The Role of Rural Health Networks in Addressing the Malpractice Issue: Rural Pennsylvania's Community Hospital Alternate Risk Transfer Project

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I. Pennsylvania Mountains Healthcare Alliance (PMHA)

A. History
B. Mission
C. Structure
D. Evolving Purposes
E. Successes and Failures

II. The Pennsylvania Malpractice Crisis

A. Accelerating increases in premiums from July 2000 to August 2001
B. August 2001 - PHICO, the largest insurer of Pennsylvania hospitals, goes into liquidation
C. January and February 2002, St. Paul, MIXX, and Princeton announce intent not to offer malpractice insurance renewals to Pennsylvania hospitals
D. Existing commercial carriers begin offering premium increases up to 600%
E. Charles Cole's total insurance premiums rose from $750,000 on December 31, 2001 to $1.6 million on January 1, 2002 with an increase in deductibles and reduction of excess coverage
F. Pennsylvania CAT Fund insolvency looming and projected surcharges staggering
G. Series of extraordinary jury awards
H. Many hospitals and physicians begin to experience that there exists no commercial malpractice insurance available at any rate
I. Many hospitals unable to obtain excess malpractice coverage
J. Hospitals begin experiencing unavailability of general liability insurance at any rate
K. Many Pennsylvania hospitals and physicians place coverage with the state's Joint Underwriting Authority (the insurer of last resort) which creates gaps in coverage with no ability to obtain excess insurance
L. An understanding of the status of Pennsylvania rural hospitals is important to an appreciation of the consequence of the malpractice crisis upon these rural hospitals. The following factors influence the viability of Pennsylvania rural hospitals:
    1. The malpractice crisis occurs in a backdrop where 73% of all Pennsylvania hospitals are experiencing negative operating margins.
    2. There are no public hospitals in this state.
    3. Pennsylvania ranks 45th in the nation in terms of Medicaid reimbursement as a percentage of cost of care.
    4. At Charles Cole, we received 71 cents of reimbursement from Medicaid for every dollar spent in caring for those patients, resulting in a loss to our hospital of in excess of $1 million per year in providing care to Medicaid recipients.
    5. Pennsylvania has the second oldest population in the country.

6. Pennsylvania has the largest rural population in the country.

M. Physician Issues
   1. 63% of all hospitals in the state report physicians retiring early, limiting practices, or re-locating to other states because of liability costs
   2. 63% of all medical residents in Pennsylvania teaching programs report they will not practice within the State of Pennsylvania
   3. 54% of all hospitals report significant recruitment problems directly tied to the cost of liability insurance
   4. 35% of all hospitals report the closure or the decreasing availability of services due to physicians leaving or due to increased liability insurance rates.
   5. 50% of Pennsylvania hospitals report medical staff members denied coverage by commercial carriers and forced to find alternative coverage. Occurrence-based policies become difficult, if not impossible, to obtain for physicians.
   6. Total cost of hospital malpractice coverage from November 1, 2001 to November 1, 2002 increases 86%, with 23% of all hospitals reporting increases of 200% or greater
   7. Pennsylvania ranks #1 of premium cost per doctor in the nation. Examples: see cost increases for two CHART members (Main Street Community Hospital (A) and (B))

III. The Formation of CHART

A. PMHA initiates an independent evaluation in July 2001 of self-insured products
B. September 2001 - PMHA and Marsh agree to join forces in attempting to structure a self-insured risk product for select community hospitals
C. October 2001 - Initial meeting of 25 hospitals with agreement reached to fund feasibility study with completion date of December 31, 2001
D. Commitment to form CHART with start date of May 1, 2002
E. CHART's mission
F. Selection of members and criteria used
G. Captive advantages
H. Captive challenges
I. CHART program design
J. CHART program cost estimate
K. The excess layer and how it is structured
L. May 1 - 10, 2002 - How CHART almost blew up
M. CHART organizational structure
N. The role of the committees and the oversight of the providers of services:
   1. Risk Management
   2. Claims
   3. Underwriting
   4. Finance
   5. Advocacy
O. The role of PMHA in CHART
P. The physician malpractice crisis and how CHART is reacting to it

Q. Major foreseeable challenges

IV. Liability Reform in Pennsylvania since the Inception of CHART

A. New sanctions for filing frivolous lawsuits
B. Changes in the collateral source rule
C. Future damages for lost earnings reduced to present value
D. Restrictions on venue shopping
E. Changes in joint and several liability rules
F. Modification of CAT Fund administration
G. $400 million in subsidies committed over next ten years to reduce CAT Fund assessments
H. Implementation of Act 13, a patient safety act
I.

V. Conclusions

A. Malpractice crisis is part of a much larger issue and cannot be effectively dealt with in a vacuum.
B. Existing tort reform legislation is inadequate to meaningfully address the problem.
C. Caps on non-economic damages are imperative.
D. The jury system does not provide an equitable, timely, or manageable process for dealing with malpractice issues. An alternative dispute resolution process is needed.
E. Unnecessary utilization is a direct by-product of the current malpractice environment and will not be effected by the tort reform measures enacted thus far.
F. Rural hospitals and physicians are paying for the cost of jury verdicts in more urban settings.
G. Patient safety must be given a high priority by hospitals and physicians.
H. Patient safety cannot be meaningfully improved within our existing regulatory environment. Substantial regulatory reform must occur with an emphasis on education of patients and providers and with a de-emphasis on paperwork, regulation, enforcement, and punition.
I. Medical malpractice reform should be addressed on the federal level within the context of a comprehensive national health policy.
J. There must be a societal recognition that the nation possesses a finite amount of resources to devote to health care and that dollars spent to support the present malpractice system detract from the best use of those limited resources.
K. Regional collaboration provides opportunities that do not require governmental action; however, if long-term reforms are not governmentally enacted, even the most well constructed rural risk alternative will not be able to survive in a continually deteriorating environment.
L. Cracks in the foundation of rural health care continue to broaden. Effective collaboration between members of rural health networks may provide significant opportunities if adequate resources are devoted to the development of these rural regionalized initiatives.