HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bills 2300 and 2310

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House Judiciary Committee

Room 60, East Wing
Main Capitol Building
Harrisburg, Pennsylvania

Monday, March 4, 2002 - 1:15 p.m.

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BEFORE:

Honorable Thomas Gannon, Majority Chairperson
Honorable Patrick Browne
Honorable Brett Feese
Honorable William Gabig
Honorable Timothy Hennessey
Honorable James Roebuck
Honorable Don Walko

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C O N T E N T S

CHAIRPERSON GANNON: The House Judiciary Committee will come to order. Today's hearing is in connection with House Bill 2300 and 2310. We've asked John H. Reed, Director of the Medical Professional Liability Cat Fund, to appear again before the committee to follow up on some of the information and questions that were asked at the last meeting.

And we had asked Mr. Reed to give us some additional data with respect to some of the comments that he gave to us at the last meeting. I'm glad to see that the attendance at this meeting is a little better than it was at the last meeting. It shows a demonstrable increase in the interest in what the Judiciary Committee is doing with respect to this very important issue, and I'm glad to hear that.

With that, I would ask if Mr. Reed is available. Thank you, Mr. Reed. I believe our staff has briefed you on some of the follow-up information that we were looking for. So if you -- when you're ready, you can proceed.

MR. REED: I'm ready, Mr. Chairman. I'm glad to be able to come before the Judiciary Committee and provide you with whatever information you want on the questions that you relayed to me on Friday afternoon, at least to the best of our ability on relatively short

notice.

Certainly, we can give you statistics on the error rates of physicians, at least as far as paid claims by the Fund. And we have the data on the physician count. I want to briefly reiterate what I said at our last meeting when I was here in January, or February, last month.

The physician flight issue obviously is of concern prospectively because the commercial rates out there have mushroomed. There are some doctors now paying up to $360,000 for primary coverage. The Fund amount this year has gone down both in claim payment and in our operational expenses.

In fact, it's dropped 10 percent on operating expenses in the past 2, 3 years. The physician count, however, has been greatly overstated, or misunderstood I should say. We're tracking the numbers very carefully. We base it on people actually paying money to us.

We don't count people twice. When we give you a statewide count, it's extremely accurate. I mean, nobody gets counted twice. And I can tell you that at the end of 2000, there were more doctors practicing in Pennsylvania than ever before. The count for 2001 is not yet complete because a lot of renewals are not until the end of the year.

As I stated to you, we are still in the

process of getting information, frankly getting the money on November and December renewals. And even when we do get that, it's still not always complete because a lot of carriers are late in giving us the information and late in getting us the payments.

Just Friday, after I got your notice to appear here, I was informed by my staff that one of the carriers sent in a remittance. That's a document listing doctors that should be insured through the Fund and giving us payments. And there were doctors that were reporting to us for the first time going back as far as 1998, 4 years ago, 1999 and 2000.

So that is why there is some vagaries in that. The Fund statistics are accurate, but sometimes the carriers are late in reporting to us. And as I said, we're still counting for 2001. However, as it stands now, even with November and December to still be tabulated, we now know that we have received surcharge on behalf of 34,669 physicians in the year 2001.

We have every expectation that when the total is done, the 2001 total will equal the number for 2000. I know that for a number of reasons, just based on the statistics but also based on what some of the carriers are telling us of what were going to come, what is yet to come in.

As I said, I don't mean to detract from those who are worried about what might happen in the future because a lot has happened since January. The rate structure in the state has changed drastically. But with that, I'll be able to answer your questions.

If you want to break out by specialty, I've handed you some papers that give you the regional counts not only by the overall specialty but by the subcategories. And as you'll see, the major numbers that are reported, for example, in orthopedic surgery are those who do major surgery.

And those numbers have not drastically gone down since 1997. I think in 2000, we counted 1,046. Whereas in 1997, we had 1,078. That's a statewide total. We can break it out for you by region as well. And I don't have that here for you today, but we'll get it reprinted and distributed to the committee.

I do have it for you by region, but I also have it broken out by each and every county in the state. And similarly, we have that for obstetrics and neurosurgery. And we've also taken the additional step of counting general practice and family practice doctors who have obstetrical delivery privileges. And I believe that should be in your packet as well.

In addition -- well, while we're at it, I'll

just summarize some of the statewide numbers. As I said, the neurosurgery, the figure for 2000 was 226, where it had been 233 in 1997. I would note that for 2001, our as yet not completed total shows 224 neurosurgeons. And as I said, there's one in there for obstetrics, too. And I don't see it right in front of me at the moment.

You also indicated you had some interest in issues involving physicians with multiple claims. And there is a couple of sheets in there giving you some statistics. We measured it from 1976 when the Fund was created to the end of 19 -- excuse me -- to the end of 2000.

And that chart shows you that during that period of time, there were 55,000-plus physicians insured by the Fund at one time or another; that 41,000 physician claims had been reported to the Fund; that more than 18,000 physicians had been subject to those claims; however, that only 5,107 of those physicians had a claim paid by the Fund but that 1,074 physicians had multiple claims paid by the Fund.

And the short of it is if you look at the common breakout, that 2 percent of the physicians are responsible for 41 percent of the money that the Cat Fund paid out on behalf of physicians during that period of time. And we made a slightly, well, a similar type of data

extract. We did it from '97 through 2001, and we also did it for '96 through 2001.

And you can see the number of physicians during those period of times -- and there's overlap obviously -- that we made 1 claim on, that we paid 2, 3, and on up. And you'll notice that in the 6-year history, there was, during that period of time, there was somebody who had had 10 claims paid on his behalf.

Going back to the earlier data, the one from '96 -- excuse me -- '76 to 2000, there was a physician that we paid on 17 times, there were 3 physicians that we paid on between 10 and 16 times, 2 physicians that we paid on 9 times, 6 that we paid on 8 times, 11 that we paid on 7 times, 18 that we paid on 6 times, 35 that we paid on 5 times, 75 that we paid on 4 times, and 231 that we paid on 3 times, and 692 that we had paid on 2 times.

And as I said, I already referenced to you the significant hit that has on our total payout. I have -- you know, I'm able to answer any other questions you might have about that.

CHAIRPERSON GANNON: Let me ask the committee if they have any questions.

REPRESENTATIVE GABIG: Thank you, Mr. Chairman. I wanted to cover a couple of areas, if I could. And the Chairman can cut me off if I'm taking too long or

if someone else wants to jump in. When you talk about medical errors, that term medical errors, what kind of term is that? Is that a legal term, insurance term? What are we talking about, medical errors?

MR. REED: Well, it depends on who's using it and how they define it.

REPRESENTATIVE GABIG: Well, you used it.

MR. REED: Well, when I'm talking about medical errors, I'm talking about malpractice, legal negligence. These are cases where we paid money because somebody's either been found responsible by a jury and a judge, an appeal's been denied, or the case has been settled on their behalf with their consent.

REPRESENTATIVE GABIG: Okay. So what we're talking about is a payment of a claim because of a jury verdict or a settlement prior to a jury verdict?

MR. REED: That's correct.

REPRESENTATIVE GABIG: And obviously, the ones that have jury verdicts, negligence has been found; is that correct? Obviously.

MR. REED: That's correct.

REPRESENTATIVE GABIG: Can you -- is there a breakdown between the ones that have a jury verdict and the ones that were settled pretrial?

MR. REED: No, not in these statistics. And

I'm not sure that we could readily do that. We keep records of trials at the office, but it's not incorporated in this. There's really only a few number of cases that we pay each year that is a result of jury verdicts.

The vast majority of the claims that we pay are a result of settlements that are made with the permission, the consent of the health care provider.

REPRESENTATIVE GABIG: Okay. And that's typical in litigation. I understand it. I mean, very few of them actually get to trial and have a jury verdict. Most of them are settled. Ninety-plus percent are settled, I guess. Is that --

MR. REED: I don't recall the exact percentage. But it's the substantial number of malpractice payments are made as a result of settlements.

REPRESENTATIVE GABIG: Now, when you have a settlement, a claim settlement, does it necessarily mean that anyone was negligent? Or does anyone admit negligence with the settlement, or do people oftentimes deny negligence but just want to settle the matter because they don't want to litigate it for 10 years or 5 years?

MR. REED: Well, that issue comes up frequently. It's undoubtedly true that there have been cases settled in the past where negligence has been denied. And normally, the paperwork is issued for release that says

that there's no liability.

But I can say that our agency as a matter of practice -- this is sometimes where we get into a battle with the health care providers themselves or with the hospitals -- we generally resist mightily any effort to settle a claim unless there's some underlying basis for liability.

But sometimes, yes, accommodations are made to the health care provider.

REPRESENTATIVE GABIG: One question. Some are settled after verdict. We talk about some being settled, or most of them being settled, the vast majority being settled prior to verdict. Some, of course, in the course of litigation are settled after a verdict.

MR. REED: That's correct, yes.

REPRESENTATIVE GABIG: As awaiting appeal, et cetera, the parties will settle; is that right?

MR. REED: That's true. That's particularly true with most of the cases you read about with the very large verdicts. They usually get settled.

REPRESENTATIVE GABIG: All right. So the term medical error is a bigger term than negligence or malpractice. That's basically settlement of a claim. And the negligence case is that, where a fact finder, a jury or a judge would actually find negligence; is that right?

MR. REED: That's generally true. You have to realize now, the statistics that we're working with are only on the more serious claims, the ones that are reported to our agency in the first instance.

REPRESENTATIVE GABIG: All right. The 2 percent and the 40 percent, or actually 41 percent according to the one document that you provided to us and referred to and I've heard, as I've been paying attention to this debate, it was mentioned on the floor and in various other forums during the debate.

What I was interested in is in the profile. And I know that's a rough word in today's world. But the profile of these doctors, these 2 percent, are there any characteristics or profiles that jump out with that 2 percent? For example, people often say it's the high risk areas of medicine that are having most of the claims, the OB/GYNs and the high surgery risk areas. Is that true or not true?

MR. REED: That's not necessarily true any longer. We pay out a great deal of money on behalf of general and family practitioners. And I forget the exact statistics now, but it's quite considerable. It probably --

REPRESENTATIVE GABIG: So of the -- let me put it to you this way: Of that 2 percent, that's a certain

number of people obviously, or doctors.

MR. REED: Right.

REPRESENTATIVE GABIG: Could you give us an idea of the ratios? Are you saying there's a lot of family practitioners? Would that be half or --

MR. REED: We have -- Representative, we have a wide variety of types of physicians that are in the mix. And we do have files with individual data on how much, for example, orthopedics cost us vis-a-vis what they have in the way of what they pay us. And same thing is true of obstetrics.

I know I had a file done on family practice. I can't tell you offhand whether that particular 2 percent, as far as volume of claims and dollars, how it weights with one group or the other. I can tell you that obviously some of the high risk specialties are heavily represented because when they do have a mistake, there are certain types of professions that if you make a mistake, there's a tremendous injury involved. Usually obstetrics and neurosurgery come immediately to mind.

On the other hand, one group that has high insurance costs, orthopedic surgeons, don't proportionately cost us as much because unless they're doing spinal work, a lot of their claims do not devastate the mind or require 24-hour-a-day custodial care for the patient.

REPRESENTATIVE GABIG: So if I understand then, you're saying that group, that 2 percent group, is fairly representative of the practice of medicine generally. Is that, is that true?

MR. REED: Yes.

REPRESENTATIVE GABIG: It would basically equate with what the general population of physicians is out there. The 2 percent falls fairly --

MR. REED: It's widely spread out. There is some weighting, I'm sure, to some of the high risk specialties naturally. How it breaks out today, I can't give you a statistic.

REPRESENTATIVE GABIG: How about geographically? There's another concern that a lot of these -- so in terms of the practice, it seems to be fairly -- some people say that in Philadelphia, in the southeast, that there's a lot higher payouts versus, say, where I come from in Cumberland County, the payouts aren't as high. Is that true? Do you find that true or not to be true?

MR. REED: There is a tremendous differential based on geography. There are counties where, first of all, you don't have much in the way of physicians. But there are counties where you do have some physicians where we still don't have much of a history of having to make

payouts on their behalf.

Philadelphia has a great percentage of the physicians of the state. And I forget what the exact total is. However, we do have a fairly high degree of payout down in the southeastern end of Pennsylvania relative to everyone else and also relative to their overall numbers.

As a result of which, we -- and I'm assuming most of the primary carriers -- charge physicians in western and central Pennsylvania a lot lower premium because they're a lower risk.

REPRESENTATIVE GABIG: So these 2 percent, not only Philadelphia but you have the surrounding counties which often, through venue, might be, you know, Montgomery County and Chester, Delaware, the I guess 5-county area. Of that 2 percent accounting for 40 percent of the payout, can you give us an idea how many come from that, say, 5-county region in the southeast?

MR. REED: I can't, I can't today give you an honest extract of that because it would be, frankly, just guessing.

REPRESENTATIVE GABIG: But clearly, from your previous answer, it's a much larger proportion. I mean, there is a profile that fits there that is coming from the southeast.

MR. REED: Yes. But it's also the practice

type, the institutions. I mean, we see marked differences in claim records from one institution to the next, or the type of institution. I mean, we have some facilities in the state, most of the larger ones frankly, but some of them cost us 3 and 4 times what they paid us in premium over the years. So they have horrible loss records.

We have other places, you know, I'd give them a gold star. We don't get much from them.

REPRESENTATIVE GABIG: All right. One other area I want to cover briefly while I have the chance is I guess you went over the one chart that shows the number of physicians since, over the past decade. And it showed '90 to 2000. And you gave us some, some preliminary numbers, I guess you'd call them, for 2001.

But one thing that sort of jumps out at me -- and I'm not a mathematician or statistician -- but it seems like in the last 5 years, it's been a much slower growth. We're at 34,000 in 1995, and we haven't broken 34,000 in 2000. In 1990, we had 30,000. It went up to 34 in 5 years.

So it was a faster growth in the first half of the decade; and it's a much, much slower growth in the second half of 1990. I guess that's certainly consistent with your numbers; is that right?

MR. REED: Yes.

REPRESENTATIVE GABIG: And do you have -- can you give us an explanation or a reason why we're seeing that kind of slowdown in the growth of physicians here in Pennsylvania?

MR. REED: Well, I think we've seen a slowdown across the country in the growth of the medical profession, for one thing. We had meteoric growth going through the '80s and into the early '90s. And it seems to have crested. Population of Pennsylvania has stagnated.

Obviously, there's higher expenses associated with practicing medicine, too. I mean, all of these are factors.

REPRESENTATIVE GABIG: It's filled up. We don't need anymore doctors somebody said.

MR. REED: I'm not saying that.

REPRESENTATIVE GABIG: But you think it's because of the stagnant economy -- not the economy. We'll go to a different committee for that one -- but the stagnant population. Although, in my area, there's a big growth in terms of the population of elderly people in Central Pennsylvania.

And a lot of them need a lot more medical attention per person than the general population, younger population. So I'm not sure just because we've sort of leveled off -- I think that's a statewide phenomenon, too,

that there's a growth in the elderly population here in Pennsylvania.

And I know they require a lot of medical care. So I guess I would have to take a look at --

MR. REED: Representative, some of the big facilities obviously have, you know, for economic reasons -- I mean, I'm not sure that -- obviously, the Fund is not involved in all the economics of the health care industry; but we watch it.

There are certain counties that had large growth in the number of doctors, and I would imagine those are the counties that are growing rapidly. But also, I see a lot of the health care systems are trying to see more patients with fewer physicians.

I mean, you see layoffs at some of these facilities. The economics of the business being they're trying to meet their needs with fewer people when they can.

REPRESENTATIVE GABIG: The -- I have a bill here that's, that's what I would call a loser pays bill that I -- the intent of it is designed to encourage settlement quicker from both sides. If you have a frivolous claim or if you have a frivolous defense or a merit, a low merit or a meritless claim or defense, I think it would encourage both sides to come to a quicker agreement and not escalate the litigation costs. Do you

have any thoughts on that?

MR. REED: Well, obviously, anything that makes both sides come to the table and talk reasonably I would be for. The one problem I have, having worked in this field for a while now, is that I know that you would, frankly, close the door for a number of the poor people to ever bring a lawsuit because they couldn't take on that risk.

There's no way they could come up with the money of financing a case. There's a lot of expense to bringing these lawsuits. There's a fair amount of expense obviously in defending them, too. So we need to strike some sort of balance.

The problem is, is that in both sides, they're not equally situated. I mean, I run an insurance operation. I can afford to defend cases on behalf of health care providers, and I can take a tough stance where necessary. And defense costs are the least of my expenses. On the other hand, some individual, they don't have that luxury.

REPRESENTATIVE GABIG: You think it would -- if a poor person was able to recover their attorneys' fees rather than giving a third or more away in a contingency fee, they would actually recover that from the defense if they were legitimate claims.

It seems to me it would actually give them a better footing and they would have a better --

MR. REED: I don't know exactly what it is you're proposing. But under that scenario, it would improve the situation obviously. You know, I haven't closely studied that issue. You know, my perspective is obviously defending claims and keeping the costs down.

REPRESENTATIVE GABIG: Thank you, sir. I appreciate it. And thank you, Mr. Chairman, as your cell phone goes off.

CHAIRPERSON GANNON: That wasn't my phone. Representative Feese.

REPRESENTATIVE FEESE: No questions.

CHAIRPERSON GANNON: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman. Good afternoon, John. John, taking a look at this particular chart, the Fund Covered. It's titled Fund Covered. But you have some of the subspecialties. And I noticed that in terms of the eastern region of the state -- I'll wait until you get the chart.

MR. REED: All right.

REPRESENTATIVE HENNESSEY: In 1997, we had, in terms of the category midwives, we had 98 midwives. We're down to 82, which is a drop of roughly 15 percent. In the OB/GYN category, we go from 1,147 in 1997 to 966, which I

think is about 15 percent.

For general practitioners, who actually do deliveries, we drop from 202 in the east to 40, which is a drop of I think just in excess of 80 percent. On the other hand, in the orthopedic - no surgery category, the second block on the right hand, we go from 10 to 45 in the east, which is an increase of about 350 percent in terms of orthopods who are saying they don't want to get involved in any kind of surgery at all.

And then at the bottom category, orthopedic surgeons, we drop about 7 percent in the east. All these, all of these numbers stop in the year 2000. I understand you have -- that's as far as your data is complete --

MR. REED: Uh-huh.

REPRESENTATIVE HENNESSEY: -- as far as today's presentation. Do you have any sense as to whether these trends, what I would think to be a trend at least in the eastern part of the state, do you have any sense that that's continuing or has been arrested in 2001 and the early part of 2002?

MR. REED: If I recall correctly -- and I'll have to go back to the data -- my belief is that on neurosurgery, that we don't see anymore drop. I think we may see some more on the OB/GYN in 2001. But it seemed like if there is one, it's very slight.

In the orthopedic, let me see if I have the preliminary numbers here with me. Well, clearly, we have dropped in the OBs in the east. We'll have to wait and see what the final number shows. As I said, we were showing --

REPRESENTATIVE HENNESSEY: I'm sorry. Are these your preliminary figures for 2001?

MR. REED: Yes, uh-huh. For 2001, I have -- it looks like in the east, we've lost about 100 of the obstetricians. So as I said, I expect that total to come up; but I don't know that it's going to come up to 966. So we're waiting to see.

REPRESENTATIVE HENNESSEY: What about OB/GYNs who are not doing delivery, divorced themselves from childbirth but do do, you know, care for the mother and the baby after birth?

MR. REED: I'm looking here for -- there's so many permutations of that. We have about 10 or 11 or 12 different subclassifications here to look at. And it's hard to make an extract of that. I haven't seen, at least initially on this, that much of a change in that regard. What I see is if I, is perhaps just outright retirements.

REPRESENTATIVE HENNESSEY: What you see are outright retirements?

MR. REED: That's what it seemed to be, at least looking at the Philadelphia and the southeastern

region reports here.

REPRESENTATIVE HENNESSEY: Well, that's certainly been one of the concerns that's been voiced to us in the southeast, that some doctors are prematurely retiring just because they can't afford the insurance costs.

MR. REED: Or going elsewhere, yes. And as we've indicated in prior testimony, where we do have a problem, it's in the southeast.

REPRESENTATIVE HENNESSEY: What are the permutations that you just referenced? You said there were 8 or 10 or 12 different permutations.

MR. REED: Well, I mean, we have gynecology - no surgery. We have gynecology - minor surgery. We have obstetrics - minor surgery. We've gynecology - major surgery. Then there's a straight specialty of gynecology.

I'm looking here in Bucks County. For whatever reason, that seems to be growing. Obstetrics/gynecology - no obstetric delivery, obstetrics/gynecology - assist major surgery, then there's obstetrics, there's obstetrics - major surgery, and there's obstetrics/gynecology - major surgery.

And there's been some crossover because each year, you may redefine the thing. So in other words, we're

counting them a different way because they have a different title now. But we've tried to group them by functional actions. And obviously, where we do see the drop-off, when we do see a drop-off, in most counties it's been relatively slight.

The big difference being in Philadelphia. And that's been in the obstetrics/gynecology - major surgery, which is all-encompassing.

REPRESENTATIVE HENNESSEY: Do you have any figures from Chester County?

MR. REED: Sure. Chester County here, obstetrics/gynecology - major surgery, we had 32 in 2000. And I have so far, in 2001, 28 in that, the most serious category. Looking at the other categories, frankly, I don't see any pickup yet in any of those other subcategories.

Most of the ones in your county are the ones with the full obstetric privileges. However, from the records I'm looking at, back in 1997, there were more general obstetricians in Chester County than there are today because it looks like the number was 39.

REPRESENTATIVE HENNESSEY: General obstetricians being someone who has full --

MR. REED: Full range privileges, doing the most serious type deliveries and cesarean sections and

things of that sort.

REPRESENTATIVE HENNESSEY: Can you provide that detailed breakdown to us?

MR. REED: Yes. We plan to. We were going to give it to you later today. I just wanted to stress the 2001 numbers are premature. I mean they're early. They're not the final totals because obviously, as I said earlier at the outset, we're still counting.

REPRESENTATIVE HENNESSEY: I don't notice a tremendous drop-off in terms of the neurosurgery category in the east. We're down from 115 in '97 to 109 in 2000. But I'm -- I think that even as we sit here today, the Pottstown Hospital doesn't have a neurosurgeon on staff. I believe Brandywine Hospital in Chester County might only have one on staff.

There seems to be, at least in the areas of the state that, in the southeast that I'm familiar with, a marked exitus of neurosurgeons in the last couple of months. So, you know, as soon as you can get us updated information on that, it might be very helpful to us.

MR. REED: Sure. I'm trying to look at the eastern region here for neurosurgery. Clearly, you had 6 in '97. You had 5 in '98, 6 in '99, 7 in 2000. And so far for 2001, I've only counted 3. So there might be a switch there. On the other hand, Lehigh County's increased.

They've got 11 now, where they only had 7 five years ago.

REPRESENTATIVE HENNESSEY: They're in the central district?

MR. REED: The counties that we, for organizational purposes, have in our eastern region totals are Bucks, Chester, Delaware, Lehigh, Montgomery, Northampton, and Philadelphia.

REPRESENTATIVE HENNESSEY: Okay. So Lehigh County would be in the southeastern section?

MR. REED: Yes.

REPRESENTATIVE HENNESSEY: I've heard, you know, anecdotally that, of orthopods moving from Pottstown in Montgomery County 3 miles or 4 miles up the road to get into Berks County so they can get into I guess the central region.

MR. REED: Berks County would be in the central region.

REPRESENTATIVE HENNESSEY: And markedly lower insurance premiums by moving their practice a couple of miles up the road.

MR. REED: Yeah. We saw even that with some other adjacent counties. Like Schuylkill County doctors wanted to go into Berks County or into Lancaster County because it's in a lower rated territory than Schuylkill County. And I have seen movement, for whatever reason,

between Northampton and Lehigh. I don't recall offhand if there's any premium differences between those 2 locations.

REPRESENTATIVE HENNESSEY: Just one other question, if I could. The '96 to 2001, 6-year history chart you have --

MR. REED: On the claims frequency? Yes, sir.

REPRESENTATIVE HENNESSEY: Yes -- you indicated the percentage of the total payout from your Fund is 28.6 percent on behalf of physicians with multiple claims. And yet the other chart in the red ink here indicates 2 percent of the physicians are accounting for 41 percent of the payout.

Is there any kind of correlation between those numbers? I mean, I haven't found it yet. And I'm not so sure I know what I'm --

MR. REED: Well, they're the same type of report. But obviously, the other 2 documents are for a much shorter time frame. If you expand the time frame, you're going to increase the number of people with multiple claims. They're going to have a chance to accrue more claims.

So your fellow that gets multiple lawsuits that have viability and end up being paid on racks more of them up. And I believe that's why the lifetime Fund figure shows a higher percentage than does the snapshot taken over

a 5- or 6-year period.

REPRESENTATIVE HENNESSEY: So this, the chart with the red ink, the frequency of claims '76 to 2000, essentially covers your experience for the lifetime of the Cat Fund?

MR. REED: From 1976 to 2000, that's correct. We haven't updated it. We haven't done it from '76 to date but --

REPRESENTATIVE HENNESSEY: One other question on a slightly different subject. And if you don't want to get off the current topic of percentages or numbers of physicians, I can come back to this later. But in private conversation, you and I have talked about the problem that your attorneys face on staff when they have a case drop in their laps right on the brink of litigation.

And, you know, can you let the committee know about what kind of a problem, as a practical matter, that creates? And we've also talked about the possibility of, you know, creating some sort of a deadline for when the attorneys for the private insurers would have to turn it over well in advance of litigation so that we don't, so we might avoid that problem.

MR. REED: The late or nonreporting of claims is a tremendous problem for the Fund. There is no incentive out there for the carrier to handle it with any

view towards protecting the Fund's interests. Ultimately, as long as they report it, we're on the hook.

And sometimes things don't get done by them that should be done, or we get it too late in the course of litigation to reach the most effective settlement. And one case that I got --

REPRESENTATIVE HENNESSEY: I'm sorry. Actually, you know, in terms of litigation, you get it before it ever gets to court. But I gather you get it just before it gets to court. So all the pretrial stuff has taken a long, long time.

MR. REED: Sure.

REPRESENTATIVE HENNESSEY: And if I understood the complaint before, you might have a case that's clearly going to be worth $800,000 and the private market, the attorneys for the private insurer might hold onto that until the eve of trial and then dump it in your lap figuring that they're going to have to pay the $500,000 and then they're out of it.

But in the meantime, it leaves you with trying to get the case pulled together and get everything ready for a trial that might start on Tuesday or the following month.

MR. REED: Representative Hennessey, let me give you 2 examples that I think illustrate the problem.

We don't always get the claim before it even goes to trial. Sometimes it doesn't get reported to us until afterwards. And then we might fight with them about whether we're prejudiced or not.

And we have a case now that could have settled for $70,000. It was a wrongful death claim. They basically conceded liability. They fought the issue saying that the woman who died's life wasn't worth $70,000. It hit for a million and a half dollars in front of a jury.

We're on the hook for that. We're fighting with them saying, you know, you prejudiced us. You should pay that, not us. I have a case that was given to me just last week. I think I got it on Thursday from my staff. One of the big health systems reported a case on a Friday, Fed-Exed materials to us on a Monday, and had tender letters into our hands on Tuesday.

And thereafter, shortly thereafter, we find that we can't defend this case. Why? They and their counsel didn't even file an answer to the complaint timely. So they're barred from answering a defense. And then we find that they didn't file the appeal on time. So they're barred from appealing it.

So there we are. And one of these defendants is truly defensible. And they're coming to us, and they want $2 million for us to settle it to protect their

interest. Clearly, if this case had been monitored correctly, had we known about it, had a defense been put out there for the physician, the physician, at the very least, in that particular case should not be liable. And the Fund should not have to pay money on his behalf.

REPRESENTATIVE HENNESSEY: How do we counteract that? We had talked about the possibility of setting a deadline, you know, just in private conversation and trying to scout for ideas here. But, you know, is there a practical solution that says that, you know, if the private insurer doesn't turn over a case, you know, with at least maybe a 2-month window before trial, that we simply not let them out of the case or force them to defend or, you know, come up with a --

MR. REED: It can be done a number of different ways. But obviously, it should be reported to the Fund at some point sufficiently in time for it to be evaluated and defensive measures to be taken if it's appropriate.

It probably would be good for the statistical interests of the entire health care industry if all claims are at least preliminarily reported to some governmental body. One of the problems you face today is you don't have any statistical base out there about how many med mal lawsuits there are, how serious they are, what's happening

with most of them.

The information that's given to us in the insurance department is extremely cursory on most claims. But at the very least, potentially serious claims should be reported to us early because some of these cases can be defended. Some of them there is liability.

And they need to be settled. And they need to be settled in a time that protects the interests of the insured, that's fair to the plaintiffs, and keeps the overall costs down so the Cat Fund surcharge isn't any higher than it needs to be.

REPRESENTATIVE HENNESSEY: Well, is there a workable solution here? I mean, is there a deadline that we can create?

MR. REED: I think so. Sure. I think, I think within a matter of a few months after the filing of a complaint, a carrier should have had enough time to evaluate a case to know whether it should be reported to the Fund or not.

One of the classic things that has cost this agency tens of millions of dollars over the years are the -- PIC was notorious for it, a carrier, one of the bankrupt carriers -- they would report and tender a case. And they would send it in by fax.

We used to call them the midnight fax. It

would come in at midnight, and the jury trial started in the morning. You can't do much in claims handling with a reporting system like that. Or if they report it to you after the discovery deadline is already closed.

You know, there's things that might be done or should be done if somebody with an interest in the Fund's layer takes a look at it. And that's what we're trying to do at our agency. We're not looking to make work for people. We're not looking to be bureaucratic, and we're certainly not. We have one of the most efficient claims operations in the country.

But there are things there that need to be done. And since it's not their interest to look after it, they sometimes don't do it. And if we don't know about it, we can't do it.

REPRESENTATIVE HENNESSEY: How do we enforce any kind of a reporting requirement?

MR. REED: I think that if they miss the reporting requirement, if they're going to work through primary carriers, they ought to be responsible for the whole amount if they miss the deadline. That would get them to report it.

REPRESENTATIVE HENNESSEY: Is there any statutory -- I mean, is there any contractual ability to hold the insurance company responsible for, say, a 600-,

$700,000 verdict if their insurance contract is limited to 500,000?

MR. REED: If you -- well, the statute now says that if they don't report the claim to us and we're prejudiced, then they can be held liable for the whole amount. The problem with that is, is that it leaves it very vague.

REPRESENTATIVE HENNESSEY: As to how you're prejudiced?

MR. REED: You have to argue about the issue of prejudice. And then the other problem is it doesn't deal with the situation where they do tell you about the case but they tell you at the 11th hour, 59th minute. And under that circumstance, we have no remedy.

REPRESENTATIVE HENNESSEY: Perhaps you can get us the citations for that. And we can take a look at that and see whether or not there's a way that we can create some deadlines that actually define prejudice as not receiving the case in a timely manner before it was reaching, it reaches the trial stage.

MR. REED: Certainly.

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

CHAIRPERSON GANNON: Representative Roebuck?

REPRESENTATIVE ROEBUCK: No questions.

CHAIRPERSON GANNON: Representative Browne.

REPRESENTATIVE BROWNE: Thank you, Mr. Chairman. Thank you, Mr. Reed, for your assistance today. Just a, I guess, follow-up on Representative Hennessey's, some of his statistical questions. And I apologize if this might be repetitive of what you had mentioned.

Can you describe the difference between Fund eligible and Fund covered? Is there a difference?

MR. REED: Well, if I recall the statutory language, a Fund eligible physician is ultimately the physician who's going to be Fund covered. You know, the difference being, of course, the Fund eligible physician has paid a surcharge or a premium to the Fund.

REPRESENTATIVE BROWNE: Okay. Is the Fund eligible the same as the total number of practicing physicians in the Commonwealth, or is that a lot higher number?

MR. REED: No. The total number of practicing number of physicians is higher. Physicians who practice less than 50 percent of the time in the state -- and I think there's about 1,400 or 1,500 of those -- are not Fund eligible. Physicians who work for various governmental entities, United States, the Commonwealth, City of Philadelphia, are not eligible.

REPRESENTATIVE BROWNE: Okay. So the

number -- the difference between the 34,904 and the total practicing less than 50 percent is about 1,500, 1,600 you said?

MR. REED: Well, it's about 1,500 doctors, I believe, that are on the border areas that basically -- we have about, I think, 1,400, 1,500 doctors who are either in New Jersey, Maryland, Ohio and are practicing in Pennsylvania but claim that they're less than 50 percent of the time.

So that expands the number of our physicians. We also have -- and I forget the exact total. I thought I gave that at the last hearing -- several hundred, you know, that work for these different other governmental bodies. The federal government has some clinics.

The Commonwealth employs physicians in certain capacities, various municipalities that have physicians.

REPRESENTATIVE BROWNE: Has that, to your information at this point -- and you can provide this later -- has that number of physicians who practice less than 50 percent been in the same trend line as the total number? Has it grown significantly over the last 5 years or --

MR. REED: I'm trying to remember now. I don't think it's been a marked increase, but there has been an increase in the last several years. And I'd have to go

back to my office and get the statistics on that. We watch it pretty carefully because -- in fact, we have a new pretty detailed form that we ask them to sign and notarize or at least to fill out an affidavit to.

If they claim they're exempt to the Fund, we don't just take it at face value. We want to know their license number in another state. We want to know who's insuring them in another state. We want to know where they practice, what hospitals they're affiliated with.

If they're working for some exempt agency like a Federal Tort Claims Act-covered institution, we want to know the details about that. We want to know who they're paying premium to, what their visit counts are so that we have a basis for checking on it or auditing the unit if that's the case because some questions have been raised about whether people are honestly exempting themselves from the Fund.

And we started sending out letters with these forms. And at least I know in one instance and probably several others we didn't get the forms back. We got premiums submitted to us.

REPRESENTATIVE BROWNE: And that 50 percent, that's based on total hours spent in each state or total reimbursements for the practice --

MR. REED: It's based on their reported

physician visits. For example -- and I know I've had some conversations with some physicians about this because there have been a number of fellows that were thinking about going to New Jersey until they found out that New Jersey rates were going up also.

But at any rate, there are surgeons here in Pennsylvania. Well, I think under the formula, it isn't going to help them that much. If they're Pennsylvania patients and they're visiting them here, I don't care if you go across the river to operate on them, you're still an orthopedic surgeon in Pennsylvania.

It's based on visit count. If you see 100 patients a week in New Jersey and you only see 20 or 30 patients in Pennsylvania, obviously you're not required to pay the Fund surcharge.

REPRESENTATIVE BROWNE: And just one last question, I guess, along the same lines. And you probably don't have this information available right now. The concerns that Representative Hennessey had regarding the drop in total number of orthopedic surgeons in the east and the west, I guess as well as central, is it possible that they, that drop is physicians who have gone from over 50 to under 50 percent in the last 4 years? Is that a possibility?

MR. REED: Well, certainly. Some of that has

in fact happened. You know, what the details are, it's hard to say. I also know that we have a number of physicians that have gone into nonoperative status. Some of these fellows are in their 60's, and they've just chosen to do that.

REPRESENTATIVE BROWNE: So that could be part of it?

MR. REED: Sure.

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

CHAIRPERSON GANNON: Thank you. With respect to the companies that went bankrupt, PHICO, which I guess is in bankruptcy yet, PIC and PIE and Reliance, where they've had cases go into the, where the Fund had to pay some of those liabilities, how is that, how is that payment distributed? Is that added into the surcharge that all physicians would pay?

MR. REED: When it has an extra effect on us, yes. Certainly.

CHAIRPERSON GANNON: Have you seen -- for example, with the PIC and PIE situation, did that have an adverse effect on the Fund?

MR. REED: It clearly did. They were a major writer to begin with. They had a significant -- PIC certainly had a significant portion of surgical

specialists, particularly in the southeast. And they were our number one source of claim payments. And they were before they were bankrupt, too.

And as I said earlier in my testimony, I had some issues with the way they handled claims. But in '99 and 2000, which I think were our peak years with them, the effect of the Guaranty Fund Law had an impact on us. Yes, carriers are paying their assessments to the Guaranty Fund to help bail these, the costs of these bankrupt carriers.

But there's been an impact on the Fund, too, which hasn't gotten discussed. And I think our staff has estimated it at different times. But during those peak years, you know, I think it was costing us approximately $30 million a year extra. And this is why: The Guaranty Fund only covers $300,000 regardless of how many defendants are covered by the bankrupt carrier in a given case.

The Guaranty Fund is able to take what they call a setoff for any other insurance benefits paid. And they took a very expansive reading of that early on. They narrowed it somewhat since then. But in a lot of medical malpractice cases, the medical bills would be paid by Blue Cross or Aetna, US Health Care, somebody of that sort.

It would wipe out the Guaranty Fund obligation to pay money to the claimant. I would get cases in some instances with 4 and 5 and sometimes maybe even more PIC

defendants and maybe later some PIE ones in the same case.

The most I'm going to get from the Guaranty Fund to contribute towards that is $300,000. And they're oftentimes not going to pay me anything. We get what we refer to in the industry as a dry tender. That means they pay us nothing. Here it is. Settle it.

Well, the law says the Cat Fund doesn't drop down. That means we don't automatically pick up. If it goes to a verdict, that 300,000 is going to be taken off the sheet; and then we'll pay the amount of money beyond that. But the problem is, is that some of these cases, if they're egregious enough, you can't afford, for the sake of your health care providers, to let them go to a verdict.

And it's very difficult to tell a claimant that he's going to get nothing to settle his case. So that forces us to pay extra amounts of money than we would in those types of cases.

We also have a situation where the Guaranty Fund is not obligated to defend the health care provider if they tender the case -- and that could be a dry tender, as I've just stated -- more than 30 days prior to trial. So if they're providing a dry tender, all of a sudden we may have to still keep fighting this case for a lot of reasons, not the least of which to get some leverage to try to negotiate a fair settlement on it.

So we've had to pick up some extra defense costs as a result of that. That and some issues where when PIGA first became involved with this, before they got their sea legs, there were some verdicts that we ended up having to pay that I don't think we should ever have had to pay. And there were some mistakes made.

In any event, it has had a cost to us. Now, PIC and PIE are winding down. They've been bankrupt for a while. I can't tell you what it's cost us in the last year or so. It's come down. But my staff, I've asked them to look at it a number of times. They've estimated that during those peak years, that did bump up our surcharge.

One of the things where it also hurt is that since they're only obligated for a certain amount of money, which they don't have to pay cash to satisfy in many instances, we may have cases where we're working on behalf of other defendants and trying to work them out but these other fellows have liability, too.

But you don't get them because we could fight with them all day. What's the sense of fighting with them to get an acknowledgment of liability and some contribution? They're not going to make a contribution. So the net effect has been, has been a burden on the Cat Fund ever since these companies started going bankrupt.

PHICO will be a particular problem. It's not

as big as PIC in the number of doctors but because it has hospitals, too. And the pressure on us is usually from the health care providers to triage risk, you know, and to pay money.

And the fact that somebody legally doesn't have to pay money doesn't solve their, their problem. And it has been a burden to the property and casualty industry because they've had to pay this 2 percent payment to PIGA. But I think it's been lost in the debate.

There's been a tremendous impact on the Fund -- although, it's hard to exactly quantify -- over the last several years as a result of these insolvencies.

CHAIRPERSON GANNON: If a company comes into Pennsylvania and starts heavily discounting its premiums to the point that it's underpricing based on the product, particularly with medical malpractice insurance or professional liability insurance, what effect, if anything, does that have on the Fund?

MR. REED: Well, prior to the change in the law at the end of 1996, it had a devastating impact on the Fund in that it forced our surcharge percentages to keep going up. We were higher percentages every year and collecting the same or less money.

It wasn't the Fund wasn't charging any more. It just had to assess a bigger percentage to get to the

same point. You changed the law at the end of '96. However, discounting, obviously if it leads to further insolvencies, is a problem to the Fund. Insolvent carriers are not good for the Fund.

CHAIRPERSON GANNON: With respect to that, what exactly was the change in the law in 1996 that protected the Fund from these, from being, from, where carriers heavily discounted?

MR. REED: Well, it protected the Fund surcharge by putting the Fund surcharge on an independent base. It was linked into the Joint Underwriting Association schedule of rates for doctors and for hospitals. It didn't correct the rest of the problem.

CHAIRPERSON GANNON: Without, without some reforms someplace else, if we eliminated that and went back to -- I guess it would be experience rating is what we're talking about. Without some other reforms in place on the insurance side, would the Fund be exposed to the same type of situation if in fact we repealed that JUA underwriting standard?

MR. REED: Well, the Fund -- I mean, the JUA was used as a mechanism because you wanted to divorce it from what was actually taking place in the marketplace. And there's nothing to say that it has to stay with the JUA. You could base it on some other type of schedule.

And clearly, underwriting could be introduced into it. I've long advocated some experience underwriting at the Fund level. Clearly, you can see that what people pay us isn't necessarily proportionate to what they cost us. I told you that the largest academic health systems, with the exception of maybe one, cost us more than they pay us.

There are obviously certain physicians -- and we've talked about that at length here -- that cost us more than they pay us. Experience rating done fairly is a good incentive to promote safe health care, and it's fair to the other ratepayers.

And that can be done by a number of mechanisms without necessarily subjecting us to the, some of the stuff that goes on out there in the marketplace. And obviously, the damage that we're suffering from today occurred under a different watch. I mean, it was back in the mid-'90s.

The discounting had a lot of impact. It had an impact on the carriers themselves. They were taking on higher limits of coverage, and they weren't charging any more for it for a fair amount of time. The problem that a lot of doctors faced was the fact that the doctors who were the lowest risks were getting the highest premiums many times, even back then.

The insurance companies nationally were

interested in selling insurance to large groups, big institutions. The bigger the group, the better. I think I'm pretty safe in saying that the collective experience of insurers around the country has been that large groups are generally the poorer risks.

Now you see hospitals -- some of these companies have had their ratings downgraded, like MIIX, which has gotten into financial trouble. They're dropping their institutional business. They're retreating to their core business of physicians.

Those discounts that were passed out in the mid-'90s were a lot of times done for marketing reasons. And some doctors in independent practices didn't get the same benefit.

CHAIRPERSON GANNON: Getting back to that, to the underwriting, are you suggesting that there be an underwriting standard divorced from the amount of premium paid for the primary coverage with respect to the Fund?

MR. REED: Well, I'm saying yes in that that way, you know, the physician or hospital's experience at the Fund level should be taken into consideration when it's determined how much they pay the Fund.

CHAIRPERSON GANNON: So that would be a separation of the current system where it's based on a calculation on the premium paid for the primary coverage?

MR. REED: Well, now it's not based on that. In other words, it's based on the payment to the JUA schedule. And one of the problems with it is we found is that the primary premiums in theory measure something different than what the Fund level is.

In other words, a lot of that information that went on into making the rates for the JUA and some of the other groups is based on the experience at the bottom level. And that doesn't always correlate well with what the experience of that provider is going to be at the upper level.

The classic example of that problem being podiatrists. Podiatrists have a frequency or a severity issue down in that lower threshold of money, but it very rarely translates into losses up at the Fund. So if you base the Fund surcharge on what they're paying for basic coverage, it basically ends up overcharging podiatrists.

There is a mechanism that could be devised that would work very fairly. You could have a community rating scheme for these different groups so that each group each year is reassessed. And their charges go up or go down, depending on what their global experience is.

Podiatrists would go down; nursing homes would go down. Some other groups might go up. We have some experience rating for hospitals at this point, but it's

limited to plus or minus 20 percent. And as a result of that, it's a fairly narrow band. And it's not allowed to take into consideration whether hospitals as a whole are carrying their weight.

Plus being a narrow band, you can't very well reward the hospitals with long records of no claims because you can't get enough offsetting from the fewer number of hospitals who have high claims.

CHAIRPERSON GANNON: What, if any -- let me preface this. Most of the complaints that I'm getting in my local office as opposed to the Harrisburg wing or the Harrisburg arm of the medical society, the complaints I'm getting from the doctors that are seeing patients mostly comes from the high end specialists, orthopedic surgeons, OB/GYN, neurosurgeons.

With a plan that would use some type of experience rating at the plan level, at the Cat Fund level with respect to the payouts from the Fund, would there be any impact on those high end specialists' contribution overall to the, to the plan? Maybe I'm not making myself clear.

MR. REED: Well, it would have an impact. How much? It's hard to quantify. I don't think it would be enough to be of much assistance to them. It would reallocate within the group how much they pay. In other

words, doctors with a better record would pay less; doctors with a worse record would pay more.

But it wouldn't address their core problem that they have today.

CHAIRPERSON GANNON: Well, that's getting to, I mean, speaking from my perspective, the physicians that have been contacting me. And I have doctors saying they've never had a paid claim and they're seeing dramatic increases --

MR. REED: And they are.

CHAIRPERSON GANNON: -- in their premiums. Would that, would that affect that particular type of physician?

MR. REED: Well, I think you're talking about, you were talking about something in law that would affect the Fund surcharge. And we can make the Fund surcharge fair. But you need to understand that what the Fund charges today, first of all, it's less than what it was a year ago.

It is one half or less of what they're paying to their primary carrier. So you can retool the Fund all you want. You're not solving their problem. Their problem today is what they have to pay for that first $500,000 of insurance.

CHAIRPERSON GANNON: Okay. How do

self-insurers -- how do you calculate the Fund surcharge for a self-insured? How is that done?

MR. REED: They're assessed on the same JUA schedule as everyone else. But self-insureds are, they became out of favor for a while when the carriers were pricing very favorably. But they've come back into favor again with some of the big hospitals because they're the only affordable alternative for them.

I mean, the self-insurance type vehicles are much less expensive for those institutions than is commercial insurance.

CHAIRPERSON GANNON: What's the general claim time line? In other words, I know you told us that you, frequently you get an overnight fax that says, you know, start writing checks. But from the time that an incident occurs that ultimately leads to a payout, do you know generally what that time frame is?

MR. REED: Well, in the past, as I think I said last month, it used to be up to 8 years in Pennsylvania, maybe even longer in some counties. With the court backlog reduction programs, it's much shorter. In Philadelphia, I can tell you that it's less than 2 years from the date that a complaint is filed or a legal action is initiated.

In our instance, we get, we get 4,800 new

claims a year that we process. And, you know, they're not gathering dust there. We close them out or deal with them. Sometimes they're only in our hands for a very, very short period of time.

At any given moment, we probably only have 100 claims where we've gotten permission or consent from somebody to try to settle the case. So it's not like there's a big backlog on our watch waiting to move cases. But obviously, each year, we close out as many as we get in.

So if I'm getting 4,700, 4,800 new claims in each year, we're closing out pretty close to that same number every year. So there's a tremendous turnover.

CHAIRPERSON GANNON: I believe, if I'm not mistaken, doesn't current law require the primary carrier to report a claim to the Fund within a certain time period?

MR. REED: It requires us to report -- it requires them to report a claim to the Fund when they reasonably believe it exceeds their primary limits; but it doesn't say when they have to do that.

CHAIRPERSON GANNON: Once a claim is reported where a carrier believes it would exceed its primary limits, what action can the, what action can the Fund take under current law to protect its interest, if anything?

MR. REED: Well, once we know that a claim

exists, obviously we develop a file on it pretty quickly. Somebody is assigned to get copies of all the underlying documents. If they've gotten to the point of extra reports, we want to see that. We obviously want to see the pleadings and find out about the discovery, talk to the attorneys involved.

When we're allowed to, we like to talk to the health care provider himself. Sometimes we'll hire other experts to try to work a different end of the case that may have been missed by the primary carrier. We will -- we have the right and we do occasionally, we'll hire counsel to come in and protect our interest if we don't think that's being adequately defended.

And obviously, one of the things that does take place is some of the carriers that are reporting cases to us, if they do it promptly enough -- and I think they have to do it within 180 days -- you know, they may try to make them eligible for 605 coverage, which is where we pick up the entire responsibility for the claim or we take over the cost of defense, where if there's a verdict, we pay from dollar one.

CHAIRPERSON GANNON: With respect to the -- you said there are several physicians in Pennsylvania who have multiple claims. Those multiple claim experiences, are they just a series of small claims?

Or are those multiple claims generally very large claims from your --

MR. REED: Well, it's like anything else. There's a lot of different varieties of it. I mean, the fellow with the 17 claims -- I think it was some years ago -- it was a number of mid-sized claims. But we've had them overall, I mean, for different amounts.

I think the average payout that we've made on behalf of a physician with multiple claims is higher than it is for a physician with just one claim. And that might be in part because the things that led to him having multiple claims makes him less presentable perhaps in court and makes it more difficult to get the case resolved for a lower figure.

CHAIRPERSON GANNON: Would it be fair to say that there could be a physician with multiple claims where the payments have been less than the primary limits and you wouldn't --

MR. REED: Oh, absolutely. The only cases I'm reporting on were the cases where the Fund has made a payment on behalf of this physician. And as I said, we get 4,700, 4,800 cases a year. We close 85 percent or more of those without any money being paid by us.

I mean, that's -- our claim examiner's primary job is to try to keep the cost of this whole program down.

And we try to close cases. If they have to be paid, we'd rather have somebody else pay it. And that wouldn't be in these statistics.

REPRESENTATIVE HENNESSEY: Did you say 85 percent?

MR. REED: Eighty-five percent of the claims that are reported to us we succeed in closing without payment.

REPRESENTATIVE HENNESSEY: Thank you.

MR. REED: One of the things I would like to take a chance to talk about is -- because we get a lot of false information out there -- doctors need to know that the Fund doesn't settle a case over their objection. If they want to go to trial, we'll take it to trial for them.

The other thing they need to know is that we don't just rubber-stamp payments. I have people -- in fact, people called me on Saturday and Sunday night this week for a case down in Philadelphia trying to resolve it. And it was a fight the whole way. They didn't get what they wanted. Ultimately, it settled for a lot less than what they told me that was the absolute bottom line that they had to have.

We get cases tendered to us sometimes. You know, the carrier says, We've got problems with this case. We're willing to pay our limit. Go do something with it.

Well, 2 things happen. Sometimes if we can get that done for us secretly, we sometimes succeed in getting the case settled for something less than their full amount of money as long as the plaintiff doesn't know that they've tendered to us. If we work cooperatively with a carrier, sometimes we can come up with arguments and defenses that help out.

The other thing that we do, sometimes cases are tendered to us by hospitals or doctors. And we win them. People get acquitted. So the Fund is not something that just marshals out payment. And I think a lot of people have taken some pop shots at the Fund without knowing the facts.

And frankly, we get blamed for a lot of things that we're not responsible for. I know doctors oftentimes think the Fund did this or that. Well, how do they know that? Because the insurance company told them or their defense counsel told them.

Well, if they only knew what was really going on, they'd find out that that's not the way it happened at all. But we don't have the same opportunity as they do to tell the doctor that information. And we certainly don't have, you know, a publicity department or advertising ads in the various trade publications.

So there is a great deal of misinformation out there by the Fund. And it's out there because, frankly, a

lot of people have deliberately put it out there.

CHAIRPERSON GANNON: If a carrier tenders a case to you, do you then have to take over the defense; or is the carrier still continuing to defend?

MR. REED: If they're not a bankrupt carrier, they're legally obligated to continue on with the defense.

CHAIRPERSON GANNON: And who directs that defense, the carrier or you, since they've tendered to you?

MR. REED: Well, we try to work in cooperation with them. They still direct the defense. Wherever possible, we try to work in concert. You know, ultimately, the carriers -- the attorney answers to the carrier, not to us. We usually have to work through the carrier to get things accomplished.

CHAIRPERSON GANNON: Is there -- any cost of defense that you expend, is that included in the surcharge that you would --

MR. REED: Yes.

CHAIRPERSON GANNON: -- that you charge back?

MR. REED: Uh-huh. And as I said earlier at the outset of the testimony, let me just give you an idea what those numbers are, what we pay for defense counsel. In '99, it was 14.2 million. We decreased that to 13.9 million in 2000. And we dropped it to 13.2 million this past year.

As I stated earlier, our overall operating expenses we reduced by 10 percent over the last several years.

CHAIRPERSON GANNON: Maybe you can help me here. When I worked in the insurance industry, when we paid cost of defense, that was not charged back to the policy holder as a surcharge. Does the same thing work with respect to professional liability insurance?

MR. REED: I believe under Pennsylvania -- in most instances in Pennsylvania, you're correct. In other words, they have -- the money that's there on the policy is for indemnity payments, and defense costs are in addition to that. Clearly, that's true at the Fund.

CHAIRPERSON GANNON: I mean, I've received a lot of complaints from physicians about the cost of defending all these lawsuits. But arguably, that wouldn't go into that particular physician's rate. It could go into the base rate but not --

MR. REED: It goes into the base rate. Carriers might look at it in making ratings for physicians. I can tell you looking overall at the industry statistics, obviously defense costs are a concern. But I noticed that they went down in 2000 as opposed to what they were in 1999 for the industry as a whole. And it's relatively a small portion of the overall equation.

CHAIRPERSON GANNON: What is the average premium paid by a general practitioner in Pennsylvania, do you know?

MR. REED: I did know. Let me see if I have the, my own little hand drawn notes. I know I did the average surcharge for Pennsylvania physicians, not just general practitioners. The average surcharge this year is about $7,100. And 5, 6 years ago, it was about 6,800 or $6,900. So it hasn't changed that much.

Obviously, it varies by territory. So it's hard for me. You say family practitioner. I mean, a family practitioner -- I don't have my rate schedule with me. But I think here in Central Pennsylvania, they pay the Fund about 3,000 and something. And I think they pay $7,700 in Philadelphia and then whatever they pay their primary carrier.

Now, it may vary by specialty. But I found that in most instances this year, the rates we're looking at this year, what we're charging -- the Fund that is -- is one half or less what the primary carriers are asking these guys to pay.

CHAIRPERSON GANNON: So if you're requesting 7,000, 14 would be what the --

MR. REED: A Philadelphia family practitioner, yeah, because last year it was about one to one. In other

words, what we charge was roughly about what they charge. And it was probably in the 14, 15 range. It was under. it was under 8 here in Central Pennsylvania.

CHAIRPERSON GANNON: So somewhere between 8 to 15 would be a fair --

MR. REED: Uh-huh.

CHAIRPERSON GANNON: Just approximation --

MR. REED: Sure.

CHAIRPERSON GANNON: -- as opposed to --

MR. REED: It may have come up a little bit this year. I don't know that the family practitioners have been subjected to the same inflation that some of the specialists have. There may be some people in Philadelphia paying in the 17 range now total.

CHAIRPERSON GANNON: I'm not including the surcharge in that. I'm just saying 8 to 15 for the primary --

MR. REED: Oh, yes.

CHAIRPERSON GANNON: -- for the GPs.

MR. REED: Sure. And last year, it was a lot lower than that.

CHAIRPERSON GANNON: And there's some neurosurgeons or high end paying up to 360,000?

MR. REED: I've run into a few, yes. We had to try to help some of them out, look for assistance

wherever we can, yeah. I've seen commercial carriers charge, give quotes to groups of doctors, like orthopedic surgeons, $100,000 each.

I've seen some other commercial carriers, ones in Philadelphia, charge a good deal more than that. And obviously, some of the quotes are as you would expect. People getting from the JUA are very, very high. But it's not just confined to Philadelphia. I've run into a couple of surgeons elsewhere in the state that have had some real problems with their primary premiums.

And we have some hospitals now having a real problem. I know a little hospital, shall we just say, up in the Central Susquehanna area. I mean, their premiums tripled overnight. And we've never paid a claim on them in our existence. So I don't know what somebody else has paid on their behalf.

CHAIRPERSON GANNON: Have you ever had an instance that you know of where you have a situation where a physician might have an office, a very small office in Philadelphia, major practice in New Jersey, say in Camden -- I'm just being hypothetical here -- but because the number of patients that he sees in Philadelphia is so small, that he's exempt from the Cat Fund surcharge but his practice is primarily focused in Jersey but the lawsuit is filed in Pennsylvania because personal service can be made

on him there and the case is resolved in Pennsylvania?

Would the Cat Fund be liable for a surcharge? What would happen in a situation like that?

MR. REED: No. If they're not covered by us, we're not liable. But we do get physicians like that in lawsuits that we're defending. You know, they have insurance with a commercial carrier in another state. And they are required to cover themselves for the base amount in Pennsylvania under our present law. They're required to get a commercial policy for that first 500,000.

CHAIRPERSON GANNON: The reason I asked that question, one of our members had suggested that we prorate that surcharge. In other words, they could practice part time in Pennsylvania, part time someplace else, and pay a prorated surcharge.

MR. REED: That's something that could be considered, sure.

CHAIRPERSON GANNON: Of course, the Fund would be liable for any payment.

MR. REED: Right. Not looking for new obligations.

CHAIRPERSON GANNON: Let me just make something clear here. You mentioned -- and I don't know if you stated it -- but with respect to those companies that have gone belly up and now the PIGA or the Guaranty Fund

has to make a payment of up to $300,000 but their obligation is offset by any other insurance.

So if a health insurance company had been paying medical expenses, that that would reduce the amount of that, that would be subtracted from that 300,000?

MR. REED: That's correct.

CHAIRPERSON GANNON: What about any other liability carrier that would make a payment on behalf of a defendant with that?

MR. REED: No, that's not the current law.

CHAIRPERSON GANNON: It's only direct insurance?

MR. REED: It's only -- it applies only to PIGA, the collateral, that setoff rule that they have.

CHAIRPERSON GANNON: Well, that's what I'm saying. Would PIGA be entitled to a setoff for payments by another liability carrier or only direct insurance payments?

MR. REED: I think it refers to payments made by other insurance. So I haven't really given it a great deal of research. I don't want to mislead you. But that's possible because I'm not sure how other insurance is officially defined.

I know there's been litigation. And I think it's been established that life insurance doesn't apply.

But what other kinds of insurance might apply I don't know.

CHAIRPERSON GANNON: What about Social Security Disability or --

MR. REED: I don't think they get a credit for public payments. I don't know. The one we normally run into are the, as you can imagine, the patient's health care insurance, you know. In other words, whoever they insure their health with obviously pays these medical bills; and PIGA gets a credit for that.

CHAIRPERSON GANNON: That's all I have at this time. Mike, did you have a question?

MR. SCHWOYER: With regard to the -- you talked about 2 percent of the physicians causing 41 percent of the harm. Representative -- Minority Chairman Blaum last week talked about, the last time we were here, talked about that and inquired as to what information was available to the public.

And I believe you said none of that, none of the Fund's information is available to the public?

MR. REED: It's available to public agencies. I mean, it goes over to the Bureau of Professional and Occupational Affairs every time we make a payment. But it's not available to the general public. Our files are, by statute, confidential.

MR. SCHWOYER: Right. But you do maintain

physician reports or physician files. So you can go back and look over the history of a physician and claims filed, claims paid, claims active, et cetera?

MR. REED: Yes, of the ones that we've been notified about.

CHAIRPERSON GANNON: You had talked a little bit about the, being notified very late. And one of the members talked about the fact that possibly that person, or that company would be liable for the entire claim where the Fund had been prejudiced.

Would it be fair to say that where the Fund has been prejudiced by late notice or late tender, that you can go back against that carrier to seek indemnity?

MR. REED: Even if we're prejudiced, if they report it to us before the verdict is returned, we don't have any clear recourse under the current statute. In other words, when they talk about late, that's failure to report resulting in prejudice.

If they report, as I said, even if it's at the last minute, they've satisfied the law. At least that's the argument.

CHAIRPERSON GANNON: Well, as a general rule, I know when I worked in the insurance industry, you know, late notice was late notice. It just had to show that we were prejudiced in our handling of the case. That's not

the situation with you?

MR. REED: It's not clear that it is. And there's a number of lawsuits under way right now where we're arguing one thing or the other about that. Obviously, we put out reservation of rights letters when we sometimes confront these situations.

But as I said, you know, we've had some mixed degree of success in the courts with protecting ourselves under those circumstances.

CHAIRPERSON GANNON: When you have a case reported to you, let's suppose it's reported timely and you see some exposure there but that case may not be resolved for a couple of years, can your agency set aside a sum of money that it would expect to pay in the year that the case is reported? In other words, can you set up some type of reserve?

MR. REED: We don't have a reserve at this point or a legal requirement for reserves. We have had -- in the past, we've had some buffer amount because we're allowed to charge a certain amount above our normal surcharge. We've done that sometimes in the form of just having cash on deposit or through reinsurance.

It's probably a very good idea. We just were never set up for it in the past.

CHAIRPERSON GANNON: If you were able to do

that under existing -- if the law were changed to permit you to do that, would that tend to distribute the losses more evenly over the years as opposed to having situations where, you know, you might have a lump of cases?

MR. REED: Yes, it would help.

CHAIRPERSON GANNON: Representative Hennessey.

REPRESENTATIVE HENNESSEY: John, let me revisit our discussion about late notice. I was under the impression that when a company held out, the primary layer company of the $500,000 was holding out and then turned over the case to you, your staff at the last minute, that they were out of the case and that your staff took over and defended the case.

And then something you said after that suggested that no, they actually go on and maintain the defense.

MR. REED: Well, they pay for the attorney. They're supposed to pay for the attorney to continue the defense under that circumstance.

REPRESENTATIVE HENNESSEY: Is it the same attorney that handled the case for the primary insurance carrier?

MR. REED: It usually is. Sometimes, though, we have not been satisfied. And there have been times when, you know, we substituted counsel.

REPRESENTATIVE HENNESSEY: From one of your own staff?

MR. REED: Not from our own staff but from one of the law firms that we use to handle 605 claims. And we don't do that very often. But sometimes we just think that a change needs to be made for one reason or the other. And we will do that.

Normally, we don't want to do that because the statute makes them responsible for it. So we'd rather use the counsel that they've hired all along to keep our costs down.

REPRESENTATIVE HENNESSEY: Okay. For the benefit of our audience, why don't you tell us what a 605 claim is.

MR. REED: A Section 605 claim is a claim that relates to care that had been given in the past, generalizing, but approximately 4 years before the lawsuit was given, or filed. They generally -- those kinds of claims relate to errors involving children or errors where the patient had no basis to know that he had been harmed as a result of malpractice until some more recent date, that type of situation.

And frankly, they're oftentimes very expensive type claims because they involve brain damaged babies or delays in diagnosis of cancer or things of that sort.

REPRESENTATIVE HENNESSEY: Thank you. I know this would sort of go against the trend because, you know, legislative proposals talked about getting rid of the Cat Fund and turning over that layer of insurance to the private insurance market.

But let's butt the trend at least in theory for a few moments here. What would happen if we were to lower the threshold amount from 500,000 to 300,000 or $200,000? What would be the effect on the insurance rates that the primary insurance carriers charge for the lesser level of exposure, and what would be the effect on the Cat Fund?

First of all, could you handle it? Secondly, what effect would it have on your rate?

MR. REED: The first thing you do is you would immediately avert the crisis that seems to be looming because you would effectively and palpably reduce the cost of medical malpractice insurance for physicians.

REPRESENTATIVE HENNESSEY: At the primary level?

MR. REED: At the primary level. If you drop down the amount they had to buy from a commercial carrier, obviously or quite logically their costs would go down.

REPRESENTATIVE HENNESSEY: Let's talk about reducing it from 500- to 200,000. Do you think that that

would be a proportionate reduction in their premium? Or because we're talking about a maximum of $200,000 exposure now, is it even a greater reduction in the premium than, say, 60 percent?

MR. REED: Well, dropping it down to the 200,000, obviously they'd still have to buy it from a primary carrier or they'd have to self-insure. But knowing what they charge when they went up the slope and knowing what they charge for increased severity factors and then calculating going back down the slope, I think savings in the, anywhere from 25 to 35 percent should be immediately available to them.

Malpractice was very inexpensive in Pennsylvania relative to the rest of the country. Back before the law changed and we started going uphill with higher primary limits, we were in the lowest third of the country in the cost of malpractice insurance back in those days because a nonprofit type mechanism, whether self-insurance or the Fund, was relatively less expensive.

Obviously, it's going to vary depending on the company. But obviously, they should save money immediately if they have to buy less insurance for a couple reasons. First of all, the carrier is less at risk. At a lower amount, the carrier has less need and perhaps can avoid the cost of reinsurance. And reinsurance is extremely

expensive right now.

At that lower amount, carriers that are not willing to enter the marketplace right now might become interested and get involved. That would increase some competition. And I believe it's quite reasonable to suggest that you could mandate a reduction in the premium from what they're charging now.

And I know that because I've looked at this data endlessly over and over again. I've seen what nonprofit entities, risk retention groups can do, what self-insurance groups can do to protect their layer. And I know that the Fund piece, if you go back down to 200, the Fund doesn't change. We don't have to increase our price tomorrow.

In fact, according to the actuarial studies I've had done, we don't even have to make a significant change in our surcharge for the next 3 or 4 years. So if we do get some tort reform --

REPRESENTATIVE HENNESSEY: Even though you've expanded your coverage from --

MR. REED: That's right. Because there's a lag in payment. There is a lag in payment. Now, it would have an impact on the unfunded liability, a decrease to -- actually, to certain amounts, it has a very minor increase in the unfunded liability.

If you go down to 200,000 and don't make any other changes, the unfunded liability obviously will start coming up. But then you can try to use some other alternative funding for that in the interim. And we're going to start reaping some benefits hopefully from some changes in the system, whether it's reduction in medical errors, whether it's maybe cutting, controlling the cost of claims in court.

I know the Legislature has been looking at a number of different things. At some point, obviously in theory, we ought to reap some savings from that. But in the immediate term, there is no need for the Fund to charge any more because the Fund is paying what it's paying; and it's based on the cases that are coming up for resolution.

And those are the cases that are in the pipeline now. And I think a lot of times, what gets lost in the discussion is the fact that we're still paying off million dollar coverages. That's the vast majority of what we pay, are million dollar coverages.

You read in the press, they talk about 700,000 versus 500,000 for the carriers. What's usually coming up in the court is 200,000 versus a million for the Fund or maybe now 300,000 versus 900,000 for the Fund. And once in a while, we'll see a 400,000 versus an 800,000.

The vast majority of our payments we make

today are on million dollar coverages. So you're not going to be giving me anything that I don't already have. So I don't have to charge any more for it right now. If there aren't any other savings, then obviously you probably ought to start putting some money aside to keep your unfunded liability from growing.

But it is a very effective, very easy way to reduce costs. It wouldn't require anything more from us. The Fund is set up today as an insurance company. We have the infrastructure. If we were asked to, we could set up and convert. We could bill the doctors directly just like an insurance carrier. They have the infrastructure there for it.

We have 40-some law firms on contract. I'm not saying that you should do it. I'm just saying if you asked us to, we could. We could step in there and fill that role.

REPRESENTATIVE HENNESSEY: Okay. And just so that we're clear, this would be a reduction in the primary level from 500 to 200 theoretically. And then the Cat Fund would cover from $200,001 up to a million 2?

MR. REED: That's correct. Yeah. That's one way.

REPRESENTATIVE HENNESSEY: Do you feel that the Cat Fund would have the capacity to do that if we

wanted to go that way as a Legislature?

MR. REED: Well, certainly, we have the capacity to do that because that's what we have been doing. And we've been doing that for 26 or 27 years. I mean, the Fund has been paying 5 times what the carriers have been paying. They've had $200,000 at stake. We've had a million dollars for every insured.

And the Fund has gotten beaten up over the years, but that's the ratio. In fact, most doctors have an additional million that they get from us for their corporation. So that's what drives the cost of claims. Now, in theory, our costs will go down because some of that is shifting over to the private sector; but it hasn't totally happened yet.

We have the capacity, obviously, to do it at 200. I've told people if we had to, we have the capacity to do it from dollar one.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRPERSON GANNON: I'm sorry. You said 2 and a million. Isn't it 7 and 5, 5 the underlying and 7 for the Fund?

MR. REED: Today -- for future coverage, it's 5 and 7, yes.

CHAIRPERSON GANNON: Yeah. That segues into my question. And that is a hypothetical. What you're

saying is it would probably benefit more to the physician without much additional cost from the Fund to reduce the primary to 200,000 and leave the total liability at 1.2, then reduce the top end from 1.2 to 1 and still leave everything else the way it is?

MR. REED: Well, obviously, it would cost less than what they're paying now, even if you kept it at 1.2, if you dropped the primary amount down to 200. Obviously, it would be better from the unfunded liability standpoint and long-term cost if you dropped the total to a million and still dropped the Fund down to 200.

Get that commercial carrier down at a lower attachment point because they seem to be reluctant to participate in the market. Or even if they're interested in participating in the market, they may have financial problems that prevent them from fully participating.

CHAIRPERSON GANNON: So what you're saying, that there's some view that by reducing the primary limit, it might have an effect on the unfunded liability?

MR. REED: Well, we've actually looked at models where you could, you wouldn't save as much. For instance, if you went to a 400-, 600,000 breakout, 400,000 primary, you'd save something off the primary and you wouldn't raise the unfunded liability a dime. It stays basically the same.

It will be a total coverage of a million as opposed to a million 2. We've modeled this a number of different ways. But bringing the primary threshold down has to save doctors money because they're going to buy less of what it is that's costing them the most. And that's that first piece of coverage.

CHAIRPERSON GANNON: I'm having -- I'm trying to understand this unfunded liability a little bit better. And let me tell you how I -- you can correct me, but this is how I conceptually see it. That represents cases that are out there where the Fund has exposure but they have no reserves set aside other than the reserves that happens to be in the pockets of every doctor right now.

So that as those cases get paid, you have to reach out and get that money from these physicians individually. But that leads me to the conclusion that had you been able to adequately reserve cases as they're reported, you would have $2.2 billion, you'd be sitting on $2.2 billion in reserves right now for cases that you may or may not pay that amount out.

You may bring those -- those cases might be resolved favorably with a zero payout, or they may be resolved and the payout exceeded the reserve, or they may be resolved and the payout equaled the reserve. Is that a fair --

MR. REED: That's fair, Representative Gannon. I mean, obviously, we haven't had that opportunity. But if we were able to reserve and had been doing so, sure. You would have a lot of money accumulated at this point. But then again, then the health care providers wouldn't have that money.

CHAIRPERSON GANNON: Yeah. But there seems to be an assumption here that every case has a payout. And that's where this unfunded liability comes in. You've said that well over 80 percent of your cases result in no payout.

MR. REED: Right.

CHAIRPERSON GANNON: So are you saying that this 2.2 unfunded liability is representative of about 15 percent or 20 percent of the cases that come in?

MR. REED: Well, frankly, it represents cases that we haven't even seen yet. It's a theoretical concept by actuaries to predict the liabilities that we will get long term for a given period of time.

CHAIRPERSON GANNON: So these would be what they call incurred but not reported cases?

MR. REED: Right.

CHAIRPERSON GANNON: So they are plugged into this unfunded liability?

MR. REED: Right.

CHAIRPERSON GANNON: So you're pretty much using, in terms of actuarially estimating the liability that you have as of today, assuming that today was the day the study was done, you're pretty much using what the insurance industry uses to determine what their potential liability is in actuarially estimating what their payouts are going to be?

MR. REED: That's right. I mean, our actuaries -- and they're outside actuaries. And we use the same techniques as the carriers do. And it's been measured by a number of different actuaries over the years. And frankly, that unfunded liability, it's reached a plateau. It's stable. It has not changed markedly in 10 years. It's basically a replenishment pool.

CHAIRPERSON GANNON: I see that in all the charts that I've seen. That's why I think it's more a theoretical number than an actual we're going to have to write checks for this amount at some point.

MR. REED: Even if I had the $2 billion, I don't have necessarily the people to pay it to at this point.

CHAIRPERSON GANNON: What, if any, impact -- if you can answer this. I don't know if you could. We've talked about reducing the liability amount to 200 or 300 or whatever that would be by placing a first

dollar deductible on those policies -- say a couple hundred dollars or a thousand or whatever -- on the liability policy so that there would be some participation by the insured at the very threshold to a limited extent.

MR. REED: Well, obviously, a deductible can help. Unfortunately, I think the insurance experts that I've talked to have told me that it generally has to be a fairly large deductible to have a real significant impact on premium, at least for the fellows like the orthopedic surgeons.

I'll give you an example. There's a group in Delaware County having a problem with insurance. They got quoted by a carrier for $500,000 coverage. And basically, every one of them got a bill for $99,600, some of them in the 100,000-some dollar range.

Then they also got an alternative quote from the same carrier on what would it be if they got $100,000 deductible per claim with, I believe, a $500,000 cap, basically reducing the insurance amount to 400,000. And the premium dropped; but it was still 78,000, as I recall.

But a deductible can reduce the cost. To a certain degree, a deductible would probably be a good idea because it puts incentives out there to try to avoid the claims in the first instance and gets the insured to work with you to manage them.

And that's one of the things -- frankly, some of the alternative insurance vehicles are good ideas. Like these doctors that are able to put themselves into a risk retention group, if it's set up right, it can be a win/win proposition for them because they insure themselves.

They can make it consistent from year to year. It basically forces them to work with one another to control their losses to avoid some of them from happening. And I think you're probably going to see more health care providers around the country go to vehicles like that.

CHAIRPERSON GANNON: Once again, you may or may not know the answer to this question. But from my experience, my professional liability comes up in May. And I received a letter from my carrier a few weeks ago, and it was a nonrenewal letter. They notified me they were not going to renew my policy.

And then they said they would be sending an application to me to complete and for underwriting purposes to consider renewing the policy. Now, I get that letter every year. And the letter says that we're required by law to notify you 60 days before the policy expires that we're not going to renew you; however, we will be sending you an application.

Now, I checked with my agent. And my agent tells me that every lawyer that they write gets that same

letter. My question is, On the professional medical liability side, do they get that type of letter also?

MR. REED: Representative Gannon, I can't honestly say. I don't know. I know obviously a lot of doctors have gotten nonrenewal notices this year. But whether they've been accompanied with applications or not, I can't say.

CHAIRPERSON GANNON: Well, it wasn't accompanied by an application. It just said an application would follow within a certain period of time. But my agent, which also writes medical mal, said yes, they do that. But I didn't know whether it was beyond that one agent across the state. It depended upon the carrier.

MR. REED: I don't know the situation on that.

CHAIRPERSON GANNON: I have no further questions. Representative Gabig.

REPRESENTATIVE GABIG: Thank you, Mr. Chairman. I didn't at the beginning thank you for your testimony. It's been very, very informative for me. And I certainly appreciate the time that you took to research these issues. I want to say one thing and then ask a question, though.

I heard the one example that you gave where I think it was because of a late notice to you or late reporting, I guess was the term, you wound up settling a

case where you thought it was defensible looking at the case, or your agency did.

And I think that's just an example of where a claim is paid out where there's not necessarily any negligence or malpractice or even, whatever this term, medical error. You would agree with that? I mean, sometimes that might have been legal malpractice or a claim adjuster malpractice.

But if -- because somebody didn't file the answer on time, got it to you late, I think that's an example of what I was talking about before. Do you agree with that?

MR. REED: Well, you're correct. There are some cases out there where we may not believe the person is negligent. The case has usually got a problem with it. But whether it crosses the line being legal negligence, that is obviously problematic.

In the 2 instances that I gave you, there clearly was medical negligence. The only issue we had was the value in the case of the woman who died. And in the second case, it was the hospital and not the doctor. In other words, the doctor had a defense; but the hospital was clearly wrong.

REPRESENTATIVE GABIG: The -- but the question that came to my mind was you said that the primary, or the

primary defenders, I guess, before they notify you, they, they do it when they have to reasonably believe that the suit will exceed their coverage.

And you gave us the example of a $70,000 evaluation where somebody evaluated a case of somebody and it turned out to be whatever. Why wouldn't they -- or what are the incentives and disincentives for them to report to you? Why wouldn't they report to you as soon as this lawsuit and say, Hey, we reasonably believe this might exceed it because last case I had, I thought it was 70,000 and it turned out to be a million dollar case? So --

MR. REED: Well, I mean, the incentives are as varied as there are people. First of all, let me say there are a lot of carriers that we have a very good working relationship with. There are some particular hospital systems that we have a very good working relationship with.

In some instances, though, they may not want to report it to us because it's personality. Sometimes it's because they're holding their own money back until the very last minute. I think that's what the case was with PIC, and they didn't want anybody looking over their shoulders.

You know, we're not, as I said, we're not rubber stamps. If somebody reports a claim to us, we are going to look at it. We're going to evaluate it. They

don't necessarily like the idea. We might ask them to do something that we think the statute requires; and that is defend the case, protect the doctor, protect the Fund's interest.

And they may have to spend some money if we look at it. A lot of them just look at the threshold layer. They say, Well, this is what we need to do to protect our interest. They don't give a lot of thought to what it does to protect the whole claim.

And the statute's set up so that the Fund's defense is dependent on their doing that job.

REPRESENTATIVE GABIG: Do you have an idea of how many cases don't get reported to you, malpractice cases?

MR. REED: Yes, roughly. I think there are about 10,500, 11,000 medical malpractice claims that were filed in Pennsylvania. And I believe this was 1999, which was the last complete year I had the statistics for. Of those, 4,500, 4,700, something of that sort, were reported to us.

Percentage-wise, I couldn't calculate that in my head real quickly. But what we do get is a subset of the total universe of claims.

REPRESENTATIVE GABIG: And you said that, I don't know if it was 80 or 85 percent of the cases you do

not pay a claim on. Those are either acquittals or -- what are the other --

MR. REED: You have to understand, when claims are -- each individual insured may represent a claim. And that's the way the industry reports statistics because you can have several carriers involved in the same case, and they each have a claim. So there's some overlap there.

What we also do is count cases. Cases are basically one victim per case. And that's a lesser number. That's about 2,500 a year. It's a lower percentage than 85 percent when you look at it from a case standpoint. In other words, there may be some doctors that are not responsible and we get them out; but we may end up having to pay for somebody else who is.

So it's hard to make a direct correlation. But my point is, is that these are all looked at individually. And, you know, we need to get the cases so that we can evaluate them.

REPRESENTATIVE GABIG: But the bottom line at some point, I guess, is somebody says, No, we're not going to pay that claim. And there's no -- and that ends it? It's all okay?

MR. REED: No. It's give and take all the time. That's why the phone rings all the time. There's letters. We get threatening letters all the time.

REPRESENTATIVE GABIG: No, no. I mean, of the ones that you wind up not paying, somebody at some point settles it, I guess at the lower level or --

MR. REED: Uh-huh.

REPRESENTATIVE GABIG: Is that what happens?

MR. REED: Sure. Well, either that or they're defended successfully. Some cases are withdrawn by plaintiffs. You know, one thing that gets lost, too, is that some cases are withdrawn, I mean, after the discovery process goes along and the trial lawyers find out more information about it.

I get -- whenever I was defending doctors, I've had some cases where, after everything got done, the guy looks at it and says, you know, somebody did do something wrong here. But they don't know that going in necessarily because they don't have all the facts, and they can't get the facts until they get the records.

REPRESENTATIVE GABIG: Just a follow-up, and then I have just one other question. If there are those incentives and disincentives, what would be -- I don't know if Representative Hennessey was asking those questions -- what would be a better way in your mind to ensure adequate notice to your agency in order to ensure a fair result?

MR. REED: I think for a whole host of

reasons, I would recommend reporting every claim, not because we necessarily have to do anything with a great many of them but it's about time we start getting a database out there on what's going on in the claim universe.

And carriers just generally don't cooperate well with one another very well. They don't like to report stuff to us. They're not real keen on reporting stuff to the insurance department. There are requirements in the law now that they give us the Section 809 reports.

It's at best cursory information. That should be fleshed out. There should be more details. We should get it every year. We should also get every claim reported to us because then some cases aren't going to take a lot of time. I'd rather open up more folders, look at them, at least build the database for insurance projection purposes.

But also, it might serve a public health purpose, having somebody having a real world, real cases, what's gone wrong. And having that all in one place I think makes a lot of sense. And the extra burden on us of getting more reports rather than less wouldn't be that much.

REPRESENTATIVE GABIG: I saw something that came across my desk today that talked about eliminating the statutory amount for primary insurance. At least that's

the way I read it. I think that's what it said. Rather than having it lowered to 200 or 300, just let the market decide what it would be. What would your thoughts be on that?

MR. REED: Well, that's been posed a few times. One of the reasons why you have the statutory requirement in coverage is that people forget what happened back in the '70s. I mean, it didn't used to be required by law. But the bottom line is that there have been med mal lawsuits for a long time and they take place in all 50 states.

Generally, health care providers want the coverage. The battle we have is not that they have coverage but they obviously want us to pay a lot of claims sometimes that we don't necessarily want to pay. But the law that was adopted brought in the mandatory coverage.

I'm presuming -- I wasn't there at the time -- a couple reasons: One, make sure the individuals are protected; and 2, to make the insurance pool as large as possible, spread the risk in order to make it available to every health care provider and to keep the costs down.

If you narrow that pool, you defeat that purpose. In some other states -- Florida comes to mind -- they have a lower statutory amount. And they don't have any governmental agency on top of it or any other kind

of a buffer.

And those $250,000 policies are very expensive down there because, for a number of reasons: Economies of scale. And the other thing is they don't have a government agency or a nonprofit entity like the Fund that sits atop them and buffers them. And a result of which is, carriers down there -- Florida's a litigious environment. They end up paying their policy limits on most every case, and that drives the cost of those coverages up.

REPRESENTATIVE GABIG: And my final question: I guess what goes on -- you talked about the one case where they sort of admitted or evaluated the case with liability, and the issue was damages. But I guess at some point, somebody's looking at liability, whether, what's the chances of liability.

And I don't know if there's a rule in the insurance industry, hey, if it's 30 percent likely that somebody's going to be filing now, we better, we better settle this claim. But I guess those kinds of thoughts do go through people's minds, though. Am I right about that?

MR. REED: Certainly.

REPRESENTATIVE GABIG: And then when you have really big damages, not a $70,000 one, but the evaluation, if we are found liable, there's going to be a big -- I guess the lower the -- even though you have a low risk of

liability, you say, Well, we better try to settle this because if we don't settle it, we're really exposed on the damages end. Is that the type of thing that happens?

MR. REED: Sure. That's part of the calculus. It happens every day.

REPRESENTATIVE GABIG: So some of these doctors might not really be negligent, but there's a risk that they might have been found to fall below the standard of care. And if they, that happens, we're going to be very exposed. So let's try to settle it at some amount, maybe less than would come back at jury, but at some amount to ensure a fair verdict for both sides, or a fair resolution for both sides. Does that, does that --

MR. REED: Those kinds of discussions take place similarly.

REPRESENTATIVE GABIG: Now, I wasn't here for the first hearing. I had another -- I was actually at the Crime Commission. I reported to my chairman that I wouldn't be able to make both of them. But the, you know -- and I understand Chairman, or Commissioner Masland was here for that hearing.

The doctors that where there is either negligence found in a verdict or a professional decision has been made that there is negligence here, I mean, real negligence and you're talking about cases where there's

double digit claims against some of these types of doctors, why aren't their licenses being taken away?

Why do we have 3 and 4 and 5 and 6 and 7 and 10, 11, and I think you even said 17 cases with one doctor if there's real negligence? Not if there's just some claims but if there's really negligence been decided, shouldn't their license be pulled after, you know, number 2, 3? At some point, shouldn't they say --

MR. REED: Now you're asking me my personal opinion. Obviously, there are some doctors that make mistakes; but they're still good doctors. They may be negligent, and they may have caused harm. But it's unlikely that they're going to do it again.

What the threshold should be, I can't say today. But obviously, there are also some doctors that we refer to as frequent fliers that have multiple problems and have harmed people multiple times and where the negligence is clear.

And the circumstances of those cases get reported every year to the National Practitioner Data Bank, which doesn't police them. But the same report that we give to the data bank we give to the Bureau of Professional and Occupational Affairs. We don't have any similar type reporting process for hospitals.

REPRESENTATIVE GABIG: And you're begging a

follow-up on that one. What would your thoughts be on that in terms of the hospitals?

MR. REED: Well, I think it probably would be a beneficial thing, that somebody should be, they should be part of the process. I'm sure there is already a process in place to review hospital quality. But looking at claim history, there might be something that the health department or whoever the regulatory body would be should take a look at.

REPRESENTATIVE GABIG: Thank you. And thank you, Mr. Chairman.

CHAIRPERSON GANNON: Just a couple of follow-up. I'm going to take advantage of your presence here. Do you ever run into a situation where a claim has been reported to you or a case has come to your attention and it's the position of the Fund that this should be settled but the underlying carrier refuses?

MR. REED: We've had that.

CHAIRPERSON GANNON: What do you do in those types of situations?

MR. REED: Well, it's, it is problematic. We sometimes send out demand letters to them asking them to tender the case to us. In a few isolated examples, we have sometimes taken the step of settling the case without their money, without their cooperation and, you know, then

threatening to go after them and sue them for their contribution.

I know I had a battle with PIC about that in a case some years ago. There's case law. Judge V. Ashton indicated that we could do that. But we're very careful about it because we don't want to abuse our position. And also, frankly, since it's not in the statute, it's case law, we don't know how, how consistently it might be enforced.

But yes, that is a problem for us sometimes. We have carriers that we think -- you know, and we've identified some cases. They've ended up costing us a fair amount of money where we thought that not only negligence but also causation, the 2 elements, were both there. And we had serious damages. And we wished they would have settled it or at least let us settle it.

CHAIRPERSON GANNON: Is that problem serious stuff that it would require, you know, from the standpoint of policy, looking into?

MR. REED: It's something that should be looked at. And as I said, it varies by carrier to carrier. Most carriers are very consciousness in that regard. They -- if they see a case is bad, they're cognizant of the fact that their insurer is at risk for more. And you get into bad faith problems.

And frankly, we've had a couple of carriers that have gotten hit pretty hard because of that, you know, that they were incorrect, unreasonable perhaps in not settling the case and has come into a big verdict. It still costs me money.

But a couple of times, I've been somewhat chagrined by here I am negotiating with a plaintiff's attorney to remit or relent on the bad faith damages portion of the case that's going against the carrier. Here I am helping them out sometimes when I didn't do it.

CHAIRPERSON GANNON: Has most professional liability policies giving the insured the right to consent a settlement, has that been a problem with respect to refusal to consent and then resulting in substantial liability?

MR. REED: First of all, let me just tell you what the Fund policy is. And this is where we sometimes have a battle with the hospitals. Our policy is that regardless of what their contractual relationship is with a doctor, the hospital, if they're an employed physician, they generally don't have a consent right, or at least a lot of facilities they don't.

We still give them a right to defend the case if there's a reasonable basis for doing so. In other words, we'll do an independent analysis. And we have

successfully defended some doctors who did not want to consent even though their employer was looking to settle the case.

On the other hand, there had been some physicians in the past who had been unreasonable about that. We've generally been able to work it out most of the time. You know, if you work with a physician, explain to them what's involved and try to get them to look at it, we've been able to get past the problem.

Some carriers have resolved it by having committees -- I know the medical society has an appeals committee. At least they did -- and some other groups so that the doctor realizes that they have some appeal, as it were, within the process, that they're not just totally at the whim of insurance executives so that their substantial rights are protected.

But clearly, if it's unreasonable from an objective standpoint to defend a case, I think probably it would save money for insurers and the Fund if they had the ability to settle the case when those circumstances present.

CHAIRPERSON GANNON: It seems what you're saying is that, it seems that what you're saying is there's more of a problem with the carriers refusing to settle than the doctors?

MR. REED: Sometimes it is, yeah. Frankly, my experience, maybe I've seen a couple too many bad examples. And I shouldn't tar all carriers with that. I've used the consent thing as an excuse. I've seen it used constantly as an excuse.

When I represented physicians, if there was a problem that cropped up, I found these are some of the most intelligent people in the world. If you talk to them, level with them, go over it with them, if it's something that they should consent to, they will. That's not always true.

CHAIRPERSON GANNON: You don't have to answer this question. But have you ever heard -- I shouldn't even ask this question -- that sometimes the hospitals will pressure the doctor not to settle?

MR. REED: I haven't heard that. I mean --

CHAIRPERSON GANNON: I'm glad you haven't heard that.

MR. REED: My general impression has been that the hospitals are usually eager to settle.

CHAIRPERSON GANNON: No. Where the doctor is not an employee. The doctor is independent.

MR. REED: Oh, yeah. Of course. They want somebody else's money in the pot.

CHAIRPERSON GANNON: With respect to the, the

item on the family practice with delivery, I mean, particularly in the eastern part of the state, we see a dramatic decline from 1997 to 2000. My question is, Does that mean that these doctors have left the area or that they're simply not doing delivery anymore?

MR. REED: It means that they're not doing delivery if they haven't kept up the privileges.

CHAIRPERSON GANNON: So that doesn't necessarily mean that this number of doctors have fled Eastern Pennsylvania?

MR. REED: No.

CHAIRPERSON GANNON: It simply means that they've elected -- and probably a couple reasons for that.

MR. REED: And there's also a miscellaneous factor at work, I think, because you've seen in Central PA that the number's gone up that have those privileges. But I think in a lot of the more populous areas of the state, as a result of what hospitals desire and maybe what customers desire, I think there's been a real move to have a full-fledged obstetrician be the one that's in charge of the pregnancy.

CHAIRPERSON GANNON: Well, you're probably not -- this isn't your area of expertise. But one of the things that came to me in terms of the questioning when we talked about the slowdown in growth of the number of

physicians from the mid-'90s to present, that we, at the same time we saw the rise of the HMOs and managed care.

And other than the malpractice situation, there might be a corollary there with the number of practitioners coming into Pennsylvania, plus population slowdown.

MR. REED: Well, the one thing I do hear from physicians consistently is the squeeze on their income. So obviously, that's a factor.

CHAIRPERSON GANNON: Well, Mr. Reed, I want to thank you for coming before the committee for the second time and providing us with a lot more detail and fleshing out in a great deal more some of the points that you made in your original testimony.

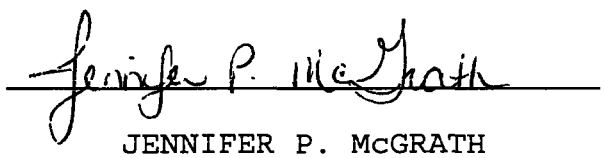
This has been extremely helpful in understanding this issue from this perspective. And I very much appreciate your willingness to come here a second time and be interrogated by the Judiciary Committee. Thank you, sir.

MR. REED: Thank you.

CHAIRPERSON GANNON: This meeting is adjourned.

(Whereupon, at 3:13 p.m., the hearing adjourned.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause and that this is a true and correct transcript of the same.



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