Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund

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EXECUTIVE SUMMARY

This Preliminary Report is intended to fulfill the requirement of Ohio Senate Bill 281 as part of the process of assessing the feasibility of a patients compensation fund in Ohio.

Senate Bill 281 was signed into law earlier this year 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 Patients Compensation Fund to cover medical malpractice claims." The legislation specifically requires that the patients compensation fund (PCF) feasibility study examine 1) the financial responsibility limits for providers that are covered by SB 281, 2) methods of funding (excluding any tax on consumers), 3) operations and administration, and 4) participation requirements. The Department has also indicated that it desires the feasibility study to examine the patients compensation fund contemplated in SB 281, and consider other patient compensation fund approaches that could be beneficial to Ohio's medical malpractice insurance market.

As a first step in developing the final feasibility study, SB 281 specifically requires 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 sets a deadline of March 3, 2003 for the preliminary report.

The general purpose of the Preliminary Report is to provide background information on patient compensation funds. There are four specific goals for the preliminary report that have been established by SB 281 and the Department of Insurance. The preliminary report is to:

1) propose the contents of the Final Feasibility Study Report,
2) propose a work plan for the Final Feasibility Study Report,
3) propose a working definition of a patients compensation fund,
4) present a summary of the general options in designing a PCF and present a summary of the options selected by the PCFs currently in use.

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Proposed Content of Final Report

The Final Feasibility Study Report will present a recommended structure for a patients compensation fund. This recommended PCF structure will be as comprehensive as possible. The structural elements that will be reviewed will include, but not be limited to, the overall structure of the PCF, required limits of coverage, funding and revenue sources, administrative structure and staffing, participation and eligibility guidelines, and system incentives. A cost benefit analysis of each option will be presented with a discussion of advantages and disadvantages and anticipated system savings. The main focus of the final report will be the proposal of a "best practices" PCF that will produce material reductions in medical malpractice system costs.

Proposed Work Plan for Final Report

We expect to continue working with Department staff to develop a common understanding of the structural options available for a PCF. In the process of developing the Final Report, we also expect to assess existing agencies and other infrastructure that may be utilized in implementing a PCF in Ohio. In the following weeks, we will work through the entire draft with Department staff so that the final report can be completed by the statutory due date.

Definition of Patients Compensation Fund

For the purposes of this report a patients compensation fund is defined as follows:

A <u>patients compensation fund</u> 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.

Current PCF Characteristics

PCFs generally share a great deal of common characteristics:

- They are organized either as a state agency or a state trust fund.
- The commissioner or Superintendent of the Department of Insurance or a Board of Governors (with an Executive Director) is usually charged with the responsibility of overseeing the PCF.
- Both voluntary and mandatory PCFs have functioned successfully for almost thirty years.

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- Most PCFs offer coverage to hospitals, physicians and other health care providers.
- A primary layer of coverage is required as a condition of eligibility for PCF coverage. This layer is generally between $100,000 and $1,000,000 per occurrence.
- Insurance companies, joint underwriting associations, and qualified self-insurance programs are all generally accepted as providers of primary layer coverage.
- While some PCFs offer unlimited excess coverage, more common limits are $500,000 to $1,000,000 of excess coverage per occurrence.
- PCFs are generally funded through an assessment of health care providers as a percentage of the premium on their primary layer policy or as a separate premium/assessment.
- PCF funds are collected directly from the health care providers or via a "pass-through" collected by the primary insurance company.
- PCFs that charge separate assessments often use rates that may vary by specialty and/or territory. Experience rating plans may be applied to reflect a provider's actual claims experience.
- Administrative services are provided both through dedicated staff and outsourcing, depending on the size of the fund and the governing authority's needs.
- Annual actuarial reviews of indicated reserves are a standard requirement. Many PCFs also perform an annual actuarial review of indicated rates.
- Many claims functions are also outsourced to take advantage of vendor's expertise.
- Asset management is generally the responsibility of the Commissioner or Superintendent of the Department of Insurance, or a Board of Governors, or the State Treasurer or Investment Board.
- Controls are usually in place to regulate the amount or percentage of funds placed in riskier securities.
- PCF funds are almost always held in a segregated account.
- Most PCF legislation also contains incentives and cost controls designed to reduce overall medical malpractice system costs. These controls commonly include:
    - Statutes of Limitations
    - Abolition of Joint and Several Liability
    - Caps on Damages
    - Limits on Attorneys' Fees

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- Mandatory Coverage at Financial Responsibility Limits
- Structured Settlements
- Abolition of the Collateral Source Rule
- Pre-trial Screening Panels
- Arbitration/Alternative Dispute Resolution

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PROPOSED CONTENT OF FINAL REPORT

The Final Feasibility Study Report needs to identify all material details of a thoroughly specified framework on which to develop a patients compensation fund. This operational structure will be presented in an outline format that would be a suitable starting point for developing administrative rules for the PCF.

The structural elements that will require discussion will include, but not be limited to, the overall structure of the PCF, required limits of coverage, funding and revenue sources, administrative structure and staffing, participation and eligibility guidelines, and system incentives.

The discussion of general PCF structure will start by examining the financial structure of the PCF (state agency, insurance pool, trust fund, etc.). Organizational structure items such as the governance of the PCF, whether through a commissioner or a Board of Directors/Governors, and the need for additional governing committees will be reviewed. Financial issues will also be discussed. These items include the need for asset segregation, regular financial reporting and a selected set of accounting rules.

The analysis of required limits of coverage will focus on three key coverage limits. First, the minimum coverage required for financial responsibility will be discussed. Second, the magnitude of the primary layer of coverage below the PCF layer will be reviewed. This review will also discuss ways a health care provider can meet this coverage requirement beyond private insurance such as self-insurance and risk retention groups. Finally, the layer of PCF coverage will be examined.

The analysis of funding and revenue sources will discuss the basis on which assessments will be levied, who they will be levied against, the loss exposures the assessments are intended to fund (occurrence or claims-made), and the mechanisms for collecting these funds. Additional options regarding classification differences by health care specialty, territory, and prior loss experience will also need to be reviewed in case an assessment of eligible health care providers is elected.

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The analysis of how the PCF is to be administered will be a significant portion of the final report. The issues in this area range from staffing issues in policy management and billing, to claims administration, to creation of a medical review board, to how the Fund's assets are managed, and what actuarial services should be provided.

A variety of questions regarding participation and eligibility guidelines need to be answered. First, should participation in the Fund be mandatory or voluntary? Should hospitals be included in the PCF? Should all physician specialties be included or only those with the highest likelihood of severe losses? Should other health care providers (e.g. Registered Nurse Anesthetists, Osteopaths, Dentists, Chiropractors, Podiatrists) be eligible for coverage?

A review of possible medical malpractice system incentives needs to be reviewed in light of SB 281 and other similar legislation. Legislation features that have been commonly implemented with other PCFs include: medical review board/pretrial claim screening, collateral source rules, revised statute of limitations, caps on certain types of damages, limits on attorneys' fees, encouragement of structured settlements, and availability of arbitration or alternative dispute resolution (ADR).

Features present in SB 281and/or other Ohio law, if any will be identified and a recommended "best practice" will be presented. Features that have resulted in difficulties for current PCFs will also be identified as an approach to be avoided. A cost benefit analysis of each option will be included along with a discussion of advantages and disadvantages.

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PROPOSED WORK PLAN FOR FINAL REPORT

The proposed work plan contained in our response to the Department's request for proposals is still essentially our intended plan.

We expect to work closely with Department staff in evaluating the content of the Preliminary Report so that a common understanding of the structural options available for a PCF can be developed. In the course of these discussions, we expect to continue developing a better understanding of the issues that are of critical importance in Ohio.

Once we have completed this evaluation of the Preliminary Report, we will begin the analysis of the costs and benefits of the different structural options available to the State of Ohio in establishing its PCF. Using the administrative rules of several other PCFs which we have available, we will develop a comprehensive framework containing all of the key design options for the PCF along with an analysis of the advantages and disadvantages of different options. These specifics are discussed in more detail in the ***PROPOSED CONTENT OF FINAL REPORT*** section of the Preliminary Report.

A draft of the Final Report will be presented by April 10, 2003. In the following two weeks, we will work through the entire draft with Department staff so that the final report can be completed by the statutory due date.

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DEFINITION OF PATIENTS COMPENSATION FUND

There are two overriding themes when one reviews the goals or purposes that define the current PCFs of states other than Ohio. The most common purpose of a PCF is to provide excess medical malpractice coverage. Wisconsin for example states that its PCF is created "for the purpose of paying that portion of a medical malpractice claim which is in excess of the limits expressed in s. 655.23" (Wis. Stat. 655.27). A summary of the purposes of the existing PCFs is provided in Exhibit 1.

Some states expand on this purpose by stating that the PCF will "guarantee affordable medical malpractice coverage" (Louisiana) or "promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers" by serving in this capacity of providing excess coverage. Nebraska goes further in stating that their PCF provides "an alternate way to determine medical malpractice claims" and thus assure available and affordable coverage to recognize that the approach to claims handling and settlement in Nebraska created by the PCF legislation is capable of improving market conditions. It is important to note that all of the current "general purpose" PCFs only provide excess coverage and require another carrier, or in some cases a JUA, residual market carrier or self-insurance program, to provide underlying coverage.

The second and less common purpose of a PCF is to address a specific type of injury that is creating a significant enough frequency of high severity claims so as to impair available and affordable coverage. The two current PCFs striving to meet this goal both address the same type of injury – birth-related neurological injuries. The Florida Birth-Related Neurological Injury Compensation Association and the Virginia Birth-Related Neurological Injury Compensation Fund were both created as an exclusive remedy for this very specific type of injury. Specific purpose PCFs of this variety tend to cover much less exposure, pay fewer claims, and use different funding techniques.

Incorporating key elements of the purposes of both types of PCF, we will state a working definition of a patients compensation fund as follows: ***A patients compensation fund is a medical***

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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.

It is worth noting that Medical Malpractice Joint Underwriting Associations (JUAs) do not meet this definition. The working definition also does not address the many tort and other claims handling reforms that are often included in PCF enabling legislation. This definition also allows the flexibility for the variety of structures (trust funds, associations, government agencies) that different states have chosen and only requires that the PCF transfer and pool risk as an insurance mechanism.

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SUMMARY OF EXISTING PATIENTS COMPENSATION FUND OPTIONS

We have reviewed and summarized the PCFs for the following states: Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, Virginia, Wisconsin, and Wyoming. Three other states (North Carolina, Oregon, Texas) either had PCF enabling legislation and repealed it or have current legislation that has never been enacted. The legislation in these states was researched, but has not been included in our review.

A wide variety of information was used in developing the summaries provided in the following pages. The actual enabling legislation for each of the current PCFs was of particular value. Recognizing the fact that the Department's staff and subsequent readers may find this information of value, all of the pertinent enabling legislation has been attached as separate appendices to the preliminary report.

General Structural Options

A summary of general PCF structural options by PCF is shown in Exhibit 1.

All current PCFs (or their predecessors) were created during the two most recent medical malpractice insurance crises or during the current one. During the crisis of 1975-76, the most common approach to market reforms was a wide ranging set of tort and claims handling reforms that sometimes included the creation of a general purpose PCF. Florida, Indiana, Kansas, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin all implemented this approach. The PCFs are all very broad in eligibility and almost always were a component of much broader legislation.

During the crisis in 1986-87, a different approach to PCFs was presented. Areas of specific concern in terms of availability and affordability, most notably birth-related neurological injuries, were the focus of special-use PCFs that did not require as extensive administrative structures or present as significant a total loss exposure as the general PCFs of the 1970's. New York was the lone exception to this trend to use-specific PCFs as they created an excess liability pool during this

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period that behaves like a PCF and provides excess coverage to physicians who have hospital privileges.

In terms of financial structure, two approaches seem to be predominant: a separate state trust fund or a state agency. The trust fund approach has the advantage of independence from state government and presents the opportunity for the involvement of other interested parties (Hospital Associations, Physicians Associations, Attorney Groups, etc.). The state agency approach allows the opportunity for better organizational controls, more access to other state agencies that can provide valuable services, a somewhat different position in claims negotiations, and independence from the influence of special interests. Kansas, Pennsylvania, and South Carolina are examples of state agencies. Florida, Louisiana, and Wyoming are examples of Trust Funds.

As with financial structure, two governance approaches are predominant: department of insurance administration and Board governance. In states like Indiana, Nebraska, New York, and Pennsylvania, the commissioner or Superintendent of insurance is given broad administrative responsibilities for the PCF. Other states, like Florida, Kansas, South Carolina, and Wisconsin, call for the appointment of a five to thirteen person Board of Directors or Governors charged with administering the PCF. It is common for the governor to have authority to appoint members to the Board. It is also common for interested trade associations (hospitals, doctors, lawyers, etc.) to control a seat or seats on a Board to represent their interests in PCF Board matters. Wisconsin also has a number of special committees that report to the Board of Governors responsible for specific areas of administration in the PCF including underwriting, claims, legal, actuarial, investments, risk management and peer review.

Limits of Coverage

A summary of coverage and limits of coverage options by PCF is shown in Exhibit 2.

While most PCFs appear to offer coverage that follows with the underlying occurrence or claims-made coverage, some states specify occurrence coverage. New Mexico requires that both the PCF coverage and the underlying be occurrence form. Other states provide PCF coverage on an occurrence basis regardless of the underlying form.

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A broad range of coverage limits are required as underlying coverage before health care providers are eligible for coverage by the various PCFs. The two birth-related neurological injury PCFs provide first dollar coverage for their specific injuries. General PCFs require as little as $50,000 in coverage (WY) or as much as $1 million per occurrence and $3 million in aggregate (NY, WI). Generally, most PCFs 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. Some states (IN, NE, PA), in recognition of the greater aggregate exposure posed by hospitals require larger aggregate primary coverage for hospitals. They may also provide different aggregate coverage in the PCF coverage layer.

An interesting eligibility issue arises regarding the issue of what types of insurance vehicles can be used to provide primary layer coverage. All states allow licensed insurance companies to provide coverage, although some require that the company has a specific rating or better from a rating agency (e.g., A.M. Best, Standard & Poors, Moody's). Some PCFs allow qualified self-insurance mechanisms, risk retention groups, or captive insurance companies. Other PCFs allow coverage from joint underwriting associations (JUAs) and other residual market insurers to meet eligibility requirements.

As broad as the required limits of primary layer coverage are, an even broader range of coverage limits are provided by the current PCFs. Some states offer unlimited excess coverage. These states include Florida (NICA only), New Mexico (medical & economic loss only), South Carolina, Virginia (medical), and Wisconsin. Other states offer excess layers ranging from $100,000/$300,000 in Kansas to $2M/$4M in Florida PCF. Most states offer between $500,000 and $1 million dollars of coverage per occurrence.

Revenue and Funding Options

A summary of revenue and funding options by PCF is shown in Exhibit 3.

With the exception of the two birth-related neurological injury PCFs and New York, all other current PCFs are funded as an assessment or premium surcharge paid by health care providers. Generally, these assessments take two forms. Some assessments are an across-the-board

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percentage of the primary layer premiums. Nebraska, for example, has gone from assessing 5% of underlying premium to 50% over the last three years. This approach has the desirable feature that the assessment is adjusted for the insured's experience to the same extent as the underlying premium has been adjusted explicitly or implicitly for the insured's experience. The potentially undesirable feature of this approach is that comparable providers with different carriers would pay different assessments purely based on their primary carrier's expense loadings or rate adequacy level. Pennsylvania removes any discrepancy between carriers by converting this percentage to a rate "based on the prevailing primary premiums." Other states provide rates instead of percentages of premium.

The states that produce rates are also faced with the complication of dealing with different classification plans in the underlying insurance coverage. Most states using this approach have engaged actuarial consulting firms to develop a classification plan based on the classes used in the unit statistical reporting plan of the statistical agent commonly used for medical malpractice coverage (Insurance Services Office, Inc.). Indiana, Louisiana, New Mexico, and Wisconsin all use this approach. Territorial differences are sometimes similarly addressed by using ISO territory definitions.

Another complication with the rate approach is the desire to incorporate a reflection of a provider's historical loss experience in his/her assessment. Some states have developed experience rating plans and claim surcharges to address this need. A claims-free discount would be another approach to consider.

Generally, the person or group with administrative authority for a PCF (e.g. Commissioner of Insurance, Board of Governors) is authorized to determine the appropriate assessment levels. Some states strictly require actuarially sound (not inadequate, excessive, or unfairly discriminatory) assessment levels. Other states allow "pay-as-you-go" or cash basis funding. This funding approach can present a significant risk that the state can be left with a significant funding shortfall and no PCF members to assess for funding. Generally, the rates or assessment percentages that a PCF wants to implement, whether accrual basis or cash basis, are subject to Department of Insurance approval. In one case (WI), the rates are subject to the approval of the

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state legislature. PCFs without some form of regulatory approval have been criticized for this lack of oversight.

Two assessment collection techniques are commonly used. States that have implemented a percentage of premiums assessment commonly require the primary layer insurer to collect the funds and serve as a "pass-through" to the PCF. This approach to collection is well suited to the assessment technique as the PCF does not necessarily have the underlying premiums for a provider readily available. Some PCFs that use class rates also use this approach and require the primary insurers to compute the PCF assessments and "pass through" the funds. This can be burdensome to implement for a primary insurer that does not use ISO classifications. The other common approach is for the health care providers to pay the assessments directly to the PCF. These payments are generally annual, semi-annual or quarterly payments. Adequate controls and penalties need to be in place for nonpayment of assessments regardless of approach.

The two birth-related neurological injury PCFs assess an annual flat fee of $5,000 to participating professionals and a "per live birth" charge to participating hospitals.

New York's Hospital Excess Liability Pool has been through a variety of funding approaches. At first, the Pool was funded by applying a surcharge on per bed rates for participating hospitals. Starting in 1987, the excess surplus of the Medical Malpractice Insurance Association (MMIA) was used to fund the Pool. These funds were exhausted in 2002. The Pool is currently unfunded in the sense that there is no specific funding method. Instead, monies from the State of New York's general fund are being used to pay claims against the Pool. This has become a cause of great concern for parties interested in the ongoing viability of the Pool.

Administrative and Operations Options

A summary of the administrative and operations options by PCF is shown in Exhibit 4.

Once the decisions as to the overall governance and administration of the PCF, a number of specific tactical decisions need to be made about the PCFs day-to-day operations. The most

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significant of these relate to compliance and policy management, billings and collections, claims administration, asset management, and actuarial services.

As a general rule, the operations of the PCF follow the administrator. If a Board of Governors is the type of governance selected, then they are often charged with selecting an executive director to carry out the daily management of the PCF either through hiring staff or outsourcing. If the insurance commissioner or superintendent has responsibility for the PCF, he/she is generally authorized to staff the PCF or outsource the necessary services. The larger funds tend to take advantage of the greater control and cost effectiveness of having more permanent staff while the smaller funds require the additional flexibility of outsourcing services. Services requiring technical expertise, such as legal and actuarial, tend to be outsourced more often than some other services. Many Insurance Department administered funds take advantage of other government agencies that have specific useful areas of expertise. For example, some PCFs get the Agency for Health Care Administration, Health Department, State Investment Board, or the State Treasurer's office involved in appropriate aspects of administering the fund.

Investment management is usually the responsibility of either the Board of Governors or the appropriate state agency in charge of investment strategies for other state funds. There are usually controls on the percentage or amounts of funds that can be invested in different types of securities.

Most PCFs require an annual review of the liabilities and held reserves of the PCF. Many PCFs also use this review as an opportunity to review the PCF assessment rates. These actuarial services can be outsourced or in some cases provided by Department of Insurance staff.

Participation and Eligibility

A summary of participation and eligibility options by PCF is shown in Exhibit 2.

The first key issue in the area of participation and eligibility is whether participation in the PCF is mandatory. Mandatory funds are usually larger than voluntary funds. Mandatory funds reduce the risk of adverse selection and allow a single claims administration procedure for all claims in the state. Voluntary funds allow for the PCF to become smaller when market conditions make

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voluntary market prices for comparable coverage attractive. However, voluntary funds, especially PCFs funded on a cash basis ("pay-as-you-go") instead of an accrual basis, are at a significant risk of their members exiting the fund when a significant rate increase or funding shortfall is realized. Florida (Hospitals only), Kansas, Pennsylvania and Wisconsin are mandatory funds.

The next significant eligibility decision is whether to include hospitals or limit the scope of the fund to physicians. Because the market conditions for hospitals and their risk management expertise are significantly different than those for physicians and surgeons, a different approach to hospitals is almost required. In fact, the differences and complexities of hospitals can create a situation where some PCFs allow hospitals but do not currently provide coverage to any hospitals in their state. If a decision is made to allow hospital coverage in a PCF, experience rating is almost a necessity to reflect the differences between hospitals in loss experience.

Different coverage requirements and PCF coverage limits are also common. The issue of allowing self-insurance as valid primary layer insurance to become eligible for PCF coverage will also be an issue. Lastly, either the physicians or the hospitals (or both) may desire that the portion of PCF funds contributed by their peers be kept separated from the other groups. Doctors groups, in particular, seem to be concerned in some jurisdictions about the greater loss potential (both per occurrence and in aggregate) presented by hospitals. Nebraska and Wyoming are the only PCFs that do not have statutory eligibility available for hospitals.

There are significant differences of opinion between states regarding the types of non-physician health care providers that should be eligible for PCF coverage. Dentists, chiropractors, podiatrists, Certified Registered Nurse Anesthetists (CRNAs), osteopaths and lab technicians are examples of categories that are specifically included in some legislation. There are also issues that need to be resolved regarding treatment of retired health care providers, interns, residents, part time employees, visiting and non-resident physicians, etc.

System Cost Reduction Incentives

A summary of general PCF structural options by PCF is shown in Exhibit 5.

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Many of the current PCFs have additional features embedded in their enabling legislation which work to reduce medical malpractice claim costs beyond the anticipated savings produced by the introduction of a PCF. Common features include:

- Statutes of Limitations
- Abolition of Joint and Several Liability
- Caps on Damages
- Limits on Attorneys' Fees
- Mandatory Coverage at Financial Responsibility Limits
- Structured Settlements
- Abolition of the Collateral Source Rule
- Pre-trial Screening Panels
- Arbitration/Alternative Dispute Resolution

(American Medical Association, *Liability Reform: Common Provisions of State Laws*)

Many of these features were present in the Medical Injury Compensation Reform Act of 1975 (MICRA) legislation introduced in California in 1975 which has become a popular blueprint for medical malpractice reform legislation.

Six states (IN, LA, NE, NM, VA, WI) have some form of medical review panel. The purpose of these panels can be to verify PCF coverage, to screen frivolous lawsuits before trial or to review physician actions for remedial or disciplinary action.

The states are sharply divided on the elimination of the collateral source rule. The collateral source rule prohibited the hearing of evidence that a claimant has been compensated from other sources for their injuries. Many of the six states that have eliminated the rule and allow other payments to reduce medical malpractice claim settlements have had these statutes tested up to the State Supreme Court. Most states where collateral source evidence is still inadmissible also have substantial case law supporting this position.

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The statute of limitations in most states measures time from both the time of the act (or omission) by the health care provider and the time the injury should have reasonably been discovered. Generally statutes of one to three years for both timings are common, and infants are commonly given a longer time frame. Pennsylvania's statute actually runs seven years.

The most common limitations on damages are limitations for punitive and non-economic damages. Florida, Kansas, New Mexico, Pennsylvania, Virginia and Wisconsin all have some form of limitation on these types of damages. Several states (IN, LA, NE, VA) also have absolute limitations on damages. This approach limits the risk of extremely large settlements but can also be viewed as limiting the recovery of those patients that have been injured most severely.

While several states have no limitations on attorneys fees (Pennsylvania has actually found these limitations unconstitutional), many states have found some reasonable cap on attorneys' fees a material way to reduce system claim costs. The least invasive approach is to allow judicial review of attorneys' fees as is done in Kansas and Nebraska. Several states (FL, NY, WI, WY) have sliding scales that vary depending on the damages and in some cases the type of judicial processes involved in settling the claim (FL).

Most states allow structured settlements as a cost effective means of paying long term scheduled damages. Some states go the additional step of encouraging or requiring periodic payments for future expenses over a certain amount ($100,000 or $250,000). Wisconsin and Florida are examples of this approach.

Several states have either binding or non-binding arbitration processes available as an alternative to trial. In some cases, the medical review panel serves as a form of arbitration. One of the most intriguing approaches is that of New York and Florida which allows a form of binding arbitration as a means of limiting damages to defendants who concede liability.

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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 and appendices are integral elements of the 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

Patient's Compensation Fund
State Comparison

		Florida Birth-Related Neurological Injury Compensation Association	Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund
General	Goal of PCF	to provide an exclusive no-fault, remedy for birt-related neurological injury claims	"paying out that portion of any claim arising out of the rendering of or failure to render medical care services...for health care providers...which is in excess of the fund entry level"	to provide a system of excess insurance for health care providers	"to provide excess professional liability coverage for defined health care providers"	"to guarantee that affordable medical malpractice coverage was available to all private providers"	"an alternate way to determine medical malpractice claims and to ensure that malpractice insurance coverage in Nebraska is available at reasonable rates."	"to promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico"
	Enabling Legislation	Florida Statute 766.303	Florida Statute 766.105	IC 34-18	K.S.A. 40-3401 - K.S.A. 40-3419	R.S. 40:1299.41 - R.S. 40:1299.48	Neb. Rev. Stat. 44-2801-2855	N.M.S.A 41-5
	Creation Date	1988	1975	1975	1976	1975	1976	1978
	Financial Structure	Non-governmental association	Trust Fund, not a State Agency	Separate Trust Account	State Agency	Special Separate Escrow Fund	Separate Trust Account	Trust Fund
	Asset Segregation	Segregated Association Fund	Segregated Account	Segregated Account		Special Separate Escrow Fund	Segregated Account	Segregated Account
	Accounting Rules (SAP/GAAP)					GAAP		
	Financial Reporting	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report
	Governance	5 Member Board of Directors	11 Member Board of Governors	Commissioner of Department of Insurance	10 Member Board of Governors	PCF Oversight Board	Director of Department of Insurance	Director of Department of Insurance
	Committees			None		PCF Oversight Board	None	None
	Meeting Frequency					Quarterly		

Ohio Department of Insurance

Patient's Compensation Fund
State Comparison

		Hospital Excess Liability Pool (NY)	Current Ohio (Under SB 120 & SB 281)	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients' Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Patients Compensation Fund	Wyoming Medical Liability Compensation Account
General	Goal of PCF	"to provide excess medical malpractice insurance coverage"	to address "concern over the rising cost of medical malpractice insurance and the difficulty that healh care practitioners have locating affordable medical malpractice insurance"	"to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions in excess of the basic insurance coverage required"	to pay that portion of a medical malpractice or general liability claim, settlement, or judgment against a licensed health care provider which is in excess of $100,000	the exclusive remedy for birth-related neurological injuries in Virginia	"(T)o provide excess medical malpractice coverage for health care providers."	"to provide physicians with excess insurance coverage"
	Enabling Legislation	N.Y.S.C.L. 28-55		MCARE Act	Code of Laws, Section 38, Chapter 79	V.C.A. 38.2 -5000 - V.C.A. 38.2 -5021	W.S. 655.27	W.S. 26-33-101 - W.S. 26-33-105
	Creation Date	1986		2002	1976	1987	1975	1997
	Financial Structure	Excess Liability Pool		Special Fund within State Treasury	State Agency	Trust Fund		Trust Fund
	Asset Segregation			Special Fund within State Treasury	Segregated Account	Segregated Account	Segregated Account	Separate Account within Trust and Agency Fund
	Accounting Rules (SAP/GAAP)				GAAP		GAAP	
	Financial Reporting	Annual Report		Annual Report	Annual Report	Annual Report	Annual Report	Annual Report
	Governance	Commissioner of Health and Superintendent of Insurance		DOI Administers the Fund	13 Member Board of Governors	7 Member Board of Directors	13 Member Board of Governors	6 Member Board of Directors
	Committees			None	Board of Governors		U/W and Actuarial, Legal, Claims, Investment/Finance and Audit, Peer Review, Risk Management	
	Meeting Frequency			None			Quarterly	

Ohio Department of Insurance

Patient's Compensation Fund
State Comparison

		Florida Birth-Related Neurological Injury Compensation Association	Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund
Structural Options	Participation	Voluntary	Hospitals Mandatory, Physicians Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary
	Eligibility	Physicians	Physicians, Hospitals	Physicians, Hospitals	Physicians, Osteopaths, Chiropractors, Podiatrists, RNAs, Medical Care Facilities, Mental Health Clinics, Dentists, Health Care LLCs Corps, etc.	Physicians, Hospitals	Physicians	Physicians, Hospitals
Coverage Options	Coverage			Occurrence or Claims-Made	Occurrence	Occurrence or Claims-Made	Occurrence or Claims-Made	Occurrence
	Required Primary Coverage (000)		$250/claim or $500/occurrence	Physicians $250/$750, Hospitals $250/$5000, $250/$7500 (>100 beds)	$200/$600	$100/$300	Physicians $200/$600, Hospitals $200/$1000	$200/$600
	Primary Coverage Options		Private Insurance or qualified Self-Insurance (for Hospitals), or JUA	Private Insurance or qualified Self-Insurance (for Hospitals)	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance
	PCF Coverage Limits	Unlimited	Physicians either $1M/3M or $2M/4M (including entry limits), Hospitals $2.5M per claim (no agg.)	$1.0M per occurrence in excess coverage	1) 100/300, 2) 300/900, 3) 800/2.4M options available	$500K plus future medical expenses less primary coverage	$1.05M per occurrence in excess coverage	$600K non-economic, unlimited medical

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Patient's Compensation Fund
State Comparison

		Hospital Excess Liability Pool (NY)	Current Ohio (Under SB 120 & SB 281)	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients' Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Patients Compensation Fund	Wyoming Medical Liability Compensation Account
Structural Options	Participation	Voluntary		Mandatory	Voluntary	Voluntary	Mandatory, with exemptions	Voluntary
	Eligibility	Physicians and Dentists with Hospital Priveleges	Physicians, Hospitals, and other health care practitioners	Physicians, Hospitals	Physicians, Hospitals	Physicians, Registered Nurses, Midwives, Hospitals	Physicians, Osteopaths, RNs, Nursing Homes, Hospitals, Ambulatory Surgery Centers, Cooperative sickness care associations	Physicians
Coverage Options	Coverage					Occurrence?	Occurrence	
	Required Primary Coverage (000)	$1M/$3M		Physicians $500/$1.5M, Hospitals $500/$2.5M	$100/$300	Not applicable, exclusive remedy	$1,000/$3,000	$50K
	Primary Coverage Options	Private Insurance, Residual Market, or Qualified Risk Retention Groups		Private Insurance, JUA or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Not applicable, exclusive remedy	Private Insurance, WHCLIP, or qualified Self-Insurance	Private Insurance
	PCF Coverage Limits	$1M per occurrence		$500/$1.5M	Unlimited	Unlimited medical and 1/2 VA average weekly wage after age 18 for all birth-related neurological injuries	Unlimited	$1M in excess coverage

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Patient's Compensation Fund
State Comparison

		Florida Birth-Related Neurological Injury Compensation Association	Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund
Funding & Revenues	Funding Approach	Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Association	Annual, Semi-annual, opr quarterly assessments	Assessments "on the same basis as premiums"	Assessments "on the same basis as premiums"	Assessments "on the same basis as premiums"	Assessments as a percentage of underlying premiums	Assessments "on the same basis as premiums"
	Funding Collection		Paid to Fund	Collected by primary insurer or risk manager as "pass-through"	Collected by primary insurer as "pass-through"	Collected by primary insurer as "pass-through"	Collected by primary insurer as "pass-through"	Collected by primary insurer as "pass-through"
	Rate Setting Authority		Board of Governors	Department of Insurance	Board of Governors	PCF Executive Director and Actuary	Director of Department of Insurance, no more than 50% of underlying premium	Insurance Division
	Rate Approval Authority		Insurance Commissioner	Department of Insurance	"reasonable, adequate, not unfairly discriminatory"	Department of Insurance	Director of Department of Insurance	Insurance Division
	Rating Classifications		Class and geographic differences allowed	9 classes based on ISO and specialty	Fund Group Classes by Specialty, with surcharge for providers providing services in Missouri	Class groups based on ISO	Same as underlying	Classes based on ISO
	Experience Rating		Permitted by law			Yes		Not currently

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Patient's Compensation Fund
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Funding & Revenues	Funding Approach	Originally hospital surcharges, then Medical Malpractice Insurance Association surplus funds, now the State's General Fund	taxes on consumers is an excluded option	"rates shall be based on the prevailing primary premium"	Pay-As-You-Go Funding	Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Fund	Administrative costs, operationg costs, and claim payments are funded through asessments on participating health care providers."	Assessments "on the same basis as premiums"
	Funding Collection	Not applicable		Collected by primary insurer as "pass-through"	Annual payments to the Fund		Health Care providers are billed annually with lump sum or quarterly payments	Collected by primary insurer as "pass-through"
	Rate Setting Authority	Not applicable		Department of Insurance	Board determined	Administered by Board of Directors	Board of Governors	Commissioner of Insurance
	Rate Approval Authority	Not applicable		Department of Insurance	None	State Corporation Commission	State Legislature	Commissioner of Insurance
	Rating Classifications	Not applicable		"rates shall be based on the prevailing primary premium"		Hospitals and Physicians	Four classes based on ISO	"on the same basis as premiums"
	Experience Rating	Not applicable		Limited				

Ohio Department of Insurance

Patient's Compensation Fund
State Comparison

		Florida Birth-Related Neurological Injury Compensation Association	Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund
Administration	Compliance/Policy Management Staff	Agency for Health Care Administration	Agency for Health Care Administration (for Board of Governors)		Fund Employees	Executive Director	DOI Administrative Staff	
	Billing & Collection	Association Staff		DOI Staff administer payments from Primary insurers	Fund Employees	Executive Director	DOI Administrative Staff	DOI Staff administer payments from Primary insurers
	Claims Administration	Administrative law judge determines coverage, Association staff administers		DOI Staff	Fund Staff monitors all Med Mal claims and suits in the state	Executive Director, Office of Risk Management	Director of Administrative Services	DOI Staff
	Asset Management	Board of Directors		Commissioner of Insurance	Director of Investments	PCF Oversight Board	State Treasurer	State Investment Department
	Asset Allocation	Board of Directors	Board of Governors	claims handling, attorney fees, expense approval, rate setting	Board of Governors, legislated limits		State Treasurer	
	Actuarial Services			Outsourced, Annual reserve and funding study	Outsourced, Annual reserve and funding study	Outsourced, Annual reserve and funding study	DOI Administrative Staff	Outsourced, Biennial Report
	DOI Obligations	Approval of Plan of Operations		Claims handling	Expertise and assistance to Board	Rate Approval	Very broad administrative responsibilities	Rates, administration, claims

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Administration	Compliance/Policy Management Staff	Commissioner of Health and Superintendent of Insurance		Department of Insurance Staff	Agency Staff	Administered by Board of Directors	Administrative Staff	
	Billing & Collection			Department of Insurance Staff	Agency Staff	Administered by Board of Directors	Administrative Staff	
	Claims Administration	HANYS Services, Inc.		Outsourced	Agency Staff	VA Workers Compensation Commission, servicing carrier to administer payment of claims	Outsourced	
	Asset Management			State Treasury	State Treasurer	Administered by Board of Directors	State of Wisconsin Investment Board	State Treasurer
	Asset Allocation			Old "Cat Fund" Assets and Liabilities were transferred	State Treasurer	Administered by Board of Directors	Developed by Board of Governors	State Treasurer
	Actuarial Services				Outsourced	Biennial Report	Outsourced, annual report required	
	DOI Obligations	Broad Administration		DOI Administers the Fund	Minimal	Review of Assessments	Provides administrative staff	Administer, Premium Collection, Rates, Reinsurance Purchase

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Incentives/ Cost Controls	Medical Review Board/ Pretrial Screenings		Each insurance company has a 90 day period to do an internal pretrial screening	Mandatory for Claims > $15K		Mandatory	Mandatory, unless waived	Mandatory
	Collateral Source	Collateral payments **do** reduce recovery	Collateral payments **do** reduce recovery	Credit available for many collateral sources	Collateral payments do not reduce recovery	Collateral payments do not reduce recovery	Credit available for some collateral sources	Evidence is **not** admissable
	Statute of Limitations	2 years from date of action or reasonable discovery, 5 years after birth	2 years from date of action or reasonable discovery, 5 years after birth	Greater of 2 years or 8th birthday	2 years after reasonably ascertainable, no more than four years after action	1 year from date of act, 1 year from date of discovery	2 years from date of injury, 1 year from date of discovery	3 years from date of action
	Damage Caps	Punitives are limited to three times compensatiiry damages	Punitives are limited to three times compensatiiry damages	$250,000 per provider, $1.25M for all qualified providers and the Fund	$250K for non-economic, punitives limited to $5M or highest income in last 5 years	$500K plus future medical expenses	$1.25M per occurrence	$600K non-economic, unlimited medical
	Attorneys' Fees	Sliding scale depending on recovery amount and type of judicial processes required	Sliding scale depending on recovery amount and type of judicial processes required	15% of PCF awards	Fees require judicial approval	None	No limits, fees are reviewable by judge	None
	Structured Settlements	Any party may request for future economic damages in excess of $250K	Any party may request for future economic damages in excess of $250K	Allowed, but not required	Not mandatory, but judges are authorized to require	PCF payments "paid as incurred"	Not required	Medical Payments must be paid as they are incurred
	Arbitration/Alternative Dispute Resolution (ADR)	Judges can refer cases to non-binding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages.	Judges can refer cases to non-binding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages.	Mandatory Medical Review panel for Claims > $15K	Arbitration Option Available	Allowed, but optional	Medical Review Panel is a non-binding option	Medical Review Commission mandatory

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Incentives/ Cost Controls	Medical Review Board/ Pretrial Screenings		Pretrial hearing to assess "reasonable good faith basis"		None	Review Panel set by Medical School Deans to determine Fund coverage	PCF Peer Review Council	Mandatory review was ruled unconstitutional
	Collateral Source	Collateral payments **do** reduce recovery	Collateral payments **do** reduce recovery	Collateral payments do not reduce recovery	Collateral payments do not reduce recovery	Collateral payments do not reduce recovery	Evidence is admissable	Collateral payments do not reduce recovery
	Statute of Limitations	Two and a half years from act or omission	1 year after cause of action, 4 years for minors with exceptions	Seven (7) year Statute of Repose	3 years from date of action or date of discovery	2 years from date of injury, 1 year from date of discovery, ten years after birth	3 years from date of injury or 1 year from date of discovery	2 years from date of injury, 2 years from date of discovery
	Damage Caps	None	No limit on compensatory, non-economic capped at greater of 3X economic and $250K, with exceptions	Punitives cannot exceed 200% of compensatory but cannot be < $100K	None	$1M cap on recoveries for bodily injury or death, $350K on punitives	Limits on non-economic damages	Unlimited
	Attorneys' Fees	(a) 30% of first $250K, (b) 25% of next $250K, (c) 20% of next $500K, (d) 15% of next $250K, (e) 10% of any amount over $1.25M	Fees greater than non-economic damages must be approved by the probate court.	Unconstitutional	None	None	(a) 33 1/3% of first $1M, (b) 25% of first $1M if liability stipulated within 180 days, and (c) 20% of amount that exceeds $1M	(a) 33 1/3%, if the claim is settled within 60 days, or (b) 40%, otherwise. 30% in excess of $1M
	Structured Settlements	Future damages in excess of $250K must be structured	Mandatory hearing to decide	Allowed, but not Mandated	Allowed, but not Mandated	Allowed	Encouraged for payments > $100K	None Mandated
	Arbitration/Alternative Dispute Resolution (ADR)	a defendant can concede liability in exchange for an agreement to arbitrate damages	Non-binding arbitration, if all parties agree to submit. Binding also available. Not revocable after 30 days.	Unconstitutional	None		Mediation System	