Final Report on the Feasibility of an Ohio Patient Compensation Fund

May 1, 2003

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May 1, 2003

Ms. Peg Ising
Assistant Director
Ohio Department of Insurance – Office of Property & Casualty Services
2100 Stella Court
Columbus, OH 43215-1067

Dear Ms. Ising:

Enclosed is the draft of the Final Report on the Feasibility of an Ohio Patients Compensation Fund.

If you should have any questions or concerns, please call me at (309) 665-5010.

Sincerely,

Robert J. Walling, III, FCAS, MAAA
Principal and Consulting Actuary

RJW:ks

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Executive Summary

EXECUTIVE SUMMARY

Senate Bill 281 (SB 281) was signed into law earlier in 2003 to address concerns about the availability and affordability of medical malpractice insurance and the impact on healthcare for residents of the state of Ohio. This legislation charged the Department of Insurance (Department) with studying "the feasibility of a patient compensation fund to cover medical malpractice claims." The legislation specifically required that the patient compensation fund (PCF) feasibility study examine:

1) the patient compensation fund contemplated in SB 281,
2) the financial responsibility limits for providers that are covered by SB 281,
3) methods of funding (excluding any tax on consumers),
4) operations and administration, and
5) participation requirements.

The Department has also indicated that it desires the feasibility study to consider other patient compensation fund approaches that could be beneficial to Ohio's medical malpractice insurance market.

In arriving at our conclusions, a significant amount of weight was placed on the experience and design features of the PCFs in four states: Indiana, Louisiana, New Mexico, and Wisconsin. These four states also belong to the group of six states that the American Medical Association views as "currently OK"[1]. The forty-four other states are either showing problem signs associated with the current medical liability crisis or are in full blown crisis. The lack of symptoms pointing to crisis is a key success measure for a PCF. An essential feature in all of the "currently OK" states is that broad reform packages were implemented that included damage caps, medical review boards, and in some cases, PCFs, limitations on attorney contingency fees and repealing of the collateral source rule that limits the admissibility of recoveries from other sources due to a medical accident.

The decision to implement a PCF is ultimately a public policy decision. Therefore, this report is an information source to assist Ohio policy makers in making informed decisions regarding the implementation of a PCF, as well as possible methods of funding, approaches to operation and

[1] The other two states are California and Colorado.

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administration, and participation requirements should a PCF be implemented. This report assumes that a decision will be made to implement a PCF and discusses a recommended structure.

SB 281 PCF

The PCF contemplated in SB 281 would provide coverage above the caps on non-economic damages. This approach would dramatically reduce the potential benefits of a PCF and the non-economic damage caps. The costs we expect to be eliminated from the medical malpractice system would not be realized and there is also the potential for increased system costs. For example, a PCF providing coverage of the type suggested in SB 281 would have no significant impact on availability or affordability because it is not comparable to the coverage currently available and does not provide coverage for economic damages. There would also be a significant opportunity for cost shifting between economic and non-economic damages.

PCF Eligibility and Participation

A PCF should be designed to create appropriate government involvement by striking a balance between enhancing market availability and affordability and allowing competitive market forces to function as much as possible. Therefore, we recommend that the eligible classes of health care providers for an Ohio PCF include:

1) all physicians and osteopaths,
2) a broad group of other health care providers, and
3) hospitals and other health care facilities.

Participation in the PCF should be voluntary so that the PCF coverage is primarily offered and purchased when market forces have not been able to provide sufficient availability or affordability. During market crisis conditions, a PCF may be able to improve/reduce market premiums. During times when the voluntary insurance market is working effectively, a voluntary PCF would not eliminate any material overall system costs.

Coverage Limits

We recommend that all health care providers be required to secure insurance coverage of $250,000 per occurrence, on either a claims-made or occurrence coverage form, to be eligible for PCF coverage. Required aggregate limits would vary between physicians and hospitals. We further

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recommend that coverage in the Ohio PCF, if implemented, begin at this $250,000 per occurrence limit and provide unlimited medical benefits above this amount with coverage up to the SB 281 caps for non-economic damages.

We recommend applying the caps on non-economic damages specified in SB 281 without the PCF providing coverage above the caps. Our analysis of the Florida medical malpractice claims data shows that the caps reduced total claim costs by as much as 16% and have the potential to reduce Ohio's medical malpractice claim costs.

PCF Funding Method

We recommend that the Ohio PCF be funded through a rate per physician or per bed for hospitals. These rates will need to be different based on the relative loss potential of different practice specialties. The PCF premiums should provide for all costs associated with the policy. The premiums should also reflect investment income on PCF funds and a risk margin to protect against worse than expected loss developments and negative fund balances. The PCF premiums need to include some form of merit rating or experience rating so providers with good experience pay less for coverage.

PCF Operation and Administration

The Ohio PCF should be established as a segregated trust fund of the state of Ohio. It should be managed by a Board of Governors (the Board) that includes representatives from a broad spectrum of parties interested in the PCF's mission. The Board should have very broad authority for the administration of the PCF, subject to the approval of the Department where appropriate. The Board should select an Executive Director to carry out the administration of the PCF on its behalf. Assets of the fund should be managed by the Ohio Treasurer of State's office using a strategy approved by the Board. Claims services should be outsourced initially. PCF premiums should be collected as a "pass-through" from the provider of primary insurance coverage. Administrative services such as billing, provider coverage status tracking, and accounting should be staffed internally or using Department staff. Specialized services, such as actuarial, legal, loss prevention and information systems development should be outsourced or provided by Department staff. The Board should be authorized to pursue strategic opportunities to purchase reinsurance for PCF loss exposures subject to established financial strength guidelines and Department approval.

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Other Recommendations

We recommend that a sliding scale on attorney contingency fees similar to California's MICRA be enacted: 40% on the first $50,000 of damages, 33% on the next $50,000, 25% of the next $500,000, and 15% of an amount exceeding $600,000. These limits on contingency fees are not contemplated in SB 281. Limiting the contingency fees could increase the payments to injured patients by 12% of total damages, on average, without adding to total system costs. This means that if both the caps on non-economic damages and the limitations on attorney fees are implemented, most injured patients with reduced non-economic damage awards would not see as large a decrease in net benefits and some would actually receive more after paying their attorneys than they do under the current system.

We also recommend the establishment of a medical review board that would make a non-binding determination on the merits of a claim before it goes to trial, eliminating some costs from the system.

In addition, we recommend that the data reporting section of SB 281 be expanded to include a regular call for data from medical malpractice insurers in the state. Creating a claim database similar to the one currently used in Florida would allow the Department to monitor the effectiveness of SB 281 and the Ohio PCF.

The remainder of this final report discusses, explains and quantifies these findings.

Background

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BACKGROUND

As a first step in developing the final feasibility study, SB 281 specifically required the production of a preliminary report to be provided to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the chairpersons of the committees of the General Assembly with jurisdiction over issues related to medical malpractice liability. The law also set a deadline of March 3, 2003 for the preliminary report. This report was distributed as required. The preliminary report provides detailed descriptions of PCF statutes and plans in other states.

In the preliminary report we introduced a definition of PCF as follows:

A patient compensation fund is a medical malpractice insurance mechanism, created by state law, designed to increase professional liability coverage availability and/or affordability primarily by providing coverage for a specific type of injury or an excess layer of coverage.

We also summarized a wide variety of structural options presented by the current PCFs including their organizational structure, eligibility and participation requirements, financial responsibility and coverage limits, funding approaches, and operational designs. These summaries became the basis for our recommendations in the final report.

In arriving at our conclusions, a significant amount of weight was placed on the experience and PCF design features in four states: Indiana, Louisiana, New Mexico, and Wisconsin. These states have generally been viewed as successful models of medical malpractice systems and their PCFs are viewed as a key component of that success. It is worth noting that these four states are all in the group of six remaining states that the American Medical Association views as “currently OK”. All other states are showing problem signs associated with the current medical liability crisis. A key feature in these four states is that their PCFs were all implemented as part of broad reform packages that included damage caps, medical review boards, and in some cases limitations on attorney contingency fees, and repeal of the collateral source rule that limits the admissibility of recoveries from other sources due to a medical accident.

SB 281 PCF

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SB 281 PCF

The language of SB 281 suggested that the Ohio PCF provide coverage only for damages in excess of the caps on non-economic damages contained in the law. There are no PCFs currently in existence that provide this type of coverage. Moreover, there are several problems with this approach to a PCF. First, it eliminates the substantial system savings that will be created by the caps on non-economic damages. Second, a PCF providing coverage of the type suggested in SB 281 would not have a significant impact on availability or affordability because it is not comparable to the coverage currently available and does not provides coverage for economic damages. There would also be a significant opportunity for cost shifting between economic and non-economic damages. In other words, an injured patient might be able to recover more damages in total if the damages are characterized as non-economic damages than if they were economic damages. This potential would place the insurance company and the PCF in a potentially adversarial position and would create a potential for increased system costs. The PCF coverage suggested in SB 281 effectively diffuses the potential value of both the non-economic damage caps and the PCF. If the PCF were implemented providing the coverage suggested in SB 281, most of the costs we expect to be eliminated from the medical malpractice system would not be reduced.

PCF Eligibility and Participation

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PCF ELIGIBILITY AND PARTICIPATION

When considering the eligibility and participation guidelines for a patient compensation fund, the answers to two questions are essential: "What types of health care providers should be eligible for coverage in the PCF?" and "Are all eligible health care providers required to participate?"

The goal of the eligibility and participation guidelines of a PCF should be to create appropriate government involvement by striking a balance between enhancing market availability and affordability for all classes and allowing competitive market forces to function as much as possible. This balanced approach allows a PCF to intervene actively during "hard" markets when primary or reinsurance premiums are high and reduce their involvement during "soft" markets when reinsurance premiums are more affordable. Our recommended eligibility and participation requirements are intended to meet these dual goals of enhancing the medical malpractice insurance market without unduly intervening in it.

Eligibility

There are generally three categories of participants in most patient compensation funds: physicians (including Osteopaths), other health care providers (Midwives, Nurse Practitioners, Optometrists, Pharmacists, Physicians Assistants, Podiatrists, Psychologists, Registered Nurses and Nurse Anesthetists, etc.), and hospitals and other health care facilities (e.g. nursing homes, outpatient treatment centers). Each of these categories represents unique eligibility issues.

While all PCFs include physicians in their eligibility, we have been asked to address the potential benefits of a PCF serving only the classes of physicians that pose the greatest availability and affordability challenges. There are several problems created by this selective approach. For example, what criteria identify the classes to be included? What if there are geographic differences in availability and affordability that are as important as class differences?

A recent study by the New Jersey Department of Banking and Insurance showed that the specialties facing the highest likelihood of rate increases of over 30% were:

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Specialty	Percentage of Insureds with Premium Increase >30%
Orthopedic Surgeons	18.9%
General Surgeons	17.0%
Podiatrists	14.4%
Neurosurgeons	13.8%
Emergency Medicine	9.1%
OB/GYN	8.9%
Internal Medicine	8.7%

Where do you draw the line for a selectively eligible PCF? Do you include the three surgical classes and the podiatrists only? Why are the ER doctors and the OB/GYNs excluded? In some recent cases, notably North Carolina, the affordability and availability concerns have been as focused on geographic differences (rural versus urban) as on specific specialties. If rural general practitioners are having more trouble getting affordable coverage than urban surgeons, a limited eligibility PCF fails to meet their needs. These concerns are exactly why all PCFs nationally, with the exception of two that focus exclusively on one type of injury (birth related neurological injuries) include all physicians in their eligibility.

The practice exhibited by the most successful PCFs in the country, including Indiana, Louisiana, New Mexico, and Wisconsin, is to take a very broad stance on eligibility for non-physician health care providers. It is very difficult to arrive at a compelling reason for including one category of health care providers, for example chiropractors, and excluding another, say podiatrists. In situations where a substantial availability crisis has occurred, the excluded group of care providers (certified registered nurse anesthetists in a recent example) inevitably questions the cause of their exclusion and is too often met with less than satisfying explanations. If the PCF's goal is to have the flexibility to provide better coverage availability and/or affordability to as many health care providers as possible, it is hard to imagine a reason to exclude a category of health care provider. Inclusiveness also extends to other situations that impact a health care provider's liability exposure including coverage for retired health care providers, interns, residents, part time employees, visiting and non-resident physicians.

The last significant eligibility decision is whether to include hospitals or limit the scope of the fund to physicians and other health care providers. Market conditions for hospitals as well as their loss exposures on both per occurrence and annual aggregate bases, their risk management expertise, and

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their willingness to retain more risk, can be significantly different than those for physicians and surgeons. Thus, a different approach for hospitals is often required. In fact, the differences and complexities of hospitals have created situations where some successful PCFs treat hospitals as eligible, but no hospitals currently participate in the program. There are several additional program design issues that need to be addressed if hospitals and other health care facilities are eligible for a PCF. These range from more individualized risk pricing, to additional risk management and loss prevention services, to experience rating considerations. As has been seen in Pennsylvania, Florida and other jurisdictions, the need for availability and affordability relief can be acutely felt by hospitals. Therefore, we recommend that hospitals and other health care facilities be eligible for PCF coverage in Ohio, as they are in Indiana, Louisiana, New Mexico, and Wisconsin. We will address the program design issues needed to accommodate hospitals in other sections of this report.

Physicians or hospitals may express a desire to segregate their PCF fund contributions from the other groups. Doctors groups, in particular, have been concerned in some jurisdictions about the greater loss potential presented by hospitals. This is a real concern; however, none of the PCFs we are focusing on have segregated their funds between hospitals and physicians. There are other approaches to mitigating the risk the PCF is exposed to by various segments of the program. For example, the underlying coverage limits, especially hospital aggregate limits, may differ from those for physicians. PCFs may also purchase reinsurance to transfer some of their loss exposures to another insurance company.

From a cost benefit perspective, the larger the group of eligible health care providers, the greater the potential system savings.

Participation

A PCF only adds value to the medical malpractice insurance market if it increases market availability or affordability. If the voluntary primary and reinsurance markets are operating efficiently, a PCF by itself is unlikely to increase availability or affordability and therefore produces little or no savings. In “soft” market conditions, an insurer seeking to buy reinsurance to protect against large losses will be able to buy coverage at a cost equal to or less than the cost of coverage through the PCF. This means that the premiums charged to the health care providers would not be reduced by a PCF. In “hard” market conditions, the cost of insurance policies backed by the

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reinsurance market would be higher than those that utilize the PCF. Thus, the PCF functions to temper the effects of a "hard" market.

Mandatory PCFs that require all medical malpractice insurance policies to include PCF coverage remove this competitive market dynamic even when the market could operate efficiently. This seems to be unnecessary government intervention that does nothing to meet the PCF's stated goal of enhanced availability and affordability.

Voluntary PCFs allow insurers to opt out of the PCF when market conditions make prices for comparable reinsurance coverage attractive. In other words, if a PCF is collecting premiums equal to 15% of primary premiums for the PCF coverage layer and there is a reinsurer willing to insure this same risk for 11% of premium, the malpractice insurer should be free to purchase the coverage from the lower cost provider and forego PCF coverage. This is no different than when an individual chooses the coverage limits on a personal automobile or homeowners insurance policy.

A risk with voluntary PCFs is that insurers will not offer or insureds will not choose PCF coverage when a significant rate increase or a funding shortfall is realized. This is especially true for PCFs that are funded on a cash (or "pay-as-you-go") basis instead of an accrual basis. Cash basis funding only charges premiums necessary to meet current cash flow obligations and leaves future liabilities, including future loss payments, unfunded. The depopulation of the fund when premiums increase can leave the state facing a significant unfunded liability. Approaches to reducing this risk will be discussed in the ***PCF Funding Method*** section.

The benefit of a PCF, without consideration of other legislative changes like caps on non-economic damages or attorneys fees will vary greatly based on market conditions. When the voluntary market is "soft," a PCF may not materially reduce overall market costs. A PCF, as an alternative for existing coverage at a comparable cost, does not reduce costs at all. In this case, it merely transfers costs to a different funding mechanism. In a market crisis, however, a PCF may increase affordability since reinsurance prices will be higher than similar costs in the PCF. It may also increase availability (capacity) because it acts as another willing insurer in the market. The potential benefits of a PCF can be seen through an analysis of historical medical malpractice reinsurance results as shown in Exhibit 1. During times when reinsurers are profitable, a PCF will

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charge premiums that do not reflect this profit, and therefore provide relief to the market. It would be expected that during market conditions when increased reinsurance premiums are at the point that reinsurers experience underwriting profits (as seen by a combined operating ratio for medical malpractice reinsurance at or below 100%), a PCF could potentially create a more affordable reinsurance alternative for primary malpractice insurers and therefore reduce overall premiums. There may also be indirect cost savings created by primary medical malpractice insurers being more willing to write the less volatile primary layer due to the presence of the PCF coverage of the excess layer during a market crisis, and therefore increasing availability.

Coverage Limits

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COVERAGE LIMITS

Financial Responsibility

In general, there are two types of coverage limits in medical malpractice policies: occurrence limits and aggregate limits. Occurrence limits apply per claim while aggregate limits are a cap on the cumulative total for all claims in a policy period, generally one year. For example, a policy with limits of $250,000 per occurrence and $1 million in aggregate means that each individual claim is covered up to the $250,000 limit and the most that will be paid for all claims in the policy period in total will not exceed $1 million.

A broad range of coverage limits are required by the various PCFs in other states as underlying coverage before health care providers are eligible for PCF coverage. Some PCFs require as little as $50,000 per occurrence in coverage, while others require as much as $1 million per occurrence and $3 million in aggregate coverage (e.g. Wisconsin). Generally, most PCFs (including Indiana and New Mexico) require a primary layer in the range of $200,000 to $250,000 per occurrence and $600,000 to $1 million in aggregate coverage to be eligible for PCF coverage. In many cases, the financial responsibility limit corresponds to the PCF requirement for the primary coverage. We recommend this approach for an Ohio PCF. Health care providers should be required to secure coverage of $250,000 per occurrence to be eligible for PCF coverage.

The matter of the required aggregate limit is more complex as hospitals, especially large ones, possess a much larger aggregate loss potential. We recommend an approach similar to Indiana where physicians are required to carry an aggregate limit of three times the occurrence limit (i.e. $750,000) and hospitals are required to carry aggregates of either $5 million or $7.5 million depending on their size, with the higher limit reserved for hospitals with more than 100 beds.

We recommend insurance companies, possibly including some excess and surplus lines carriers, qualified self-insurance programs, and any applicable joint underwriting associations or residual market facilities be accepted as providers of primary layer coverage. Insurance companies should be required to possess a specific rating or better from a rating agency (e.g., A.M. Best, Standard & Poors, Moody's) to provide primary layer coverage that meets PCF eligibility. This standard should

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be developed by Department staff. Similar qualification standards for self-insurance mechanisms will need to be developed if an Ohio PCF is implemented.

There are two types of insurance policies (coverage forms) currently in use for medical malpractice coverage: claims-made and occurrence forms. Claims-made coverage provides coverage for claims reported during the policy period, sometimes subject to certain limitations based on when the incident creating the claim actually occurred. Occurrence coverage, on the other hand, provides coverage for claims that occur during the coverage period, regardless of when they are reported. For example, assume a physician purchases coverage every year on January 1st. An injury to one of the physician's patients occurs in 1999 but the claim is not reported until 2001. If the physician purchases occurrence coverage, the claim applies to his 1999 policy. If the physician purchases claims-made coverage, the 2001 policy applies. We recommend that both claims-made and occurrence coverage forms be allowed to meet financial responsibility coverage requirements.

Tort Caps

The most significant impact on insurance premiums of SB 281, MICRA (the California medical malpractice reform legislation), and similar laws is the impact of caps on non-economic damages. SB 281 provides that most medical malpractice claims be limited to the greater of $250,000 or three times economic damages, subject to a maximum of $350,000 per plaintiff and $500,000 per occurrence. More severe injuries increase the maximums to $500,000 per plaintiff and $1 million per occurrence. We have analyzed the impact of these caps on a large database of medical malpractice claims. The results are summarized in Exhibit 2. For the period from 1/1/1999 to 3/1/2003, the caps on non-economic damages in SB 281 reduced claim costs in the data by up to 16%. For the sake of comparison, we also evaluated the impact of implementing the $250,000 cap on non-economic damages contained in the MICRA legislation in California. This stricter limit on non-economic damages reduced claim costs in the data by up to 20% over the same period. We prefer the SB 281 non-economic damage caps to the MICRA cap, because those with the largest economic damages, and in all likelihood the most significant injuries, will receive more benefits with SB 281.

The extent to which these cost reductions will be realized in Ohio depends on a number of issues. The cost reductions do not reflect the potential impact of judicial testing to delay or reduce the

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realization of the benefits of the damage caps. They also do not reflect the fact that some claims that occurred prior to the enactment of SB 281, and therefore not subject to the damage caps, still have not been reported. In addition, there is a potential for the migration of some non-economic damages to economic damages. For example, without the SB 281 caps, damages paid to the family of a deceased mother who had no outside income can be broadly awarded as pain and suffering, or non-economic damages. Under the SB 281 caps, the costs of the services that can be replaced may be more fully itemized and listed as economic damages

We recognize that SB 281 eliminates the collateral source rule and acknowledge that this should have an impact on insurance premiums in Ohio. However, there is very little data available to identify the likely impact of this change and we have not estimated the impact in this report. We also expect this change to go through some of the same judicial testing it has experienced in other states, which may delay the realization of any benefits.

PCF Coverage

We recommend that if an Ohio PCF is to be implemented, the PCF coverage should begin at the financial responsibility limit of $250,000 per occurrence, subject to the proposed aggregates that vary between physicians and hospitals, and provide unlimited medical coverage, and non-economic damages up to the SB 281 limits. This is essentially the approach that has been implemented in the PCFs of Indiana, Louisiana, and New Mexico

PCF Funding Method

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PCF FUNDING METHOD

The only successful approach to funding a PCF to date has been charging health care providers premiums for PCF coverage as part of their overall insurance costs. This cost to health care providers will be offset by the reduction in their primary insurance premium due to the reduction in primary limits. Any approach to funding a PCF that does not directly assess health care providers presents the potential to remove incentives for loss prevention. This occurs because health care providers would not experience direct economic consequences for their actions. While the insurance process tends to reduce these economic consequences, more indirect funding approaches, such as some form of corporate taxation on medical services or income, would largely eliminate them.

Typically the assessment of health care provider premiums has been done either as a percentage of primary coverage premium or as a rate applied per doctor or other appropriate exposure base (e.g. per bed). An example of a percentage assessment is Nebraska's premium charge which is 100% of primary coverage premiums for all covered physicians. An example of a rate per exposure method is that in 1999 OB/GYNs in Indiana paid $15,326 per physician for PCF coverage and in 2000 hospitals paid $503 per acute care bed. We recommend a rate per exposure approach as is used in Indiana, Louisiana, and New Mexico. This approach has the desirable feature that comparable health care providers with comparable experience and rating characteristics but different insurance companies would pay the same PCF premiums. In other words, the PCF premiums are independent of the primary coverage premiums.

The premiums charged by the PCF must be actuarially sound. Actuarially sound premiums provide for all costs associated with an individual risk transfer and are not excessive, inadequate, or unfairly discriminatory. To meet these criteria, the PCF premiums should consider:

1) past and prospective loss and expense experience in different types of practice,
2) past and prospective experience of the fund, and
3) loss and expense experience of the healthcare provider.

Consideration of past and prospective loss and expense experience in different types of practice involves several important issues. PCF premiums for physicians must reflect the relative risk

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represented by different specialties. Generally, successful PCFs have addressed this concern by basing their rates on differences in loss potential using classification codes of the Insurance Services Office, Inc. (ISO) as the basis for their groupings. Part-time and semi-retired status is generally reflected in a discount off of otherwise applicable premiums. Premiums for non-physician health care providers are generally charged per provider and are based on the premiums for physicians. Health care facilities generally use occupied bed counts and outpatient visits as the exposure bases for their premiums, which is consistent with how their underlying coverage is priced.

In order to consider the past and prospective experience of the fund, PCF premiums should be on an accrual basis to reflect "all future costs associated with an individual risk transfer[2]." This approach is identical to most insurance products, including personal automobile or homeowners insurance where the premiums that individuals pay are intended to be sufficient to pay all losses and expenses associated with that policy. Some PCFs instead use an approach called "pay-as-you-go" or cash basis funding. This funding approach charges premiums sufficient only to meet the insurance program's needs in the coming year, leaving all future loss payments unfunded. "Pay-as-you-go" has the mirage-like advantage that in the program's first few years significant cash flow savings can be realized by the PCF and thus the health care providers. This approach is purely a shift in timing and does not eliminate <u>any</u> ultimate costs to the medical malpractice insurance market. Furthermore, "pay-as-you-go" funding with a PCF that uses voluntary participation can present a significant risk to the state. If a voluntary participation PCF experiences a significant rate increase or a funding shortfall there is nothing to prevent the members from exiting the fund and leaving the PCF with a large unfunded inventory of unpaid claims. This situation can leave the state facing a significant unfunded liability. We strongly recommend against cash basis funding of a PCF.

Two other factors related to prospective PCF experience should also be considered: reflecting the investment income on PCF funds before it pays claims and setting premiums to provide for worse than expected results. Since there is a considerable delay between the beginning of the funding period and the actual payment of losses arising from that period, significant investment income can be generated on unpaid loss reserves. Therefore, it is appropriate to recognize investment income to be earned on assets held to fund unpaid liabilities. As a result, losses that have been "discounted"

[2] The Casualty Actuarial Society's Statement of Principles Regarding Property and Casualty Insurance Ratemaking, Principle 4 states, "A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer."

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for this investment income should be used in the PCF rate setting process. The discount factors should reflect an interest rate that is consistent with a conservative estimate of the anticipated long-term investment rate of return to be earned by PCF assets.

The maintenance of a PCF is similar to that of a commercial insurer, with one major difference: a PCF is not required to maintain or build capital or equity. However, the need for an additional risk margin to protect against actual losses being greater than assumed in the premiums is not diminished. Therefore the premiums used by a PCF should include a risk margin to protect against worse than expected loss development, reducing the possibility of negative fund balances**.**

In order for the funding program to reflect the loss and expense experience of the healthcare provider, some form of merit rating or experience rating is appropriate. For physicians and related health care providers a straightforward claim free discount or accident surcharge may be a sufficient approach to reflecting past experience. Due to the generally larger and more complex loss exposures for hospitals, a more sophisticated experience rating methodology is essential to adjusting PCF premiums for the experience of specific hospitals. Some states actually go so far as to require an actuarial study developing the required PCF contribution on a specific hospital basis. While we find this approach conceptually attractive, we believe an experience rating plan can provide sufficient predictive accuracy at a much lower cost.

In order to ensure the actuarial soundness of the PCFs premiums the group with administrative authority of most successful PCFs, for example a Board of Governors, is required by law to regularly determine appropriate rate levels. These proposed premiums are subject to the approval of the state's insurance department. We consider this type of control over the PCF's premiums to be an essential part of regulatory oversight of a PCF. As a means of ensuring the affordability of PCF premiums, a reasonable limit on premiums relative to primary layer premiums should be considered. For example, one state currently limits PCF premiums at 100% of primary layer premiums. This limit will be highly dependent on the layer of coverage provided by the PCF as well as any applicable damage caps. It will also depend on the risk margin required to prevent negative fund balances.

PCF Operation and Administration

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PCF OPERATIONS AND ADMINISTRATION

Structure and Governance

We recommend that the PCF be established as a separate trust fund or trust account of the state with funds held in a segregated account, as is common practice for other successful PCFs.

The optimal governance structure of this trust account, used in many of the most successful PCFs, assigns management of the PCF to the Board. This Board is generally comprised of representatives of a number of interested parties including, but not necessarily limited to:

1) the insurance industry,
2) the state medical society,
3) the state hospital association,
4) the state bar association,
5) the insurance department, and
6) the public.

The Board's authority should broadly include the administration, management, operation and defense of the fund including:

1) collecting all premiums,
2) collecting claims experience,
3) employing or contracting for services necessary to the operation of the fund, including the employment of an executive director to delegate the daily oversight of PCF operations and administration,
4) defending of the fund against all claims, and
5) paying claims and operational expense obligations within the PCFs authority.

In many cases, the insurance department either provides staff services necessary for the operation of the PCF or, with the approval of the Board, contracts for all or part of these services. This approach appears to provide a means to have the interests of all parties represented while allowing the insurance department sufficient regulatory oversight.

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Asset Management

Distributions from the PCF should be restricted to those within the authority of the Board, subject to the purposes of the PCF and in some cases subject to the approval of the Department. Most PCFs take advantage of existing asset management and investment capabilities that exist elsewhere in the state government. The Ohio Treasurer of State's office appears to provide these services to other state agencies and would be a likely resource for an Ohio PCF. Controls are usually in place to regulate the amount or percentage of funds placed in riskier securities. We recommend that these guidelines be developed by the Ohio Treasurer of State's office and approved by the Board.

Claims Administration

Because of the voluntary nature of the proposed PCF, we recommend that the claims administration initially be outsourced. The selected third party administrator should be selected based on its ability to resist and defend unmeritous or exaggerated claims, while at the same time resolve legitimate claims promptly and fairly. Expertise in handling large and catastrophic medical malpractice claims should be a key criterion in selecting this third party administrator. In the early stages of the PCF, outsourcing claims handling will be a cost effective means of having claims expertise for the limited number of reported claims. As the claims portfolio of the PCF matures and the volume of claims activity grows to a predictable volume, hiring dedicated claims staff should be considered.

The legislation creating the PCF should clearly state that insurers associated with PCF coverage have a duty to defend the PCF and their insureds. This will help in reducing inflated claim settlements when claims exceed the primary coverage layer and enter the PCF layer.

Policy Administration and Underwriting

We recommend that the Ohio PCF require primary insurers to compute the PCF premiums and "pass through" the funds monthly to the PCF, payable within thirty days after the premium has been received. This can be done by making sure the PCF legislation places the duty upon the insurer or risk manager (for a self-insured) to collect the premium provided by the Act. From a regulatory perspective, an endorsement to the policy of medical malpractice insurance, which certifies payment of the premium, should be made mandatory. This approach to collection is well suited to PCFs with voluntary eligibility and is one that national medical malpractice insurers are familiar and comfortable with. Requiring health care providers to pay the premiums directly to the PCF is

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more administratively cumbersome for the healthcare provider and the PCF. Adequate controls and penalties need to be in place for nonpayment of premiums.

Specialized services that will not initially require full time staffing, such as actuarial, claims administration, legal, and information systems development should all be outsourced. The Department may also be a resource for providing some of these services. Other functions that will require full time internal staffing include billing, provider coverage status tracking, and accounting. As mentioned before, the Department may consider providing this staff or permit their external recruitment.

Reinsurance

The Board should be permitted the opportunity to cede reinsurance to an insurer authorized to do business in the state or pursue other loss funding management to preserve the solvency and integrity of the fund, subject to Department approval. Granting this amount of risk management authority allows the Board to take advantage of market opportunities to transfer risk when they exist. We also recommend that objective guidelines for the financial strength of any entity to whom PCF risk is transferred include a minimum financial rating and company size in addition to the regulatory approval requirements.

Financial Reporting

Quarterly financial reporting to the Department is another important element of the oversight of a PCF. In addition, annual audits of PCF financial statements and actuarial reviews of the liabilities and indicated reserves are standard requirements for successful PCFs. Many PCFs also perform an annual actuarial review of indicated premiums.

Other Recommendations

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OTHER RECOMMENDATIONS

Attorney Contingency Fees

While SB 281 currently has no limitation on attorney contingency fees, the limitation on non-economic damages in and of itself will reduce the dollars paid in contingency fees. We estimate that the limits on non-economic damages in SB 281 will reduce attorney contingency fees by approximately 5%. This savings is produced by applying an assumed contingency fee of 33% to both the unlimited and the limited damages. We believe that this assumption on current contingency fees is somewhat conservative but reasonable.

We also computed the impact of implementing a sliding scale limitation on contingency fees similar to California's: 40% on the first $50,000 of damages, 33% on the next $50,000, 25% of the next $500,000, and 15% of any amount exceeding $600,000. This change has no direct impact on malpractice losses or premiums but it does have a significant impact on the amount of damages realized after contingency fees by the injured patient or his/her beneficiaries. These caps would increase damages retained by injured patients by approximately 12% of total damages as is shown in Exhibit 2. This increase would offset a significant portion of the reduction in non-economic damages from the injured patient's perspective. Therefore, if both the caps on non-economic damages and the limitations on attorney fees are implemented, most injured patients would not see as large a decrease in net benefits, and some would actually receive more in net benefits after paying their attorneys than they do under the current system. We recommend these limitations be legislated so that the combination of caps on non-economic damages and attorney fees can work together to eliminate significant system costs and mitigate a significant portion of those reductions from the perspective of the injured patient.

For example, assume an injured patient had been awarded $350,000 in non-economic damages and $100,000 in economic damages for an injury. Under the current system, if the attorney charges a 40% contingency fee, the patient receives $270,000 in actual compensation after attorney fees are paid ([100,000 + 350,000] * (1 – 40%)). If the caps on non-economic damages and the sliding scale on contingency fees were both enacted, this patient would be awarded $300,000 in non-economic damages (three times economic), a reduction of $50,000. However, the attorney fees

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would also be reduced so that the patient's actual compensation would be $288,500, an increase of $18,500.

As with the evaluation of the damage caps, these estimates do not reflect the potential impact of judicial testing, or the potential for greater itemization of some damages and the resulting migration from non-economic to economic damages.

Medical Review Board

One medical malpractice system reform from MICRA that was not enacted in SB 281 as related to claims was the medical review board. A medical review board is a group that hears the merits of the claim before a lawsuit is filed and makes a non-binding determination on the merits of the claim. In SB 281, there is a provision for a judicial process to verify "good cause." Unfortunately, this judicial process engages after the time that a medical review panel is effective at eliminating costs from the system. The key benefit of a medical review board is that it eliminates lawsuits from the system before they happen by identifying whether a claim has merit or not. Another key benefit of a medical review panel over a "good cause" verification action in court is that a medical review panel can effectively provide remedial or disciplinary action depending on the healthcare provider's actions that will hopefully prevent injuries in the future.

Data Collection

It is essential that the data collection requirements of Section 2303.23 of SB 281 be implemented in a way that creates a robust database for monitoring medical malpractice experience in Ohio, the actual impacts of SB 281, and an Ohio PCF. Section 2303.23 requires that every clerk of a court of common pleas in the state submit an annual report to the Department containing information on all medical malpractice claims. The major drawback of this approach is that claims that are not brought in suit will not be in the database. We suggest that the information request be expanded significantly to include all of the data elements currently included in the Florida Department of Insurance database (see Exhibit 3) for all medical malpractice claims, regardless of whether they go to suit. To accomplish this, the request for data will need to be redirected to the insurance companies as a special annual data call.

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A data call of current insurers in the state that captures historical exposures and losses for healthcare providers has been used very effectively in other PCF states to establish and update the class relativities for the PCF coverage layer. This data call can also be used as a means of identifying additional rating characteristics that influence PCF experience (e.g. territory). Characteristics that have been identified as possibly improving predictive accuracy should be monitored for future consideration as rating variables.

Data

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DATA

In order to evaluate the impact of SB 281, including the PCF provisions, a database was needed. This database needed to contain a credible number of historical medical malpractice claims with detail showing the values of the various loss components. These components would include economic damages, non-economic damages, punitive damages, and attorney fees. Further data detail including the type and severity of injury, the date of the event's occurrence and the date of disposition of the claim was also needed. A number of data sources were considered and evaluated for the purpose of determining the impact of establishing a PCF in Ohio. They included: 1) Insurance Services Office, Inc. (ISO) information from their current Ohio increased limits factors filing, 2) Physician Insurers Association of America (PIAA) data, 3) Jury Verdict Research data, 4) Missouri Department of Insurance data, 5) National Practitioner Data Bank (NPDB), and 6) Florida Department of Insurance data. None of these data sources provided a precise match to the desired data either because the data was not specifically for Ohio or it lacked the descriptive detail necessary to analyze the impact of statutory changes.

In the end, the Florida data was determined to be the best available data for analyzing the impact of the recommended caps on non-economic damages and attorney contingency fees. The Florida Department of Insurance has been collecting data on individual medical malpractice claims since 1975. This data contains tremendous descriptive detail about the claim damage amounts, but also about the characteristics of the claim itself. A list of the data fields in the database is included as Exhibit 3. We also compared the Florida data to the Missouri data and the ISO data to assess the reasonableness and appropriateness of the Florida data. These tests are shown in Exhibit 4.

For this feasibility study, we have chosen to examine claims in the state of Florida that closed during the period from January 1, 1993 through March 1, 2003. This produced 21,639 individual claim records. We applied both the SB 281 limitations and the MICRA caps on a claim by claim basis and produced aggregate totals by year of claim disposal (closing). We chose to summarize results in this manner so that the impact of claim severity trends could be shown explicitly instead of applying some sort of severity trend to the historical data.

Conditions and Limitations

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CONDITIONS & LIMITATIONS

This report is being provided for the use of the Ohio Department of Insurance. It is understood that the Superintendent of Insurance is also expected to distribute this report to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the chairpersons of the committees of the General Assembly with jurisdiction over issues relating to medical malpractice liability. This distribution as well as any further distribution to the makers of public policy in the State of Ohio is hereby granted.

If this report is distributed, the report should be distributed in its entirety. All recipients of this report should be aware that Pinnacle is available to answer any questions regarding the report. These third parties should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data and interpretations contained herein that would result in the creation of any duty or liability by Pinnacle to the third party.

Judgments as to conclusions, recommendations, methods, and data contained in this report should be made only after studying the report in its entirety. Furthermore, we are available to explain any matter presented herein, and it is assumed that the user of this report will seek such explanation as to any matter in question. It should be understood that the exhibits are integral elements of the report. The preliminary report as well as its exhibits and appendices should also be considered elements of the final report.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules.

Index of Exhibits

Ohio Department of Insurance

Exhibit 1

Patients Compensation Fund Feasibility Study

Medical Malpractice Reinsurance Results

	Industry Ceded Medical Malpractice Experience					
Accident Year (1)	Earned Premium (2)	Incurred Loss & LAE (3)	Loss & LAE Ratio (4)	Underwriting Expense Ratio (5)	Combined Operating Ratio (6)	Underwriting Profit Ratio (7)
2001	2,066	1,985	96.1%	15.4%	111.5%	-11.5%
2000	1,727	2,078	120.4%	15.4%	135.7%	-35.7%
1999	1,486	2,270	152.7%	16.2%	168.9%	-68.9%
1998	1,388	2,118	152.6%	15.8%	168.4%	-68.4%
1997	1,391	1,913	137.5%	16.0%	153.5%	-53.5%
1996	1,375	1,738	126.4%	16.0%	142.4%	-42.4%
1995	2,077	1,476	71.1%	16.0%	87.1%	12.9%
1994	1,252	953	76.1%	16.0%	92.1%	7.9%
1993	1,123	843	75.0%	16.0%	91.0%	9.0%
1992	1,068	811	76.0%	16.0%	92.0%	8.0%
1991	1,072	1,093	101.9%	16.0%	117.9%	-17.9%
1990	1,128	866	76.8%	16.0%	92.8%	7.2%

All dollar amounts are in millions.

Footnotes

(3) LAE - Loss Adjustment Expenses

(4) = (3) / (2) Loss and LAE Ratio - The ratio of incurred loss and loss adjustment expenses to earned premium.

(5) Underwriting Expense Ratio - Ratio of commissions, taxes, other acquisition and general expenses to earned premium.

(6) = (4) + (5) Combined Operating Ratio - The ratio of the sum of all loss and underwriting costs to earned premium.

(7) = 1.0 - (6) Underwriting Profit Ratio - The ratio of profits from underwriting operations to earned premium.

Source: A.M. Best Company Aggregates and Averages

Ohio Department of Insurance

Exhibit 2

Patients Compensation Fund Feasibility Study

Estimated Savings Due to Tort Caps

Disposition Year	Total Loss & ALAE	Total Loss & ALAE w/ SB 281	Percent Reduction	Total Loss & ALAE w/ $250K Cap	Percent Reduction
1993	328,124	298,473	-9.0%	293,252	-10.6%
1994	353,401	324,015	-8.3%	313,252	-11.4%
1995	472,506	430,164	-9.0%	410,157	-13.2%
1996	623,082	542,949	-12.9%	522,806	-16.1%
1997	604,143	536,939	-11.1%	514,138	-14.9%
1998	558,919	503,955	-9.8%	485,315	-13.2%
1999	481,048	406,052	-15.6%	386,909	-19.6%
2000	462,379	384,424	-16.9%	366,466	-20.7%
2001	383,058	326,902	-14.7%	313,723	-18.1%
2002	438,025	375,691	-14.2%	363,951	-16.9%
3/1/03	75,998	62,939	-17.2%	60,633	-20.2%
Total	4,780,682	4,192,503	-12.3%	4,030,602	-15.7%
1999-current	1,840,507	1,556,008	-15.5%	1,491,682	-19.0%

Estimated Savings Due to Limited Contingency Fees

Disposition Year	Total Loss & ALAE	Estimated Current Cont. Fees	Estimated SB 281 Cont. Fees	Eliminated Fees as a Percent of Loss & ALAE	Estimated MICRA Cont. Fees	Eliminated Fees as a Percent of Loss & ALAE
1993	328,124	88,282	78,498	-3.0%	54,226	-10.4%
1994	353,401	94,789	85,092	-2.7%	60,800	-9.6%
1995	472,506	129,126	115,153	-3.0%	79,808	-10.4%
1996	623,082	177,019	150,575	-4.2%	99,192	-12.5%
1997	604,143	172,415	150,237	-3.7%	101,667	-11.7%
1998	558,919	161,482	143,344	-3.2%	97,724	-11.4%
1999	481,048	141,913	117,164	-5.1%	79,256	-13.0%
2000	462,379	136,369	110,644	-5.6%	72,757	-13.8%
2001	383,058	110,467	91,936	-4.8%	63,869	-12.2%
2002	438,025	124,584	104,014	-4.7%	71,918	-12.0%
3/1/03	75,998	22,845	18,536	-5.7%	11,668	-14.7%
Total	4,780,682	1,359,291	1,165,192	-4.1%	792,887	-11.8%
1999-current	1,840,507	536,179	442,294	-5.1%	299,469	-12.9%

All dollar amounts are in thousands

Note: This layout does not contain injured party identifying fields

FIELD NAME	FIELD SIZE	DESCRIPTION
MPL_DEPT_FILE_NUM	11	Unique file identifier
MPL_INSD_CLAIM_NUM	20	Claim number assigned by insurance company
MPL_INJURY_LOCATION	3	Code that indicates the place where injury occurred
INJURY_LOCATION_DESC	125	Description of place where injury occurred
MPL_INJ_LOC_OTHER	40	If INJURY_LOCATION_DESC is other, description is entered here
MPL_INSTITUTION	60	Institution where injury occurred
MPL_INST_CODE	10	Institution code
MPL_INST_INJRY_LOCATION_PI	3	Location code identifying a specific location where injury occurred
INST_INJRY_LOCATION_DESC	125	Description of specific location where injury occurred
MPL_INST_INJ_LOC_OTHER	40	If INST_INJRY_LOCATION_DESC is other, description is entered here
MPL_OCCURRENCE_DATE	DATE	Date injury occurred
MPL_REPORT_DATE	DATE	Date injury reported
MPL_IP_DOB	DATE	Injured party's date of birth
MPL_IP_SEX	1	Injured party's sex
MPL_FINAL_DIAGNOSIS	2000	Final diagnosis for which treatment was sought or rendered
MPL_MISDIAGNOSIS	2000	Description of misdiagnosis made, if any, of the patient's actual condition
MPL_INJURY_CAUSE	2000	Cause of injury
MPL_PRINCIPAL_INJURY	2000	Principal injury giving rise to the claim
MPL_SEV_OF_INJURY_PI	3	Code indicating the rate for the most serious injury
SEVERITY_DESC	125	Description of the rate for most serious injury
MPL_SUIT_DATE	DATE	Date suit was filed in court
MPL_CASENUM	20	Case number issued by the court
MPL_SUIT_COUNTY	30	County where suit was filed
MPL_FIN_DATE_DISP	DATE	Date of final claim disposition
MPL_FIN_METH_DISP	3	Code indicating final method of disposition
FIN_METH_DESC	125	Description of final method of disposition
MPL_STAGE_OF	3	Stage of settlement
STAGE_OF_DESC	125	Stage of settlement description
MPL_COURT	3	Code indicating court proceedings results
COURT_DESC	125	Court proceedings results description
MPL_ARBITRATION	3	Code that identifies arbitration type
ARBITRATION_DESC	125	Description of arbitration type
MPL_SETTLE	1	Code if settlement resulted in payment to plaintiff
SETTLE_DESC	125	Payment to plaintiff description
MPL_INDEMNITY_PAID	11	Amount paid to plaintiff by primary insurer
MPL_LOSS_ADJUST	9	Loss adjustment expense paid to defense counsel
MPL_LOSS_ADJUST_OTHER	9	All other loss adjustment expense paid
MPL_IP_MEDICAL_TO_DATE	10	Injured party's economic medical loss incurred to date
MPL_IP_WAGE_LOSS_TO_DATE	10	Injured party's economic wage loss incurred to date
MPL_IP_OTHER_EXPENSE_TO_DATE	10	Injured party's economic other loss incurred to date
MPL_IP_MEDICAL_FUTURE	10	Injured party's estimated future medical loss
MPL_IP_WAGE_LOSS_FUTURE	10	Injured party's estimated future wage loss
MPL_IP_OTHER_EXPENSE_FUTURE	10	Injured party's estimated future other loss
MPL_IP_NON_ECONOMIC_LOSS	10	Amount paid for injured party's non-economic loss
MPL_STEPS_TAKEN	2000	Safety management steps taken by insured
MPL_DIAGNOSTIC_CODE	10	Diagnostic code of patient's condition
MPL_COURT_OTHER	40	
MPL_INSURER_TYPE	12	Primary or Excess
MPL_DEDUCT	9	Deductible

Note: This layout does not contain injured party identifying fields

FIELD NAME	FIELD SIZE	DESCRIPTION
INSD_INSTYPE	12	Insured insurance type (Entity or Individual)
INSD_ENTITY	60	If INSD_INSTYPE is Entity, entity name
INSD_LAST_NM	20	If INSD_INSTYPE is Individual, individual last name
INSD_FIRST_NM	20	If INSD_INSTYPE is Individual, individual first name
INSD_MI	1	If INSD_INSTYPE is Individual, individual middle initial
INSD_ADDR	80	Insured address
INSD_CITY	30	Insured city
INSD_STATE	2	Insured state
INSD_ZIP	9	Insured zip
INSD_COUNTY	30	Insured county
INSD_POLICY_NO	25	Insured policy number
INSD_PER_CLAIM_LIMIT	10	Insured per claim limit
INSD_AGGREGATE_LIMIT	10	Insured aggregate limit
INSD_MPL_SEPC_CODE	5	Insured specialty code
INSD_MPL_PROF_LNUM	10	Insured professional license number
INSD_MPL_PROF_BUS	3	Insured profession or business type
INSD_MPL_PROF_BUS_OTHER	60	If INSD_MPL_PROF_BUS is other, description is entered here
INSD_MPL_CERT_NUM	10	Insured certification number
INSD_POSITION	30	Not used
INSR_NAME	60	Insurer name
INSR_FEIN	9	Insurer FEIN
INSR_NAIC_GROUP	4	Insurer National Association of Insurance Commissioners group
INSR_NAIC_CODE	5	Insurer National Association of Insurance Commissioners code
INSR_COA	5	Insurer certificate of authority

Ohio Department of Insurance

Exhibit 4

Patients Compensation Fund Feasibility Study

I. Comparison of Source Data - Percentage of Loss by Layer

Physicians and Surgeons

Limit $(000)	OH ISO ILF Data	MO DOI Severity Data	FL DOI Severity Detail
100	22.4%	22.1%	24.4%
300	44.8%	50.3%	47.8%
500	54.5%	67.5%	58.6%
1,000	68.0%	87.1%	71.3%
2,000	79.5%	97.3%	80.4%

Hospitals

Limit $(000)	OH ISO ILF Data	MO DOI Severity Data	FL DOI Severity Detail
100	29.3%	20.4%	17.9%
300	44.4%	49.4%	32.6%
500	52.9%	60.8%	41.1%
1,000	64.8%	75.8%	54.0%
2,000	75.8%	92.8%	67.8%

II. Percentage of Loss by Loss Component

Component	MO DOI Severity Data	FL DOI Severity Detail
Economic Damages	41.7%	46.1%
Non-Economic Damages	34.7%	40.1%
Loss Adjustment Expense	23.7%	13.8%