WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings … RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
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- *Committee Reports … CR*
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- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
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- *Miscellaneous … Misc*
- **05hr_ATF-MM_Misc_pt33b**

- *Record of Comm. Proceedings … RCP*
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Pennsylvania's Health Care System

The ability to assure access to affordably priced, high-quality health care is an important element in Pennsylvania's relative attractiveness to residents and businesses. The health care system is therefore vital to the state's economic and social well-being, as well as the physical health of its inhabitants. Among other things, teaching hospitals help anchor the state's health care system, producing physicians for a national market as well as health services locally. The state itself is one of the largest purchasers of medical services, a fact reflected in Medicaid's share of Pennsylvania's state budget. The medical malpractice crisis and potential reforms must be assessed in light of these public policy issues. The following data provide background on access to health care in Pennsylvania, its quality, and its cost. As yet, however, there is little information directly connecting malpractice liability to medical performance. Possibly the most urgent question is the extent to which current problems of availability and affordability of liability insurance affect patients' access to care.

Access to and Cost of Health Coverage

Pennsylvania's twelve million residents closely resemble their counterparts across the U.S. (Exhibit 23). Pennsylvanians are slightly older; 14% are age 65 and above, two percentage points above the national average. The state has under half the proportion of non-whites as the U.S. generally (14% versus 30%). Pennsylvania residents are slightly more likely to live in metropolitan areas (85% versus 81%). They enjoy slightly higher than average family incomes (about 4% above the national average) as well as slightly lower rates of poverty and unemployment.

The state's population is heavily concentrated in and around the two biggest cities, Philadelphia and Pittsburgh, in the southeast and southwest (Exhibit 24). Although Pennsylvania is highly metropolitan in percentage terms, it has the nation's largest rural

Exhibit 23. Demographically, Pennsylvania Resembles the US at Large

Recent Population Data

Characteristic	PA	US
Residents, 1999-2000 (millions)	11.8	275.7
Children 18 and under (%)	26	28
Age 65 and above (%)	14	12
Metropolitan residents (%)	85	81
Race/ethnicity (%)		
White	86	70
Black	9	13
Hispanic	3	12
Other	2	5
Economics		
Median Family Income, 1998-2000	$29,000	$27,830
Under Federal Poverty Level, 1999-2000 (%)	13	15
Unemployment Rate (Seasonally Adjusted)		
Oct. 2002 (%)	5.3	5.7
Oct. 2001 (%)	5.0	5.4

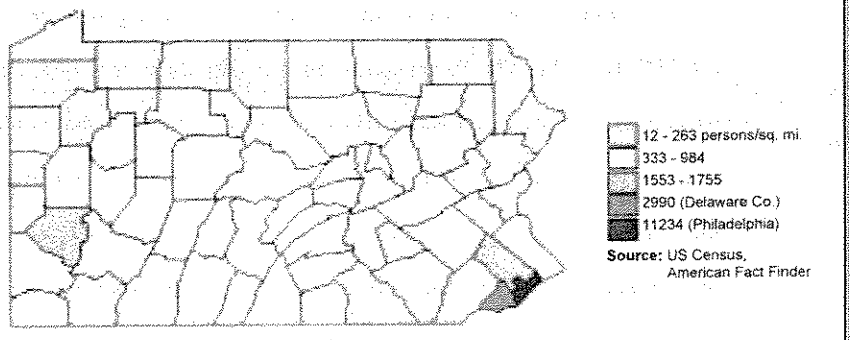
Source: Kaiser Family Foundation, State Health Facts <http://www.statehealthfacts.kff.org>

population because of the state's overall size and its many well settled farming communities (Pennsylvania Economy League 2002).

Pennsylvania has high rates of health insurance coverage (Exhibit 25). Only 9% of residents are uninsured, about one third less than the national average and even below the well-insured neighboring states. Pennsylvania's advantage mainly comes from employer-sponsored insurance (ESI) — private coverage provided as an employee benefit.

Exhibit 24. Pennsylvania Has a Mix of Urban and Rural Counties

Persons per Square Mile, by County, 2000



The state's rates of private insurance coverage are about 3% above the national average both for workers (own ESI) and for dependents (other ESI). Slightly more Pennsylvanians are covered by Medicare because of the state's relatively elderly population. Medicaid covers slightly less than the national average—not because eligibility standards are low but because fewer people qualify, a result

Exhibit 25. A High Share of Pennsylvanians Have Health Insurance
Coverage Comparisons with Neighboring States, US (average, 2000 & 2001)

type of insurance	US	PA	MD	NJ	NY	OH
ESI--own	30.4%	32.9%	33.4%	33.4%	28.5%	31.9%
ESI--other	29.0%	32.3%	34.6%	31.5%	27.4%	32.5%
Private Non-Group	4.6%	4.2%	3.8%	2.4%	3.5%	3.9%
Medicaid and Other State	8.1%	7.1%	4.2%	5.3%	11.3%	6.8%
Medicare and other Federal	13.5%	14.5%	12.7%	14.7%	13.4%	13.7%
Uninsured	14.5%	9.0%	11.4%	12.7%	15.9%	11.2%

Source: Urban Institute, 2002. Notes: "ESI" is employer-sponsored insurance; two years of CPS data were used to assure sufficient sample size

of the state's relatively low poverty rate. A relatively high proportion of Pennsylvanians' health insurance coverage is arranged through HMOs, according to national statistics (Exhibit 26). Fully one third of Pennsylvanians are enrolled in HMOs, including Medicare and Medicaid enrollees. Starting from a low baseline, Pennsylvania HMO growth greatly outpaced that of the nation as a whole during the 1980s. By 1990, Pennsylvania had almost reached the national average. HMO enrollment continued to grow at rates one-third higher than the national average until peaking in 1998. HMO enrollment in Pennsylvania and nationally has declined since that time. HMO penetration is higher in urban areas. In 1998,

Exhibit 26. Pennsylvania Ranks High in HMO Coverage
Percentages of population enrolled

State	1980	1985	1990	2000	2001	ave. ann. pct. chg. 1980-90	ave. ann. pct. chg. 1990-2001
United States	4.0	7.9	13.5	30.0	27.9	12.9%	7.5%
New York	5.5	8.0	15.1	35.8	35.0	10.6%	8.8%
New Jersey	2.0	5.6	12.3	30.9	31.7	19.9%	9.9%
Pennsylvania	1.2	5.0	12.5	33.9	33.4	26.4%	10.3%
Ohio	2.2	6.7	13.3	25.1	23.4	19.7%	5.8%
Delaware	--	3.9	17.5	22.0	22.8	--	2.7%
Maryland	2.0	4.8	14.2	43.9	38.4	21.7%	10.5%
West Virginia	0.7	1.7	3.9	10.3	10.9	18.7%	10.8%

Source: CDC, Health, United States, 2002, Table 146
<http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf>
Note: Includes Medicare & Medicaid HMOs, full population

for example, HMO penetration was more than twice as high in metropolitan Philadelphia as in the Harrisburg-Lebanon-Carlisle metropolitan area (McDonnell and Fronstin 1999).

A few health insurers dominate the market in many communities in Pennsylvania. One late-1990s study found that the top insurer in the six-county Pittsburgh metropolitan statistical area had a 69% market share (Guadagnino 2000). The next three firms accounted for nearly all the remainder. For the nine-county Philadelphia metropolitan area, the top insurer had a 57% market share, the next largest 19%, and no other firm more than 3.5%.

Access to Health Care Practitioners and Institutions

One determinant of access to health care is adequacy of insurance coverage. For Pennsylvania, this is quite good, as noted above. Also vital is adequate supply and distribution of providers, notably hospitals and physicians.

Pennsylvania ranks relatively high in measures of hospital supply and usage (Lewin Group 2001). Hospital beds per population declined from 1980-1997—by 29% nationally, but by 21% in Pennsylvania (HRSA 2000). In 1999, Pennsylvania had almost 20% more beds per thousand people than the nation at large and ranked 18th highest among states (Exhibit 27). Usage of hospitals was even higher; inpatient days per thousand were 25% above the national average and ranked 9th among states. This helped hospitals maintain a higher than average occupancy rate.

Pennsylvania has about 10% more doctors of medicine (MDs) per population than the nation at large (Exhibit 28). Pennsylvania and its surrounding states also exceed national averages for other health professionals

Exhibit 27. Hospital Supply in Pennsylvania Exceeds National Averages: 1999 Capacity Measures

	PA	US ave.	PA rank
Hospital beds/1,000 pop'n	3.59	3.04	18
Admissions/1,000	146.3	118.7	6
Average length of stay	6.1	5.9	19
Inpatient days/1,000	888.2	703.7	9
Occupancy rate	67.9%	63.4%	11

Source: Lewin Group (2001) using Am. Hosp. Ass'n data; Note: rank is among 50 states and DC; thus, 17 jurisdictions had more beds/pop'n

per population. Nurse practitioners are the main exception; the state has only about half the national average (HRSA 2000.) The "additional" Pennsylvania physicians relative to the national average are specialists. The state's supply of primary-care physicians is almost exactly average, about 6 per 10,000 in 1998 (HRSA 2000). In addition, however, the state has substantially more osteopathic physicians (DOs) than most other states.

From 1975-1995, Pennsylvania gained physicians in active patient care, both absolutely and relative to the national average (Exhibit 28). The state's edge declined marginally during 1995-2000, as growth in physicians per population slowed. That period was also marked by consolidation among health insurers and hospital systems. Furthermore, hospitals affiliated with or acquired physician practices, with related growth in employed physicians.

Exhibit 28. Pennsylvania Ranks High in Physician-Population Ratio
But Its Rate of Growth Has Slowed in Recent Years

	Physician-Population Ratio, PA & US, 1975-2000				Ann. Pct. Chg.	
	1975	1985	1995	2000	1975-1995	1995-2000
PA	13.9	19.2	24.6	25.4	2.8%	0.6%
US	13.5	18.0	21.3	22.7	2.2%	1.3%

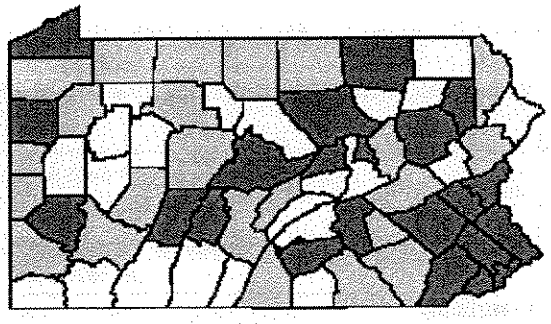
Source: CDC 2002 , Table 100 <http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf>
Note: ratios are doctors of medicine in patient care per 10,000 civilian population

Physicians are not spread evenly across Pennsylvania. Philadelphia has by far the heaviest concentration of physicians (Exhibit 29). A caveat about mapping physicians' principal locations is that it does not necessarily reflect their service areas. Patients may see providers in different offices, and physicians may practice in more than one location.

Pennsylvania physicians are slightly younger than average. Of physicians in the state in 1998, 28% were 55 years of age or older, compared to 31% of physicians nationwide. The state's academic centers produce a substantial portion of the nation's new physicians. Medical schools in Pennsylvania graduated 1,008 new allopathic and 259 new osteopathic physicians in 1997, ranking second among the 46 states with medical schools.

On a per capita basis, Pennsylvania graduated more new physicians per 100,000 population (10.5) than the national average (6.6), and ranked 6th. Pennsylvania produces a high share of its physicians in its own medical schools: Among active allopathic patient care physicians in Pennsylvania in 1998, 43% graduated from in-state medical schools, compared with a national average of 32% (HRSA 2000).

Exhibit 29. Pennsylvania Physicians Are Unevenly Distributed
Physicians per 100,000 population, 1998



Source: HRSA (2000)

Quality of Health Care

Evidence on the overall quality of U.S. medical care is limited. State-specific measures of how well doctors and hospitals perform are even less readily available. General health system performance is partially reflected in state rankings of population health status. These suggest that Pennsylvania is typical of the U.S. at large. One leading compilation of state public health measures ranked Pennsylvania 23rd overall among states in 2002 (Exhibit 30), little changed from 1990. Pennsylvania scored well on extent of insurance coverage as already noted and spending for public health and Medicaid, as discussed below. It scored worse on success in reducing tobacco use, adequacy of prenatal care, and total mortality rates, as well as death rates from specific causes.

Such population-based measures are somewhat distant from the allegations of substandard individual performance contained in medical malpractice claims. Service

Exhibit 30. Pennsylvania Ranks Near Average in Population Health Status
Specific Public Health Measures, 1990 & 2002

Health Measure	1990		2002	
	Rate	Rank	Rate	Rank
Prevalence of Smoking (% of pop'n)	29.3	23	24.5	34
Adequacy of Prenatal Care (% of pregnant women)	71.5	21	73.9	31
Lack of Health Insurance (% without health insurance)	7.7	4	9.2	6
Support for Public Health Care (Ratio to nat'l ave.)	0.75	18	2.07	7
Heart Disease (Deaths per 100,000 pop'n)	346.2	43	289.7	36
Cancer Deaths (Deaths per 100,000 pop'n)	212.4	43	220.0	37
Total Mortality (Deaths per 100,000 pop'n)	929.1	43	913.3	35
Infant Mortality (Deaths per 1,000 live births)	10.3	30	7.2	29
Overall		20		23

Source: United Health Foundation

quality is more directly relevant. One very recent analysis tracked national and state-level changes in performance on 22 quality indicators for Medicare services. It ranked Pennsylvania 16th in 1998-99 and 31st in 2000-2001 (Jencks et al. 2003). By comparison, New Jersey ranked 43rd, New York ranked 24th, and Ohio ranked 38th in 2000-2001. The scores were based on process-of-care measures such as prevention and treatment of acute myocardial infarction, breast cancer, diabetes mellitus, heart failure, pneumonia, and stroke. The analysis was performed by the federal Centers for Medicare and Medicaid Services and covered only care delivered to fee-for-service Medicare beneficiaries.

Quality varies by medical provider and by service. Pennsylvania and some other states have measured and publicly reported outcomes of certain hospitals procedures, notably coronary bypass surgery, whose outcomes vary widely by hospital (PHC4 2001). The goal is to effect institutional improvements through performance feedback, which was successful in New York's pioneering program (Chassin 2002). Whether medical liability, which changes from place to place within states, contributes to local practice variation has not been established. Finally, it is worth observing that some Pennsylvania hospitals rank very high nationally in qualitative surveys such as the *US News & World Report* rankings.

Health Care Spending

Spending on medical services is high in Pennsylvania by many measures. Overall, Pennsylvania's per capita personal health care expenditures in 1998 were 11% above the national average, 7th highest among states (Exhibit 31) and totaling some 14% of gross state product compared with a national average of 12% (KFF 2003). The entire region has high costs for medical care; among neighboring states, only Ohio is near the national average. During 1991-1998, medical spending in Pennsylvania grew at the same rate as in the nation as a whole.

Exhibit 31. Pennsylvania Ranks High in Medical Spending
Per Capita Personal Health Care Spending by State, 1991-1998

State	1991	1998	rank, 1998	As % of US Ave	Ave. Ann. % Growth
US Average	$2,685	$3,759	--	100.0%	4.9%
New York	3,288	4,706	2	125.2%	5.3%
Delaware	2,878	4,258	5	113.3%	5.8%
New Jersey	2,966	4,197	6	111.7%	5.1%
Pennsylvania	2,988	4,168	7	110.9%	4.9%
West Virginia	2,568	4,044	9	107.6%	6.7%
Maryland	2,796	3,848	13	102.4%	4.7%
Ohio	2,709	3,747	21	99.7%	4.7%

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, 1998 State Estimates -- per Capita Personal Health Care <http://cms.hhs.gov/statistics/nhe/state-estimates-residence/us-per-capita10.asp>
Note: The highest state is Massachusetts, just above NY at 128%; the lowest is Utah, at 73%; DC excluded because distorted by border-crossing

The distribution of personal health care spending in Pennsylvania is similar to that of the U.S. overall (Exhibit 32). However, the share of spending for physicians is about 10% below the national average. Correspondingly, the institutional share of spending is higher in Pennsylvania, especially for nursing homes.

Nonetheless, in 2000, the average annual cost of employment-based health insurance in Pennsylvania was almost identical to the US average. Individual and family coverage averaged $2,467.06 and $6,721.41 in Pennsylvania versus $2,654.67 and $6,772.47 nationally (KFF 2003).

Medicare payments per enrollee are high in Pennsylvania (8.6% above the nation

Exhibit 32. Pennsylvania Medical Spending Patterns Resemble Those of the US
Distribution of Personal Health Care Spending by Service, 1998

Personal Health Care Spending by Type of Service		
Service	PA (%)	US (%)
Hospital Care	38.3	37.4
Nursing Home Care	11.7	8.6
Physician & Other Professional	26.5	29.1
Drugs & Other Medical Nondurables	12.3	12.0
Dental Services	4.3	5.3
Home Health Care	2.2	2.9
Medical Durables	1.4	1.5
Other Personal Health Care	3.2	3.1

Source: Kaiser Family Foundation

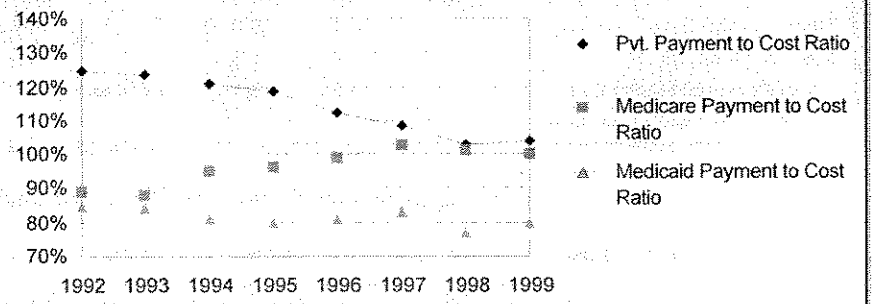
as a whole in 1999), although they grew at only half the national rate from 1994-1999. A marked increase in the managed care share of Medicare may have helped curb spending growth. Between 1994 and 1999, Pennsylvania rose from 3.3% to 27.5% (national average increase=17.8%) (CDC 2002). Medicare is the biggest payer for hospitals, and has reduced payment growth since the Balanced Budget Act of 1997. Large teaching hospitals have been the hardest hit, which has a significant impact on Pennsylvania because of its many academic medical centers. Medicare also reduced physicians' fees, including a roughly 5% reduction for 2003. Similar cuts are scheduled for the next three years, but Congress may modify the timetable for implementing them.

The Pennsylvania Medical Assistance Program is the fourth largest Medicaid program in the nation. Spending for services and administration increased by 50% from $6.4 billion in 1994 to $9.6 billion in 1999. The state spends 27.4% of its budget on Medicaid, half again as much as the national average of 19.6%. Medicaid spending is more moderate on a per enrollee basis; in 1998, Pennsylvania ranked 18th in the nation (36th if long-term care is excluded) (Lewin Group 2001).

Private health insurers seem able to hold down physician fees; the largest insurer in Philadelphia unilaterally cut payment rates in 1998 (Guadagnino 1998). According to news accounts, however, this same plan increased physician payments in 2002 and plans to do so again in light of increased malpractice premium burdens on physicians (NEPA News 2002). For hospitals, one analysis suggests that the prices

paid by Pennsylvania health plans declined in the late 1990s and are lower relative to hospital costs than national norms (Lewin Group 2001) (Exhibit 33). Whereas Medicaid payments in 1999 were only 4% below hospital costs nationally, Medicaid payments were 20% below hospital costs in Pennsylvania (ninth lowest among states). Conversely, whereas private payment levels were about 15% above costs nationally, they were only 4% above costs in Pennsylvania (fourth lowest among states). Medicare payment levels were almost the same in Pennsylvania and the nation at large. According to this analysis, the low payment-to-cost ratios are attributable to low payments, not high costs. Hospital officials assert that Pennsylvania's hospitals are highly efficient because for a decade they have successfully cut costs, partly in response to constrained payments.

Exhibit 33. Pennsylvania Hospitals Face Stringent Reimbursement Payment to Cost Ratios by Payer, 1992-1999



Source: Lewin Group 2001

An implication of the Lewin analysis is that hospitals have very limited ability to respond to fiscal shocks—either payer-imposed price cuts or higher costs like those for malpractice coverage. According to Pennsylvania-only data compiled by the Pennsylvania Health Care Cost Containment Council (PHC4 2003), the operating margins of the state's hospitals dropped in 1998 and 1999, with hospitals in the latter year losing one quarter of a cent on each dollar of patient revenue. Subsequent years have seen a recovery, but only to about a 2% margin, which is lower than national averages.

Conclusion

This report provides policy-makers with necessary context for generating and evaluating options for insurance and legal reform. Health care constitutes a major industrial sector in Pennsylvania. Preventing serious effects on medical services therefore is important to the state's economic health as well as its physical health. Health care providers in Pennsylvania have encountered steep increases in the cost of liability insurance since 2000, as many liability insurers have withdrawn from the market and premiums have risen for available coverage. While the medical malpractice insurance crisis is national in scope, Pennsylvania has been especially hard hit. As a result, Pennsylvania – traditionally in the middle of the pack – is now a high-cost state.

General economic trends explain part of Pennsylvania's situation, but other factors are state-specific. Pennsylvania physicians and hospitals are uniquely burdened by high assessments for the state's catastrophic loss fund. While cyclical changes within the insurance industry are clearly a factor affecting the affordability of liability coverage in Pennsylvania and elsewhere, the largest component is the rising cost of legal claims. Pennsylvania exceeds national averages for legal costs because of high claims rates and payouts. This is particularly the case in Philadelphia, where plaintiffs are twice as likely to win jury trials as in the rest of the country, and where a substantial percentage of cases result in verdicts greater than $1 million.

No clear evidence yet exists as to the effects of the malpractice crisis on Pennsylvania's health care system. The state's supply of medical providers was little changed by the first medical liability crisis in 1975, and provider-to-population ratios for both hospitals and physicians rose relative to the nation through the mid-1980s liability insurance crisis and well into the 1990s. However, the current crisis presents greater reason for concern. Providers, particularly hospitals, are under greater financial strain now than in past crises. It may be that access problems pertain only to certain regions of the

state (e.g., rural areas, inner cities), certain patient subgroups (e.g., Medicaid patients, the uninsured), or certain medical subspecialties (e.g., obstetrics, orthopedics, neurosurgery).

Because the problems afflicting Pennsylvania's malpractice system have developed over time, they will take time to resolve. The overhang of unresolved claims and various features of the state's liability insurance market make it very difficult to reduce costs in the short term. Therefore, subsidies that allow health care providers to maintain coverage would seem to be the only practical approach to alleviating the current crisis. In the longer term, a wider range of strategies exists to control costs, improve predictability, and attract insurers to the Pennsylvania market. In addition to conventional tort and insurance reforms, lawmakers should consider systematic changes to the way that injuries caused by medical care are identified, compensated, and prevented. Although much is known about the malpractice system, much remains to be learned. The difficult public policy decisions that must be made should be based on detailed, current, and objective information.

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About the Project

The Project on Medical Liability in Pennsylvania (www.medliabilitypa.org) is a two-year program of research, consultation, and communication funded by The Pew Charitable Trusts that seeks to provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system, to broaden participation in the debate to include new constituencies and perspectives, and to focus attention on the relationship between medical liability and the overall health and prosperity of the Commonwealth.

The Pew Charitable Trusts (www.pewtrusts.com) support nonprofit activities in the areas of culture, education, the environment, health and human services, public policy and religion. Based in Philadelphia, with an office in Washington, D.C., the Trusts make strategic investments to help organizations and citizens develop practical solutions to difficult problems. In 2002, with approximately $3.8 billion in assets, the Trusts committed over $166 million to 287 nonprofit organizations.

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