiums and make PA a less attractive state for physicians to practice.

The Lehigh County Medical Society (LCMS)

The Lehigh County Medical Society (LCMS), founded in 1852, serves as an avenue to unite Lehigh County physicians into a single body to advocate for health policy that provides the highest standard of healthcare for the people of Lehigh County.

The NORCAL Group

The NORCAL Group of companies (“NORCAL Group”) - NORCAL Mutual Insurance Company, NORCAL Specialty Insurance Company, FD Insurance Company, Medicus Insurance Company, and Preferred Physicians Medical Risk Retention Group - provides medical professional liability insurance to physicians, health care extenders, medical groups, hospitals, community clinics, and allied health care facilities throughout the country. It has over 32,000 insureds across the nation coming from diverse specialties. The NORCAL Group safeguards its policyholders from risk, guides them through the unexpected and protects their practice of medicine. The proposed venue rule change will encourage forum shopping in medical professional liability cases, which will negatively impact physicians, discourage physician retention in the state, and unnecessarily impede patients’ access to quality care.

Pennsylvania Academy of Dermatology and Dermatologic Surgery (PAD)

The Pennsylvania Academy of Dermatology and Dermatologic Surgery (PAD) is a Pennsylvania non-profit organization solely representing the interests and concerns of all dermatologists and their patients in the Commonwealth. PAD opposes the state Supreme Court’s Civil Procedural Rules Committee’s proposed change to the MPL venue rules. The proposed rule change will negatively impact physicians, medical training programs, and patient care—particularly in rural Pennsylvania—by resurrecting forum shopping in medical professional liability cases.

The Pennsylvania Psychiatric Society (PaPS)

The Pennsylvania Psychiatric Society (PaPS), a district branch of the American Psychiatric Association, is a member organization comprised of more than 1,700 physicians practicing the specialty of psychiatry in the commonwealth. PaPS opposes the commonwealth’s Supreme Court’s Civil Procedural Rules Committee’s proposed changes to the current Medical Professional Liability law related to change of venue. The enactment of such a monumental change would inadvertently restrict patient access to critical and often life-altering mental health and substance use treatment and services only afforded by our current physician members and those members in training program across the state.

The Philadelphia County Medical Society (PCMS)

The Philadelphia County Medical Society (PCMS) has been representing physicians as they treat patients, advance science, maintain the standards of the profession, and protect the public health in Philadelphia County for more than 175 years. PCMS strongly opposes the State Supreme Court’s Civil Procedural Rules Committee’s proposed change in the venue rule. The proposed changes will lead to increased cost of medical liability insurance in Pennsylvania that will again negatively impact patient access to quality care.