

FINAL REPORT AND RECOMMENDATIONS
OF THE
OHIO MEDICAL MALPRACTICE COMMISSION

APRIL 2005

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I. INTRODUCTION

Overview

The Ohio Medical Malpractice Commission was created in 2003 in legislation to address the medical liability crisis in Ohio. That legislation, Senate Bill (“S.B.”) 281 (R-Goodman), was enacted in response to concerns that rapidly rising medical malpractice insurance premiums were driving away health care providers and compromising the ability of Ohio consumers to receive the health care they need.¹ The bill contained a comprehensive set of tort reforms aimed at addressing litigation costs and stabilizing the Ohio medical malpractice market. Governor Bob Taft signed S.B. 281 on January 10, 2003. The bill became effective on April 11, 2003.

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In order to further analyze the causes of the current medical liability crisis, and to explore possible solutions in addition to tort reform, S.B. 281 created the Ohio Medical Malpractice Commission (“Commission”). The Commission is composed of nine members, including representatives of the insurance industry, health care providers, and the legal system. (Exhibit A). The Commission’s first meeting was held in May 2003 and at the June meeting Commission members adopted the following mission statement:

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

The Commission’s statutory requirements and mission statement indicate a desire among all members to conduct a thorough analysis of the causes of the current crisis. All Commission members are united in their intent to avert another crisis in which the health care of Ohio consumers could be compromised, and to mitigate the current crisis as possible. The Commission does note that many members voiced concern with the overall health system, including reimbursement rates for Ohio providers. Although reimbursement may be relevant to the affordability of medical liability coverage, the Commission has not examined that issue.

The enactment of S.B. 281 in Ohio was intended to respond to concerns raised by providers that Ohio medical liability insurance had become unaffordable, thereby creating a situation where medical liability insurance was no longer available to certain physicians.² Ohio’s tort reform efforts were preceded by enactment of similar laws in other states. Among the states already with medical malpractice tort reform are Colorado, Indiana, Wisconsin, Louisiana, California, and New Mexico. These states are commonly referred to as “non-crisis” states as defined by the American Medical Association. A primary feature of such tort reform, including Ohio’s, is caps on non-economic damages in medical malpractice lawsuits. While caps in some states include caps on economic damages (Colorado, Virginia, and Indiana) and lower caps than Ohio implemented, Ohio established caps on non-economic damages generally at \$500,000, with a \$1,000,000 cap for catastrophic injuries involving permanent and substantial physical deformity, loss of a limb or bodily organ system, or for an injury that deprives a person of independently caring for himself and performing life-sustaining activities.

Senate Bill 281 also changed the statute of repose to generally bar claims initiated more than four years after the occurrence of the act or omission constituting the basis of the claim, required a plaintiff's attorney whose contingency fees exceed the applicable amount of the limits on damages to file an application in the probate court for approval of the fees, and mandated lawsuit data reporting to the Department of Insurance.

Charge of Commission

As provided by S.B. 281, the Commission has two charges. First, the Commission is required to study the effects of the tort reforms contained in S.B. 281 on the medical malpractice marketplace. Second, the Commission is required to investigate the problems posed by, and the issues surrounding, medical malpractice. The Commission is required to submit a report of its findings to the Ohio General Assembly in April 2005.

Another piece of legislation impacting the Commission, Senate Bill 86 (R-Stivers), became effective on April 13, 2004. (Exhibit B). Senate Bill 86 added several additional charges to the Commission's mission. Those new charges require the Commission to

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

Onset of the Ohio Medical Liability Crisis

In the late 1990's, the Ohio medical liability insurance market began to slip into what we now recognize as a crisis. Rapidly rising costs caused the profitability for insurers doing business in Ohio to plummet. In 1999, Ohio's medical liability insurers reported underwriting costs that were 50.2 percent higher than the premium they collected. In 2000, underwriting costs exceeded premium by 67.9 percent. (Exhibit C). Underwriting costs are those directly related to providing insurance, including claim investigation and payment, defense of policyholders and operating expenses. By 2000, companies were forced to react to the increasing costs and began to raise rates dramatically. By late 2001, insurers were leaving the market and rates were rapidly rising.

Since 2000, nine insurers have left the Ohio medical liability market. St. Paul, First Professionals, Professionals Advocate, Lawrenceville, Phico, Clarendon, CNA, Farmers, and Frontier all withdrew from Ohio and other states due to the difficulties faced in this line of business. The surplus lines market, where providers turn when admitted insurance carriers turn away business, grew significantly.

Health care providers faced increasing difficulty finding affordable medical liability insurance coverage since rates were rising rapidly. The five major medical liability insurance companies in the state, Medical Protective, ProAssurance, OHIC Insurance Company, American Physicians, and The Doctors Company, which collectively cover nearly 72 percent of the Ohio market, raised their rates dramatically. The attached exhibit shows the average rate change for Ohio "Physicians and Surgeons" since 2000. (Exhibit D). The average change in 2002 was the highest at 31.2 percent. Some areas of Ohio, such as the counties in the northeast and along the eastern border, experienced even higher increases. Medical specialties such as OB/GYNs, neurosurgeons, radiologists, and emergency/trauma providers were hit particularly hard.

Despite the rate increases, the premiums collected by medical liability insurers in Ohio have not been sufficient to cover the costs of providing insurance, such as the cost of investigation, defense and payment of claims and operating expenses. Financial reports by Ohio medical liability insurers have not shown a profit since the mid-1990's, with insurers reporting underwriting losses in each of the last five years. (Exhibit C). All five of the top insurers received downgrades from rating agencies over the last five years, and today only two have high "A-" ratings and one is unrated.

Another fact illustrating the crisis is the number of inquiries by Ohio providers and requests for help made to the Ohio Department of Insurance. Since late 2002, the Department has assisted 223 doctors regarding their medical liability insurance coverage. Many of the calls demonstrated that certain specialties such as obstetrics were particularly impacted by rate increases. Another 17 doctors asked the Medical Coverage Assistance Program (MCAP) to help them secure medical liability insurance coverage. Additionally, the Department has documented that 228 doctors have retired, reduced or eliminated high-risk procedures, or moved to another state. Of those doctors, 97 decided to drop their private practice, reduce or eliminate high-risk procedures, or otherwise change the service they provide; 68 decided to retire and 63 have moved to another state. As a result of these ongoing dialogues and concerns about the availability of physicians, the Department conducted a survey of Ohio providers to ascertain their concerns about the current crisis.

Impact of the Crisis on Doctors and Their Patients

In the summer of 2004, the Ohio Department of Insurance commissioned a survey of 8,000 doctors to understand how rising premiums affected the doctors' practices and their patients. (Exhibit E). The results demonstrated that the rising medical liability insurance costs have significantly affected physician behavior. Nearly 40 percent of the 1,359 doctors who responded to the survey indicated that they have retired or plan to retire in the next three years due to rising insurance costs, yet only 9 percent of the respondents were over age 64.

Northeast Ohio can anticipate the highest number of those retirements, with more than 40 percent of the local physicians planning to leave in the next three years.

Ohio's patient population is being impacted, with a significant reduction in patient services already having occurred. Sixty-six percent of doctors surveyed indicated that they have turned down high-risk procedure patients or have referred those patients elsewhere. The situation is critical in southeast Ohio, where 95 percent of doctors surveyed have declined or referred high-risk patients. In northeast Ohio, 48 percent of OB/GYN and family practice physicians reported they have stopped delivering babies due to high medical liability insurance costs. Over half of the osteopathic doctors who responded indicated that they are no longer delivering babies.

Rising insurance costs also have affected where doctors see patients. Doctors have reduced the number of patients they see in nursing homes and in home care and hospice settings. Southeast and northeast Ohio have been hit particularly hard with 60 percent of responding southeast Ohio doctors having cut their in-home visits, and 54 percent of responding northeast Ohio doctors reporting that they have done the same. Responding doctors also indicated that, as a result of these high medical liability premium costs, they are being forced to see more patients to remain financially viable and many are cutting staff. In short, the survey reported that high medical liability premiums are having an effect on health care services in Ohio, and that Ohio could soon face a crisis of access to care.

Initial Signs of Recovery

The Ohio medical liability market is beginning to show signs of recovery. Two new medical liability companies, OHA Insurance Solutions, Inc. and Healthcare Underwriters Group Mutual of Ohio, have been licensed in Ohio in the last year and a half. The five major medical liability insurers in the Ohio market have stayed in Ohio throughout these difficult times. These companies indicated to the Commission during a joint legislative hearing on April 19, 2004 that among other factors, Ohio's enactment of medical malpractice tort reform legislation made them more confident about the future of Ohio's medical liability marketplace.

Medical liability rates appear to be slowly stabilizing. In 2004, rates for the top five companies increased an average of 20 percent. The average increase, while still high, is smaller than that of the two previous years. So far in 2005, two of the top five insurers, Medical Protective and The Doctors Company, have filed and implemented rate changes averaging 12 percent. Moreover, in the past year, some of these insurers have filed decreases for some regions of the state. The Doctors Company lowered rates for General Practice by 1 percent in northwest and in southeast Ohio, and by 9 percent in central and southwest Ohio. Medical Protective filed a decrease of 3 percent for General Practice in northeast Ohio. By the end of 2005, Ohio may see average rate changes below 10 percent.

Ohio medical liability insurers are also slowly moving toward profitability, which helps ensure that the medical liability companies will remain in the market and will fulfill their financial obligations to their policyholders. Underwriting losses have steadily

decreased since 2000. (Exhibit C). While the latest year's results are not yet available, continued movement toward profitability is expected and the industry could report an operating profit for 2004 in Ohio. If that occurs, this will be the first year since 1997 that Ohio's medical liability insurance industry has reported a profit.³

Still in Crisis

While the Ohio medical liability market is beginning to recover, it is still in a state of crisis. Positive signs in the marketplace do not mean that doctors are no longer facing extremely high premiums. Although rate increases are stabilizing, doctors in Ohio are still suffering from the effects of rising rates. Premiums are overall much higher than they were just five years ago. For example, rates for OB/GYNs in Cuyahoga County for the top five companies averaged \$60,000 in 2000. Now the average is \$145,000. In Athens County, the average rate for neurosurgeons was \$54,000 in 2000. Today the average is \$125,000. General surgeons in Franklin County paid an average of \$33,000 in 2000, and now face an average premium of \$68,000.⁴

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

II. FINDINGS AND RECOMMENDATIONS OF THE COMMISSION

In this environment, the Commission held 26 meetings over a two-year period in order to meet its statutory charges. Speakers with expertise on particular medical malpractice-related topics were invited to testify before the Commission. The Commission heard testimony from actuaries, doctors, state regulators and other experts. A list of the Commission's meetings, the topics covered, and the witnesses who testified before the Commission is attached. (Exhibit F). Based upon a review of the testimony, the Ohio Medical Malpractice Commission makes the following findings and recommendations.⁵

A. Effects of Senate Bill 281

The Commission concludes that because of the nature of ratemaking - primarily relying on loss experience over a period of time - and the fact that most medical malpractice cases now being heard in Ohio courts are not subject to S.B. 281 because they were brought and/or arose before its effective date, the Commission cannot conclusively evaluate the effects of the new law on the Ohio market, or on medical malpractice cases in Ohio.

However, based on testimony and data from states that do have tort reform in place, the Commission fully expects tort reform to have a stabilizing impact on the medical malpractice market in Ohio over time. Insurance department representatives from Indiana, Wisconsin, and New Mexico testified about the positive impact damage caps and patient

compensation funds have had on their respective markets and statistics from those states and Louisiana show their relative market stability compared to Ohio's. (Exhibit G). In addition, the Texas commissioner testified that an in-house, peer reviewed study of their recent tort reform, which included a \$250,000 cap on non-economic damages, estimated a 12 percent reduction in medical malpractice rates. Countrywide, those states with longstanding tort reform have more stable markets than Ohio's, and the American Medical Association's designation of non-crisis states also reflects this fact. (Exhibit H).

In addition, at the Commission's joint meeting with members of the House and Senate Insurance Committees on April 19, 2004, representatives of the five major medical liability insurers in Ohio (which hold about 70 percent of the market share) testified. Several indicated their increased confidence in operating in Ohio in light of the passage of medical malpractice tort reform, notwithstanding the fact that the industry has been losing money in Ohio since 1998. (Exhibit C). The Director of Insurance also has reported to the Commission that Department conversations with these insurers over the last two years indicate that a major reason they are still operating in Ohio is the passage of tort reform, since they are not compelled to remain in the market but are more optimistic the market will improve with tort reform.

RECOMMENDATION:

The Commission strongly recommends that S.B. 281 remain in effect in Ohio with the expectation that it will help to stabilize the medical malpractice market over time.

B. Ratemaking

The Commission heard testimony about ratemaking. Testimony included discussion of the ratemaking process, Department review of medical malpractice rate filings, various rate review standards such as "prior approval" and "file and use," and the role of investment income on ratemaking.

The Commission acknowledges and agrees with the testimony of most witnesses, including insurance actuaries, that the primary driver of medical malpractice rates is the costs associated with losses and defense of claims. For the three most recent years of financial reports, these costs have exceeded premiums collected by the top five medical malpractice insurance companies in Ohio by an average of 23.7 percent and have increased by 57 percent (241,488,088 to 378,313,587). (Exhibit I). In the last five years, rates for those insurers have increased more than 100 percent. (Exhibit D). The entire medical liability insurance industry has lost money in Ohio since 1998. (Exhibit C). Profit figures in Ohio for 2002 and 2003 show that the costs to provide this insurance exceeded premium by 46 percent in 2002 and by 30 percent in 2003.

Allegations that investment losses have caused the rapid rise in medical malpractice premiums in Ohio in the last several years are without basis. Returns on investments have been about 4 percent to 5 percent since 1999. Ohio law and regulation prohibit the recoupment of investment losses in prospective rates, and the Department ensures through

its rate review that this does not occur. ORC §3937.02 (D). Further, investment income primarily plays a part in ratemaking with respect to the estimated return on funds placed in reserves, to determine whether sufficient reserves, including investment earnings, will be available to pay claims. The Department reviews companies' estimates used in these calculations carefully.

Ohio's regulatory system for property and casualty rates is known as "file and use," meaning that while companies must file their rates with the Department, they may use them immediately. The Department can reject rates if after review the Department determines the rates are unfairly discriminatory, inadequate or excessive. Other states have different systems, such as "use and file" (no prior review) and "prior approval" (requiring insurance department approval before use). None of these systems appears to be distinctive in improving rates or insurance markets. In fact, according to some companies, prior approval often results in delays and political bickering before rate changes can be implemented, potentially impacting a company's financial condition. This concerns insurance regulators who also oversee the financial condition of insurance companies to protect consumers.

No legal requirement exists to compel companies to file their rate changes on a regular basis, although the practice in Ohio's volatile medical liability market has been for companies to file rate changes at least annually, and usually before a change has become effective to allow the Department time to review it beforehand. The Department has implemented procedures in the last two years to intensify scrutiny of rates and to hold companies accountable for proposed increases.

In addition, no legal requirement exists to compel companies to remain in Ohio. Despite the hard Ohio market and lack of profits in medical liability coverage, five major companies have remained in Ohio, two more have been licensed in the last year, and 32 additional companies continue to write at least \$1 million in coverage each. This is a more positive trend following the departure of nine companies from Ohio between 2000 and 2002.

RECOMMENDATIONS:

- 1.) The Commission does not recommend a change in the rate review system in Ohio since rates are well regulated.
- 2.) The Commission recommends that the Department require medical malpractice companies to file and justify their rates, even if no change is requested, at least once every year.

C. Data Collection

Senate Bill 281, the tort reform bill, required clerks of court to report medical malpractice lawsuit data to the Department, which developed a system for collecting the data. However, testimony of the Department and county clerks indicated the insufficiency and unreliability of the data collected under that system. As a result, the Commission

recommended in its Interim Report the passage of legislation requiring more comprehensive data reporting.

Subsequently, House Bill 215 (R-Schmidt) was enacted September 13, 2004, requiring detailed data reporting to the Department by insurance companies and self-insureds. The Department recently promulgated O.A.C. 3901-1-64, effective January 2, 2005, implementing H.B. 215 and requiring medical malpractice insurers and others who assume liability to pay medical, dental, optometric, and chiropractic claims to report judgment, settlement and other closed case data to the Department. Further, H.B. 425 (R-Stewart, effective April 27, 2005) contained uncodified language requesting the Ohio Supreme Court to adopt a rule requiring attorneys to report fee expense information to the Department.

The Commission concludes that the new data reporting and collection requirements appear to be comprehensive and sufficient at the present time but should be evaluated after being fully implemented to determine whether additional changes are warranted.

Confidentiality of data continues to be an issue, however. The Commission agrees that the data should remain confidential, except in the aggregate. Members expressed concern that if specific individual case data were released, insurers might not be as forthcoming with accurate data and individual medical providers could be put at some risk. Two members believe that raw data should be available so that the public can draw its own conclusions.

RECOMMENDATIONS:

- 1.) The new data collection provisions of H.B. 215, O.A.C. 3901-1-64, and H.B. 425 should be evaluated annually after each annual cycle of data has been collected. The annual report by the Department required by H.B. 215 should provide the basis for this evaluation.
- 2.) Data collected should remain confidential as required by current law.

D. Medical Error Reduction

While long known to members of the medical and legal profession, errors in the delivery of health care occur. The Institute of Medicine report issued in 2000 entitled *To Err is Human: Building a Safer Health System* focused attention on this issue. In addition, although redundancies and checks within the health care delivery system help reduce error, medical errors do occur. Whether or not most errors result in lawsuits is not clear, although a 1991 New England Journal of Medicine article evaluating a 1984 New York study indicated that only 7.7 percent of actual cases of error result in lawsuits. In addition, a 2003 GAO report estimates that 70 to 86 percent of all medical malpractice verdicts result in no payment, suggesting that not all cases are deemed meritorious.

The Commission heard testimony regarding several initiatives occurring in Ohio to address medical error. A major initiative in this area jointly sponsored by the Ohio State Medical Association, the Ohio Osteopathic Association, and the Ohio Hospital Association is the Ohio Patient Safety Institute. This organization, formed in 2000, has investigated the development of a statewide system for reporting medical errors and has undertaken a variety of initiatives to raise the awareness of participants in healthcare delivery throughout the state to patient safety and the need for improvement. Another initiative was presented to the Commission by the Ohio University College of Osteopathic Medicine, which has developed a Patient Safety Committee to research the causes of error and promote a culture of safety. Commission member Frank Pandora pointed out that most large hospitals and hospital systems have initiatives to reduce error in health care delivery underway. The Ohio State Medical Board also has an interest in reducing medical error and a responsibility to investigate medical error brought to it in the form of complaints received. The Medical Board testified that it lacks sufficient resources to investigate all complaints received in a timely fashion.

The Commission heard testimony that much of the work in the area of patient safety is based on a “systems” approach to the reduction of medical error. The approach recognizes that the occurrence of an error in the delivery of health care may involve the failure of a system to perform appropriately rather than the failure of a single or small number of members of the health care delivery team. Such an approach does not necessarily de-emphasize individual responsibility but recognizes that systems should be designed to reduce the opportunity for error to occur, and in order to improve must go beyond the emphasis on individual blame.

In addition, the Commission heard testimony that improving the structure of the health care delivery system to improve safety will require extensive capital investment in the near future. Improving data systems and investment in technology to improve safety will need capital resources currently unavailable to many participants in the system. The Commission encourages the exploration of creative ways for state government to assist in the capital investment in the health care delivery system to make it the safest possible system.

Ohio lacks a statewide uniform medical error reporting protocol, requirement or system. Although the Joint Commission on Accreditation of Health Care Organizations imposes reporting requirements of so-called sentinel events on its accredited hospitals, these requirements do not extend to the outpatient environment and do not cover the entire scope of “medical errors.”

The Commission also finds that, in spite of efforts by organizations described above, the state does not have an adequately funded, centralized system for the evaluation and dissemination of best practices in the area of patient safety. Six states have established “patient safety centers” with varying oversight and funding but all with a general mission of educating health care providers on best practices. The intended goals of such a center in Ohio would be to coordinate patient safety efforts at institutions across the state, work to identify best practices in patient safety, educate health care providers about best practices,

identify funding sources for the implementation of best practice strategies, develop data collection systems and protocols for error reporting and make appropriate recommendations to the legislature concerning the funding of such activities. Such a center should be structured as a partnership among appropriate state government units and appropriate private institutions, organizations and associations.

The Commission strongly believes there is a need for a coordinated and directed effort in medical error reduction. An important step would be the development of a medical error reporting system to allow the systematic study of the errors occurring to develop appropriate response to them. Confidentiality of data needs to be addressed. Members expressed concern that if specific individual patient, physician and hospital data were released, as opposed to aggregate data, such release may weaken the reporting of medical errors. The improvement of patient safety in Ohio is an important and appropriate goal and will require governmental support and partnerships with components of the health care delivery system.

The Commission believes that cooperative ventures among the Department of Health, the Ohio State Medical Board, other agencies, private institutions and organizations may be fostered to develop and implement a statewide protocol for medical error reporting and a statewide repository for such information. This would require legislation mandating and funding such an initiative, which would add legitimacy to this effort.

RECOMMENDATION:

The Commission strongly recommends the creation of a "patient safety center" as described above which would include the development of a medical error disclosure to patients protocol and a statewide uniform medical error reporting system.

E. Health Care Access, Recruitment, and Retention

The Commission heard specific testimony from leaders at medical education institutions in Ohio that recruitment of new doctors and retention of experienced doctors, particularly in certain specialties like surgery and obstetrics, have been impacted by the medical malpractice crisis. In addition to anecdotal evidence from doctors and hospitals across the state, the Doctors' Survey commissioned by the Department in the summer of 2004 reflected the alarming response from almost 40 percent of doctors responding to the survey that they have retired or plan to retire in the next three years due to rising insurance expenses. The Doctors' Survey also indicated an impact on health care access because of doctors' increasing unwillingness to conduct certain high-risk procedures or to see patients in certain locations (such as nursing homes) and doctors' increasing practice of ordering more tests to defend their medical decisions.

The State Medical Board testified that the number of licensed doctors in Ohio is increasing, but it does not keep track of the number of licensed doctors who are retired, who moved their practices to another state, or who have otherwise limited their practice by curtailing high-risk procedures.

The Commission concludes that a correlation exists between the medical malpractice crisis and access to health care and recruitment and retention of doctors. The efforts of the Department and legislature to stabilize the medical malpractice market should help Ohio retain physicians in the long-term. Various institutions are exploring their own initiatives to retain and recruit physicians, including providing coverage through captives and risk retention groups.

RECOMMENDATIONS:

- 1.) The Commission recommends the investigation of programs to forgive educational loans and other incentives for doctors in certain specialties and for those doctors who agree to stay in Ohio for a specified period of time.
- 2.) The State and the Department should continue to monitor patient access to health care and doctor departures, and advise appropriate parties and agencies of such issues.

F. Patient Compensation and Other Compensation Funds

The Department conducted a feasibility study of patient compensation funds in 2003 (Pinnacle Report) pursuant to the directive in S.B. 281, and hired another consultant in 2004 to develop specific models for a patient compensation fund (PCF) in Ohio (Milliman Report). Milliman recommended that an Ohio PCF provide coverage over a primary layer of \$500,000, up to \$1 million in coverage, and require participation by all health care providers, including self-insured providers, which would pay premiums to fund the PCF. The Milliman report concluded that the anticipated change in overall premium based on the recommended model would be about a 5 percent reduction. The Department's position is that the long-term stabilizing impact of a PCF warrants its serious consideration, but other Commission members were not persuaded by this argument. However, Commission members did recognize the thorough research of the Department and Commission on PCFs. Members do not believe that a PCF with only a 5 percent possible reduction in premiums would be beneficial. Ohio healthcare providers indicated they sought a more significant impact on premiums for them to support implementation of a PCF.

The Commission also heard testimony on two specialized funds in Virginia and Florida for birth-related injuries. No information appears to be available in Ohio on the extent of these types of cases.

RECOMMENDATION:

The Commission recommends that no further action on a PCF, funded solely by health care providers, be taken at this time.

G. Captive Initiative

The Department has developed legislation that would permit the formation of and provide for the regulation of captive insurers in Ohio. The Commission heard testimony about the advantages of captives - among other benefits, cheaper rates because of lower administrative costs - but discussed the need for financial standards and oversight in Ohio to protect doctors and patients. The Commission believes that such legislation could increase insurance capacity in Ohio, particularly needed in the medical liability market.

States like Vermont and South Carolina have captive statutes which allow captives to write a wide range of commercial coverage, not just medical liability. These states have attracted more companies to form captive insurers in their states rather than in offshore jurisdictions.

RECOMMENDATION:

The Commission recommends that the Department continue to investigate captive formation in Ohio, which could result in related legislation.

H. Non-Meritorious Lawsuits

The Commission recognizes that claims, settlements and lawsuits generate costs for insurance companies, whether or not any money is paid out to the claimant. The Commission heard considerable testimony that these cost factors drive premium increases. The failure to mitigate these costs will impact a provider's liability premium regardless of the underlying merits of the lawsuits involved.

Consistent with these concerns and recommendations made in the Commission's Interim Report, the General Assembly enacted H.B. 215 (effective September 13, 2004) which requested the Ohio Supreme Court's implementation of a rule of civil procedure requiring an affidavit of merit for the plaintiff at the initial filing of a medical malpractice case. The Supreme Court has finalized amended Civil Rule 10, which will be effective July 1, 2005. In addition, H.B. 215 provided for the filing of affidavits of non-involvement to excuse certain named parties, with the goal of dismissing certain inappropriate parties earlier in the process, thereby reducing associated costs. This provision became effective September 13, 2004.

Finally, H.B. 215 gives the Ohio State Medical Board disciplinary authority over out-of-state medical experts who come into the state to testify. This provision allows the Medical Board to monitor the caliber and veracity of medical experts in an effort to curtail unqualified "experts" from lending ostensible credibility to non-meritorious lawsuits.

The Commission also heard testimony on the viability of binding arbitration, pretrial screening panels, and medical review boards. The Commission research indicates many issues still need to be resolved regarding these proposals, including whether they are constitutionally feasible, reduce costs or save time. Evidence from states which currently

employ such measures was not conclusive on these issues. A pilot program for a less formal mediation alternative could avoid many of the constitutional issues which surfaced in the debate over pretrial screening panels and could be tested through the pilot program to evaluate its effectiveness.

RECOMMENDATIONS:

- 1.) The Commission recommends a pilot project of a less formal mediation alternative in conjunction with the Supreme Court.
- 2.) Although cost is a factor (typically a specialized court costs \$100,000 per year per county), the Commission recommends a pilot project in one or more counties that establishes medical malpractice courts or dockets, which may provide increased efficiency and competency.
- 3.) The Commission recommends that the process reforms enacted in H.B. 215 be evaluated by the Supreme Court after they have been in effect for two years to determine their impact on medical malpractice cases. This evaluation should be reported to the Governor, legislative leadership, and the Department.

I. Charitable Immunity

The Commission was given a new task in Senate Bill 86 of the 125th General Assembly, which extended the charitable immunity law to volunteer health care professionals regardless of where they provide the service. The Commission was directed to review the following and finds accordingly with respect to each issue:

(1) The affordability and availability of medical malpractice insurance for health care volunteers and nonprofit health care referral organizations: According to testimony before the Commission, 87 percent of the members of the Ohio Association of Free Clinics find it difficult to access affordable professional liability coverage despite both the existence of Ohio's charitable immunity law and no lawsuits filed against Ohio free clinics. At least one Ohio medical liability insurance carrier is offering coverage for free clinic staff.

(2) The feasibility of state-provided catastrophic claims coverage to health care workers providing care to the indigent and uninsured: The Commission heard testimony from Virginia and Iowa, states that indemnify or provide state coverage for charitable providers. Ohio currently only indemnifies its state employees and does not have a statutory mechanism to indemnify others. To provide indemnification or to pay premiums would be a significant funding issue in Ohio.

(3) The feasibility of a state fund to provide compensation to persons injured as a result of the negligence of health care volunteers: Providing a state fund to compensate injured persons would also face funding hurdles. Further, since no claims have been made against Ohio free clinics, the Commission does not believe that a state fund to provide

compensation to persons injured as a result of the negligence of health care volunteers is currently warranted.

(4) Other states' Good Samaritan laws: The Commission also learned that Ohio's approach to charitable immunity is comparable to a majority of other states' approaches.

The Commission finds that S.B. 86 is a good step toward encouraging charitable care in Ohio. However, free clinics still have difficulty obtaining affordable medical liability coverage, even though no claims have been made against Ohio free clinics.

RECOMMENDATIONS:

- 1.) The Commission recommends the issuance of guidelines by the Ohio Department of Insurance which would require medical liability insurance carriers to incorporate into their underwriting and pricing of policies for free clinics appropriate modifications to reflect past and prospective claim experience in Ohio.
- 2.) The Commission recommends the inclusion of free clinics in a statewide medical error reporting system in order to ensure that patients are receiving the best care possible.

J. Medical Liability Underwriting Association

House Bill 282 (R-Flowers, enacted April 4, 2004) provided for the transfer of the \$12 million previously held by the 1975 Ohio Joint Underwriting Association into a new fund that could be used to create a new medical liability company or to fund other medical malpractice initiatives as approved by the Ohio General Assembly. The legislation also gave the Director of Insurance authority to create a Medical Liability Underwriting Association ("MLUA") if the current medical malpractice market were to further deteriorate. The MLUA would write primary insurance coverage for doctors unable to find coverage.

RECOMMENDATION:

Due to the unpredictable and volatile nature of the medical malpractice market, and the Department's recent testimony on stabilizing but still uncertain market conditions, the Commission strongly urges the legislature to retain the current funding set aside for the potential enactment of the MLUA and for future medical malpractice initiatives.

K. Miscellaneous Recommendations

- 1.) During the hearings, several physician witnesses testified on the difficulty of affording the current premiums for professional liability coverage. Even more troublesome than the current pricing is the necessity of purchasing prior acts or "tail" coverage to protect and maintain existing coverage limits after retirement or changing companies. Under previous custom a company would grant a deceased,

disabled or retiring practitioner continuing coverage for any events/claims occurring during the existence of the policy's terms at no additional cost. Medical liability insurers traditionally provided tail coverage as a prepaid component of prior premiums. Companies require an amount equal to 1-2 years of mature premium prior to the physician retiring before the end of the five-year vesting period, or changing from one company to another. Additionally, market conditions have forced some physicians to switch professional liability companies several times, creating the necessity of purchasing of multiple tail policies.

According to comments by Texas Insurance Commissioner Jose Montemayor, the state of Texas has a mechanism to address part of this problem. When a company that sold policies in Texas leaves and refuses to offer a tail policy for a physician's liability coverage, the existing Texas Joint Underwriting Authority ("JUA") is authorized to provide that tail policy coverage to the physician when he or she purchases primary coverage from the JUA.

As stated earlier in this report, nine companies left Ohio between 2000 and 2002, forcing their policyholders to find tail liability policies from those companies even if the companies' financial conditions were questionable or the companies were no longer doing business in the state. Ohio has already recognized the importance of maintaining the availability of medical professional liability insurance by creating the statutory authority to establish the MLUA. The MLUA would provide primary coverage in case the remaining carriers were to decide to leave Ohio or limit their participation in the market.

The Commission recommends that the Department of Insurance investigate the economic implications of the MLUA or another state insurance entity providing prior acts or tail coverage if the original insurer has become insolvent or stopped doing business in the state. The results of this investigation could provide the basis for legislation.

- 2.) The Commission recommends that if the Department determines that the long-term medical malpractice market has stabilized and the future funding of an MLUA is unnecessary, then the current MLUA funding should be directed to fund other medical malpractice initiatives.
- 3.) The Commission recommends that the Department continue to monitor the medical liability market in Ohio, and recommends that biennially, beginning two years after issuance of this report, the Department provide a market analysis of the medical liability market to the Governor and the legislature.

¹ Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(B)(1) and (2): “[T]he General Assembly declares its intent to accomplish all of the following by the enactment of this act: (1) To stem the exodus of medical malpractice insurers from the Ohio market; [and] (2) To increase the availability of medical malpractice insurance to Ohio’s hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state. . . .”

² Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(A)(3)(c): "As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports 15 percent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs."

³ "State of the Medical Malpractice Market," Ohio Department of Insurance Director before the Ohio Medical Malpractice Commission, February 28, 2005.

⁴ Top five companies' medical malpractice 2000-2004 rate filings submitted to the Ohio Department of Insurance.

⁵ Minority views will be expressed separately.