HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bill 2122

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House Judiciary Committee

Main Capitol Building
Room 140, Majority Caucus Room
Harrisburg, Pennsylvania

Tuesday, July 9, 1996 - 9:30 a.m.

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BEFORE:

Honorable Thomas Gannon, Majority Chairman
Honorable Jerry Birmelin
Honorable J. Scot Chadwick, Acting Chairman
Honorable Timothy Hennessey
Honorable Al Masland
Honorable Robert Reber
Honorable Thomas Caltagirone
Honorable Lisa Boscola
Honorable Andrew Carn
Honorable Frank Dermody
Honorable Michael Horsey
Honorable Harold James
Honorable Kathy Manderino
Honorable Mark Cohen

ALSO PRESENT:

Judy Sedesse
Administrative Assistant to Committee

Karen Dalton
Counsel to Committee

C O N T E N T S

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CHAIRMAN GANNON: I'd like to convene the public hearings on House Bill 2122 introduced by Representative Scot Chadwick. And with that, I would like to recognize Representative Chadwick for a brief statement.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. I appreciate the opportunity to say a couple of words before we start this hearing. I suppose in a sense this looks to some people like closing the barn door after the horse is out since the House has already passed medical malpractice reform in the form of amendments to Senate Bill 790.

And in the event that the Senate concurs to those amendments, the results of this hearing will be academic; however, we certainly have no guarantee that the Senate is going to concur to those amendments.

And this issue has a way of coming back to us from time to time. We have an excellent list of witnesses today. And in the event that we do have an opportunity to address the issue again, I suspect we'll learn a lot today that will be useful to us.

So I thank the Chairman for convening

this hearing and look forward to the testimony of the witnesses. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Our first witness is Senator Henry G. Hager, President and Chief Executive Officer of the Insurance Federation of Pennsylvania. Welcome, Senator Hager.

SENATOR HAGER: Thank you, Mr. Gannon. In the interest of brevity and having had the opportunity just a moment ago to review testimony proposed to be introduced here by Mr. Mulvihill, I'm going to kind of skip back and forth through my testimony. It might save some time.

First of all, I'm very grateful for the opportunity. This is the third and real time that I have been scheduled to testify on this issue before your Committee. The first time I guess the witnesses ran long because the subject was interesting.

And the second time, was either the budget or workers' comp which decided, the Chairman, that he should probably postpone the hearing. So here I am. He promised me first crack at you, and I'm glad to have it.

So Members of the Committee, if I may, let's just skip the first two. You've already said who I am. I'd like to start on the third paragraph of my testimony for those of you who are following.

On September 20th of last year, I testified before the Senate Banking and Insurance Committee on a bill designed to bolster the solvency of the Medical Professional Liability Catastrophe Loss Trust Fund created under Article 7 of this same Act.

I noted then that as a member of the Senate in '74 and '75, I participated in the formulation of this Act, including its effort to reform medical malpractice actions by requiring their mandatory submission to knowledgeable arbitration panels.

This effort came to naught when various features of that arbitration system were ruled unconstitutional by the Pennsylvania Supreme Court, chiefly because in the legislative negotiations we ended up with seven-member panels requiring so many doctors, so many lawyers; and you never could get a panel together to sit. And so justice delayed was

justice denied.

And the Supreme Court said, This isn't working. And that was the end of that Act. It is gratifying to see that the bipartisan sponsors of this Bill introduced by Representative Scot Chadwick have tackled medical malpractice reform by replacing the five articles of the original Act, Articles 2 through 7, with six articles making both substantive and procedural medical malpractice reforms.

The Federation is enthusiastic about many of those changes; however, the Federation opposes for open market reasons the mandatory rate rollback provisions in Section 7 of the Bill. Allow me to comment briefly on both of these aspects of the Bill in the time remaining to me.

We support, in short, informed consent, warranties, the collateral sources, the punitive damages, that Statute of Limitations of the frivolous filings sections of this Bill.

All of these bearing on the standards to be applied to malpractice claims present attempts to balance the rights of claimants against the rights of the medical services

providers which allegedly have harmed them and the rights of those footing the costs of the system, which is virtually all of the rest of us.

This last group, in essence, the public, has the right to reasonable restraints against the claim system running amok and contorting the practices and the costs within it.

Those latter costs are often poorly understood by the public and the media and, moreover, are often overlooked in the politics of such debates because no particular interest group except insurers, who have their own problems in the legislature, represents that view.

Skipping down to the middle of this, the next paragraph, there are people who say that you should not listen to insurance companies because after all, they're involved in this and they have a money interest.

And the problem with that is that deprives the people out there who pay the premium of their most knowledgeable advocates. The fact is it is shortsighted to think that you shouldn't listen to us.

Because of rate setting mechanisms and the freedom to choose coverage in the markets, insurers themselves are not the primary victims of excesses in the tort system, medical malpractice or otherwise -- we collect the premiums. We invest the money. We pay the claims. And the costs that we face, we pass on -- insurance policyholders in all types of coverages are.

That means that it is the responsible citizens of the Commonwealth who bear the costs of any abuses or imbalances. These come in forms of higher costs for businesses and consumers, more expensive insurance coverages, noncompetitiveness of the Pennsylvania and the U.S. economies, and ultimately a lowered standard of living.

Savings in this system, after all, are available for many things including, perhaps, creating new jobs and new opportunities. In any event, while lawmakers properly will -- and insurers will not -- be the final arbiter of the equity of these balances, the new standards in Article 2-A governing professional liability claims certainly strike a more reasonable

balance.

It's hard to argue that a health care provider should be a guarantor of a cure absent a written contract to that effect. Likewise with the exception for minors and foreign objects left in someone's body, it also seems reasonable to close claims at the earlier of two years after a person knows about the injury or four years after the breach of duty which gave rise to an injury.

Many of the balancing decisions in this first new Article are more difficult. Is it reasonable to limit punitive damages to 200 percent of compensatory damages at the same time as standards for their imposition are stiffened? We think so, but I doubt that the trial bar will.

The Federation has always favored a collateral source rule, and Section 203-A certainly seems a reasonable one. It is long since time to limit our tort system to redress those unfortunate enough to be injured by the negligence of others and weeding out elements which exist primarily to enrich claimants and to subsidize unreasonable claims.

Now I have to deviate from the testimony for just a moment to say that I have received an inner-office memorandum from Keith Bateman, an attorney at the Alliance of American Insurers, to John Kuchka (phonetic), who is an executive of that outfit, which points out that language on page 6 of the Act, really in paragraph 6 -- or paragraph B at the top, if I could find it up here -- it says that we have to offset any damages -- a jury has to offset any damages in a medical malpractice case by those payments which may come through some group contract, which would include workers' comp. Not only that which he has received prior to trial, but those which he will receive in the future.

And the concern which the Alliance raises is that that particular language is liable to make workers' comp carriers, whether they are insurance carriers or wholly-owned or self-insured I mean, will have to pay for the negligence of some physician or some medical mistake afterward. And they think that that raises an issue which you ought to address.

I don't have language at this moment; but I wanted particularly, Mr. Chadwick, to make

you aware that may raise an issue which we should look at in our effort to make sure that we don't allow people to collect under the first-party insurance, workers' comp, and any of the public payments such as social security or disability and at the same time limit the workers' comp and limit the collection from a medical provider.

We may, in fact, just shift the burden someplace else; and so we probably should take a look at that. Articles 3 and 4 represent changes in pretrial and trial procedures which have been found in many tort reform efforts over the past decade.

There seems to be developing both in the Commonwealth and across the country a consensus that attorneys should be held accountable for good faith in their pleadings; experts should be experts; those without any substantial involvement in a claim should not be dragged through one; and discovery and pretrial procedures should be utilized to expedite claim resolutions, not delay them and provide a means of oppression for claimants or defendants.

Article 6-A creates an alternate dispute

resolution system though the voluntary use of arbitration. The plan is clearly voluntary, can be canceled at will within 30 days of execution, and is invalid after three years. It is an attempt to introduce A.D.R. to an area to which it seems particularly suited.

There is no attempt to load up the three person panel absent a contrary arrangement for a different number of arbitrators. The medical community's desire to test these procedures to resolve claims of those likewise willing to abide by A.D.R. should be enacted.

In summary, we support the tort reform contained in House Bill 2122. Pennsylvania particularly needs to be in the forefront of states implementing efforts to control the total costs of its health care system.

As a state known for its medical facilities from Erie to Danville to Williamsport to Pittsburgh to Philadelphia, medical schools and hospitals, we send a positive message to commerce and to medicine by taking firm control over the mechanisms awarding redress for that system's failures.

By making sure that prompt, fair, and

adequate compensation is the goal of the system, Pennsylvania will protect its position as a leading center of a profession, industry, and education which other states understandably covet.

But now with your permission, I'd like to talk about the rate rollback provisions included in this Bill found in Sections 1007.3 and 1007.4 on pages 24 and 25.

The first one, Section 1007.3, is a novel one which grows out of the frustration targets of lawsuits experience when the company which insures them, and thus, is liable for the payment of legal costs and the possibility of a runaway verdict decides that it's wise economically to settle the case rather than continue the costs and risk the large verdict. The target believes, and often correctly, that I didn't do anything wrong.

Those evaluating the case for trial know that given the present state of our liability system a jury is liable to disagree and even if they don't still award the plaintiff a verdict for all of the well-chronicled reasons; sympathy, insurer deep pockets, etc.

Insisting by statute that insurers can be handcuffed by those they insure and whose assessment of their own legal liabilities may be skewed by lack of objectivity and by unfamiliarity with what can happen in the courts is, generally, a bad idea.

But, specifically, it is absolutely unnecessary in Pennsylvania where all medical professional liability insurance policies include a consent to settle clause.

My objection to the statutory imposition of such a contract clause is the migratory nature of such language. If you mandate it for physicians, why not for all others including, for instance, automobile drivers?

If the market has arrived by itself at this agreement, what great vacuum demands the rush of statute to fill a non-existent hole in the law? Perhaps it is to justify the Bill's mandated reduction of 5 percent in premium if such a consent to settle clause is not part of the contract.

Well, as I have just pointed out, there appears to be no such malpractice insurance contract in Pennsylvania. Further, the 5

percent reduction in premium was not scientifically nor actuarially arrived at. It is purely arbitrary.

That brings us to the mandated 10 percent rollback as of the effective date of this Act, which is set at 60 days after signing. All of the provisions of the Act prior to Sections 1007.3 and 4 are designed to and will open up the medical malpractice insurance market in Pennsylvania and will bring down its costs.

In an undistorted market, rates will follow costs. High costs will force high rates, and low costs will be followed by low rates.

Please remember that there are two checks against unjustified high rates: prior approval based upon economic analysis by the insurance commissioner, and competition for business in the marketplace. All of that is predicated upon an undistorted market.

Most of the provisions of House Bill 2122 will have a cost lowering effect. The provisions regarding collateral source, punitive damages, trial bifurcation, standards of evidence, standards of expert testimony, statutes of limitations, frivolous lawsuits,

periodic payments, and arbitration will, if enacted, cause companies to refigure their rates and will, I believe, lead to lower insurance premiums.

But -- and it is a big but -- I can't, you can't, and nobody else can price them at 10 percent now and an additional 5 percent five years down the road. Let me modify that. You can by legislative fiat, but you can't force a competitive marketplace.

My wager would be that if you include such a mandate you will severly restrict, if not shut down, that marketplace. The last time it was done here in Pennsylvania was in Act 6, automobile insurance. I remember the result.

Many companies stopped writing, the Assigned Risk Plan grew by the thousands monthly, and tens of companies were given extraordinary circumstance rate relief by Governor Casey's insurance commissioner. It was more than a year before the market settled down.

Interestingly enough, it was only after the mandatory rate rollback period expired that the marketplace began to open up again and rates have stabilized.

Why? Not because of the rollback, but because the medical cost containment provisions of the Act have worked. The Casey Administration priced the, quote, reforms in the bill.

A look at the record will clearly show that within the filings the only costs and rates which reduced were due to medical cost containment, not to any of the other provisions of the bill.

As a matter of fact, the filings of the first -- the first one which where trumpeted by the Administration were filings by the Erie Insurance Company which reduced its rates some 8 percent.

And if you looked at the individual classifications of risks underwritten in the policies and for which rate reductions were either requested or rate increases were requested, the only area where there were rate reductions were the medical payments or the cost of the medical system.

Every other one went up. The liability went up. The property damage went up. But there was enough reduction in the medical costs

that the overall premium went down.

Now, in an open market, runaway costs have been bridled, the Assigned Risk Pool is shrinking month after month, and there are new insurers in the market, almost on a weekly basis. But those salutary results came not from the rate rollback, but from lowered medical costs to insurers and real competition between them.

I know that the medical society's desire for the rate rollback is based upon a need for assurance that this attempt at reform will work. We hear the call that should be heard -- this testimony was written before the passage of the workers' comp law -- we heard the call from the business community in the effort to reduce the costs of workers' compensation. It is natural, and it is easily understood.

What is not so easily understood, apparently, is that attempts to manipulate the marketplace always restrict the marketplace. What good are lower prices for a product if you can't buy the product?

The good news is that insurance costs less. The bad news is that nobody seems to be

selling it or if they are, they are being extra careful through underwriting about which providers are able to get it.

If this Legislature provides the cost savings, the industry will respond. There is real competition out there right now. The costs are too high, yes. If you do not destroy that market by arbitrary rate rollbacks, the competition will be there providing lower rates based upon lower costs; and, I believe that the market will continue to improve.

It is not possible to price soft reforms. Some of the reforms included in this Bill are subjective indeed. Who can tell how much will be saved by different standards of evidence or different standards for judging an expert?

After experience in the system, if there are unpredictable cost savings, those savings will be reflected in even lower rates. You just are required to have faith in the free market system and in the Insurance Department to assure that rates are neither inadequate, excessive, nor unfairly discriminatory.

That's the law, and that's all that's

required. Lower the costs and rates will come down. Rate suppression never works for very long. However, you can encourage a lower cost, competitive marketplace. The danger of mandated rate rollbacks isn't confined to their arbitrary nature.

Who knows whether the cost savings built into this Bill are worth less or more than 10 percent? Another 5 percent in five years is an even wilder guess now for all of the mundane reasons such as inflation and changes in medical procedures.

But who among you can guarantee which, if any, of the cost saving measures now contained in the Bill will remain there throughout the legislative process? With all due respect, the answer to that is none of you.

Further, none of you can realistically promise that if those cost saving measures are reduced, so will be the rate rollback. The wiser course may well be to include a clause requiring a new rate filing based upon the changes which become law with the passage of the final form of this Bill. That language I could support enthusiastically.

Thank you Mr. Chairman, Members of the Committee.

CHAIRMAN GANNON: Thank you, Senator Hager. Representative -- we'll now take questions from the Committee. Representative Horsey, do you have any questions?

REPRESENTATIVE HORSEY: No.

CHAIRMAN GANNON: Representative Masland?

REPRESENTATIVE MASLAND: No.

CHAIRMAN GANNON: Representative Chadwick?

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. I have spoken with Mr. Hager on a number of occasions about this, so we probably don't need to go into a lot of dialogue about this. But I do have one question I'd like to ask you, sir.

As you know, the Legislature just enacted Workers' Compensation Reform, and there was some provisions in there relating to new insurance rates.

SENATOR HAGER: Section 30.

REPRESENTATIVE CHADWICK: Yes. What would your position be if the language in 2122

was replaced with language similar to that?

SENATOR HAGER: I probably would support it. I have a bit of a concern about the language in Section 30. There is a -- what happens there is that the Insurance Department is empowered to hire an independent actuary to make a filing; and then the Workers' Comp Rating Bureau is to reflect that filing in its filing.

The word is probably an unfortunate one because it may mean that their filing is to be a mirror image. Or it may mean, I think properly, that the filing should -- by the Rating Bureau should show that it has considered the language of the original filing.

In any event, the Commissioner has the right to modify that. But I don't think it makes sense in the case of a workers' comp to handcuff the Workers' Comp Rating Bureau, which does have some expertise of its own, just so you've got to parrot whatever comes back from the independent actuary.

We would not face that here because we don't have a Workers' Comp Rating Bureau or something like it in medical malpractice.

So that if you had language which says

that the -- based upon the law changes that insurers are to consider those changes and to make new filings which the Insurance Commissioner is to rule upon, I would support it.

I don't think you need to say that she is empowered to hire an independent actuary. She has that power already. It's mere surplusage. If you said it, I suppose I wouldn't object to it; but I think it's mere surplusage.

REPRESENTATIVE CHADWICK: Thank you. That's the only question I have, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Senator Hager, with regard to the question of waiver of a jury trial, we heard in the House floor debate that some of the reasons that this might be an attractive alternative for claimants was the fact that they would have quicker access to a panel and a quicker decision, the decision would be based on the experience of a number of professional people

with long-standing experience in the field.

And it seems to me that those may all be good reasons to move in the direction of the panel. What concerns me is the cancellation period. The way the Bill was written and this Bill was drafted, if you agree -- when you're going to see your doctor at some point in the process, probably initially, if you agree to waive your right to a jury trial at that point, as I read the Bill, you have 30 days from that date to withdraw your waiver.

And oftentimes -- I think you would agree -- that you don't even know there's a problem within the first 30-day period. Would you agree with that?

SENATOR HAGER: Representative Hennessey, I'd like to avoid that question if I could; and so I'm going to. I haven't practiced law in a courtroom since probably 1976 when I became Republican leader.

And I am here to present the view of the Insurance Federation of Pennsylvania. I don't think that I would have either specific personal recommendation or one in my role as president of the Insurance Federation on whether that should

be 30, 45, 60, or something else. So I don't think we have a position on that particular section of the Bill.

REPRESENTATIVE HENNESSEY: I appreciate your candor there. And for the benefit of any other witnesses that might be testifying, I may ask that same question of them.

It seems to me that perhaps the fairer way to do it would be to require that time period to run after the discovery of a injury because if indeed then it is an attractive alternative, then the people who have to make that decision or are faced with that decision who may get unnecessarily involved here as opposed to be something that's locked in before anybody knows they might have a problem that would require any type of litigation.

In the future if you want to comment on this or supply any information as far as the Insurance Federation's viewpoints, we'll be happy to accept that.

SENATOR HAGER: I generally think it's good for people to make decisions when they're well informed, but that's not the Federation's position. We have addressed the issue. I do

think it's a good idea for people to know what they're doing before they agree to anything.

REPRESENTATIVE HENNESSEY: One other question, with regard to collateral sources -- I think you mentioned Social Security -- in the Workers' Comp Bill that we passed, I think we limited the offset to within 50 percent of the Social Security, I guess, in recognition of the fact that people contribute an equal amount as their employers to the Social Security system. Are you aware of that limitation?

SENATOR HAGER: I'm aware of that, yes.

REPRESENTATIVE HENNESSEY: I don't think that's in the Bill, but you would agree from the Insurance Federation's viewpoint that maybe that's a fairer way to offset?

SENATOR HAGER: We have not addressed that either. And from the stand -- it depends -- that's up to you as a legislature. You are the arbiter of what's fair out there. I can tell you from the insurance standpoint that whatever you do in the way of savings will get passed on.

The fact is if it costs insurers less, they can make a profit still at some lower level

of payout as well as at some higher level of payout. And we are basically a pass-through kind of an industry. And so I guess that's an economic decision that you folks will have to make.

It's a balancing the interests, which frankly I haven't had to indulge in since 1984, and sometimes it's good not to have that. That really is your decision, not mine. The more money you save, the less medical malpractice insurance is going to cost.

REPRESENTATIVE HENNESSEY: Who would be the group that could give us some sort of good handle on what kind of savings we might experience if we adopted the provisions in this Bill?

The reason I'm asking that, it seems the Bill makes major changes in the existing system. And if we were going to do that and be able to back the medical community and say we saved them 7 percent, I suspect we'll get the cold shoulder and say, Well, thanks. You haven't really done a whole lot to help us. We were paying $70,000 and now we're going to be paying $65,000. So thanks a lot.

It seems to me that if we're going to pass these same changes and make major changes in the existing system we ought to be able to at least expect that we're going to have very substantial reductions in premiums; otherwise, why engage in the exercise?

SENATOR HAGER: The danger for me in that is that if we were to get some -- if some companies were to voluntarily or at your request give you some numbers, those numbers got a life of their own. The Bill changes by the time it's passed, the savings aren't there, and yet everybody's expecting those numbers.

And once again, it's the insurance industry who then gets blamed for not passing on the savings. I think that -- I understand the desire to have it; but in almost everything you pass here, there is an intended effect. You don't always know exactly what it's going to be.

I do think that if you were to pass a bill with most of these savings intact, you would see a rather dramatic number in the filings which would be filed by the companies. I think there are significant savings here.

I have not asked for a number because I

don't want to have one; and further, I don't know -- I think if I were to ask three or four companies I'd get different numbers as they all have a different line of -- book of business.

Some are dealing with specialties which seem to be more prone to lawsuits than others, and there isn't a way that you can give a blanket number which would cover all specialties and cover all companies.

REPRESENTATIVE HENNESSEY: Thank you very much.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Representative Carn.

REPRESENTATIVE CARN: Thank you, Senator Hager. Just following up on the concept Representative Hennessey was raising, what do the insurance companies use as a basis for determining a fair profit margin?

SENATOR HAGER: Well, I think the answer to that is a complicated one but it includes how much business they're going to be able to write tomorrow. It includes actuarial studies of what they've had to pay on claims before, what is happening with inflation, what is happening with current claims of the system, and trying to

project that for the future.

Remember that in insurance profits are probably more important that in any other business because unless you can build a surplus, you are not allowed to write new coverage. If you were to start an insurance company today and -- just take automobile insurance, for instance.

If you were to charge somebody to go to your neck of the woods 1500 to $2,000 for insurance on a car and that car has an accident, it's probable -- it's definite that the claims against the company are going to be more than the premiums so that you have to have reserves in order to be able to meet claims beyond any current dividends or -- excuse me -- any current premiums which you are getting.

At the same time, the insurance commissioner wisely said that unless you have unencumbered surplus, we're not going to allow you to write anything more than you're presently writing.

And the only way that you can get surplus is either from profits or from going out and selling stock and getting new equity from

people who are willing to put their money in.

You have to build -- in order to have a building book of business in order to be able to take care of a growing economy, you have to have profits which you can -- you can assign to surplus so that you can support new premiums.

REPRESENTATIVE CARN: That's all understandable. My question is, How do they determine what that amount is? I heard all the factors.

Once they take all these factors into consideration, then do they say, Well, let's create a 10 percent profit margin, let's create a 25 percent profit margin, let's create a 200 percent -- I'm trying to get a sense of how the industry thinks on that question after taking all of those factors in the decision?

SENATOR HAGER: I would suspect the competition is what decides that more than anything else. If you have a very competitive marketplace, people are going to shave their profits in order to get business.

REPRESENTATIVE CARN: So they don't have no minimum level that they --

SENATOR HAGER: No.

REPRESENTATIVE CARN: -- that they established themselves?

SENATOR HAGER: No. But remember that they have -- there are requirements, most importantly, solvency requirements imposed by the various state insurance commissions. And so we have to keep --

REPRESENTATIVE CARN: We understand that.

SENATOR HAGER: So they have to keep doing it. They have to keep putting money where they can.

REPRESENTATIVE CARN: We understand the responsibilities, obligations, and goals. I was just trying to get a sense of what level of --

SENATOR HAGER: I don't think there is such a number.

REPRESENTATIVE CARN: All right.

SENATOR HAGER: I think it would vary from company to company.

REPRESENTATIVE CARN: Thank you.

SENATOR HAGER: Thank you.

CHAIRMAN GANNON: Thank you, Representative Carn. Representative Boscola?

REPRESENTATIVE BOSCOLA: No thanks.

CHAIRMAN GANNON: Representative Dermody?

REPRESENTATIVE DERMODY: (No audible response.)

CHAIRMAN GANNON: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Good morning.

SENATOR HAGER: Good morning.

REPRESENTATIVE MANDERINO: My line of questioning goes along where Representatives Hennessey and Carn were. But I want to try to focus on it, if I could, from an insurance perspective versus the legal or lawsuit perspective.

And before I ask the questions, part of what I'm basing my understanding on -- so correct me if I'm wrong -- is the whole -- I'm a novice in this -- the whole practice of reserving and how you reserve monies for potential future claims in the system.

And I was making the assumption when you listed in your testimony all the various pieces of this legislation that will, you believe, lead to lowering insurance premiums that it's because

you can look at those things and say, I won't have to reserve as much or I won't have to reserve as long. Is that a correct assumption?

SENATOR HAGER: For some of them it is, yes. I mentioned that there are some soft proposals here which probably can't be priced. And as a matter of fact, I think an awful lot of it is going to be the actuarial science, which includes a whole -- more assumptions than I can handle in making some -- in making some -- some informed estimates of how much will be saved in future malpractice actions by the industry.

REPRESENTATIVE MANDERINO: Okay. So for example, one of the things that Representative Hennessey picked up, the signing of a waiver of a jury trial, if that has as it has in the Bill now a 30-day to reconsider and withdraw your waiver, then am I correct in assuming that within 30 days you would know whether or not I potentially have to reserve for any future claim being a jury trial or I can now reserve that this is going to be an arbitration thing and I know that arbitration proceedings in general are 35 percent less costly than a jury trial would be.

SENATOR HAGER: I don't know about the 35 percent.

REPRESENTATIVE MANDERINO: I'm just throwing that number out. That's my conservative estimate. I don't know what yours is, and that was going to be my next question.

SENATOR HAGER: I don't have such an estimate. But there isn't any question that expedited resolution of these things gets rid of the drag of transaction costs, yes.

REPRESENTATIVE MANDERINO: Okay. Is it not able now because even though we have no mandatory arbitration, we do have arbitrations within the system, meaning the medical malpractice insurance system, correct?

SENATOR HAGER: Yes.

REPRESENTATIVE MANDERINO: I mean, you do sometimes have cases that go to arbitration?

SENATOR HAGER: Yes.

REPRESENTATIVE MANDERINO: You're saying it is not -- you're not able to say on average an arbitration proceeding saves "x" percentage on costs?

SENATOR HAGER: I'm not.

REPRESENTATIVE MANDERINO: Those figures

are not available to be put together or they just haven't been put together?

SENATOR HAGER: I don't know the answer to that.

REPRESENTATIVE MANDERINO: Okay. And then would I be correct in assuming that any lengthening of that time -- whatever that cost savings is, any lengthening of that time of withdrawal, while we don't know how much cost savings we would be making, we would be making less the longer that we extend that time period?

SENATOR HAGER: Well, I think and I know and you know from common experience that the preparation for jury trial, the time involved, all of the motions plus the risk of a runaway jury are viewed by insurance companies as cost factors which they reflect in their rates, yes. And I believe that an arbitration system will be less expensive, much less expensive.

REPRESENTATIVE MANDERINO: One of the other things that you point to is a potential cost saving. And Representative Hennessey pointed out or somebody pointed out with regard to -- I call it the absolute statute of limitations clause. I don't know if anybody

else would put that name on it.

But there's basically a two years from date of discovery or absolutely four years and after four years you're out of the ballpark. Based on if we passed a law that put what I'm calling the absolute four year statute of limitations on medical malpractice claims, can you estimate the potential savings?

I mean, now are you not reserving for claimants potentially 10 or 15 years down the line? And what cost savings can we expect if we truncate that to a maximum of four years?

SENATOR HAGER: I can't give you specific answers, Representative Manderino. I'm not an actuary. But there is no question that a term frequently heard when we talk about insurance in these halls is the incurred but not reported reserve, the IBNR.

And there is no question that you would reduce the unknown quantity of cases which would have to be reserved for in the incurred but not reported category. So yes, there would be a savings.

I really believe that you would have to wait -- unfortunately, you'd have to wait and

see what this Bill produces and then see what the companies -- what the actuaries do with the new law.

REPRESENTATIVE MANDERINO: One of the other provisions in the bill is something that provides for no award of delay damages unless those delay damages are by way of sanctions.

Is the industry able to give us any figures with regard to how often delay damages are awarded and at what magnitude --

SENATOR HAGER: No.

REPRESENTATIVE MANDERINO: -- that that occurs?

SENATOR HAGER: No. Remember --

REPRESENTATIVE MANDERINO: One of the other -- I'm sorry. Go ahead.

SENATOR HAGER: What I was going to say, Remember, what I'm doing is commenting on from an insurance standpoint on provisions which have been offered largely by the medical society as suggestions for changing the law.

REPRESENTATIVE MANDERINO: Yes.

SENATOR HAGER: It doesn't mean that I am unwilling to talk about them, but I don't want it to appear that I am the advocate for

each and every one of the suggestions in this bill.

REPRESENTATIVE MANDERINO: I understand that; but I'm reading from your testimony that says, Provisions regarding collateral source, punitive damages, trial bifurcation, standards of evidence, standards of expert testimony, statues of limitations, frivolous lawsuits, periodic payments, and arbitration, if enacted, will cause companies to reduce -- or to refigure their rates and will, I believe, lead to lower insurance premiums.

And then later in your testimony when you argue against the 5 percent rollback, you say, But who knows whether the cost savings going into this Bill are worth more or less than 10 percent or 5 percent, et cetera, et cetera.

So I'm looking at it and I'm saying we're making some very significant changes with regard to the rights of potential claimants, and I want to know if I'm going to get my money's worth. That's why I'm asking my questions.

SENATOR HAGER: Well, I guess my answer to you has to be the same as to Representative Hennessey. You do a lot of things here with

intended results, and you don't know specifically what those results are going to be until you have changed the rules and the people playing the game have changed their game.

And the same is true here in the medical malpractice as it is in most other things.

REPRESENTATIVE MANDERINO: Yes, I absolutely agree with you. As a matter of fact, that's why whenever all my docs write me, I write them and say to them I don't want the same mistakes we've had with automobile insurance and the same mistakes we've had with a lot of other insurance.

Why aren't you writing me about insurance market reform because I want the answers to the questions that Representative Carn is asking?

Before I make any other changes from a liability end, I want to know what to expect from an insurance end. And I'm not getting those answers, and that's where I'm having problems.

SENATOR HAGER: Well, you're about to get them in workers' comp. It might be a very good -- it might be a very instructive. You're

about to get them right there.

And I think that as was pointed out in Scott Chadwick's question to me that whatever you see there I think you can gauge by analogy and by experience and by empirical thinking that if reforms that we put into law there -- reforms in my eyes; they might not be in yours -- if the changes we made result in premium savings, can we by extrapolation expect that in medical malpractice? I tell you that I believe that that is what will happen.

REPRESENTATIVE MANDERINO: Let me then get away from the cost questions that I had and just ask about two other things. I met with a bunch of -- or a group of about a dozen doctors from my area right after we passed Mr. Chadwick's bill as an amendment.

And one of the questions that I asked and problems that I had with the bill -- and I actually learned some very interesting things from them about why they thought this clause was important. And it goes to how they as doctors are rated by insurance companies.

There's a provision in here that would allow a doctor to send -- basically send in an

affidavit and say I wasn't involved in the alleged malpractice. Let me out of the suit.

And it's written in such a way that it's supposedly nonprejudicial, meaning if later you find out they should have been involved you can bring them back in. But the problem with the clause how it's written now is there no tolling of the Statute of Limitations.

So if I let them out today and then a year and a half or two years down -- you know, I file the claim a year after my surgery and then a year and a half later I'm finding out that, gee, that person should have been back in the suit, I haven't tolled the statute of limitations against that person.

That's something I think that we can fix by legislation by putting a tolling provision in there. But one of the reasons that they said that suit -- that clause was important was because as soon as they -- when they're filling out an insurance premium, as soon as they put on there that I'm a party to a suit, even if they say but I had nothing to do with it and I'm going to be let out or whatever, that that affects their premiums.

My question is, Could you explain to me why that is, how that is? And if we can -- if we can do a tolling statute, so to speak, for a lawsuit that says -- I'm not sure why we are letting someone out of a lawsuit on this end when maybe the tolling or the affidavit should be going on the other end.

Let the affidavit go to the insurance company and let the insurance company not affect their rates until they find out whether they have a claim there. Can you just explain that whole process to me better?

SENATOR HAGER: No, I can't because I'm not sure that it is. I think it is very possible then in the relationship between a doctor and his insurance company that something like that can be explained and will not be reflected in his rate.

REPRESENTATIVE MANDERINO: Well, I'll tell you honest to goodness I was sitting in a room with more than a --

SENATOR HAGER: I understand that --

REPRESENTATIVE MANDERINO: -- dozen doctors and they all were shaking their heads --

SENATOR HAGER: I understand that. I

also understand that when you get to writing legislation, an awful lot of legislation is enacted on anecdote or horror story. And I am not certain that that is the practice across the industry.

But if it is, I don't mind its being addressed just as I think that the suggestion you've made about the fact that there is not a perfect overlay between the affidavit to get out of a lawsuit and the Statute of Limitations. I think that ought to be addressed. I don't think anybody should be let of a lawsuit who should be in it.

On the other hand, let's face facts, Representative Manderino, there are an awful lot of people under our current law in lawsuits who have no business being there. And there's a huge amount of costs because it's just fun to sue anybody and everybody and get what you can from anybody.

And that's part of what's being addressed here as it should be addressed throughout all of our tort law.

REPRESENTATIVE MANDERINO: Well, I will agree with you that there are a lot of people

named in suits that in the end aren't held liable. I would disagree with your characterization that they are done that way for fun.

SENATOR HAGER: Well --

REPRESENTATIVE MANDERINO: I think it's done that way because, in all honesty, the way the laws are, the way they are with regard to hospitals, the relationship between doctors and hospitals, who are employees, who aren't employees who come under the -- I can't think of the word. It just went out of my mind with regard to liability for an employer and employee versus an independent contractor.

I think that is more the reasons that everyone that possibly touched that person's body is named in the firsthand until they sort it all out.

SENATOR HAGER: Well, generally I suppose we shouldn't; but I'll tell you specifically I disagree with you. There are many, many times when people are named in lawsuits for on reason and one reason only, and that's to get their insurance in the game.

REPRESENTATIVE MANDERINO: My last

question goes to the issue of -- and, again, I'm not an expert on insurance matters. But I know that when I was practicing law the majority of legal malpractice insurance policies were written on a claims-made basis, and there were very few.

It's kind of a like a dinosaur in an occurrence-based policy. As I talk to doctors, it seems like it's the opposite in the medical liability line, meaning most doctors' policies are written on an occurrence basis.

My question is, How does the difference between occurrence-based versus claims-made based policies or does it affect the premium paid because of the time period of when things happen, how long you have to reserve, and all that kind of stuff?

And if so, is there something I don't understand about the two as to why in the -- for example, in the legal malpractice basis they seem to be writing claims made and then in medical they write occurrence?

SENATOR HAGER: Well, I don't know if there's something you don't understand about the two; and so I don't know how to respond to that.

REPRESENTATIVE MANDERINO: Okay. Let me be a little -- can you say -- and I don't know if you can or not -- are -- for the same line of insurance, would an occurrence-based policy be more expensive than a claims-made policy?

SENATOR HAGER: No, I can't tell you that because the companies make a decision about what kind of policy they want to write. Every once in a while, it seems to me that it almost is cyclical. They decide that they want to be doing occurrence-based or they'd rather be doing claims-made.

But from the standpoint of the reasons that most went to claims-made is because of the fact that there is no statute of repose and lots of times you're stuck on policies that you wrote and now the lawsuit comes along and you have no idea about how long ago it was or what your relationship was.

Frequently, insurance companies have a heck of a time even putting back together whether or not they were on the claim at the time.

REPRESENTATIVE MANDERINO: That usually occurs if you've had an occurrence-based

policy --

SENATOR HAGER: That's correct.

REPRESENTATIVE MANDERINO: -- correct, where a claim might be popping up 15 years later. But in a claims-made policy, if I'm insured by you for the year 1996 and the claim is made against me in the year 1996, you know it's yours?

SENATOR HAGER: Yeah. But the thing wrong with that is the claim's made in '96 but maybe the action which gave rise to the claim occurred prior to the time you went on it.

You insure them in '96, but the accident took place or the alleged malpractice took place in 1986. So all of it is once again an actuarial exercise and companies trying to decide when and where or which kind of policy's best for them.

REPRESENTATIVE MANDERINO: Thank you. You've been very kind to indulge all my questions, Mr. Chairman. I'm completed for now.

CHAIRMAN GANNON: Thank you, Representative Manderino. Representative Reber.

REPRESENTATIVE REBER: Thank you, Mr. Chairman. Being chairman myself, I see

we're running behind schedule already. And I know the pressures are building on you when you're i that predicament.

CHAIRMAN GANNON: I'm willing to help. I'll get out of here if you'd like.

REPRESENTATIVE REBER: I'll shorten my questions. Two real quick ones, Senator. One of the concerns I've had for years -- and I guess to some extent it even comes from my practicing in the area to some extent on a minimal basis but nevertheless on some basis -- and it goes to the dilatory or frivolous motions claims and defenses.

The concern I have, I recently was involved a medical malpractice case where I was representing an additional defendant who was joined in the action as sort of an afterthought. And this one was rather emblematic.

And I know other cases similarly on this issue have been emblematic and I know speaking to a lot of attorneys. I get very concerned where the insurance defense people hit you with, you know, virtually the plethora of motions to produce documents; motions to inspect; first and second and third sets of interrogatories;

depositions of everybody from, you know, the mother to the brother in the case.

And once that's all done, nothing really happens and the case is settled. And there was really -- in the vast majority of at least my experience of incidences there was no real need for the plethora of discovery and time frame, what have you, that went into it.

And I'm just wondering if in the course of our Section 206-A we ought to take a look at some way to cut down on that cost because our last hearing I seem to recall when we discussed this House Bill before there was concern about the percentage of dollars that are paid out that go not to the ultimate claimant or plaintiff, if you will, but to both defense as well as plaintiff's attorneys and the costs and what have you.

And I'm just wondering if your association -- the Federation, I should say in one respect is doing anything to cut down on the defense costs or alternatively is there anything we can do for lack of a better area in Section 206-A, for instance, to be somewhat assisted to cut down on what I consider to be unnecessary

motions and various things that are done.

SENATOR HAGER: Well, it looks to me like 206-A addresses not only plaintiff's but defense counsel. And I would like to, if I could, my -- the next witnesses here are from the Pennsylvania Defense Institute, and maybe they are better at answering that.

I can also tell you that I am a partner in a law firm which from time to time represents insurance companies. And I can tell you that the insurance companies are doing what they can because they are really perusing bills in finite detail and they're not paying for a whole lot of extraneous legal work. But, yeah, I -- I want to see savings in the system from both sides.

REPRESENTATIVE REBER: My feeling's always been over the years whether we're talking about automobile insurance reform or whatever you don't just solve it by one particular area. It's a whole menu where you get a tenth of a percent savings here, a half a percent there, maybe 1 1/2 in an another area.

And I think we have to look to those areas, bringing them all together to really effectuate the appropriate kind of savings that

everyone would like to see take place.

And this at least in my opinion, from my experience and observations over 24 years in my view is one area were there could be a significant amount of -- I shouldn't say significant -- but a savings factor built in on this. We should take a harder look at that and specifically define it with even more specificity in that particular section.

And one last quickly, on the Statute of Limitations section on page 8 of the bill, line 27, we talk about the four-year limitation not applying where there is a foreign object left in the individual's body.

I have a concern because, again, I'm aware of two most recent instances not where we're talking about a foreign object being left in the body; but in this day and age of medical wonders, we have a lot of artificial devices that are being placed in the body.

I have experience most recently with two cases where a hip and a knee artificially placed were the wrong size. And from what I've been told, it's relatively apparent that they were the wrong size.

The individuals have labored with these particular problems for a significant period of time. And in my opinion under the Statute of Limitations language in Section 205-A, they may very well get estopped from raising any claim because they in some way shape or form under the reasonable diligence language should have known or what have you.

I'm just wondering if we ought to visit the section regarding foreign objects and give some specificity again to the area where we have these artificial implants, artificial devices, what have you, and see if there is some form of openness, it becomes apparent that there can be a showing.

I think you understand where I'm going and where I'm coming from. And I'm just wondering if you have any comment on that particular aspect in light of what's happening in today's medicine and the tremendous amount of so-called foreign implants that are being left in the bodies.

SENATOR HAGER: Representative Reber, like a lot of other questions being asked of me today, particularly in the beginning by

Representative Hennessey, that's not an area of my expertise or I really don't feel I'd be advancing the cause of the insurance industry which I represent to get into that.

I think that really is a fairness issue for the Legislature to decide upon. And I might also suggest that you ask the question of the next witnesses who are involved in the trial of these cases on an everyday basis. I'm not.

REPRESENTATIVE REBER: Thank you very much, sir. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Reber. Senator Hager, assume that as a result of changes in the law that a company's underwriting income exceeded what they anticipated when they set their rates.

What safeguards would there in place or are in place today to protect against a company simply adjusting its reserves upwards to adjust for that unanticipated increase in underwriting income?

SENATOR HAGER: Well, there are a couple. First of all, they are examined by the Insurance Department and overreserving has never really been a issue. It's been talked about by,

I think, people outside the industry as -- specifically by the trial bar as a defense to any of these actions.

But the biggest problem in insurance is underreserving and the insolvency which flows therefrom. They don't have the monies when they have to pay the claim.

Secondly -- and I have an example which is analogous -- there is a company in the Federation who is required -- and it's really, I guess, symptomatic of other companies, its problems -- it's required by the Insurance Department to put more in the reserves than the IRS will allow.

They're saying -- see, money which goes into reserve is a liability; it's not an asset. Although you can use it to make money, you can invest it, you have not control of it. You can't put it on the asset side of the books. It really belongs to the policyholders.

And if on the one hand the insurance commissioner says you will reserve -- let's take a number -- you will reserve $4 million for this. And the IRS says, Well, not under our rules you won't. You'll only put 2. That means

you have $2 million of income upon which you have to pay taxes to the IRS, which, in fact, is not income to you at all. It's a loss.

And remember that insurers are audited on a regular basis not only by the insurance departments but also by the IRS. And they have to file a tax return under oath every year so that their -- first of all, I don't think the problem exists.

I think it's talked about as a defensive measure, but I don't think that a problem of overreserving exists. And if it does, it makes no economic sense for the insurance company at all because they end up paying income taxes on something which is really not an income item to them at all.

CHAIRMAN GANNON: Thank you, Senator, for being with us today and providing testimony and sharing that information. Our next witness is Edward Nielsen, Executive Vice President of the Pennsylvania Academy of Family Physicians; Todd Sagin, Vice President; and Charles Artz, Esquire, Counsel, Pennsylvania Academy of Family Physicians.

MR. NIELSEN: Good Morning, Mr. Chair

and Committee. My name is Ed Nielsen. For the last nine years, I've been the Chief Executive Officer of the Pennsylvania Academy of Family Physicians.

CHAIRMAN GANNON: Can I interrupt for a second, Mr. Nielsen. I have to go to a very brief meeting, and I'm going to ask Representative Chadwick to chair the meeting in my absence.

MR. NIELSEN: Now I'll speak to the side. My name is Ed Nielsen had --

ACTING CHAIRMAN CHADWICK: Mr. Nielsen, this akin to hiring a fox to guard the hen house. But I thank the Chairman, and we'll proceed.

MR. NIELSEN: Those protocols out of the way, thank you, Mr. Acting Chair. One more time, my name is Ed Nielsen. For the last nine years I've been the Chief Executive Officer of the 42000 member Pennsylvania Academy of Family Physicians.

By way of introduction, to my immediate right is Charles Artz, Esquire, our General Counsel and an actively practicing health care litigator. And to my far right is not Dr. Todd

Sagin, but Victor Cotton, M.D., J.D., a practicing physician, a practicing lawyer, and an associate of Mr. Artz'. We believe that Dr. Cotton will bring a very unique perspective to these hearings.

Let me first and foremost say that for the record, the Pennsylvania Academy supports both House Bill 2122 and the new version, Senate Bill 790, currently residing over in the Senate.

We believe it's extraordinarily important that we continue the dialogue in sun shine, as it were, to deal with this most important issue. What you're going to hear from us is a segue from Senator Hager is to expeditiously get at one very important particular piece of tort reform, that being frivolous lawsuits.

Some of the Q and A that's gone on back and forth here has provided the absolutely perfect opportunity. And in the interest of Senator Hager's point and the Chair's point of expeditiously conducting these hearings, I'd like to turn the testimony over to Charlie Artz, who will speak specifically to the acceleration of the Dragonetti Act.

MR. ARTZ: Mr. Chairman, Members of the Committee, I've had the good fortune to argue before each of our appellate courts in the Commonwealth of Pennsylvania and count this as a privilege to provide you with testimony today.

What the basis of our testimony is, is that we are recommending a concept to improve the provisions in House Bill 2122 and those -- that legislation's efforts curve frivolous lawsuits against physicians.

The problem can be best demonstrated by an example. These are facts of a real-life case, and I'll state those facts briefly. A resident was observing surgery in an operating room for purely educational purposes.

The patient following and during the surgery had an adverse outcome. The surgeon was sued; but the resident was also sued even though the resident was not involved in any preoperative care, the resident was not involved in any postoperative care, and the resident was not involved in any intraoperative care.

The resident's name was not even listed in the medical records in the chart during surgery. There is no conceivable duty of care

that attaches between the resident who observed that surgery and the patient who is arguably injured during the surgery by the surgeon.

There exists no imaginable theory of recovery under the law to name that resident in the lawsuit. Yet the resident was still sued, was dragged through the discovery process, has been hassled and harangued and has been taken through depositions and is still not out of the case some four years later.

I'd like to emphasize that the resident in my real-life example was not simply asked to give an account of what occurred in the OR or what she witnessed, but she was sued as a defendant.

And Ladies and Gentlemen of the Committee, that is an outrageous situation. That is an outrageous circumstance that needs to be addressed by this legislation and by our proposal.

Other examples of frivolous lawsuits include treatment that has been provided by a physician that is clearly within the standard of care and the physician is nevertheless sued.

And secondly, a referral made

particularly by our clients, the Family Physicians, a family physician makes a referral to another type of provider -- a surgeon or a subspecialist or something like that -- that provider is arguably negligent and yet the family physician is routinely named in the lawsuit.

As a matter of law, as a matter of well-settled legal principle in this Commonwealth, there is no cause of action for a negligent referral. It doesn't exist. It's been addressed by our appellate courts two times.

One case I have cited in the outline. Another case is Shaw versus Kirshbaum (phonetic) at 653 Atlantic Second page 12 from 1994. It's unequivocal; there is no -- there is no cause of action for a negligent referral.

Now these frivolous lawsuits that I'm talking about are filed typically by undiscerning, inexperienced, untalented, or I dare to say, unethical counsel often on the eve of the expiration of the Statute of Limitations or, most egregiously, to seek a nuisance value settlement. This problem is real, and I'm here

to tell you there are bad lawyers just like there are some bad doctors.

During the last hearing which we observed, several questions were asked by some of the Members who are here and some Members who are not here whether there's any real disincentive under the current law to prevent the filing of a frivolous lawsuit.

The answer is yes, there is a present disincentive under the law; however, that disincentive is woefully inadequate. What we're proposing to do is to amend the Wrongful Use of Civil Proceedings Act. That is the current statute under the law that provides this disincentive.

It's commonly referred to as the Dragonetti Act. And this creates a disincentive for a plaintiff to file a frivolous lawsuit under the present law. I give you the citation to the statute in the testimony, and I've attached a copy of the statute to the testimony as well.

The Dragonetti Act permits a successful defendant to sue for compensatory damages, punitive damages, witness costs, and attorneys

fees following the successful defense of a frivolous lawsuit. And I've cited that provision of the law as well.

Now, a frivolous lawsuit is defined under the Dragonetti Act as a suit, No. 1, that lacks probable cause; or No. 2, was brought in a grossly negligent manner.

The Dragonetti Act clearly applies to medical malpractice cases, and I've given you the Gentzler versus Atlee citation of 1995 Superior Court case in which the Court ruled that No. 1, the Dragonetti Act applied; and No. 2, a cause of action, in fact, was stated by a physician against an attorney for bringing a frivolous lawsuit against the physician.

I've also used the Dragonetti Act two times in my own practice for physicians who have had the temerity to wait the seven or eight years later and then go back after a plaintiff and a plaintiff's attorney who brought a frivolous suit.

But unfortunately, the cause of action under the Dragonetti Act does not accrue until a claim against the physician is, quote, terminated. That's what it says under the law.

Now common sense interpretation of terminated means that once the trial is concluded; however, our Pennsylvania Supreme Court has ruled that the term terminated means that all appeals must be exhausted.

In other words, a case is not terminated against a physician after he wins a jury verdict, but the case is terminated against the physician after he wins the jury verdict; post trial motions are filed, briefed, argued, concluded; and an appeal to the Superior Court is made, arguments, brief, opinion, and then the Allocatur Petition to the Supreme Court.

Then maybe the Supreme Court takes the case and decides it or maybe the Supreme Court denies Allocatur. Then the case is terminated.

And when you look at the number of -- the amount of time it takes to bring the suit to trial in the first place plus you add about three more years of appellate work in there, we're looking at a minimum of five to seven years before a case can be terminated.

And so therefore, there's no -- because of that time lag, there's no real disincentive under the law because the physician at that

point just wants to get this thing out of his or her life. And so that's not a real disincentive under the law.

Now House Bill 2122 does address frivolous lawsuits in Section 302-A. It sanctions attorneys who bring frivolous lawsuits. And the language contained in the legislation is similar to Rule 11 under Federal Court Practice.

And the Academy supports the Bill as it's written, but what we're doing today is submitting to this Committee an alternative proposal to deal with frivolous lawsuits. And it is as Ed Nielsen said. Our idea is to accelerate a cause of action under the Dragonetti Act.

I'd like to describe a few of the major principles and then give you some reasons, some advantages of this language. And then we can discuss if you'd like -- if we have questions, we also have the amendatory language attached itself.

First principle under the proposal: A medical malpractice defendant could assert a Dragonetti cause of action as a counterclaim

filed concurrently with New Matter.

So what our statute would do -- what our amendment would do would be to revise the term -- the meaning of the term termination so a case could be brought by a physician -- a frivolous lawsuit action could be brought by the physician when the physician files his answer to the complaint. That's the appropriate time when a counterclaim can be asserted, as you know.

Secondly, we would not impose any limitations on existing discovery rules. First, many local rules of court already require rapid completion of discovery; and so we wouldn't tinker with that existing system.

But here's the meat of the proposal. If the plaintiff at the conclusion of discovery where the plaintiff has the opportunity to conduct all the depositions and interrogatories and look at all the documents pertinent to the case, if the plaintiff attorney then looks at all of the information that he or she has and determines that the physician was either not involved in the actual care that pertains to the alleged negligence or, in fact, one of the physicians who's been sued really provided care

that was within the standard of care, then the plaintiff should withdraw the claim with prejudice right at that very point at the close of discovery.

And if the plaintiff does that, the idea is that the physician loses his or her right to bring the Dragonetti cause of action or to proceed with his or her Dragonetti cause of action. So that's the trade-off.

If the plaintiff conducts discovery, finds that there's nothing there, the plaintiff can withdraw the case with prejudice and then the physician doesn't have any rights of action back against the plaintiff. So there's a protection built in there.

Next if the plaintiff does not withdraw the frivolous lawsuit at the completion of discovery or before a Motion for Summary Judgment is filed and if the physician files a Motion for Summary Judgment and the trial court grants the Motion for Summary Judgment, then we propose that a legal presumption would arise that the claim against the physician was frivolous.

And if the presumption is not rebutted,

then the judge would impose damages against the plaintiff and/or the plaintiff's attorney depending on who was counterclaimed.

Now the damages against the attorney or the plaintiff individually would be the same damages that exist under the Act, which include compensatory and punitive damages, expert witness fees, attorney's fees.

And we propose to add one other element of damages. The new element of damages we would propose would for the physician to calculate the number of hours that the physician spent working on this case preparing for depositions and those kinds of things multiplied by $200 per hour so that there would be an extra fee to the physician for his or her time span in preparing against a frivolous lawsuit.

Now, the plaintiff may rebut this presumption; so we have constitutional protections guaranteed here. This is not any rebuttal of presumption. The plaintiff can rebut the presumption by showing, No. 1, that probable cause, in fact, existed, that there was a sufficient level of facts pleaded to show a viable claim; or No. 2, that a good faith

extension, modification, or reversal of existing law is the basis of the claim.

Now that is 100 percent consistent with the ethical rules of when an attorney can bring a cause of action. Of course, there's Supreme Court precedent that says the ethical rules do form an independent cause of action, so we can't just look to the existing ethical rules. We'd have to put it in this statute as well.

Also, if a physician decides not to file a Dragonetti counterclaim or if the physician's attorney simply fails to do so, the physician doesn't lose his right to bring a Dragonetti Act cause of action. It's just the action could be brought under the existing procedures under the law. We have also included that contingency.

And then, finally, if the malpractice plaintiff survives the physician's Motion for Summary Judgment, the presumption in favor of the physician does not arise; however, the physician's claim is not extinguished. It merely proceeds under the existing burden of proof.

Just a couple of advantages and we'll close our testimony. No. 1 and most important,

under this proposal, the patient's right to recover damages for bona fide medical negligence are fully intact and unimpeded in any way.

No. 2, this permits the physicians to accelerate the existing remedy under the judicial code. And we've talked about that sufficiently.

No. 3, the plaintiff gets more than an adequate opportunity to discover whether the physician had any role in the alleged negligence or whether the physician acted outside the standard of care.

Now, if the plaintiff as we discussed withdraws the case after conducting full discovery but before the physician files the summary judgment motion, the plaintiff walks away clean, is completely protected.

And even though the physician has endured what we believe to be unnecessary hassle, that's -- the period of hassle has been shortened dramatically.

And this is the public policy balance that we are trying to achieve with this proposal and that on one hand the plaintiff's interest in conducting adequate discovery to determine the

liability of a physician is preserved and protected and at the same time, the physician's interest in being dropped promptly from a frivolous claim is also being advanced.

Next, this permits the plaintiff's counsel to fully explore discovery and does not place counsel in jeopardy for professional negligence, very important for our brother and sisters in the Trial Lawyers' Association and the Bar Association.

The fact is that when you're practicing and you have a busy practice, sometimes you're going to run right up against the Statute of Limitations; and sometimes you're going to need to sue everybody in site.

And maybe my client doesn't necessarily agree with that, but you're going to need to file perhaps a writ of summons against everybody who was involved just to protect -- for the attorney to protect him or herself against professional negligence.

And we are fully allowing the discovery process to proceed while allowing that kind of writ. Depending on other provisions in the law, of course, that kind of writ would be

appropriate in order to conduct the adequate discovery.

Now the nature of professional liability cases in my experience is that very, very few of these are dismissed on a demurrer, which is a Motion to Dismiss on Summary Judgment or at directed verdict. Only the truly frivolous claims are dismissed at this stage of the proceedings.

There is a huge difference between a meritless case and a frivolous case. A meritless case can be a case that is lost -- or, I'm sorry, a meritless case is one that a physician can prevail upon. But that doesn't make it frivolous.

Just because you lose or just because a physician wins doesn't mean it was a frivolous case. But we're really attacking the frivolous cases, the ones that make no sense as a matter of law or as a matter of fact from the outset.

Now, our proposal satisfies all applicable constitutional standards; no fundamental rights are impaired or impinged; we have created a public policy balance that we think can work; and on behalf of the

Pennsylvania Academy of Family Physicians, I respectfully request that the Committee consider our proposal and adopt it in any legislation that's passed out of Committee.

I thank you for your time. We're prepared -- Ed, Vick, and myself are prepared to take questions; and I'm also prepared to address Representative Hennessey's issue and Representative Reber's questions that were proposed to Senator Hager.

ACTING CHAIRMAN CHADWICK: Thank you, gentlemen. The Chair would ask the members in view of the fact that we're already so far behind schedule to keep their questions as brief as possible.

Representative Horsey, any questions?

REPRESENTATIVE HORSEY: Just a brief question, relevant to the resident who observed the surgery in the surgical rooms. He leaves the surgical room; he goes out of the hospital. On the way home, he's still in his blues because he's a resident. He's a doctor. He's still in his blues.

He sees an accident, and he goes over to the guy hanging out with both arms hanging off

and he stands there and observes. I just need to have the question answered, should he be sued? Yes or no?

MR. ARTZ: Representative, a light is shining directly in my eyes and I didn't get all of the facts. After the resident left the O/R still in the scrubs, and then what did the resident see?

CHAIRMAN GANNON: He goes out the hospital, he sees an accident, and he goes over to the scene of the accident and observes. Should he be sued by the person in the accident?

MR. ARTZ: Well, that's not a medical malpractice case, number one.

REPRESENTATIVE HORSEY: I'm just asking yes or no.

MR. ARTZ: Should he be sued by --

REPRESENTATIVE HORSEY: If he just stands there and observes.

MR. ARTZ: Observes for what purpose? For any purpose --

REPRESENTATIVE HORSEY: For any purpose, he just observes. He doesn't take any action.

MR. ARTZ: Absolutely not.

REPRESENTATIVE HORSEY: He should not be

sued?

MR. ARTZ: Absolutely not. In my record --

REPRESENTATIVE HORSEY: That's fine.

MR. ARTZ: My recollection now is that there's no duty under any law to treat somebody; but if you do treat, then you have a duty of care that arises.

REPRESENTATIVE HORSEY: Okay. Thank you very much. Another quick question is, Primary physician, man goes to a foot doctor -- and this is Representative Chadwick's famous one -- man goes to a foot doctor for ten years and he dies as a result of a stomach ailment, should he be allowed to sue the foot doctor? Yes or no?

MR. COTTON: If I may answer that?

REPRESENTATIVE HORSEY: Yes because I think you know what I'm talking about.

MR. COTTON: If there's some way -- and sometimes things in medicine seem crazy; but they actually make sense. If there's some way that foot problem could be linked to the stomach cancer, then yes, that doctor should be sued for not making that connection.

And if the plaintiff can prove that,

that the doctor should have made that connection, then that plaintiff should recover. However, if there's no medical conceivable way that that foot problem could in any way be related to that stomach problem, then no, I would consider that a frivolous lawsuit that should not be brought.

REPRESENTATIVE HORSEY: Okay. But the significance there is that he died from tapeworm. One of the Representatives made the point that it was frivolous, it was crazy for a foot doctor to be sued for a stomach ailment. And I was trying --

MR. COTTON: It may not be frivolous.

MR. HORSEY: Exactly.

MR. COTTON: And under our proposal --

REPRESENTATIVE HORSEY: That's the only point I was trying to make. Thank you.

MR. COTTON: Under our proposal, Representative --

REPRESENTATIVE HORSEY: And you need to be a doctor -- just one second, sir. It's very curious that you decided to answer because you're a doctor and a lawyer?

MR. COTTON: Correct.

REPRESENTATIVE HORSEY: You need to be a doctor to make that type of -- come to that type of conclusion. And I notice that of the three, you made that determination.

And I think that determination warranted as an attorney was made as a result of you being a doctor. So thank you very much. That's it. Thank you, Representative Chadwick.

ACTING CHAIRMAN CHADWICK: Mr. Masland.

REPRESENTATIVE MASLAND: Thank you, Representative Chadwick. I just, in the interest of time, will make a brief comment because I'm sure this is going to be discussed at greater length.

With respect to your proposal to accelerate the Dragonetti cause of action, let me say that I am a co-sponsor of this bill and I believe we need to do something about frivolous lawsuits not just in medical malpractice claims but in other claims.

But my initial gut reaction seeing this proposal for the first time this morning is that you're really whistling in the wind there. I don't think that -- I think it goes too far.

I think that there is an argument that can be made that it does have a chilling effect on the filing of suits, it does -- could -- and, again, this is my gut reaction -- it could go against the constitution, the Pennsylvania constitution with respect to the fact that our courts are open to the public in such a way that you basically set up a number of hurdles that a claimant, a plaintiff could potentially have to overcome that aren't ordinarily there.

I think you'd be better off sticking with the provisions that are in House Bill 2122. But if you're looking to propose this for leverage, maybe then it makes some sense; but otherwise, I think you're going too far. Thank you.

MR. NIELSEN: May I respond? I'd like to suggest that your initial reaction is -- I understand where you're coming from with that. I respectfully request you to take a look at it a little bit further. We believe that it may not, in fact, go too far at all.

REPRESENTATIVE MASLAND: I'll take a look at it further; but, you know, when I see paying a physician -- paying in addition to the

other claims a physician $200 per hour for the time to, you know, to present their defense, you know, I just feel that that's a little bit outrageous too.

But, again, I'm supportive of this Bill; but I've always had clients that I have represented -- not in malpractice cases but in negligence cases -- where it's very difficult dealing with doctors who do not want to even have a deposition taken of them so they put outrageous, outrageous costs on their time for one hour.

And, you know, I just see something like this as falling in the same line. I think that a provision like this does not -- is not in the best interest of the medical community and I think really you're going too far.

And, I mean, I think you need to take a second look at what you're doing because I think it does go beyond what this Bill can accomplish and it goes beyond the interest of medicine.

ACTING CHAIRMAN CHADWICK: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you. Doctor, just following up on Representative

Masland's discussion and your own, with regard that this Dragonetti -- the acceleration of the Dragonetti situation, if we were to turn the tables and say that the improper use of the Dragonetti procedure would entail the physician or the malpractice insurer paying out-of-pocket the attorney or the plaintiff for their time, if you brought a Dragonetti case and lost, does that cool your ardor for that kind of a provision in accelerating it as quickly as you would like to see it accelerated?

It seems to me if you're going to use this as a lever so to speak or as a way of trying to stop frivolous lawsuits -- I think we can all agree that that's an admiral goal -- you've got to be prepared to accept the idea that some insurance companies may file it in every case whether there's merit to the case or not or if it's in any way a gray area, then they may well use it as way to try to force quick settlements or to end the case in some preliminary posture as opposed letting it go all the way through.

It seems to me it would be only fair that if we're going to pay doctors or ask people

to pay for doctors' time to defend themselves, then when you sue an attorney or sue the plaintiff for bringing an improper claim and you lose, then you have to be prepared to pay out-of-pocket for that as well.

And I don't think that's in your proposal; but perhaps if we're going to consider it, we ought to turn it around.

MR. ARTZ: Representative Hennessey, it's certainly implicit and the Act would apply to that. And I would agree with your point that if a frivolous counterclaim was brought, the procedure would be that the plaintiff would then file a motion to dismiss that and the same principles should apply.

REPRESENTATIVE HENNESSEY: I assume you probably want to pay the attorney less than 200 bucks an hour, right?

MR. ARTZ: Well, prevailing rate.

REPRESENTATIVE HENNESSEY: Okay. One other question is, You used the anecdote about a resident who was observing and was still named in the lawsuit. And you said at least from your perspective he was only observing. What is the plaintiff saying in that case?

Are they saying that he was simply an observer and somehow had a duty toward the patient? Or are they saying something else, that he somehow was involved in the delivery of care?

MR. COTTON: Perhaps I can answer that. I'm very familiar with that defendant. That defendant is my wife. And she was listed as being present in the operating room.

When that medical record is generated -- an operative report is generated, it lists all those present in the operating room, including nurses and other people that are just there not actually operating.

She was listed as being present. And I suspect what happened is that when the attorney for the plaintiff got that medical record, they simply looked and saw Joy Cotton, M.D., and said, Well, there's another doctor there. Let's list her as well.

And perhaps it was defense counsel overlooking something, but she was drug along with this thing. And it's now been about four years and is still being drug along with this and it hasn't been dropped.

REPRESENTATIVE HENNESSEY: Why isn't she out by a Motion for a Summary Judgment?

MR. COTTON: Well, that's probably something I need to speak to her defense counsel about; but we haven't done that yet.

REPRESENTATIVE HENNESSEY: You haven't asked to be removed from the case?

MR. COTTON: It's something that -- I'm not her defense counsel.

REPRESENTATIVE HENNESSEY: I understand.

MR. COTTON: It's something that -- it's one of those things that's on my desk; and I've never actually done it.

REPRESENTATIVE HENNESSEY: It's interesting because when you first delivered that, it sounds crazy that somebody would do that.

When you examine it a little bit and find out that she is a doctor now and perhaps it's a mistake that could easily be corrected if somebody would simply bring it to the plaintiff's counsel's attention, but that hasn't been done yet or no motion has been made to get her out of the case.

That anecdote sort of loses some of its

thunder as far as whether or not it's unfair for her to be named because it sounds like it's a mistake in denomination of her as a defendant.

MR. ARTZ: But there's a practical issue there too. And that is insurance defense counsel is not -- may not have authority to do that yet. I just don't -- we just --

REPRESENTATIVE HENNESSEY: Insurance company's defense counsel may not have authority from the insurance company to try to get a person out who has nothing to do with any potential liability in the case?

MR. ARTZ: I'm just trying to elucidate some potential reasons why that just hasn't occurred. I mean, the fact is she shouldn't have been sued. I mean, that's the point of the example.

REPRESENTATIVE HENNESSEY: I understand that. Thank you, Mr. Chairman.

ACTING CHAIRMAN CHADWICK: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chadwick. I had a whole line of questioning, I guess, built on the example we've just been talking about. And at first I thought

we were going to all concede that maybe it wasn't the best example; but, Mr. Artz, you're still trying to make the point that maybe that doctor shouldn't have been in that case from the beginning.

I guess -- I listened very carefully to the proposed amendments to Dragonetti that you have. And correct me if I'm misunderstanding what you are proposing, but you acknowledged that sometimes an attorney may be up against a statute of limitations when they first file a writ.

You acknowledged that under even your amended Dragonetti that until the discovery is taken you may not know what the connection is. Unless I am mistaken, having never gone to medical school, I think that residents can sometimes be -- they're doctors in training.

They can actually be operating in an operating room, whether or not in that particular example they were or they weren't. But how does the plaintiff's counsel know that until they take them to discovery to find that out?

And even under your proposed Dragonetti

amendments, that resident wouldn't be let out until after the discovery is completed. Am I missing something?

MR. ARTZ: The point is that at the very point in time when the plaintiff's counsel gets a chance to look as those documents, which is very, very quickly, it would be evident on the face of the documents that the resident in our example had nothing to do with the care.

And there's absolutely no theory under the law that would justify her being in the case. So while we're proposing an extension to close the discovery, there's also a good faith duty, I think, to let that person out quickly.

REPRESENTATIVE MANDERINO: Okay. I guess we're going to disagree on whether or not that was a good example to use because all the other people up here are mumbling along with I am is that at the first moment that you realized that you had a basis for a Motion for Summary Judgment, and I'm not sure what we're doing seven years later.

Let me just ask two other questions that are fairly specific. I asked Mr. Hager from the Insurance Federation this. One of the problems

that I have with the affidavit for nonprejudicial release that is made available early on in the proceedings with this is that there was no balancing, tolling of the statute of limitations, vis-a-vis, that person that you're letting out.

Would you from your Family Physicians organization have a problem with putting a tolling statute of limitations language in the Bill?

MR. ARTZ: With respect to the existing Bill, Representative, or our example?

REPRESENTATIVE MANDERINO: Yeah. I'm not exactly sure what clause it is. But it basically says if I was named as a party to the suit and I don't think I belong as a party to the suit I can send in an affidavit and you have to release me without prejudice.

But it doesn't then say and the statute of limitations is tolled. So if during discovery and you found out you shouldn't have let me out, you can bring me back in if the statute has run.

I'm just saying you would recognize that as a fairness issue, I assume, and wouldn't have

a problem with if you let somebody out on an affidavit, you also tolled the statute of limitations should you need to bring them back in?

MR. ARTZ: That was a leading question, Representative. May I explain my answer?

REPRESENTATIVE MANDERINO: Sure.

MR. ARTZ: The Academy's official position is that it supports Representative Chadwick's bill as drafted. Personally, I would agree that it would be fair to insert a tolling provision.

REPRESENTATIVE MANDERINO: Okay. Do you have -- and I actually -- I will look at them more in depth and more thoughtfully, your proposed additional amendments to the Dragonetti to deal with frivolousness coming from the claimant/plaintiff's side.

One of the other concerns that I have deals with delay from the defense side. Do you have any suggestions vis-a-vis some of the attempts to accelerate the discovery process in this Bill?

I guess my question would be, Do you think that those attempts to put time frames and

expedite discovery on the Bill weigh equally on claimants as well as defendants as they're drafted?

And do you have any additional suggestions from either side, I guess, with regard to how you could expedite or at least cut down on the multitude of motions and sets of interrogatories and everything that goes out?

MR. ARTZ: Okay. That's a compound question. I'll try to answer that. As I stated in my testimony, many local courts already have limitations on the time frames and they have limitations on the number of interrogatories.

For example, Philadelphia County, Dauphin County, and several other counties limit interrogatories to forty. They have a stocked, standard set of interrogatories in a medical malpractice action.

What I would recommend is that this Committee write a letter to the Pennsylvania Supreme Court and ask that body to issue a rule to be inserted in the Pennsylvania Rules of Civil Procedure standardizing that which this Committee would think is reasonable.

And I think the Philadelphia example and

the Dauphin County example are good ones that should be imposed statewide, and I think that would be a good remedy. And I think the Court would be open to that.

REPRESENTATIVE MANDERINO: Thank you. I have no more questions.

ACTING CHAIRMAN CHADWICK: I see the Chairman has returned. Representative Reber and I are the only two left to go.

CHAIRMAN GANNON: Representative Reber.

REPRESENTATIVE REBER: Thank you, Mr. Chairman. I guess I can mark off my first question which was I was curious as to what was the opinion of the Court of the order in dismissing the Motion for Summary Judgment in the infamous intern case; but since there was none file, obviously there was no order entered. So that does not become a question.

Let me ask you this, You don't have any objection if Title 42 and Section 8351 would be amended to allow your concept or some hybrid of your concept to be available for all persons, not just doctors, I assume?

MR. ARTZ: No, I have no objection to that, Representative Reber. The one concern is

that if you would try to apply this to a circumstance like products liability or commercial litigation, many of those kinds of cases, particularly in commercial litigation, are resolved on summary judgment. And I don't think a legal presumption should arise there.

The uniqueness of raising the legal presumption in a medical malpractice case is that so very few of them are resolved because if you have a factual dispute between experts that's a legitimate, rational, factual dispute, that case isn't going to be dismissed on summary judgment. That case isn't going to be dismissed on directed verdict. That's going to get to the jury.

REPRESENTATIVE REBER: I mean, you could have that in any kind of civil proceeding. I could have, you know, two expert witnesses on damages done to a classic car in a restoration case.

I mean, you know, it just seems to me to be, you know, the height of denial of equal protection to take this particular form and dovetail it. And I assume that if we were going to do something like this under Title 42 we're

going to take a look at it under the overall generic subject of tort reform as opposed to giving this particular specialized uniqueness to just a particular profession or particular segment of a society or a particular class of individuals, I guess, is my concern.

MR. ARTZ: Yes. And the Court -- and if you would apply this to other circumstances, the presumption that would be raised is certainly rebuttal.

REPRESENTATIVE REBER: I have no further questions.

CHAIRMAN GANNON: Thank you, Representative Reber. Representative Dermody.

REPRESENTATIVE DERMODY: Thank you, Mr. Chairman. I just have one question. In response to one of Representative Manderino's questions, you suggested on discovery issuing the interrogatories.

And I believe you suggested that we write a letter -- the Committee write a letter to the Supreme Court suggesting they change the Rule of Civil Procedure on that issue. Contained in this Bill there's some discovery issues that deal with limiting discovery to the

deadlines for discovery, that type of thing.

Would you agree that there would be some constitutional problems with those infringements -- those and discussions of discovery issues because of the rule making that's -- litigated in the Supreme Court?

MR. ARTZ: With respect to discovery issues, there's no case law. I guess you're going to the issue of encroachment and a separation of powers issue?

REPRESENTATIVE DERMODY: Well, clearly the Constitution rule making -- the Rules of Civil procedure up to the Supreme Court. You would agree with me there, right?

MR. ARTZ: Well, that's Article 10 -- I'm sorry. Article 5, Section 10(a), that's what it says.

REPRESENTATIVE DERMODY: Right. So the fact that you've already discussed that we should write a rule on interrogatories, but this Bill does address several discovery issues. Do you think there's a problem with those areas?

MR. ARTZ: It's possible. I don't know how the Court would rule.

REPRESENTATIVE DERMODY: All right.

Thanks. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Dermody. Representative Chadwick.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. The question I'm going to ask you does not relate to frivolous lawsuits. And since you haven't prepared for this, I'll understand if you don't have the answer today and you have to get back to me; but it's a matter that's been weighing on my mind for a while now.

I would assume that a substantial percentage of the members of the Academy of Family Physicians are general practitioners; is that accurate?

MR. NIELSEN: Depending on what you mean by general practitioner, probably not. The majority members of the Academy are board certified and/or residents and trained family physicians.

The GP acronym is something that basically has over time been phased out. We're now dealing with board certified and residency-trained family doctors.

REPRESENTATIVE CHADWICK: Thank you. Then it would be accurate to say that a substantial percentage of the people in your association are doing family practice?

MR. NIELSEN: Correct.

REPRESENTATIVE CHADWICK: And a substantial percentage of them may well be involved in doing referrals?

MR. NIELSEN: Yes.

REPRESENTATIVE CHADWICK: Great. As you may recall, during the debate on Senate Bill 790, Mr. Cohen offered an amendment that would have collapsed the number of categories, rating categories for medical malpractice insurance. And I offered a rather passionate defense against that amendment.

My position and I think your position probably and a substantial percentage of the medical community's position has been in the past that that would simply have physicians who were doing low-risk procedures and who had low rates subsidizing the insurance rates for those that were in the high-risk specialties.

That amendment was defeated. I was having a conversation last month with Mark

Fennesee (phonetic) from the Trial Lawyer's Association. He's here. And Mark, if I in any way misstate our conversation, will you correct me?

MR. FENNESEE: Love to.

REPRESENTATIVE CHADWICK: And we were talking about this subject. And he suggested that Mr. Cohen's idea was a good one and that part of the ultimate solution of medical malpractice insurance was to collapse the number of categories.

And I offered my usual passionate defense as to why low-risk, general practitioners should not be subsidizing the high-risk specialists. And his response to that was, But those low-risk physicians are accepting referral fees from the high-risk specialists.

That took me aback. I have to confess that I'm only familiar with one general practice physician. That was my father. I know that in 25 years of practice he never took a single referral fee.

In fact, his referrals cost him a lot of money in long distance phone calls. I don't know and I don't know if you know whether or not

there is a wide-spread practice of specialists giving referral fees to the doctors who refer to them. Do you know?

MR. ARTZ: I can tell you that the referral fee -- the answer is there is probably not because the referral fee circumstance you're talking about, Representative Chadwick, is illegal under the Federal Fraud and Abuse Act with respect to as it would apply to any Medicare or Medicaid patient.

It's illegal under the Stark Legislation, which applies to the same body of insureds. It's illegal under the Workers' Compensation Reform Act that you passed in 1993, and it's legal arguably under the Auto Insurance Reform Act that you passed.

And Blue Shield has a contractual prohibition in its bylaws or its regulations for participating physicians that that type of fee is illegal. That pretty much takes care of the gamut.

And you passed -- along with Act 6, you passed a broad insurance fraud prohibition which arguably covers this situation. So it's illegal under any existing payer system so that the

likelihood of any referral is zero because it's illegal under all circumstances.

REPRESENTATIVE CHADWICK: Thank you. That's the only question I had, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Considering your proposal, one of my concerns is that if this was permitted as similar to a New Matter in response to the filing of the complaint that you might just end up with a cottage pleading of every time you got a complaint filed you'd automatically file this Dragonetti counterclaim, Would you have any problem if it was -- the counterclaim would not arise until after discovery was closed on a case so that all parties would have all the facts on the table and at that point if one of the providers felt that this -- he should not be involved in this litigation that he could then have the right to file his counterclaim?

MR. ARTZ: It's a good idea.

CHAIRMAN GANNON: And my second point would be that the counterclaim would be heard in a forum other than the forum where the case in chief would be heard.

And the reason I'm thinking of that is that neither party would be prejudiced by the outcome of any Dragonetti-type counterclaim so that if one or the other side lost or there was a draw that that wouldn't have any impact and influence if the case in chief went forward. That's all.

MR. ARTZ: That would be acceptable as well. It would just be a matter of internal procedure inside the county court.

CHAIRMAN GANNON: Okay. That was my question. Thank you very much, Mr. Artz.

MR. ARTZ: Mr. Chairman, Representative Hennessey had a question. Did you want to explore that with us, or should we just get off?

REPRESENTATIVE HENNESSEY: Which one was it -- the waiver jury trial?

MR. ARTZ: No. It was the one on page 20 of the Bill had to do with the agreement to arbitrate health care claims.

REPRESENTATIVE HENNESSEY: The waiver of jury trial?

MR. ARTZ: Right.

REPRESENTATIVE HENNESSEY: The question

as I posed to Mr. Hager was the time frame for withdrawing that is 30 days after it's executed, which may be early in the process, well before anybody is aware that they have potential for the basis for a malpractice action.

And if, in fact, there were benefits, a speedy trial, you know, the review by an experienced, professionally-trained panel, wouldn't it be fairer to ask the person to make that decision once they know that there is the potential for litigation rather than early in the process?

MR. ARTZ: And I have a couple comments for that. First, the provision in this section of the Bill is consistent with the spirit of the Unfair Trade Practices and Consumer Protection Law with respect to a cooling off period after any kind of an agreement is signed.

It's actually more generous. Usually, you have a three-day cooling off period under that law. What you might want to consider is to adding language to the end of the notice provision that goes to the patient.

There's a big block of language that's got to be put on that thing that says something

along the lines of take this agreement to your lawyer for review, which is very similar to the notice that's contained on any lawsuit that's filed.

Big letters, Take this to your lawyer at once. And so somebody can seek competent counsel to get some insight on that. Also --

REPRESENTATIVE HENNESSEY: Mr. Artz, do you really expect people, you know, when they go to see their doctor to say, I'm paying for a doctor. I'm also going to pay to have my lawyer review this potential when I don't even know that I've been injured by a doctor?

I mean, people just aren't going to do that in everyday practice. That's better in theory than it is in practice.

MR. ARTZ: Well, I was just offering an alternative.

REPRESENTATIVE HENNESSEY: Okay. Yeah, you have the cooling-off period for three days generally when you've bought something. Then you've made the decision to buy it and incur the expense and the law gives you three days from that decision because that is the crucial decision.

The question of whether or not you waive a jury trial it seems to me is better -- is more informed -- that decision is more informed if you make it when you know that the case has a potential for litigation, not if you make it before the doctor ever gets around to scheduling surgery, for example.

MR. ARTZ: But if you buy a house or a car, you don't know in three days that it's a piece of junk or there's a major problem with the house or the car. And you have that cooling off period before the potential cause of action accrues as well.

But personally -- I mean, again, the Academy's position is we support Representative Chadwick's bill. Personally, I wouldn't have a problem in terms of fairness if somebody had the opportunity to withdraw from -- walk out of that agreement at that point in time where they may seek counsel at a point in time where it may be more practical, as you said.

REPRESENTATIVE HENNESSEY: Okay. Thank you.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Just a quick

follow-up. On that referral business, those statutes that you spoke about, weren't they principally prohibiting self-referrals? In other words, where I have a interest in another entity and I'm referring patients to them. That Stark, I believe that was the prohibition there and under Act 6 it was for self-referral principle.

MR. ARTZ: But the principle is represented, again, any time there's a financial relationship. So any time money is coming back for referral, even if it's to an entity that I have an ownership interest in or I have a financial relationship with a person or entity to which the referral is made, it's still prohibited.

CHAIRMAN GANNON: Thank you, Mr. Artz. We're going to take about a 10-minute break to give our stenographer a chance to change the paper and take a breather and resume.

Many of the Members of the Committee and the guests the witnesses know that there is an event this evening that some of you are attending. So I would appreciate it if we can be as judicious as possible with our time with

the remaining witnesses insofar as questions are concerned.

(At which time, a brief break was taken.)

CHAIRMAN GANNON: Our next witness is Dr. Leonard Finkelstein, President and Chief Executive Officer of the Philadelphia College of Osteopathic Medicine. Welcome Dr. Finkelstein.

DR. FINKELSTEIN: Thank you, Mr. Chairman. And thank you Representatives on this Committee for allowing me to come before you today.

First of all, I am also a osteopathic physician and a neurologic surgeon. And as a surgeon, unlike a lawyer, I probably will get done a lot quicker, all due respect.

PCOM -- I'm going to give you some statistics that relate to the college because the thrust of my presentation relates to the students and the physicians that we ultimately produce.

PCOM is the largest of the seventeen colleges of osteopathic medicine in the United States. We have approximately 1,000 students in the medical school, 70 percent of which are from this Commonwealth.

Our college produces more primary care physicians than any medical school in the country. Most of our graduates are practicing family medicine.

Of the 43,047 osteopathic physicians practicing in Pennsylvania, 70 percent were trained at PCOM and are in 65 of the 67 counties in the Commonwealth.

20 percent of our alumni practice in our large cities, but the great majority practice in our small towns and in our rural communities. Presently 52 Pennsylvania counties are represented in our total student body, and I am here today representing our students as well as physicians in this Commonwealth.

The need for tort reform in this country's universal. The litigious nature of our society has become a national problem that affects every citizen by increasing the costs of daily living significantly.

I'm here today to discuss one specific area of tort reform as it refers to medical malpractice. It must be stated up front that tort reform in the Pennsylvania Medical Professional Liability Catastrophe Loss Fund,

Act 3, or the CAT Fund are separate issues.

In fact, the problem that we are having with the CAT Fund only accentuates the need for tort reform. And I must state that in the numerous discussions I've had with Representatives and Senators regarding this topic, almost invariably they tell me they're working to reform the CAT Fund.

Well, there's no question that work has to be done there; but, again, the thrust of this is tort reform, not the CAT Fund. The problem is what the price of liability insurance does not only to the cost of health care but to society in general.

We all know about defensive medicine and what it does regarding unnecessary laboratory testing, unnecessary imaging procedures, and unnecessary doctor visits. Do we know or even think about what it does to the cost of medical education?

In my medical school, Philadelphia College of Osteopathic Medicine, the expenses projected for fiscal year 1997 in graduate medical education -- and I'll refer to that as GME -- are $12,744,212.

GME medical liability insurance costs are projected to total $2,142,180. This represents 16.7 -- almost 17 percent of the total GME budget, money that is allocated for the education of interns and residents, our future physicians.

This additional expense for our teaching hospitals, most of which are having problems because of the increasing patient reimbursement and it also impacts on the tuition at the undergraduate level.

The following are examples of the rising costs of medical malpractice insurance for PCMO residents and interns over the past three years. The numbers represent the total of insurance premiums plus CAT Fund surcharges per resident per fiscal year.

And I've taken three or four of the residencies that are involved and the most commonly thought of. Family medicine, which is our largest program, in 1995, per resident the cost was $4052. In '96, it went up to $7692. And this year, the current fiscal year, the cost is $8379, over twice that of 1995.

In general surgery in 1995 it was 7195.

And I'll skip the '96 and go right to '97. It went to $16,339 per resident. In OB/GYN, which is, of course, one of higher-risk specialties, in '95 it was $16,656. And in '97, it went up to $38,168, again, over double in three years.

Orthopedic surgery, another high-risk specialty, '95, 16,556. In '97, it went to $38,124. In our fiscal year, 1995, the CAT Fund surcharge was 93 percent of premium. The fiscal year -- our fiscal year, 1996, it was 102 percent of premium plus the emergency surcharge of 68 percent.

The premium for fiscal '97 is, as you all know, 164 percent of premium. When you multiply these numbers by the hundreds, it represents real money. And for your information, our school is relatively small compared to the other medical schools.

We have approximately 200 interns, residents, and a small number of full-time teaching positions that we fully fund as far as liability insurance as well as the rest of their salary and benefits.

Your other medical schools, Penn Jeff, Temple, and Philadelphia, Allegheny colleges,

Hershey, Pittsburgh, their numbers are two and three and four times that of ours. And you can imagine what the cost to those schools are.

The average debt of PCMO class of '96 was $119,242 per graduating student. Any increase in tuition will only add to the debt of these future classes. There is no doubt in my mind that this will in the near future be a significant deterrent to college graduates seeking a career in medicine.

Another ramification affects graduate medical education. The increasing costs combined with the diminishing federal reimbursement are already resulting in the closing of training programs across the country.

Due to the high number of specialized physicians in practice, this will not have a significant impact now but certainly will in the not so distant future. This country has led the world in health care because of the highly-trained physician work force it produces.

The high cost of litigation today has changed the definition of justice in this country. Right or wrong is no longer the equation. We only ask how much will it cost to

win? How much will it cost to settle? What is the risk if the case goes to jury? Will the plaintiff settle for less than the risk?

Most of the time we settle because the cost is less to settle than to win or defend. And I can tell you that I personally have to deal with this issue one or two times per month every month at a cost that I hate to even think about.

Most of the time, the reasons are totally ridiculous; but money is paid because it's less expensive to pay it than to fight. In medical malpractice, the problem most of the time is not malpractice but a result less than expected by the patient or an event that caused great harm that was not related to a medical misadventure.

The allocation of awards by either jury or settlement is not based on culpability but on whose pockets are the deepest. The huge size of some awards is not based only on money spent, wages lost, pain and suffering, but also include lawyers' fees, how deep are the pockets of all the parties involved no matter how remote their involvement and punishment would be to

providers.

And I must also add based on some of the previous testimony that I heard and you heard this morning relating to frivolous cases or involvement of people that are really not part of the problem.

I have been personally sued at least six times because I am president of a medical facility who allowed a surgeon to do an act that I was totally responsible for.

And the reasons that I was sued was because I did this, I allowed this person to do these unspeakable acts because I wanted to make a profit for my institution. That is the way it's worded more or less. And that is just doing business according to the trial lawyers that represent these plaintiffs.

And how a president of a medical school that has dozens or fifties or hundreds of surgeons working as individuals doing their own thing would be responsible and dragged into a suit, it absolutely boggles my mind.

And one thing that I haven't heard here today and hear whether we should do this or we shouldn't do this, we should throw it out, it's

frivolous, it's whatever, the cost of getting out of the case is significant.

The minute my name appears or anybody's name appears, it's hundreds or thousands of dollars just to get it thrown out when you're paying 200, $300 an hour for an attorney representing you to do it. And that just adds to the problem that is ongoing.

Patient right activists and trial lawyers state that they believe the defensive medicine argument and other positions that tort reform advocates make are overstated.

They believe that medical malpractice can only be reduced by making providers financially accountable for errors. I cannot disagree more. As you know, Act 1975 dash 111 requires that all physicians in Pennsylvania must carry medical malpractice insurance to be licensed to practice in the Commonwealth.

They are automatically covered by the CAT Fund for awards greater than their primary coverage. Under this system, punishment is not only paid for by the defendant providers but shared by all who must pay this huge cost for liability insurance. There must be a better

way.

There should be no punishment where there is no negligence or intent to do harm. If there is negligence, the punishment must be directed to the offending provider or providers only, not to the universe of providers and indirectly to society in general.

Payment should be for the plaintiff's uncovered costs plus reasonable estimate of lost income or wages. Awards should be not inflated to cover the contingency fees of attorneys. The amount of payments for pain and suffering should be controlled.

Depending on the nature of the offense, the revocature of licensure and even incarceration should be considered. The problem is bad doctors. And the way to handle bad doctors is to get them out of business, not to tax society for their mistakes. And I personally will testify any time.

Act 111 was passed in 1975, 21 years ago. This Act has been a large Band-aid covering a sore which not only has not healed but has gotten worse.

The answer for the crisis that existed

in '95 was tort reform, not Act 111. This still is the best answer in 1996. House Bill 2122 addresses many of the problems producing the medical liability insurance crisis.

It eliminates frivolous clauses, caps punitive damages, expedites the process, and eliminates duplicate fees. Moreover, the Bill will attempt to make available professional liability insurance at a reasonable cost.

The time for passing this type of bill is over twenty years overdue. This crisis has a stranglehold on us as physicians and healers. It diminishes our powers as teachers and protectors of the public well-being. Let's once and for all end the medical malpractice crisis.

And I must end by telling you this, I have been a surgeon for 33 years. I have taught students at the undergraduate level for this entire period of time to the present. I have trained residents both as a program director and a participant in a residency training program.

I have treated probably 3 to 4,000 patients for prostate cancer and most other problems in my specialty. I believe I am one of the best in my field.

Within the next month or two, I am retiring from active practice because the level of practice with my administrative responsibilities is such that it does not pay me to pay for that malpractice insurance that I must have to maintain my license in the Commonwealth of Pennsylvania.

And I am not alone. This Commonwealth because of this system is losing the best of its best. And I thank you very much for listening.

CHAIRMAN GANNON: Thank you, Dr. Finkelstein. We don't have any -- I'm sorry. Representative Hennessey.

REPRESENTATIVE HENNESSEY: Dr. Finkelstein, thank you. Thank you, Mr. Chairman. I'm struck by the information you provided on the bottom of page 1. Your insurance for general surgery has doubled in over a three-year span, it looks like, for a resident.

But even at $16,000, I don't know what that does in the marketplace. For a million dollars worth of coverage, maybe it's too much money; maybe it's not. Who pays for that? Does the school pay for that? Does the hospital?

DR. FINKELSTEIN: Both.

REPRESENTATIVE HENNESSEY: What does a resident make?

DR. FINKELSTEIN: A resident's salary I would say in our institution averages and varies according to the specialty between 30 -- and the year of their program between 30 and, max, probably $36,000 a year.

REPRESENTATIVE HENNESSEY: So in essence, if you were to be asked to pay for that out-of-pocket, that would be a tremendous --

DR. FINKELSTEIN: Impossible, plus and the fact is that your insurance for these are well over half of their salary.

REPRESENTATIVE HENNESSEY: I'm sorry?

DR. FINKELSTEIN: The malpractice insurance for each of them is usually over half of their salary, at least the surgeons.

REPRESENTATIVE HENNESSEY: Moving along, I think you identified the problems and said the problem is bad doctors and we should put them out of business.

In your experience, has that actually worked because I know that in my own experience I've heard stories and maybe they are just

rumors with no basis in fact about doctors who had alcoholic problems and, you know, nurses who joked that, hey, this guy's a better surgeon when he's drunk than other people are when they're sober.

But it seems that the hospital peer review committees don't really want to take any action against those doctors even though they may be able to point to an identifiable problem because the doctors themselves arm themselves with lawyers and say, hey, you come after me and take away my livelihood, then I'm going to sue you and take away whatever I can from you.

And doctors, you know, whether or not it's the courageous thing to do or not - it seems to me it's not -- they seem to back away, well, I'm not going to put my personal assets at risk to clear the ranks of a bad doctor.

How do we address that problem? If your solution is simply going after bad doctors, if doctors don't do it, aren't going to identify the bad apples in their own basket, how are the rest of us supposed to do it?

DR. FINKELSTEIN: As I stated, the problem of tort reform is universal. It's not

just medical malpractice. I -- when the PSRO system was in place regarding the review of hospitals and Medicare systems, which was during the 70's, for the Feds, I was on their executive committee and board.

And there were two or three hospitals and probably about a dozen or fifteen physicians that we during our reviews identified as very culpable and doing bad things to patients.

And the hardest and most difficult thing for us to do was to take action because of the legal system because of the due process system that everybody is entitled to in this country. Because there's a difficulty in one area, does that mean you have to deal with it unfairly in another? I don't believe so.

I believe that the medical profession has to continue to improve on the way it polices itself because nobody can police a physician other than physicians as far as knowledge of right and wrong.

That's where -- if there's flaws, that's where we should address our efforts, not by increasing insurance policies to cover these people who probably should be out of business.

I think there's a growing number of physicians who are willing to stand up and testify as to when something is really negligence, really malpractice, rather than just some event that happened in spite of best efforts.

I never had a problem doing it myself, and I know many of my colleagues that are in the same position. We obviously will not stand up and defend somebody for some lawyer who would like to orchestrate a case that has no merit.

And we have doctors that do that. That's the problem. Wherever there's a lawyer who's orchestrating the case that's not factual, he or she will find a physician who's willing to collaborate one way or another, which is another reason why identification of experts and demanding that experts truly are experts when they testify is so important. I believe that's part of this Act.

I mean, there isn't anything any more ludicrous than to have physician who is not in practice, who hasn't been in practice for twenty years, not even in a specialty calling him or herself an expert and testifying on behalf of a

plaintiff, because you very rarely have that type of physician testifying for the defense.

REPRESENTATIVE HENNESSEY: Thank you, Doctor. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Representative Manderino.

DR. FINKELSTEIN: She said she wasn't going to ask me anything.

REPRESENTATIVE MANDERINO: I told him I wasn't going to ask him any questions, but I just want to make sure that I'm using the -- interpreting the cost of premium figures that you gave us with the right background information.

The figures that you gave us, for example, for orthopedic surgery in 1995, $16,500-some, that's the combined primary insurance and the CAT Fund --

DR. FINKELSTEIN: Yes.

REPRESENTATIVE MANDERINO: -- figure? And primary insurance is $200,000 worth of liability coverage. CAT Fund is a million --

DR. FINKELSTEIN: Yes.

REPRESENTATIVE MANDERINO: -- over that?

Okay. I just wanted to make that clear on the record. I did want to ask one substantive question since you mentioned the part of this Bill that deals with experts.

I hear what the medical community is saying about that; but I also have a bit of a problem with it in this respect -- and I think what I'm saying is probably something in between what's proposed in the Bill and what is currently allowed now.

But I could understand your argument vis-a-vis an orthopedic surgeon being an expert -- the expert being an orthopedic surgeon if the alleged malpractice was something that went specifically to the practice of the orthopod or the actual surgery that deals with that.

I'm not quite sure if I'm willing to go so far to say that the expert has to be an orthopedic surgeon if the alleged malpractice had something to do that you do in every general surgical procedure, whether it was -- I mean, I don't have enough expertise to say -- but if sponges are used in orthopedic surgery and whether a sponge was left in the body or

something is something that could happen in any surgical practice, I'm not sure why you have to find an orthopedic surgeon to tell you that about an orthopedic surgeon and not just a broader specialty.

Am I missing something in my understanding of the practice of medicine or the use of experts?

DR. FINKELSTEIN: No. I think that you're being too specific. I don't think I was alluding to that at all. An expert is an expert to deal with its subject, and it doesn't necessarily have to be an orthopedic surgeon in an orthopedic case if the problem is generic, as long as the person is an expert in that generic problem.

But we have experts, quote, experts who are expert in nothing other than that they're in the business of being experts.

REPRESENTATIVE MANDERINO: Okay. So you would be comfortable with a definition of who can be an expert in the field defining that expert by what it is they're testifying about and not who they're testifying against?

DR. FINKELSTEIN: Correct.

REPRESENTATIVE MANDERINO: Okay. Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Manderino. Representative Chadwick.

REPRESENTATIVE CHADWICK: Thank you, Mr. Chairman. Not so much a question as a comment. Representative Hennessey brought up the subject of cracking down on physicians who commit malpractice.

And one of the most overlooked sections of this Bill is Article 5-A, Section 501-A requires mandates that insurance companies that make payments either in settlement of cases or as a result of judgments in lawsuits requires that they report each and every one of those to the appropriate state licensing board.

Section 502-A grants immunity -- which as Representative Hennessey pointed out is important -- grants immunity to insurers for doing that.

Section 503-A requires the state licensing board to investigate each and every one of them, and I'll read right from it. If the information obtained through the

investigation warrants, the board shall promptly initiate a disciplinary proceeding against the health care prior.

And finally Section 504-A requires the licensing board to submit annual reports to the General Assembly. In all the -- with all the attention that's been paid to the tort reform and insurance sections of this Bill, I think it's a shame that we overlook Article 5-A because we are taking some pretty firm steps in this legislation to crack down on physicians who commit malpractice as well.

And I thank the Chairman for the opportunity to point that out.

CHAIRMAN GANNON: Thank you, Representative Chadwick. Dr. Finkelstein, you had commented on some type of physician discipline in your remarks and, of course, Representative Chadwick pointed out to us that there are provisions in his Bill dealing with this issue of discipline.

As I understand -- let me put this in context, Florida provides a mechanism whereby if a physician other than in a vicarious situation is directly involved in malpractice and found to

be guilty of malpractice three times, then his license to practice medicine is suspended.

Would you have any comment or reaction to that type of a measure?

DR. FINKELSTEIN: I think if it's defined as to what is actually malpractice, I absolutely would be supportive of it, getting rid of a doctor who has proven himself or herself to be a menace to patients and to society in general.

There's no questions. The statistics show that a small number of physicians are responsible for the majority of cases that are won by plaintiffs. So in that vein, yes.

But the perfect example, again, a personal experience, a patient of mine who is a Medicare patient in for a hernia repair in the days before we brought them in and sent them out before they were out of anesthesia, at night, climbed over side rails, fell and fractured an orbit.

I was sued obviously because it was my fault he climbed over the rails and fractured -- and fell and fractured his orbit. And a settlement was made. It never went to

trial, but a settlement was made again because to go to jury, poor guy fractured, whatever.

Should I have that on my record as a malpractice suit and be at risk for losing my license to practice. Obviously that -- that would be not fair.

So if that type of situation where there's an event that happens but it has nothing to do with the doctor's ability or skills or there was an act that should not have been done, as long as that's protected --

CHAIRMAN GANNON: So you're suggesting some direct act of negligence on the part --

DR. FINKELSTEIN: Yes.

CHAIRMAN GANNON: -- of the physician? Thank you, Dr. Finkelstein. I appreciate you taking your time to be with us today and presenting your testimony.

Our next witness is Keith Mulvihill, Esquire, Co-chair, Professional Liability Committee, the Pennsylvania Defense Institute. Welcome, Mr. Mulvihill.

MR. MULVIHILL: Thank you, Mr. Chairman. Good morning. As Mr. Gannon pointed out, I am Keith Mulvihill. I am the co-chair of the

Professional Liability Committee of the Pennsylvania Defense Institute.

The Pennsylvania Defense Institute is an independent organization of civil defense trial lawyers, insurance executives, and self-insureds. We represent the views of the defense bar in connection with that organization.

PDI is particularly pleased to have the opportunity to present its viewpoint in light of the testimony given before this Committee by Mr. Arthur Picone, the president of the Pennsylvania Bar Association back in March of this year.

With all due respect to Mr. Picone, one of the things I want to do here today is to make it clear to the Committee that there are a substantial number of lawyers in Pennsylvania who support tort reform.

I want to some extent deviate from the prepared testimony in order to maybe expedite things a little bit and address some of the issues which have been raised in some of the questions.

The fundamental goals of our system of

civil justice should be to fairly and promptly resolve claims and to provide fair and just compensation to Pennsylvania citizens who have been injured by the negligence of another.

The Pennsylvania Defense Institute believes that House Bill 2122 will help to accomplish those goals. But before I discuss the specific provisions of the Bill, I want to stress that most of our members are civil defense trial lawyers who appear in court on a regular basis and we strongly support the jury system.

The members of the Pennsylvania Defense Institute recognize that and our experience teaches us that although no system involving humans can ever be perfect, the jury system is the best means yet devised for resolving disputes.

But our experience also teaches us and I think the Committee has probably heard from a number of witnesses who have brought this experience to light that jury trials are an expensive and often burdensome way of resolving disputes.

And the Pennsylvania Defense Institute

believes that reasonable reforms would help to make the jury system more effective and more balanced. I've outlined in the written testimony the six areas in which we believe reforms would be appropriate, and I'm not going to go into those here. I want to discuss more generally the certain points in the Bill itself.

As I said, the first goal of the justice system should be prompt resolution of disputes. And we believe that one of the best ways to accomplish that goal is to enact provisions which will help to weed out meritless claims at the earliest possible times so that scarce judicial and other resources are not wasted on such claims.

This Bill will help to accomplish that goal by establishing a requirement that the plaintiff's lawyer certify that he or she has obtained a written report from a qualified expert in support of the claim prior to filing a complaint.

This requirement is patterned after a similar requirement in the Federal Rules of Civil Procedure, and we believe it is a reasonable and necessary reform.

Indeed, it is somewhat surprising to us that lawyers would oppose such a provision since Pennsylvania law has long required a plaintiff in a malpractice case to present expert testimony in support of his or her claim in order to have the case submitted to a jury.

So the only change that would result from this Bill is that the plaintiff's lawyer would have to retain an expert before subjecting the defendant to the anxiety and expense of a lawsuit.

House Bill 2122 will also help to resolve cases more quickly by requiring that the discovery process, which has been pointed out in some of the questions, as one of the most time consuming and expensive aspects of litigation, is completed promptly. And I think more importantly by providing for early judicial involvement which helps to narrow the issues in the case and, if possible, in many cases resolve the case short of trial.

Once again, this is another provision which we find hard to understand why lawyers would oppose because these types of provisions will lead, we believe, to faster resolution of

all claims to the benefit of all parties.

The second goal of the civil justice system is to provide fair, just, and adequate compensation to victims of medical and other types of negligence. And we believe House Bill 2122 will help to achieve that goal.

It is important to keep in mind what compensation is. A basic definition of compensation is to make someone whole. House Bill 2122 contains several reasonable provisions regarding damages which would allow victims of medical negligence to be made whole but at the same time prevent them from obtaining a windfall or double recovery.

And in evaluating these provisions, we think it's important to keep in mind what the Bill does not do. Unlike tort reforms enacted in many other jurisdictions, House Bill 2122 does not limit the total amount of compensatory damages that may be awarded to a victim of medical negligence.

A jury would still be able to award any amount that the jury believed to be appropriate for pain, suffering, and other noneconomic damages such as loss of the pleasures of life

and loss of consortium.

The Bill does, however, contain provisions similar to provisions in the Motor Vehicle Financial Responsibility Law that would limit the plaintiff's right to be reimbursed for out-of-pocket losses to those for which the plaintiff truly is out-of-pocket.

Under existing laws, the Committee knows plaintiffs can be reimbursed for the same expenses. Defendants are prohibited from even making a jury aware that the plaintiff has already been reimbursed.

This type of double recovery we believe represents a windfall to the plaintiff and the plaintiff's lawyer, and there's no sound reason why such damages should be recoverable. While this is a change in the existing Pennsylvania law, we believe it's a sensible and not unprecedented change and one that will not reduce the plaintiff's right to be made whole.

With regard to the area of punitive damages, we believe this is an appropriate limitation on punitive damages. And I want to point out one thing that I didn't mention in the written testimony.

One thing I think that's important to keep in mind with regard to punitive damages in the malpractice field is that you are most often dealing with individuals here.

The defendants are generally going to be individuals, not as in products liability and other areas, large corporations. And while an award of two times the compensatory damages might not be enough to punish General Motors or Chrysler or another large corporation, that is a very significant amount for an individual physician in most cases.

And you must also keep in mind that those types of damages are not covered by insurance. So that is very significant to the individual physician.

Another way to provide a more prompt and less expensive resolution of malpractice claims is to take cases out of the court system. Alternative dispute resolution is rapidly becoming more popular in many areas as lawyers and more importantly their clients recognize the substantial cost savings that can be achieved.

The arbitration provision of House Bill 2122 which are also similar to the provisions in

the Motor Vehicle Financial Responsibility Law we think provide an opportunity for substantial savings for all litigants, both claimants and defendants, and to the court system.

It is important to stress, however, that as we understand this Bill, the arbitration provisions are entirely voluntary so that the procedure does no infringe on the patient's important Constitutional right to a jury trial.

Nothing in the Constitution, however, prevents parties from voluntarily agreeing to resolve their disputes outside of the court system. And we think this Bill sensibly provides a procedural framework for doing so.

I wanted to address Representative Hennessey's question concerning the 30-day limitation after the execution of the arbitration provision. You'd suggested that one way to change that might be to include a discovery provision in that part of the Act which would, as I understand it, have the 30 days begin to run out after discovery of the malpractice.

I think one of the big problems you're going to run into with that is that if you

include that kind of provision you're going to engender a lot of litigation about when you discover the malpractice.

That's already a very fertile field for litigation regarding Statute of Limitations problems. And I think what you're going to do is you're going to increase that kind of litigation with regard to this provision.

It seems to me that while 30 days may not be the right number, I think it would be better to have a definite time limit. And in any case, you're asking them to sign these agreements before they know that malpractice has occurred.

In most cases if there's been malpractice, it's going to be apparent shortly after the procedure. Maybe 30 days isn't the right time. Maybe it should 120 days or something like that. But I think a definite cut-off time makes more sense than including a discovery provision.

REPRESENTATIVE HENNESSEY: If I might just interject, Mr. Chairman, maybe it makes some sense to do it 30 or 60 or 90 days after the surgical event --

MR. MULVIHILL: Yes.

REPRESENTATIVE HENNESSEY: -- as opposed to after discovery if that's too ephemeral a concept. The idea that you sign it when you first go in to see a doctor and maybe that surgery doesn't take place for six months and you're already five months beyond your withdrawal period before you ever get the surgery. Trouble is the concept.

MR. MULVIHILL: I think that kind of provision would make sense. I agree.

REPRESENTATIVE HENNESSEY: Thank you. Sorry for the interruption.

MR. MULVIHILL: The last specific provision of the Bill that I wanted to discuss is the Bill's change in the limitations period for filing malpractice cases.

As I say, we support reforms which would clearly define the limitation period; and we think House Bill 2122 includes two significant provisions in this area which we support:

First, the Bill returns the limitations period for claims by minors to something closer to what it was prior to 1984 when there was a tolling statute in that for minors.

And secondly, it would require any claim to be brought within four years of the medical treatment, essentially a four-year statute of repose.

Under current statutes, malpractice claims must be filed within two years of the date of the injury; but as many of you pointed out, the courts have defined the date of injury to mean the date the plaintiff actually discovered the injury.

There have been numerous cases defining the discovery rule, but the effect of the rule has been in many cases to allow plaintiffs to file lawsuits based on medical treatment rendered ten and sometimes even twenty years before the case is filed.

The longest delays are in cases involving treatment of minors because of the 1984 statute which allowed minors to toll the Statute of Limitations until they reach 18.

As an example of what could happen when these two rules are combined, I was recently asked to represent two doctors who were sued in 1995 for medical treatment rendered to a minor in 1977.

I'm sure the Committee can imagine the difficulty in that kind of case in locating records and witnesses for events that took place almost twenty years ago.

It is our position that allowing such claims is fundamentally unfair to any defendant and contrary to the purposes of limitation periods, which is to provide a clear definition of when lawsuits must be filed and to prevent the filing of stale claims.

I want to discuss just briefly one final issue that was raised by Mr. Picone in his testimony, and that is the argument which he made very strenuously that this Bill should not be adopted because it would create special rules for malpractice cases.

It is true as Mr. Picone states that this Bill would change the rules and make them different from the rules that would apply to many other types of claims. We don't think that's a reason not to support the Bill.

On the contrary, the Pennsylvania Defense Institute urges this body to adopt similar reforms in other areas of the law to restore some balance to those areas as well.

In conclusion, let me say again that the Pennsylvania Defense Institute strongly supports House Bill 2122 which we believe would bring much needed common sense reform to the medical malpractice field.

On behalf of the Pennsylvania Defense Institute, I urge you to support House Bill 2122.

CHAIRMAN GANNON: Thank you, Mr. Mulvihill. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. With regard to the expert report filing before you have a complaint, I have two specific questions.

Is it your understanding that under this proposed legislation as well as under the similar -- well, let me ask you first about the similar requirement in the Federal and Civil Procedure.

Can you just explain to me briefly what that is and is the expert report that you have to have before you file a complaint the same expert report that you must use at trial and for the same reasons that you must use it?

How does the discovery process and what

you might learn either favorable or unfavorable to the case play into that whole issue?

MR. MULVIHILL: You're asking two separate questions. I think this Bill goes a little farther than what's in Federal Rules -- Civil Procedural Rule 111.

The requirement for having an expert report is not something that's contained in the federal rules. And if I indicated that it was, I apologize. I didn't mean to indicate that.

Nonetheless, we think that the requirement for an expert report makes sense. It is our understanding of this Bill that the report that would be -- you'd have to have before filing a complaint would not have to be the same as the report you'd have to have in order to survive a Motion for Summary Judgment later on in the case or at time of trial.

And we think that a plaintiff's lawyer could take into account the information learned in discovery before preparing the final report, which would be what would be used at trial.

REPRESENTATIVE MANDERINO: And it's my understanding that if instead of filing a complaint I file a writ of summons, I wouldn't

even under the proposed legislation here need an expert report in order to file a writ of -- to toll the statute?

CHAIRMAN GANNON: That's how I read it too. And I think that's important because one of the things that has been raised is that in many cases somebody comes into your office with a question about medical treatment and you interview them and you find out that, well, we're a week, five days away from the Statute of Limitations running.

We think that the provision which allows you to file a writ of summons and then have some additional time before you have to file a complaint is the kind of thing which would allow a lawyer to go out and have the records reviewed by somebody and find out if there is some basis to support this.

I have to say, I generally do defense work but our office does occasionally represent plaintiffs this these types of cases. And it is our practice before ever filing a case to have the records reviewed by someone who we would consider to be an expert in the area and not file a case unless we can get a doctor to come

in and say we think you have a good case.

REPRESENTATIVE MANDERINO: I agree. And when I practiced law, I did both plaintiff and defense work. That was the practice of the firm that I was with.

But it was also not uncommon to have somebody give you a preliminary review and say, yes, I believe there was negligence and culpability here. It's okay to proceed, but I don't want to be your expert in the case.

And that's why I was asking how you think that plays in vis-a-vis what you're proposing and supporting in 2212.

MR. MULVIHILL: That's right. That does happen a lot. And I think this Bill would allow for that sort of situation. I don't think you have to actually produce the written report. You just have to certify that, yeah, I've talked to somebody and they've said I think this is a good case.

REPRESENTATIVE MANDERINO: Thank you. With regard to the collateral sources -- and I'm not going to disagree with you as you characterize it that sometimes that could result in a windfall or double recovery.

But my concern is that I know at least with regard to workers' compensation or medical assistance, if that was the source of somebody's original payment for their -- for their medical expenses, that there is a lien on any recovery from a lawsuit to reimburse that public source or that private insurer for that.

Would the proposal put forth into 12 basically cut those primary payers out of the picture and make them carry the burden for payment of medical assistance?

Should we put a collateral source rule in as is proposed in this Bill? How do you see that issue playing itself out?

MR. MULVIHILL: I think what you suggest is probably right, that it probably would mean that you're putting the burden for the compensation payments on the workers' comp insurer or the medical insurer as opposed to the liability carrier for the doctor.

And in that respect, I think that is simply a balancing act of where it is most appropriate to place that burden. The collateral source though in -- from the standpoint of a trial lawyer though is important

for a particular reason.

And that's because in a case where those benefits are recoverable, what you have is the plaintiff's lawyer at the end of a case stands up and he gets out the blackboard and he says, here's my client's damages and he writes $100,000 for medical expenses or $10,000 or whatever the number is.

And what you find is that if there's recovery, the noneconomic damages are based on those figures. The reason that we think it's important that there be reform in that area is so that the noneconomic damages are not in a sense inflated by the recovery of economic damages for which the person has already been paid.

REPRESENTATIVE MANDERINO: Aren't there two issues in this regard? One is the disclosure of collateral sources, and one is the offset. Right now you're saying neither is allowed under law, but doesn't this Bill provide for both?

MR. MULVIHILL: Yes, it does.

REPRESENTATIVE MANDERINO: Okay. And wouldn't the issue of noneconomic damages based

on compensatory damages, wouldn't at least that part of the equation be addressed just by the disclosure of collateral sources and not necessarily a mandatory offset?

So you can each from a fairness point of view make your argument of, well, there were collateral sources; and then the plaintiff's person saying, there are collateral sources. But what they're *not* saying is the state paid for that under medical assistance and we should reimburse the taxpayers for that -- that case. Do you understand what I'm saying?

MR. MULVIHILL: I understand what you're saying. I have to say when you get into the last part about saying that the state -- we should reimburse the state, I'm not sure that we would support a provision like that.

I think there are, as you point out though, two ways to approach this; either allowing disclosure or not allowing recovery. Now in the financial responsibility law for motor vehicles, it is both.

They are not recoverable, and you are not allowed to tell the jury that damages have been incurred. And I think that's worked well

in that area.

REPRESENTATIVE MANDERINO: Okay. And that's my last area of questioning because you likened what's being proposed here to similar provisions of the Motor Vehicle Financial Responsible Law. That was on the bottom of page 6 of your testimony.

And I'm actually having a problem finding the similarity. I mean, I know that in the Motor Vehicle Financial Responsibility I as a purchaser of my own automobile insurance for which I am personally paying the premiums can decide to choose limited tort and, therefore, I know that I'm giving up my right to sue against my own policy for serious bodily injury in exchange for my own reduction of the premium that I'm paying on my car insurance.

And if that's the similar provision that we have in Motor Vehicle Financial Responsibility Law, I don't see it as a correlation to what we're talking about here unless there's something else in the Motor Vehicle Financial Responsibility Law that you're referring to.

And so if you could clarify that for me,

I'd appreciate it.

MR. MULVIHILL: I -- apparently, I didn't make it clear; and I apologize for that. What I was referring to there were the provisions of the Motor Vehicle Financial Responsibility Law dealing with arbitration of underinsured and uninsured motorists claims.

There are provisions in that law and in the policies for submitting those cases to an arbitration procedure, a procedure which as I understand it is similar to the procedure that is being suggested here where each side picks an arbitrator and then each side's arbitrator picks a third arbitrator and you have basically a trial in front of those arbitrators.

REPRESENTATIVE MANDERINO: Okay. So you're saying that the arbitration procedure is similar, but you're not trying to say that the trade-offs in terms of mandating or assuming the risk of that arbitration is the same?

See, I'm sitting there saying everything's in my control, when I'm paying the premiums for the automobile. So what I choose to trade off is within my control vis-a-vis how much I want to pay for the premium.

I don't see that as analogous between what some other third party is paying for their premium vis-a-vis my rights either expanded or limited to sue for potential liability because they are two different actors.

MR. MULVIHILL: I think that's right. Maybe not I'm understanding exactly what you're getting at. The limited tort provisions in the Motor Vehicle Financial Responsibility Law apply to third-party claims.

If you and I were in an accident and I had limited tort on my policy, I could not sue you for pain and suffering unless I had what the Act defines as serious bodily injury.

REPRESENTATIVE MANDERINO: Right.

MR. MULVIHILL: There is, however, a different provision to which the arbitration provisions apply. And that is if I sue you and you only have $30,000 in liability coverage and I have damages which are far in excess of that, I then have a claim against my own carrier for underinsured motorist coverage.

That claim, the underinsured motorist coverage, is by law submitted to arbitration. Those provisions as to how that arbitration will

be conducted are similar to the provisions in this bill. And that's what I was referring to.

REPRESENTATIVE MANDERINO: Thank you very much.

MR. MULVIHILL: And they have worked well, I would say. And I might also address one other point, Representative Manderino, you had brought earlier. And that was the withdrawal without prejudice based on the Affidavit of Noninvolvement.

As I understand the law -- you were suggesting that there may need to be some tolling provision included with that. As I understand the law, when a case is dismissed without prejudice, the without prejudice means that you then have an additional statute of limitations where you can bring that case, revive that case basically. That's what's meant by without prejudice.

And so you would have another two years from that dismissal to conduct further discovery. And if it turns out that the Affidavit of Noninvolvement is wrong, you could then revive the case without having to worry about the original Statute of Limitations.

That's what I understand the dismissal without prejudice means.

CHAIRMAN GANNON: Thank you, Representative Manderino. Represent Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Mr. Mulvihill, with regard to the various thrusts of the proposal, I think most people would agree that we should stop frivolous lawsuits and impose sanctions for meritless suits for requiring experts to be qualified so we can be sure that there is merit to a suit.

Let me focus on the questions that you raised with regard to the extension of the Statute of Limitations by the courts from the date of discovery.

It seems to me that really is a horse of a different color because there we're not talking about the ferreting out the meritless lawsuits and just dealing with ones that actually have some basis for liability.

When you're are dealing with the Statute of Limitations, that cuts across the border between the suits that have merit, maybe a tremendous potential or a tremendous merit, regardless of the fact that -- without

regard for the fact that they have that merit we just throw them out.

Is that a priority as far as you view the various proposals in this Bill? It seems to me if it is that perhaps there should be a little priority because there because we're not dealing with just getting rid of the problem cases but we're actually affecting somebody's substantive rights.

And the concern I would have is a minor may have parents who simply don't believe in suing the doctor or if you live in a small town you don't want to sue the medical establishment for fear that you'll never get medical treatment from the doctors in that town again.

And I've run into that experience myself with parents who simply are afraid to challenge the medical community in their locale. If they choose not to sue and the child becomes 18 or 19 or 20 years old and finds out that they've really been impaired for the rest of their life, shouldn't that child have a right to make that decision on his own?

Is it fair to say that child should be punished because the doctor really needs to be

able to have a lower insurance premium or the insurance company should have some more predictability?

MR. MULVIHILL: Let me say we think -- I mean, I think you're talking about a fundamental, philosophical question about whether we should have statutes of limitation at all.

REPRESENTATIVE HENNESSEY: Well, I think that we're obviously going to have them. We have them, and they're well established in law. The question is whether or not we should truncate the existing Statute of Limitations for minors.

MR. MULVIHILL: Well, and if philosophically you agree that we should have statutes of limitation and the reason you have them is I think the reasons that I pointed out is that you want to prohibit the filing of what are essentially stale claims because it is very difficulty for the person who's being sued to defend against stale claims.

Then the question becomes, you know, how do you balance and where do you draw the law line? We think this Bill makes reasonable

provisions for drawing that line.

With regard to minors, up until 1984 for most of the history of this Commonwealth, there was no tolling permitted for minors. There still would be a tolling provision for minors somewhat less than there is now.

We think that's a reasonable way to go about it. That's someone that philosophically you have to dry draw the line somewhere. And you can differ about where it is reasonable to draw that line.

REPRESENTATIVE HENNESSEY: Okay. Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Mr. Mulvihill, where the arbitration, are you -- there's two types of arbitration; one is the common law and the other is statutory.

When you refer to the arbitration proposed in this legislation, are you looking at it in the context of the common law arbitration or statutory arbitration?

MR. MULVIHILL: That's a good question, and I get those confused all the time. The Bill does not specify which one of those two

procedures would be followed. I would think this would be statutory arbitration, but the Bill does not specify.

And it may be something that should be clarified in the Bill so that you know better which one of the two procedures you're following because it does make some difference particularly with regard to court review of those decisions.

CHAIRMAN GANNON: Pennsylvania has a statutory arbitration act that's been on the books for years. It's been well litigated and well defined.

My question would be, Would you have any problem if that statutory arbitration act is referenced in this legislation as opposed to that hybrid that now is included in the Bill?

MR. MULVIHILL: Frankly, I need to think about that a little more. I can't remember exactly the details of the statutory procedure.

CHAIRMAN GANNON: The arbitration statute that we have on the books has procedural guidelines and has all types of points for appointment of arbitrators, dismissal of arbitrators, the appeal process of the

arbitration.

It sets out from "a" to "z" the arbitration process, and it is a statutory arbitration. In fact, a case just came down with Erie insurance company that cannot be revoked. Take for instance here you do not want to arbitrate, the insured did. And the court came back and said they had no jurisdiction because the parties had agreed to a statutory arbitration scheme under the system of Pennsylvania statute.

So my question would be whether or not and of course you say --

MR. MULVIHILL: Yeah, I think I should say that I think one of the -- one of the concerns that we did have about this Bill was that the arbitration provisions are not very clearly defined. The procedures are somewhat vague.

For example, who can be an arbitrator. If the -- one of the parties said, you know, I want the clerk at the 7-11 down the street to be my arbitrator; is that okay? And maybe it is. Maybe that's what we want to do.

But I think it might be a good idea to maybe revisit those provisions and spell out in

some detail who it is that can be arbitrators and what procedures should be followed. I think you've raised a good point with regard to that.

CHAIRMAN GANNON: Concerning the collateral source disclosure, I think you said and my recollection is that, you know, either it was deducted or it was a credit offset for the collateral source or there was disclosure that there was some other collateral source available to a party.

MR. MULVIHILL: Yeah, I think that's the two ways of handling it.

CHAIRMAN GANNON: Would that include -- and I'm not trying to ask you a trick question -- would that include what I would call complete disclosure?

And the reason I say that is one of the arguments against collateral source, for example, let's say I'm receiving some kind of benefit that I paid a premium for, whether I broke my -- or I had an injury as a result of falling down the steps, my medical insurance would pay for my medical costs -- or my additional medical loss because of some tort risk that was done against me.

The point is that I pay premium for that coverage, that protection. The argument is that now the party who caused my injury is getting the benefit of something that I paid for. So the collateral source would be excluded.

Now take that one further extension, if you're going to have disclosure, then you're going to have complete disclosure. The complete disclosure being the fact that the plaintiff paid for this collateral source benefit that he's now getting.

And I think that would be up to the jury to decide or the court to decide whether or not they wanted to give any offset.

MR. MULVIHILL: As I read the Bill -- and maybe I'm not correct about this -- but as I read it, I thought that the collateral source provisions were limited to what would be characterized as public benefits not just --

CHAIRMAN GANNON: I think it talks in terms of --

MR. MULVIHILL: -- private.

CHAIRMAN GANNON -- two. You're right. There is a public collateral source and the

other one's nonpublic. They talked about group and employee/employer provided benefits. You have group benefits on page 7, and then the public benefits.

I'm not talking about public benefits because I think that would be another argument; but I'm concerned about the issue of the group benefits and if there's going to be disclosure that there would be complete disclosure that, in fact, these benefits were purchased irrespective of whether or not a person was injured as a result of a tort.

In this particular instance, the argument being that the tort-feasor is getting the benefit of something that the plaintiff purchased, not in anticipation of a tort but simply that they purchased to protect themselves and their assets and now that protection would run to the defendant.

And if you were going to have an off-set that there would be disclosure if that, in fact, was the case?

MR. MULVIHILL: Well, I think the way that is addressed in the Bill is by limiting the collateral source to public or group

benefits.

CHAIRMAN GANNON: That's what I'm talking about.

MR. MULVIHILL: Yeah. I understand that. And where I'm going with that is I think that since you're talking about benefits which by definition the plaintiff has not paid out of his or her own pocket, I'm not so sure that the disclosure that somebody paid for those makes a whole lot of sense.

I think that might make more sense if you were talking about trying to include in this private health insurance that the plaintiff has purchased out of his or her own pocket.

CHAIRMAN GANNON: I don't want to drag this out, but perhaps for purposes of discussion maybe it would be better to differentiate between a benefit and an entitlement.

Public benefit being an entitlement, so to speak; for example, Medicaid coverage, something like that. That's a different argument. I'm talking about a benefit as opposed to an entitlement. Anyway, thank you for presenting your testimony today and taking a little time from your day to be with us. Thank

you.

CHAIRMAN GANNON: Our next witness is Michael A. Donio, Director of Projects with the People's Medical Society. Mr. Donio, thank you and welcome.

MR. DONIO: Thank you, Mr. Chairman. Mr. Chairman and Members of the Committee, my name is Michael Donio. I'm the Director of Projects with the People's Medical Society.

We are a national health care consumer advocacy and information organization headquartered in Allentown, Pennsylvania. We've been around about thirteen years. And on behalf of our Pennsylvania members and our national members, I want to thank you for permitting me to testify here today on the reforms proposed in House Bill 2122.

I think the issues are of great importance to all medical consumers. We feel that once again the rights of the citizens of the Commonwealth of Pennsylvania are under assault by a group of professionals who believe themselves to be above the law and exempt from any personal liability.

The doctors represented by the

Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Society support this so-called tort reform measure that if enacted would only create more obstacles to justice and further discourage injured consumers from having their day in court.

Legislative bodies should not be about limiting a citizen's access to the courts but should be about protecting constitutionally-given rights.

The overall intent of House Bill 2122 is to place physicians above the law and give them a virtual exemption from liability. Why should we as the public and you who are elected to represent our interests allow one profession to be above the law?

Have we done it for plumbers, contractors, architects, or other professionals? I think not. So why do it for the medical profession which long ago lost its Marcus Welby image?

The spate of frivolous lawsuits so often raised is noting more than a smoke screen. If the truth be known, there are far more injured consumers who are unable to obtain the services

of an attorney than there are filing frivolous lawsuits.

I have personally spoken with older women who tell me they were injured by physicians yet are unable to find an attorney who is willing to take their case. They tell me because their lives aren't worth much once they reach 65 and even if the attorney could recover the damages, it would not be enough to make the case worthwhile.

And as bad as women are treated by the tort system, children are treated worse. The youngest and most vulnerable among us are having their legal rights infringed before they are old enough to understand what is happening.

In state after state, physicians and their lobbyists have attempted to convince lawmakers to reduce the Statute of Limitations making it more difficult for a child or his or her family to file a lawsuit for injuries that occurred at or shortly after birth but weren't discovered until later.

What do we say to these children and their families whose rights have been abrogated by a medical profession that is more interested

in protecting its financial interests than the health interests of patients?

Section 205-A, subsections (c), (d), and (e) are not in the best interests of minors or their parents. The so-called arbitration agreement found in Section 601-A through 606-A is nothing more than forcing the consumer to sign away his or her access to the courts, a right guaranteed by the Constitution.

Since when does the state have the right to suspend the American Constitution? How can the proponents of House Bill 2122 look us in the eye and tell us that consumers don't have the right to be fully informed on medical procedures?

Section 201-A goes against the very idea of an informed consumer making an informed decision. Informed consent is the very foundation of a positive and productive physician/consumer relationship.

Full disclosure should be commonplace and occur whenever a service or procedure is required. In fact, shortly after the founding of the People's Medical Society, our first major effort was to draft model legislation that would require full disclosure of all medical

information.

This includes hospital nosocomial infection rates, outcomes of surgical procedures by surgeons. The rate of c-sections, and so forth. I would like to note that much of the legislation that created the PA Health Care Cost Containment Council was derived from the People's Medical Society's model disclosure act.

Anything less than full disclosure to the patient borders on gross negligence. HB 2122 not only does nothing to advance the exchange of information between consumer and physician but actually permits physicians to determine to what extent they will provide the medical consumers with any information. This must not be permitted.

Two additional onerous items found in House Bill 2122 are Section 403-A, periodic payment of damages, and Section 203-A, the collateral source rule.

For some members of the medical community, it's not enough that the consumer has been injured by malpractice, they want to make the person endure more suffering by requiring periodic payments when a consumer is fortunate

enough to win a case.

As written, this reform applies to all personal injury cases. I would wager that a physician injured by a defective product would be the first to scream if his lawyer told him his award was reduced if he couldn't collect total damages because the Pennsylvania Legislature said he'd received enough compensation.

Can you imagine the scene where a surgeon who is driving along in his or her Mercedes is broadsided by a delivery truck and is left with hand injuries so severe that surgery is no longer possible? Even if the surgeon goes to court and wins, he or she can only collect periodic payments for injuries suffered and the loss of income.

And adding insult to injury, many physicians carry rather hefty disability insurance, the Collateral Source Rule found in House Bill 2122 would be invoked to reduce the award. I wonder if the physicians who marched in Harrisburg on May 7th thought of that potential development.

In conclusion, I offer the following:

The real issues are tort reform, liability insurance reform, and Medical Licensing Board Reform.

To lay the entire blame for this situation at the feet of so-called suit-happy medical consumer is wrong and totally misses the point. We are in reality facing a three-headed problem.

Reasonable people will entertain some adjustments to the tort system if they believe the system is honestly being abused, but it must be demonstrated beyond a reasonable doubt.

As a health care consumer organization, we certainly don't encourage lawsuits unless the situation presented is so egregious as to demand it.

We would prefer that the consumer experience a positive outcome and encounter no serious problems. Even if one allows for some lawsuits, we have very little proof that the system is being abused. This becomes even more apparent when you consider that for every twenty cases filed only one case ever gets to court.

The pricing policies of liability insurance companies must be examined. Is this

industry toying with physicians by creating too many risk pools where there are too few physicians to adequately spread the risk and responsibility thereby contributing to higher costs for liability insurance?

National statistics would tend to support the claim that liability insurance for all surgical specialties as a percentage of office expenses is no more costly than office space -- 5.4 percent versus 5.0 percent.

Many physicians in Pennsylvania are insured by their own bed pan mutual. Are they in actuality raising the rates on themselves? An investigation of the industry by a legislative body is the only fair way to resolve this situation.

If doctors are serious about reform, they should be demanding that their members who cause most malpractice be stripped of their licenses. Yet studies show virtually no bad doctors are turned in by their colleagues.

And finally, it's time that the Medical Licensing Board becomes more responsive to consumers and begins to properly discipline the profession. One method to achieve this goal is

to require that it be composed entirely of consumers. Not just one or two, but 100 percent consumer members.

Technical advisory panels composed of medical practitioners would be available to assist the consumer members. In addition, the board should be funded at a level sufficient to hire extra inspectors and investigators to track down leads and collect evidence needed to take action against a malpracticing physician.

A reasonable funding mechanism is for the board to collect a licensing fee of more than a few dollars. We believe a flat fee of $1,000 or a percentage of gross is a workable solution.

In summary then, as consumers, we are calling upon the legislators of Pennsylvania to support the rights of medical consumers and reject HB 2122 on the merits. The real malpractice crisis is malpractice itself, and HB 2122 does nothing to resolve it.

If, on the other hand, the intent is to make it more difficult for consumers to have their day in court and to seek justice, then I think that will be accomplished.

In conclusion, I just want to thank you for giving me this opportunity to present the consumers' side since we seem to be the folks who are squeezed in the middle between lawyers and doctors.

CHAIRMAN GANNON: Thank you, Mr. Donio. Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Let me just pose a question to you that you don't have to answer today because actually I would like you to think about it and maybe give us a written response.

But you acknowledge in your testimony that at least as you see it that there's a three-legged stool here and that at least one of the legs of the stool is tort reform and that reasonable people will entertain some adjustments.

And I think that particularly as a health care consumer advocacy organization I assume that you would agree with me that accessibility and affordability of quality health care is a primary concern for consumers and that consumers are individually bearing a larger percentage of the costs of their own

care whether it's through co-payment of employer-provided group insurance or their own or what their coverage doesn't pay.

In light of that, I would be interested in whether or not there are specific provisions in this proposal that are in that classification that you described that you think consumers -- adjustments that consumers could live with in light of the goal of wanting to have affordable quality health care.

So you don't need to comment now; but if you could send us a note or direct some sort of comments to that, I'd appreciate it.

MR. DONIO: Okay. Fine, I'll work -- we have some ideas on that of things that might expedite things and make it available so consumers will have access and we also improve the quality.

CHAIRMAN GANNON: Thank you, Representative Manderino. Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Mr. Donio, with regard to the question about whether physicians adequately police their own ranks, Mr. Chadwick --

Representative Chadwick related us to page 17 in his bill which offers immunity to both the malpractice insurer and any person who reports payments of judgments or, I guess, payments of judgments against that particular doctor cloaks them with immunity for that disclosure.

In your view I gather that doesn't go far enough, and I would tend to agree with that. But tell us why you don't think that goes far enough.

MR. DONIO: I think if we look at the Federal level going back to 1986, President Reagan signed Public Law 99660, the Health Care Quality Improvement Act.

And one of the provisions of that set up the National Practitioner Data Bank where incidents were to be reported by the licensing boards, by hospitals, by health maintenance organizations, and any health entity that hired physicians if there was a problem with physicians, nurses, you name it.

The other thing that was set up in 99660 was a provision for good faith peer review. If a physician saw a fellow physician who was having problems with something, they

could report them to the appropriate licensing board and action could be taken where there was an impaired physician.

Unfortunately, this Bill has been on the books since it was signed in 1986. And evidently it's not working very well because there are still problems with getting physicians who are causing the problem out of practice.

We had an incident in Ohio with Dr. James Burk (phonetic) who was doing surgery on women for a period of twenty years. His colleagues knew this was going on. He was basically doing surgery that he claimed was -- following child birth or something, he was going to, quote, fix them up. And actually he was causing some type of deformities.

His fellow physicians knew he was doing it. And it wasn't until women began discussing among themselves there's a problem here that the state said, We'll take some action.

And as it turned out, that's when they found out that his fellow physicians knew for twenty years. So obviously what we passed at the federal level and this still isn't strong enough. We feel we need more consumer

involvement.

REPRESENTATIVE HENNESSEY: One of the things that I would point out to you and the Committee is as I read Section 502-A on page 17, it only cloaks the reporter with immunity if he reports the payment of a malpractice award.

It doesn't seem to go so far as to extend immunity to a doctor who reports another doctor for malpractice for an event which in that doctor's -- in the reporting doctor's judgement amounts to malpractice unless it's somehow followed-up with an award.

So I think the immunity as granted probably tries to get to the problem you're talking about that I questioned earlier, but it doesn't, I mean, go near far enough to get to the source of the problem.

MR. DONIO: I think 99660 intended that as long as I'm a physician and you're a physician and I see you doing something wrong, if I report you because of what's going on, not for a financial gain.

If I would have done it because you're taking my patients, then obviously, I would be in the wrong. But for some reason, the

community -- the physician community has not inculcated the beliefs or else they don't trust the provisions of the good faith community.

And the peer review is just lacking, and that's why we feel there must be more consumer involvement. And as I tried to point out, we feel this is a three-pronged effort.

It's not just one-sided. We have to address it, and I think it's important to get all sides in a room to try to resolve this situation. We don't think the physicians who aren't causing the problem should be carrying all the burden for those who are.

By the same token, I get telephone calls every week. I get letters in my organization from people who have had problems, they see an attorney, and the attorney says, I think you have a case; but we can't do it in this community because, Hey, I play golf with the hospital administrator or I know the medical director or his daughter and my daughter are so and so.

There are so many barriers. And if we begin to erect more on the legal side, we just make it more difficult for people to just get

simple justice. I don't think we're asking for to hit the lottery.

I don't think -- I've not spoken to anyone who's ever filed a case who said, Yeah, I want to get rich so I can retire tomorrow. Most of the time I've spoken to people who say I want to take action not to benefit myself but to prevent someone else from experiencing this same problem.

REPRESENTATIVE HENNESSEY: I think you just touched on one issue that sort of raises its head in this area, and that is whether the immunity in and of itself is sufficient to address the problem because you can grant the doctor all kinds of immunity, but if the doctor still has to practice in the same hospital or in the same operating floor or whatever, you know, in the same theater with that other doctor -- it's not going to be, you know, I guess we can't expect doctors to be showing up in droves to testify against their friends and their social contacts.

MR. DONIO: Right. And this is a problem. And it wasn't just pointed out by consumer groups. It was pointed out by Otis

Bowen, who at one time was secretary of Health and Human Services, himself a physician and former governor who said at an AMA convention there's a conspiracy of silence. And we've got to break through that.

REPRESENTATIVE HENNESSEY: Thank you very much. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. And thank you, Mr. Donio, for being here today and sharing your testimony.

MR. DONIO: Thank you very much.

CHAIRMAN GANNON: Our next witness is Mr. James Redmond, Senior Vice President, Legislative Services, Hospital Association of Pennsylvania. Welcome, Mr. Redmond, and thank you for being here today.

MR. REDMOND: Good afternoon, Mr. Chairman and Members of the Committee. I don't get the opportunity to speak before this Committee very often, but one of the things I do know is that given the nature of the subject and the expertise of the members of this Committee, it is important that I have my expert with me.

And to my immediate left is Mr. Donald Tortorice, Esquire, who is with the law firm of Duane, Morris and Heckscher, which is the law firm that the Hospital Association of Pennsylvania has used for sometime. And Don and I've been involved in numerous attempts to do tort reform here in Pennsylvania.

First of all, I want to express our appreciation to Representative Chadwick for introducing this Bill. Like any system designed by our society, it is important that we periodically visit its purpose and whether or not it's achieving the benefits that we intended it to achieve in a cost-effective manner.

And we appreciate, Mr. Chairman, your efforts to examine this Bill and to examine our medical liabilities professional system here in Pennsylvania and just make sure that the purposes that we want as a society are being carried out in a cost effective manner.

And one of the things that Representative Manderino mentioned to the previous testifier, I think, is really the most crucial one. And that is there are lots of arguments that could be made about whether or

not certain tort reforms should be enacted or not enacted.

But if the primary concern is with respect to access to affordable health care then, we can no longer turn our heads and talk about not looking at the tort system with an effort in mind of making sure that we are controlling costs because those costs are borne ultimately by taxpayers and by the consumers of this Commonwealth.

And if there are ways in which we can improve upon the system to make sure that individuals have access to care in an affordable manner and that when there are mistakes that are made or outcomes that are unexpected that those individuals have the ability is to redress in the system and to do that in a cost-effective manner and in a timely manner. We should make every attempt to make suggestions on how we can improve upon the system.

The Bill in our mind has a couple of strengths and a couple of weaknesses. On the strength side, any way in which use of the collateral source rule can be applied, use of the periodic payments for future damages, making

sure that the experts are indeed qualified to give an opinion and to try at least on an experimental basis the option of the binding arbitration system we think makes a great deal of sense. And for us represents the key components of this Bill.

The two areas which we are concerned about with this Bill are first with the joint inseparable liability rule that there are cases where individuals are brought into a suit but only have limited, minimal liability. And we don't think that current rule which would assess the entire liability on that party is appropriate. So we suggest that that be considered and added into the this.

And the second is the 10 percent rollback on the insurance premiums. It's been mentioned to you before and I know members of this Committee are familiar with the problems of the Medical Liability Catastrophe Loss Fund.

And one of the principle concerns in that particular system is that the discounting of primary coverage rates is undermining the CAT Fund surcharges and if we put in a provision that calls for a further 10 percent rollback,

all we're going to do is squeeze one end of the balloon and it's going to bust at the other end with the CAT Fund. So we do not think that the 10 percent rollback on primary rates is a good idea.

Let me stop there. I know it's late and we're behind schedule. And Don and I would be happy to answer questions. I'm probably most of the questions to Don.

CHAIRMAN GANNON: Representative Manderino.

REPRESENTATIVE MANDERINO: I won't disappoint you, Mr. Chairman, in both asking questions and trying to be brief.

One of the points that bothers me and I think some other Members of the Committee with regard to the binding arbitration procedure is the when in the process you choose that option. Or another way of putting it, waive your right to a jury trial and concerns that people have about consumers not making that at an informed time.

My question goes to, I mean, if we change the proposal before us now so that you're not making that decision about whether or not to

go into binding arbitration until after the fact, until you seek attorney counsel because you think there might have been malpractice and you want to see you have your case, isn't there still, I mean, couldn't we do a -- maybe this is more a question -- and I apologize, I didn't hear your last name before --

MR. TORTORICE: It's Tortorice.

REPRESENTATIVE MANDERINO: I guess the point that I'm trying to say is it seems to me that the speedy resolution of an issue is not just a desire of the doc or the defendants but it's equally a desire of the plaintiff who when injured needs -- I mean, they don't want to hear when they walk into their attorney office that any potential recovery for their injury and their pain and suffering is five years down the line. I mean, that's just an egregious result for them.

Couldn't we build an arbitration procedure that could guarantee a result within a year and wouldn't that in and of itself be enough incentive for at least some significant percentage of plaintiffs to choose that as an option but choose it once they've walked into

the door and they know what it is they're dealing with and not when they've entered the doctor's office and aren't even anticipating a negligent action or something like that?

I guess I would appreciate some comment or insight on whether or not you think that would work.

MR. REDMOND: Just a quick response. I'll let Don add to it. I would agree with you that the best time to do that is when the consumer is making certain choices.

And for those of us that are employed, we make choices usually on a yearly basis for our employer to sign up with a particular managed care entity or to add a dependent or drop a dependent.

And it would seem to me that that would be the best time to make a similar decision much like what we have on the Motor Vehicle Responsibility Act that I saved some money through maybe a co-payment or a co-premium that I have to pay in return for knowing that I'm going to go through -- I agree to give up some of my rights through an arbitration system.

You've added some refinements, but I

would start -- the best time is when I make those kinds of decisions, not when I'm going to go see a doctor or after I have visited a doctor.

MR. TORTORICE: One thing you have to presuppose is that we're dealing with sentient adults who are making decisions all the time with respect to very profound effects upon their lives.

When you enter into an IRA account and put all of your life savings and with a brokerage firm, you typically are going to be asked to sign an arbitration agreement and it's binding then, you don't anticipate later on that they're going to be churning an account and doing something that's actionable.

If you build a house, the biggest investment you ever make in your life, you may easily be asked to sign an arbitration agreement. To ask someone to sign an agreement at the time of commencement of medical treatment is not really extraordinary.

In fact, there is a good argument I think that can be made to the extent that it is a time when you are most objective. You aren't

under the stress of either immediate medical treatment or the aftermath of medical treatment.

Arbitration is by and large a good thing. You have said it in a number of different occasions. You passed a statutory arbitration law.

I think it is not unfair to ask a patient at the commencement of a physician or hospital relationship to consider whether they want to use the conventional tort system or whether they want to use arbitration and make that binding.

If you think that it should be another time within 30 days after medical treatment, that is your decision. The most important thing is to have an arbitration option.

REPRESENTATIVE MANDERINO: I am wondering -- and maybe this calls for speculation, Jim, that you can't make -- but as our health systems are changing so much and as we're getting into more integrated health systems and things like that where the hospitals, the doctors, and everyone's kind of going to be in self-contained units it seems, I mean, isn't there some way in the context of

that happening in the health care system that we can achieve some sort of economy in this whole liability issue so that instead of there being the hospital and their liability carriers and the doctor and their liability carrier and the nurse and her liability carrier and pulling all these parties in for potentially the same negligent act and having all of these potential payers in the field, I mean, are we seeing the systems integrate that the liability carriers and coverages is integrating too?

MR. REDMOND: Yes. There are two things that can happen. First of all, you're talking about in terms of integration more and more hospitals and physicians are being covered either under their own self-insured plan or by the same carrier and being defended by the same defense firm.

In addition, under those kinds of arrangements, there's a lot more effective risk management activity going on to prevent claims from happening in the first place.

Also from what I understand that even when there are two separate companies, one company representing the physician and one

company representing the hospital, more and more they are getting involved in some sort of voluntary binding arbitration to determine the degree of liability that they're involved in.

So there's some integration even amongst the insurance companies when it's known that there is going to be a claim made. Now the question is, who pays?

REPRESENTATIVE MANDERINO: And my final area of questioning and I understood the point that you were making with regard to what effect or role that has vis-a-vis the primary insurance carrier and the implication potentially for the CAT Fund.

I don't know if your association has an opinion; but I am questioning whether or not it makes sense -- I mean, I'm not sure in this day and age whether a $200,000 limit on the liability to the primary insurer is a figure that still makes sense. And I don't know if your association has an opinion on that; but if so, I'd be interested in it.

MR. REDMOND: Yes, we do. Our view is that the CAT Fund was the right mechanism at that time, which was during a time of

availability problems back in the mid-70's and that it's no longer meeting our needs.

And what we'd like to see is that the private sector be used and that this arbitrary distinction between the $200,000 level and the $1.2 million mandated level be removed and that if hospitals and their affiliated physicians can self-insure or buy insurance in the marketplace, they should be allowed to opt out of the CAT Fund.

However, because of the way in which the CAT Fund is financed, which is on a pay-as-you-go basis, there is an unfunded liability that exists that is an obligation that we all share.

So even if we allow hospitals and their affiliated physicians to opt out of the CAT Fund. It does not relieve us of the responsibility to continue to pay off that unfunded liability that has grown over the past twenty years.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Manderino. Representative

Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Mr. Tortorice --

MR. TORTORICE: Yes, very well.

REPRESENTATIVE HENNESSEY: I'm going to see if I can ask you a question that follows-up on a statement made earlier by a witness, Mr. Hager, of the Insurance Federation.

The question he asked and answered in his testimony, is it reasonable to limit punitive damages to 200 percent of compensatory damages at the same time as standards for their imposition are stiffened? We think so.

I tend to look at that and I can foresee a situation where a doctor is, you know, operating under circumstances of stress, financial, whether it's emotional stress or divorce proceedings whatever it might be, doesn't do a whole lot of damage but is a real basket case in terms of his ability to properly conduct surgery. And maybe he's just lucky enough that he doesn't do any major damage.

If an award comes back at $40,000, under those kind of unusual circumstances, is there really a reasonable basis to limit

punitive damages to $80,000 or should we allow punitive damages to do what they're intended to do, which is to be set high enough by a jury that this kind of thing just doesn't happen again?

MR. TORTORICE: There are really a couple of different levels of answers that can be given. The first would start out by contending that punitive damages really have no place whatever in the civil law system.

If something is to be punishment, then it should be pursued under the criminal code. And if someone is to be punished, then the preponderance of the evidence should not be the level at which they are punished. It should be beyond a reasonable doubt. That's one answer.

Another answer is punitive damages in the area of medical malpractice are relatively infrequent. And the occurrence of one example of actions that would give rise to punitive damages are, I would venture, almost never instructive of someone as to something they should or should not do.

When we look at punitive damages being 200 percent of compensatory damages, we're really

looking at what we're going to charge a health care delivery system in order to compensate a victim of malpractice.

Now we begin with the prospect that compensatory damages have already been awarded. So the victim of the malpractice is already fully compensated for all of his or her economic damages and for all of his or her emotional suffering.

With that -- and the only thing we do beyond that is to punish. And setting a reasonable limit -- and 200 percent seems to be to my equitable judgment a sensible limit -- I would think it would be worthwhile, yes.

REPRESENTATIVE HENNESSEY: The problem I'm having is trying to figure out why -- and I don't want to necessarily target you with the testimony of a prior witness -- if a 10 percent rate rollback is arbitrary and a 5 percent rollback in the future, a 5 percent limit on increases is arbitrary, why is 200 percent reasonable in terms of, you know, looking at the other side -- the flip side of that coin?

I mean, it seems to me that that's equally arbitrary as a figure and in certain

circumstances won't have the desired effect because it won't be high enough based on the luck of the draw, so to speak, in terms of the outcome in terms of compensatory damages to have the desired effect of limiting that kind of conduct in the future.

Maybe an alternative that the Committee might want to consider is diverting some or all of the punitive damage award to society in general, the general fund or the --

MR. TORTORICE: That was an earlier reiteration of a bill that was considered by this Committee.

REPRESENTATIVE HENNESSEY: It seems to me that might be a better way to address the problem. It allows punitive damages to be set by a jury, the same jury that we trust to make the decision in the first place at a high enough figure that it would, you know, deter that kind of conduct.

On the way up here today, I was thinking of QB-7 where the jury awarded a penny to a, you know -- do you remember that? But the purpose was they were sending a message. And sometimes those punitive damages send a message.

MR. TORTORICE; Jerry Spence's argument to the jury where he says if you wanted to punish a paperboy you ask how much do you make in a week when you deliver papers? And the answer is $15, let's say. A $25 punition to the paperboy would be substantial. It would be a week's work.

And if you have a punitive damages case against General Motors, you might want to stop and say -- or how much does General Motors make in a week, you know. That makes a very effective appeal to a jury for numbers with lots and lots of zeros.

But when we're talking about punitive damages, what are the objectives; to prevent outrageous conduct. Now, do we prevent outrageous conduct in punishing someone in a perhaps published, probably unpublished event in Common Pleas Court in Allentown or Pittsburgh.

Or do we best say, all right, if you have outrageous conduct, we're going to have a rule that that must be reported to the disciplinary board and the disciplinary board then must look at the circumstances and make a decision as to whether you can continue in your

profession.

And by the way, not simply that circumstances, but the rules are going to apply to everybody. And I think that Representative Chadwick very artfully wove the mandatory requirements into the Bill very effectively.

And I think that you serve the objectives of a legislation in that methodology much more so than the ad hoc passage of money from defendant to plaintiff that really serves no purpose except to enrich in most cases the one-third cut of my brethren.

REPRESENTATIVE HENNESSEY: Let me just follow-up on that a second. The reporting requirements start on page 16 and cover page 17 and into page 18 of the proposal. And quite honestly, I'd like you to take a look at that and at a later time submit some language that you think might cover the problem that I see.

Because as I look at page 17, line 13, the only thing that's cloaked in immunity for personal immunity is a report given under Section 501 which I don't think deals with the disclosure of some sort of outrageous conduct or mal-- you know, some sort of event of

malpractice.

I think the only thing that's covered is the report of a judgment being paid. And if immunity is going to be our answer, and it may be or it may have some shortcomings as we talked with the previous witness about, even if you're immune, are you going to do it to the guy -- turn in the fellow you play golf with on Saturday or go to the country club to see or have dinner with.

But if immunity's going to be the only answer it obviously it seems to me that we've got to expand it so that it covers not just the report of the judgement because that's very mechanical and clerical in nature, but the report of a claimed malpractice by someone who's there and able to witness it while it's happening and has the courage to turn that person in.

So if you could look at that and give the Committee the benefit of some wording that you think might cover that, I'd appreciate it.

MR. TORTORICE: I'd be happy to do that.

REPRESENTATIVE HENNESSEY: And let me just ask Mr. Redmond one question, is the 10

percent reduction in the amount hospitals are paying a reduction from, say, a million to $900,000, is that significant enough to drive this entire effort? Or is it -- should we be looking for something that gives us considerably more rate relief than a 10 percent reduction?

As I said earlier, I don't know anybody that's going to throw accolades -- a surgeon that's paying 100,000 thousand bucks isn't going to think of us as wonderful people if we tell him he's only has to pay 90,000 bucks next year. He's going to save $10,000 of his money, but the 90,000 bucks is still a headache.

MR. REDMOND: That's a difficult question to answer. I think the system ought to be -- we ought to make sure that the system rewards good performance and that good hospitals and good physicians are not subsidizing bad hospitals and bad physicians or poor performing.

And so I don't think you can talk about across-the-board reductions. But if you're performing well in a certain area, the reductions should be in the 25, 30, 50 percent area. And maybe it's going to cost somebody else that much more. It ought to be based on

the performance.

MR. TORTORICE: There's an irony that we have to deal with at the present time. And that is that at least primary medical malpractice premiums are probably lower than they should be. And the reason for that --

REPRESENTATIVE HENNESSEY: Lower than they should be? We don't hear many complaints about that.

MR. TORTORICE: And I'll give you an anecdote. And that is that the Pennsylvania Joint Underwriter Association, which is the insurer of last resort, filed a rate adjustment filing within the past year which was revenue neutral that it increased some classifications of insureds and decreased others.

And the insurance commissioner pointed out that because of the underwriting loss of the JUA, it should probably be increased. The JUA then reported back to the commission that its rates essentially are driven by the private market, being private market rates plus 15 percent because they are a residual market.

And that has been the experience in Pennsylvania over the past five years. I mean,

competition in writing primary medical malpractice insurance has been withering.

The uniform testimony of John Reed, the director of the CAT Fund, has been -- the CAT Fund's current problems at least in part are driven by the fact that the percentages are higher to pay the unfunded liabilities because the base upon which the percentages are computed have been going down and they have been going down over the past five years.

And that's due essentially to, I think, competitive forces in the marketplace. A 10 percent rollback would be effective only if we can translate whatever is done in this Bill to a savings in insurance premiums.

I don't think that really has been done with any kind of precision. And one of the effects thankfully is that it's not something that will stay on the books forever because in the subsequent year if losses are such that the rollback is untenable, then rate increases would have to be filed.

So in the long run, we really aren't going to benefit or lose if the insurers driven by a competitive market file for competitive

rates.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

CHAIRMAN GANNON: Thank you, Representative Hennessey. Just one question with respect to the punitive damages. And I think there was in the testimony equating that the criminal type of a fine. As I understand it, the punitive damage is a civil fine for some misconduct over and above compensation.

However, in the criminal area, there is no -- generally no relationship between the confinement and the fine. You can fine folks that they get probation for some criminal offense but get a very substantial fine for that conduct or they receive lengthy prison sentences and very nominal fines.

So I don't see a rational -- on that basis, a rational relationship between the amount of compensation for in order to make the injured party whole and the amount of civil fine that would be imposed to as a punitive measure to punish the person for that misconduct.

MR. TORTORICE: I do not expect this Committee or the House to write out punitive

damages from the civil law. I think the attempt that Representative Chadwick made was to bring the prospect of unrestrained punitive damages within some element of restraint. That's the important thing to do.

If $80,000 isn't enough, then perhaps there could be an authorization of something that would be a lumping fine. Authorize it, you know, up to -- well, authorize $100,000 but not more than 200 or 300 percent of compensatory damages if such amount would be above $100,000.

The point is, do what you think is a good thing, is a fair thing but has some restraint attached to it. That's the point.

CHAIRMAN GANNON: Thank you, Mr. Tortorice. I'm sorry --

REPRESENTATIVE HENNESSEY: Just if I can follow-up on that, in the McDonald's coffee burning case, the one that seems to be driving so many people up here in terms of needing some restraints on that, if I remember, that was a 3 or $4 million verdict that was eventually reduced to $600,000 by the judge. So there is that safety valve already there where punitive damages if they're outrageous can be brought

back under control by the judge. I guess some people would argue that 600 or whatever the figure was, $600,000 is still too much.

But the fact of the matter is as I understood the case there were seven or eight different skin grafts that have taken place and there have been several hundred claims filed against McDonald's knowing that, and they continued to serve scalding hot coffee knowing this was a problem.

The people were being scalded, and it didn't make a difference to them. They seemed to be doing it as a result of the marketing department saying, hey, we may be scalding people, but we sure are selling a lot of piping hot coffee.

And it was that kind of thing that lead the jury -- I understand from my readings of the reports of the case, that was the kind of thing that drove the jury to set an unreasonably high sum for punitive damages.

The trouble is the news media reported that 3 or 4 or $5 million verdict. They don't report very well the reduction to a much more reasonable level.

MR. TORTORICE: Or the loss of psychic powers in Philadelphia, that case --

REPRESENTATIVE HENNESSEY: I just couldn't understand why that woman couldn't foresee she was going to lose that case.

MR. TORTORICE: She did and she didn't tell anybody, which may have been withholding evidence. But I don't think that was punitive damages. I think that was general compensatory damages.

You know, we have spent too much time on punitive damages. That is not a very big piece of fruit in this basket. Collateral sources and frivolous suits are much more important in terms of saving expenses, which really is the beast that's eating up so much of the cost of this personally.

REPRESENTATIVE HENNESSEY: Thanks.

CHAIRMAN GANNON: That's a good point. I think Representative Hennessey makes a good point too that a lot of what happens is driven by news reports.

And a jury comes back with a $5 million verdict and that makes the front page and of course that drives the process. However, we

don't get the later story where that's been reduced to a couple thousand dollars by a much more, you know, reasoned court or by appeal.

So, you know, there is a process that checks this to some extent; but I can understand what you're saying is to deal with that with some restraint.

And I do agree that there are a number of other issues that perhaps are far more important and have more impact in terms of numbers than, say, punitive damages, but it's a very inflammatory issue and it tends it drive the debate.

I think the important issue is on this arbitration. There seems to be a lot of usage, interusage of definitions that don't mean the same thing when we talk about statutory and common law arbitration and what the effects of those are.

Statutory arbitration doesn't take you out of the court system. I mean, you can ultimately end up back in the court system. So does that really expedite the process or just add another element in?

Common law arbitration on the other hand

would keep you out of the court system, but that tends to go in and out of disfavor depending upon whose ox is getting gored by the arbitrators.

So there's got to be some trade-offs here as to whether an arbitration system, some type of a hybrid that's put into this bill which can discern whether it is common law or statutory or whether we have a voluntary arbitration system that is a -- follows our existing statutory scheme which is, you know, try to test it. And it works very well in some instances. Whether or not it will work in malpractice, I don't know; but certainly it's something that I'm willing to look at.

MR. TORTORICE: I think that if you take punitive damages out of this Bill, the arbitration system out of this Bill, pass the rest of it, you will have done a good job. Pass the rest of it. That's the important phrase.

CHAIRMAN GANNON: Thank very much, Mr. Redmond and thank you very much Mr. Tortorice for being here today and sharing your testimony with the Committee.

We have one more witness who may or may

not be here. We passed over Mr. Michael Morrill, Pennsylvania Director of Citizen's Action, the Pennsylvania Chapter. Is he in the room? Is he here today?

I'm sure that he had wanted to testify and he's probably delayed for some reason, a good reason. So I'm going to ask staff if they would contact Mr. Morrill and ask if he would submit his written remarks to the Committee as part of record of these proceedings.

With that, this Committee hearing is closed; and I thank everybody for your attendance.

(At 1:43 p.m., the hearing was adjourned.)

C E R T I F I C A T E

I, Deirdre J. Meyer, Reporter, Notary Public, duly commissioned and qualified in and for the County of Lancaster, Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript of my stenotype notes taken by me and subsequently reduced to computer printout under my supervision, and that this copy is a correct record of the same.

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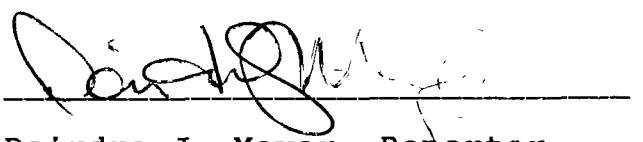

Deirdre J. Meyer, Reporter, Notary Public. My commission expires August 10, 1998.