

**INTERIM REPORT**  
**OF THE OHIO MEDICAL MALPRACTICE COMMISSION**

**I. Introduction**

**Creation of Commission under Senate Bill 281**

The Ohio Medical Malpractice Commission was created in 2003 as a part of legislation designed to address the medical liability crisis in Ohio. That legislation, Senate Bill (“S.B.”) 281, was enacted in response to concerns that rapidly rising premiums were driving away medical malpractice providers and tightening the Ohio medical liability insurance market. The bill contained a comprehensive set of tort reforms aimed at addressing litigation costs and at stabilizing the Ohio medical malpractice market. Governor Bob Taft signed S.B. 281 on January 10, 2003. The bill became effective on April 11, 2003.

In order to further analyze the causes of the current medical liability crisis, and explore possible solutions in addition to tort reform, S.B. 281 created the Ohio Medical Malpractice Commission (“Commission”). The Commission is composed of nine members, all of whom must have expertise on medical liability issues. The insurance industry, health care providers, and the legal system are all represented on the Commission. The members of the Commission are

Ann Womer Benjamin, Esq.  
Director  
Ohio Department of Insurance  
Columbus, Ohio  
Chairman of the Commission

Steve Collier, Esq.  
Connelly, Jackson & Collier  
Toledo, Ohio

Ray Mazzotta  
President & CEO  
OHIC Insurance Co.  
Columbus, Ohio

Gerald Draper, Esq.  
Roetzel & Andress LPA  
Columbus, Ohio

D. Brent Mulgrew  
Executive Director  
Ohio State Medical Association  
Hilliard, Ohio

George Dunigan  
Director of Government Relations  
Ohio University COM/OOA  
Columbus, Ohio

Frank Pandora II, Esq.  
Sr. VP & General Counsel  
Ohio Health  
Columbus, Ohio

William Kose, MD  
Rawson, Ohio

Wayne Wheeler, MD  
Portsmouth, Ohio

## **Charge of Commission**

As provided by S.B. 281, the Commission has two charges. First, the Commission is required to study the effects of the tort reforms contained in S.B. 281 on the medical malpractice marketplace. Second, the Commission is required to investigate the problems posed by, and the issues surrounding, medical malpractice. The Commission must submit a report of its findings to the Ohio General Assembly on or before April 11, 2005, which is two years after the effective date of the bill. However, because of the increasingly urgent nature of this issue, the Commission has decided to issue this interim report to detail its progress.

Another piece of legislation impacting the Commission, Senate Bill 86 (125<sup>th</sup> General Assembly), recently passed both chambers of the Legislature and was signed by Governor Bob Taft on January 14, 2004. S.B. 86 adds several additional charges to the Commission's mission. Those new charges require the Commission to

- Study the affordability and availability of medical malpractice insurance for health care professionals and other workers who are volunteers and for nonprofit health care referral organizations.
- Study whether the state should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and workers to utilize as volunteers in providing health-related diagnoses, care, or treatment to indigent and uninsured persons.
- Study whether the state should create a fund to provide compensation to indigent and uninsured persons who are injured as a result of the negligence or misconduct by volunteer health care professionals and workers.
- Study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law.

The Commission must submit a report of its findings to the General Assembly not later than two years after the effective date of S.B. 86.

## **Provisions of Senate Bill 281**

Senate Bill 281 contained a number of tort reform measures designed to stabilize the medical liability market in Ohio. The reforms impact medical, dental, optometric and chiropractic claims that arise on or after April 11, 2003. The reforms implemented by S.B. 281 include the following:

- Limits on non-economic damages – Non-economic compensatory damages are generally capped at \$500,000. For injuries involving permanent and substantial physical deformity, loss of a limb or bodily organ system, or for an injury that deprives a person of independently caring for himself and performing life-sustaining activities, non-economic compensatory damages are capped at \$1,000,000.
- Collateral sources – Sources of benefits available to a plaintiff as a result of a medical malpractice injury may be introduced at trial.
- Arbitration – Expands the law governing arbitration to include agreements between a patient and healthcare providers other than just physicians or hospitals, and shortens the time before which such agreements become irrevocable.
- Notice of claim – Prohibits an insurer from considering the existence of a 180-day written notice letter when determining an insured's premium or rates.
- Statutes of limitations and repose – The statute of limitations to bring a medical malpractice claim is one year after the cause of action accrues. The statute of repose generally bars claims initiated more than four years after the occurrence of the act or omission constituting the basis of the claim.

- Good faith motion – Allows a defendant to compel a hearing to test whether a claim is supported by reasonable good faith.

## **II. Medical Liability Market**

### **General Overview**

Ohio, like many other states, is in the midst of a medical liability insurance crisis. Health care providers are having difficulty finding affordable medical liability insurance coverage since rates have been rising rapidly. In addition, in the past few years, the market has tightened as a number of insurers have left the Ohio market. St. Paul, Farmers' Insurance Company, First Professional, and Professional Advocates have all exited the Ohio market since December of 2001.

The Ohio market currently is dominated by five medical malpractice insurers. Those five insurers, Medical Protective, Medical Assurance, OHIC Insurance Company ("OHIC"), American Physicians, and the Doctors' Company control nearly 72 percent of the Ohio market. The top three, Medical Protective, Medical Assurance and OHIC, control nearly 60 percent of the market. Medical Protective, OHIC and American Physicians have all recently received downgrades by rating agencies.

Another indication of the tightening medical liability market is the growth of the surplus lines market. Surplus lines companies are insurance carriers that provide coverage in markets where admitted insurance carriers refuse to write some risk. Since 2002, four additional surplus lines companies have begun to write medical malpractice insurance in Ohio. Surplus lines carriers are not regulated by the Department of Insurance ("Department").

In 2003, rates for the top five companies increased an average of 30 percent. Some areas of Ohio, such as the counties in the northeast and along the eastern border, have seen even higher increases. This is particularly true for medical specialties such as OB/GYNs, radiologists, and emergency/trauma providers.

The difficulties in finding affordable medical liability insurance coverage raise concerns that health care providers, particularly those in the high-risk specialties, will limit care, leave Ohio, or leave the profession entirely. Ohio health care consumers may experience increasing difficulty seeing the provider of their choice. Costs to consumers may also rise if providers over-prescribe, over-treat, and over-test their patients to avoid potential lawsuits.

A majority of the Commission recognizes that the crisis has escalated in the last several months, and that doctors appear to be leaving Ohio or closing practices. Those together with further financial issues facing several of the top five medical liability insurers heighten the concerns about the market and the urgency of implementing measures to stabilize the situation. See the attached appendices. All submitted presentations are available for review at the Ohio Department of Insurance.

### **Difficulty in Evaluating the Impact of Senate Bill 281**

At this early stage the impact of Senate Bill 281 on the Ohio medical liability market cannot be assessed since the reforms did not become effective until April 11, 2003. Accordingly, the law is not applicable to many of the medical malpractice cases currently pending in Ohio courts. Furthermore, most of those cases involving claims that arose on or after April 11, 2003, to which S.B. 281 would apply, will not close for many years. As those cases begin to wind their way through the court system, more data about the impact of S.B. 281 should become available.

An additional problem is how to collect the data on medical liability claims. Senate Bill 281 does contain some mechanisms for collecting this data. The bill requires every clerk of a common pleas court to file with the Ohio Department of Insurance, before January 15 of each year, a report containing information regarding each medical, dental, optometric, and chiropractic claim that has been filed and is pending in that court of common pleas. The information in the report must include

- The style and number of the case;
- The date the case was filed;
- Whether or not there has been a trial and, if so, the date of the trial;
- The current status of the case;
- Whether or not the parties have agreed on a settlement of the case;
- Whether a judgment has been rendered and, if so, the nature of the judgment including the date and the amounts of compensatory damages that represent economic and non-economic loss; and
- If a judgment has been rendered, whether an appeal has been filed or whether the time to file an appeal has expired.

The Department currently is examining these reports. One shortcoming of the information in these reports is that, although each report indicates when the case was filed, it does not necessarily indicate when the cause of action accrued and, accordingly, whether the claim is subject to S.B. 281. Even if the applicability of S.B. 281 was apparent, given the short amount of time that has elapsed since the bill became effective, definitive conclusions from the data will be difficult, if not impossible, to draw at this time.

Another shortcoming of the data coming from the clerks of court is that it does not include detailed settlement information. County clerks are required to report whether a case has settled, but they cannot report details of that settlement where the settlement is confidential. They also cannot provide information on claims when no case is filed or the case is arbitrated. This information is necessary to fully evaluate the impact of S.B. 281 on the Ohio medical liability market.

In order to address these shortcomings in data, the Department issued a data call in October of 2003 to all medical malpractice insurers licensed in Ohio. The data call was issued pursuant to Director Womer Benjamin's market conduct and financial exam authority and will seek to collect specific information about medical malpractice claims. While the specific data is confidential pursuant to statute, the Department will issue a report with the data in aggregate form. The data in the report should provide the Ohio Medical Malpractice Commission with an additional tool to measure the impact of S.B. 281.

Lastly, in addition to the recentness of S.B. 281 and the difficulty in collecting good data, another obstacle to the evaluation of the impact of S.B. 281 is that its constitutionality, particularly its limits on non-economic damages, has not been tested. The Ohio Supreme Court previously has found limits on general non-economic damages to be unconstitutional. Insurers may be reluctant to take S.B. 281 into account when setting rates because of the uncertainty surrounding the future survival of the limitations on non-economic damages. If insurers reduce rates now, and the limitations are later found to be unconstitutional, the insurers will be in difficult financial circumstances where they may have set rates that inadequately address future losses. Until the constitutionality of S.B. 281 is addressed by the Ohio Supreme Court, uncertainty over the future viability of the non-economic damage limitations will hamper the Commission's efforts to fully evaluate the impact of S.B. 281 on the Ohio medical liability market. Even after the constitutionality is determined, the Commission may have difficulty measuring whether there will be an impact because S.B. 281 may not have been in effect long enough to measure the impact.

### **III. Progress of the Commission**

#### **General Approach, Number of Meetings, Topics Reviewed**

The first meeting of the Commission was held at the Ohio Department of Insurance on May 9, 2003. The Commission members reviewed their statutory charge and agreed that the charge encompassed not only review of the impact of S.B. 281 and the study of general medical malpractice issues, but also the investigation and recommendation of possible additional steps the General Assembly could take to help alleviate the crisis. The Commission adopted a statement of purpose to guide its deliberations:

Provide available, affordable, and stable medical liability coverage for the Ohio medical community while providing for patient safety and redress for those who are negligently harmed.

The Commission has held nine monthly meetings (the Commission did not meet in November) to review different medical malpractice issues. Speakers with expertise on particular medical malpractice-related topics were invited to testify before the Commission. The Commission has heard testimony from actuaries, doctors, state regulators and other experts on a number of topics. Among the issues and topics that have been reviewed by the Commission are the following:

#### **A. RATEMAKING**

At the June 11, 2003 meeting, the Commission heard testimony from three speakers about ratemaking:

**James Hurley**  
**Chairperson, Medical Malpractice Sub-commission**  
**American Academy of Actuaries**

Mr. Hurley discussed the causes of the medical liability insurance crisis, the ratemaking process, and the impact of tort reform, in general, on the medical malpractice market. Mr. Hurley also stated that, based on the portfolios of the medical malpractice insurers, he did not believe the investment losses of the late nineties contributed to current medical malpractice rates.

**Jeffrey J. Smith**  
**Vice President and Lead Reserving Actuary**  
**The Medical Protective Company**

Mr. Smith discussed ratemaking goals and how companies estimate rates to achieve those goals. He further provided testimony about what is involved in determining the rates of medical malpractice insurance.

**John R. Pedrick**  
**Chief Actuary, Property & Casualty Division**  
**Ohio Department of Insurance**

Mr. Pedrick discussed the regulatory authority for ratemaking and the application of actuarial principles, standards of practice and Ohio law to the Ohio Department of Insurance's review of ratemaking requests. Mr. Pedrick also discussed the relationship between ratemaking and solvency, and cautioned that rates cannot be reduced if they are not at an adequate level.

Mr. Pedrick explained that Ohio has a “file and use” system whereby an insurer can use a rate change once it is filed with the Department. The Department has the statutory duty to review the filed rate to determine if it is excessive, inadequate, or unfairly discriminatory based on statutory and actuarial standards. If the rate, as presented and substantiated by the insurer in its rate filing, is not excessive, inadequate or unfairly discriminatory, the Department must accept the rate request. The Department has no authority to set insurance rates.

Mr. Pedrick testified that 60-70 percent of all medical malpractice claims are closed with no payment to the claimant, and only about 5 percent of total claims get to trial. Industry financial data analyzed by the Department on aggregate costs illustrates that investigation and defense costs total about 20 percent of the total rate, which also includes actual claim payouts at 58 percent, agent commissions at 6 percent, and other operational costs at 17 percent. Therefore, reducing these costs could impact rates and the insurance company’s overall costs.

At the October 22, 2003 meeting, the Commission heard testimony from a fourth speaker about ratemaking:

**Eric Nordman**  
**Director of Research**  
**National Association of Insurance Commissioners**

Mr. Nordman gave an overview of the various regulatory rate review standards, such as “prior approval” and “file and use,” which have been used by different states to review rates and attempt to stabilize medical malpractice rates. Mr. Nordman cautioned that due to the high-risk nature of writing medical liability policies, a change in the current regulatory system (“file and use”) may cause medical malpractice insurers to leave the market.

## **B. PATIENT COMPENSATION FUND**

At the July 15, 2003 meeting, the Commission heard testimony about Patient Compensation Funds (“PCF”):

**Robert J. Walling, FCAS, MAAA,**  
**Pinnacle Actuarial Resources, Inc.**

Mr. Walling testified regarding the *Feasibility of an Ohio Patient Compensation Fund* report Pinnacle prepared for the Ohio Department of Insurance. The report was required by S.B. 281. Mr. Walling concluded that damage caps would contribute to a reduction in medical malpractice claim costs and a PCF could account for an additional drop in costs.

The Commission expressed an interest in learning more about the possibilities of a PCF and sought further testimony from regulators from states that had a functioning PCF. The Commission was particularly interested in hearing from those states in which the medical malpractice insurance market was not in “crisis” as defined by the American Medical Association.

At the December 17, 2003 meeting, the Commission heard testimony from state regulators from Wisconsin, New Mexico, and Indiana. The regulators included the following:

**Jorge Gomez**  
**Commissioner**  
**Wisconsin Department of Insurance**

**Thomas R. Rushton**  
**Deputy Superintendent**  
**New Mexico Department of Insurance**

**Cynthia D. Donovan**  
**Deputy Commissioner, Financial Services Operations**  
**Indiana Department of Insurance.**

**Annette Gunter**  
**Manager, Patients' Compensation Fund**  
**Indiana Department of Insurance.**

All of the regulators testified about the PCFs in their respective states and how implementation of the PCFs affected their state's medical liability markets. The speakers concluded that the PCFs in their respective states, together with tort reform, had contributed to their states' stable medical liability markets.

### **C. DATA COLLECTION**

In an effort to determine what data was available about the medical liability market in Ohio, and to determine what information still needed to be collected, the Commission dedicated a meeting to data collection. At the August 5, 2003 meeting, representatives from the Ohio Supreme Court, County Clerks of Court, and the Ohio Department of Insurance testified about their data collection efforts:

**Doug Stephens**  
**Director of Judicial and Court Services**  
**Ohio Supreme Court**

**Diane Hatcher**  
**Manager of Case Management Systems**  
**Ohio Supreme Court**

Mr. Stephens and Ms. Hatcher explained how the Ohio Supreme Court collects information on professional liability court cases. Local courts are required to forward information regarding professional liability cases to the Ohio Supreme Court. Unfortunately for the Commission, Mr. Stephens and Ms. Hatcher testified that the information does not differentiate medical malpractice cases from other professional liability cases. The data also does not include data regarding cases settled out of court. Ohio Supreme Court records indicated that the number of professional tort cases filed and tried to a verdict has remained relatively stable, rising only gradually since 1990.

**Lynne Mazeika**  
**Lake County Clerk of Courts**

**Todd Bickle**  
**Muskingum County Clerk of Courts**

Ms. Mazeika and Mr. Bickle testified about the data Ohio clerks of court are required to collect pursuant to S.B. 281. They explained the difficulties of collecting this information. Ms. Mazeika and Mr. Bickle expressed concerns about the technology and resources available to collect and transmit the data, and further noted that many clerks were not qualified to interpret court documents regarding medical malpractice data since clerks of court are not required to be

attorneys. Lastly, they noted that they could not report data regarding settlements when those settlements were confidential between the parties.

**Peg Ising**  
**Assistant Director, Property and Casualty Division**  
**Ohio Department of Insurance,**

Ms. Ising testified about the data the Department currently collects and how it is collected. The Department collects data regarding medical malpractice in several ways. The Department receives data through rate filings, annual statements, “fast track” reports as well as through a 2002 Department market availability initiative in which medical malpractice companies submit new business, cancellation and non-renewal data to the Department.

Ms. Ising also gave a general outline of a data call the Department was preparing to issue to all medical liability insurers in Ohio. The data call would be issued under Ohio Director of Insurance Ann Womer Benjamin’s market conduct and financial exam authority and would collect specific claim data, including data regarding settlements. Ms. Ising testified that the data received pursuant to the data call would be confidential, but that the Department would issue a report containing aggregate data that would be available to the Commission and the public. Subsequent to Ms. Ising’s testimony, the data call was issued in October of 2003.

#### **D. MEDICAL ERRORS**

At the September 26, 2003 meeting, the Commission heard from three speakers about medical errors. The speakers were as follows:

**Thomas A. Dilling, J.D.**  
**Executive Director**  
**State Medical Board of Ohio**

Mr. Dilling explained the role of the State Medical Board in addressing medical error. He testified that the Board receives approximately 3,000 complaints per year, 60 percent of which are investigated by the Board. Mr. Dilling testified the biggest challenges facing the Board included access to doctor peer review, remediation of doctors who need help, and receiving doctors’ case information years after an incident due to pending litigation.

**Brian F. Keaton, M.D. FACEP**  
**Attending Physician and EM Informatics of the Dept. of Emergency Medicine**  
**Summa Health System**

Mr. Keaton testified about efforts to use technology to prevent medical errors. Mr. Keaton suggested insurance discounts be offered as incentives for doctors to use technology to prevent patient care errors. He said the biggest obstacle to using technology to reduce medical errors is cost.

**Andrew Thomas, M.D.**  
**Ohio Patient Safety Institute**  
**The Ohio State University**

Mr. Thomas discussed the Institute’s goal to further a culture of safety within the medical community and programs offered by the Institute to further that goal. He testified that the Institute is building a business plan for a statewide medical error reporting system.

**Theresa M. Tonies, R.N., J.D.**  
**Risk Counsel**  
**Barberton Citizens Hospital**

Ms. Tonies testified how disclosure within the medical field can lead to reduction of medical errors. She also testified that she would like to see a statewide patient safety model and quicker resolution of cases.

#### **E. ALTERNATIVE RISK MECHANISMS**

At the October 22, 2003 meeting, the Commission heard testimony about the Ohio Joint Underwriting Association (“Ohio JUA”) and about the state of the alternative risk market:

**Norm Beal**  
**Administrator**  
**Ohio JUA**

Mr. Beal gave the Commission an overview of the Ohio JUA, including what he understood were the reasons for its creation in 1975, how it functioned, and how it affected the medical liability market. Mr. Beal explained that the legislature later stopped the writing of new JUA policies on December 31, 1980 due to an improved medical liability market. Mr. Beal and Commission members discussed whether a new JUA could help alleviate the current medical malpractice crisis.

**Susan Stanfield**  
**Vice-President**  
**Marsh USA, Inc.**

Ms. Stanfield discussed the pros and cons of alternative risk arrangements such as risk retention groups and captives. She stated that while many such arrangements appeal to providers due to lower costs, alternative risk arrangements might cost providers significantly more in the long run if losses are higher than expected. Ms. Stanfield also suggested that a state safety net for insureds of well-run risk retention groups and captives might help stabilize the health care system if insolvency occurs.

#### **F. MEDICAL REVIEW BOARDS**

In December of 2003, the Commission heard testimony from state regulators from four witnesses about Medical Review Boards:

**Jorge Gomez**  
**Commissioner**  
**Wisconsin Department of Insurance**

**Thomas R. Rushton**  
**Deputy Superintendent**  
**New Mexico Department of Insurance**

**Cynthia D. Donovan**  
**Deputy Commissioner, Financial Services Operations**  
**Indiana Department of Insurance**

**Annette Gunter**  
**Manager, Patients’ Compensation Fund**  
**Indiana Department of Insurance.**

The regulators discussed their state regulatory systems, including how their states’ medical review boards (MRBs) worked. The witnesses, except for Commissioner Gomez, testified that the MRBs, in conjunction with their PCFs, had proven a useful tool in stabilizing the

medical malpractice market. The Commission discussed whether review by an MRB should be mandatory. In New Mexico, no medical malpractice action may be filed in any court before it is filed with the state's MRB and its decision is rendered. In Indiana, a medical malpractice claimant cannot access the PCF until the claim goes through Indiana's version of an MRB. Wisconsin law provides for mandatory review by a mediation panel, although Commissioner Gomez stated that he did not believe the panel review was a "big piece of the answer," since weak cases were "triaged" during the course of the litigation, and that tort reform and Wisconsin's PCF were the primary contributors to rate stability.

**Gerald S. Leeseberg, Esq.**  
**Leeseberg & Valentine**

Mr. Leeseberg, who testified on behalf of the Ohio Academy of Trial Lawyers, was skeptical that MRBs would be helpful to address the medical malpractice crisis, but said he was working with other interested parties to help ensure that a pending bill in the General Assembly addressing MRBs was properly drafted. Mr. Leeseberg indicated that the quality of the counsel can be significant in the outcome of the case.

#### **IV. Commission Evaluation of Options to Date**

The first priority of the Commission was to establish a common understanding among members of the medical malpractice market, the fundamentals of ratemaking, and the Department's statutory obligations regarding rate review. Therefore, initial meetings of the Commission were devoted to establishing a baseline of knowledge as opposed to studying specific options. Early on, the consensus of the group was that because the current medical liability insurance market is unstable, having sharply increasing premiums over the last several years and increasing surcharges on specialties and practitioners in certain geographic areas, the Commission should explore options that may help alleviate short-term cost concerns for providers as well as those options that may supplement current reforms in the long-term. A summary of the options and possible recommendations follows.

Finally, members discussed whether the medical malpractice issue is part of a larger systemic problem in the delivery of health care, which is plagued by declining or flat reimbursements, escalating health care costs, and the inability of providers to pass actual costs on to their patients. Because of the enormity of these issues and the Commission's statutory obligation, the focus of the Commission is limited to its statutory charge with a specific focus on the availability and affordability of medical liability insurance while providing for patient safety and redress.

#### **Data Collection**

The Commission sought to identify what information was collected regarding medical liability insurance and identify what information should be collected. The Ohio Department of Insurance receives aggregate loss data from insurers when they file their rate requests as required by law. The data is not broken out into specific lawsuits, judgments or settlements unless the Department requests such information in follow-up during the rate review. In addition, S.B. 281 requires all 88 county clerks of court to collect and submit medical malpractice lawsuit data annually to the Department beginning January 15, 2004. That data must include detailed case information, status, and settlement (if known) or judgment specifics with a breakdown as to economic and non-economic damages.

To supplement the information submitted by the clerks of court, the Department initiated its own data call of claims information held by insurance companies. This data call is modeled

after similar data studies conducted by Illinois and Florida. Florida law (Chapter 627) provides for detailed reporting and publication of lawsuit data for a variety of professional liability litigation including medical and legal malpractice.

Proposed recommendations:

- The Commission fairly uniformly feels additional data is needed to evaluate more completely the causes of the medical liability crisis in Ohio and has preliminarily identified several tools to collect information including the following:
  - Issuance of an annual report of information submitted by the clerks of court to the Ohio Department of Insurance. Senate Bill 281 did not contain this requirement. This information could be compiled and made available to stakeholders and various media.
  - Issuance of an annual report of aggregate information obtained through the Department's claims data study. This information is being collected from all companies that report written premium. The Department intends to issue a report regarding aggregate information and analysis of any specific trends in the Ohio market. This report could be modeled after a report issued annually by the State of Illinois. Information obtained on specific claims, claimants, and medical information or company specific information are confidential and not subject to Ohio's public records law.
- The Commission recommends the passage of legislation for the reporting of lawsuit data patterned after section 627.912 of the Florida Statutes.
  - Data would be reported to the Ohio Department of Insurance by self-insureds, licensed insurers, and surplus lines insurers selling medical liability coverage in Ohio.
  - Data should be audited as collected to make sure it is accurate.
  - The issue of confidentiality of the data needs to be addressed.
  - The data should be reported by the Department by specialty and by county.
  - The legislation should contain a penalty provision for failure to comply, probably enforced by the Department.
  - Once enacted, the need for the county clerk reporting provisions of S.B. 281 should be reconsidered.

### **Medical Error Reduction**

The Commission examined the question of the impact of medical errors on the availability and affordability of medical malpractice insurance. Members generally agreed that medical errors do occur and that the need exists to standardize collection of information regarding medical errors and to promote solutions to the prevention of medical errors. The Commission heard testimony from the Ohio State Medical Board, which identified a lack of resources to address the approximately 3,000 complaints it receives annually. Currently, the Board only opens investigations on 60 percent of all cases. The Ohio Patient Safety Institute testified that it was developing a statewide system for reporting medical errors. In addition, testimony was heard from a variety of sources that technology exists which has the potential for reducing medical error.

### Proposed Recommendations:

- The Commission encourages continuing efforts to identify barriers to sharing information from patient safety committees so providers can learn from their mistakes.
- The Commission urges health care provider associations to develop a protocol for disclosing medical errors to patients and reducing the incidence of medical errors.
- In addition, the Commission should study measures in place at the present time for reporting medical errors to patients and if sufficient measures are not in place they should be strongly considered.
- The Commission encourages insurance companies to provide risk management programs and identify risk reduction measures to their insureds.

### **Non-meritorious Lawsuits**

Most, but not all, members of the Commission have identified non-meritorious or “frivolous” lawsuits in medical malpractice as a cost driving factor which needs more review. The Commission did not discuss a definition of “frivolous” and is hampered from doing so by the lack of data on claims and lawsuit frequency from which to develop a standard. Most of the information received by the Commission is anecdotal.

However, the Commission recognizes that in the aggregate, claims, settlements and lawsuits do generate costs for insurance companies, whether or not any money is paid out to the claimant. Most members believe that failure to mitigate these costs will impact a provider’s liability premium regardless of the underlying merits of the lawsuits involved.

### Proposed Recommendations:

- All but one Commission member endorse generally the concept of a medical review process to pre-screen lawsuits and urge the legislature and interested parties to continue to pursue this measure expeditiously. This recommendation is not an endorsement of any specific legislation at this time.
- The Commission should evaluate the actual use of Ohio Civil Rule 11 and R.C. 2323.51 by defendants and judges.
- The Commission recommends that the Ohio Supreme Court consider special certification of attorneys authorized to bring medical malpractice cases.
- The Commission should explore greater use of alternative dispute resolution mechanisms.

### **Tort Reform and Other Legal System Reforms**

The Commission is charged with studying the impact of Senate Bill 281 and further discussion of tort reform is a topic which generates considerable debate. The Commission has not discussed or reached consensus on any legal system reforms.

As a ground rule, the Commission decided not to revisit the merits of S.B. 281 passed by the legislature in 2002. Part of the current debate regarding tort reform centers on the fact that, currently, data is not collected from which to draw conclusions about the impact and the frequency of verdicts on malpractice premiums. The Department does review aggregate cost data associated with investigating, defending, and settling claims with respect to company rate filings. However, prior to S. B. 281, detailed individual lawsuit information was not collected nor compiled by the Department. Data collected pursuant to S.B. 281 will begin providing some

useful information, but it will be prospective only since the law's enactment; past trends will not be reflected.

#### Proposed Recommendations:

- The Commission should obtain information from other states regarding the impact of tort reform. Specific information and testimony from states which have enacted significant tort reform could also help in the evaluation. Representatives from Wisconsin, Indiana and New Mexico have testified as to the measures those states have employed; testimony from California, Florida and Colorado might also be instructive.
- The Commission could explore the need for modifying caps on damages beyond those imposed by S.B. 281, even on economic damages.
- Most members of the Commission agree that the Commission should explore the need for statutory changes such as limiting attorney fees, and should explore changing the statute of limitations including the 180 day notice provision, changing the burden of proof to the higher standard of "clear and convincing" from "preponderance," or requiring the plaintiff and defendant to file an expert's report before the trial would proceed.
- The Commission should explore creating separate courts to handle medical liability cases, review the GAO report on medical liability issues, and explore the impact of tort reform on victims.

#### **Alternative Risk Mechanisms**

Senate Bill 281 mandated that the Department of Insurance study the feasibility of a patient compensation fund ("PCF"). A PCF typically provides an excess layer of coverage for health care providers above primary coverage. In many states, the requirement for primary coverage is typically \$250,000 which is purchased by the provider. The Department contracted with Pinnacle Actuarial Resources to conduct such a study. The Commission also received testimony from states with PCFs, Wisconsin, Indiana, and New Mexico, all of which reported an apparent positive impact on insurance rates. Wisconsin provided the most comprehensive testimony regarding PCFs as well as tort reform and should be explored more fully.

The Commission also discussed risk retention groups and captives in providing medical malpractice insurance. In addition, the Commission reviewed the purpose and operation of the Ohio Medical Professional Liability Underwriting Association created in 1975.

The Commission was briefed on the Department's initiative to set aside remaining monies from the 1975 Joint Underwriting Association to fund possible initiatives including but not limited to those recommended by the Commission. House Bill ("H.B.") 282 unanimously passed the Ohio House of Representatives on January 7, 2004. House Bill 282, sought by the Department, would provide for the transfer of the \$12 million still held by the Ohio JUA into a new fund that could be used to create a new medical liability company or to fund other medical malpractice initiatives as approved by the Ohio General Assembly. The legislation would also give the Director of Insurance authority to create a Medical Liability Underwriting Association ("MLUA") if the current medical malpractice market further deteriorates. The MLUA would write primary insurance coverage for doctors unable to find coverage. The legislation has been passed unanimously by the Ohio Senate and awaits concurrence in the House.

### Proposed Recommendations:

- The Commission should further consider PCFs, especially specific data on the impact on rates. However, a majority of the Commission recommends to the legislature immediate consideration of the establishment of a patient compensation fund since the testimony from states employing them indicated that they help reduce rates.
- The Commission should examine the possibility of a no-fault compensation fund to compensate injured claimants in certain types of cases, such as birth injury cases.
- The Commission recommends the immediate passage of H.B. 282.

### **V. Additional Issues for Review**

The Commission plans to review a number of additional topics in 2004, many of which were identified above. In addition, the Commission will explore those issues necessary to address the new charges contained in S.B. 86, including the affordability and availability of medical malpractice insurance for health care volunteers and nonprofit health care referral organizations, the feasibility of state-provided catastrophic claims coverage to health-care volunteers, and the feasibility of a state fund to provide compensation to persons injured as a result of the negligence of health care volunteers. The Commission will also review other states' Good Samaritan laws.

### **VI. Conclusion**

The Ohio Medical Malpractice Commission cautions the public to recognize this is only an interim report; a final report by the Commission is not due until April of 2005. Nevertheless, the following legislative action is recommended by the Commission at this time:

- House Bill 282, which authorizes the Director of Insurance to create a Medical Liability Underwriting Association if the current medical malpractice market further deteriorates, should immediately be passed by the General Assembly and presented to Governor Bob Taft for signature.
- Legislation requiring the reporting of medical malpractice lawsuit data, patterned after section 627.912 of the Florida Statutes, should be enacted by the Ohio General Assembly. Such legislation is necessary to fully evaluate the causes of the medical liability crisis in Ohio and to assist the Department and General Assembly in monitoring the market.
- The General Assembly and interested parties should continue to pursue expeditiously legislation creating a medical review screening process to pre-screen medical malpractice lawsuits.
- The General Assembly should give immediate consideration to establishing a patient compensation fund to help reduce medical malpractice rates.