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Bill Analysis
Legislative Service Commission

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(As Introduced)

Rep. Flowers

BILL SUMMARY

- Outright repeals existing laws creating and governing the Joint Underwriting Association formed under a medical professional liability insurance plan to provide for the administration and provision of medical malpractice insurance.
- Creates the Patient's Compensation Fund (the Fund) to be used solely to pay amounts in settlements and judgments of medical claims involving qualified providers that are in excess of \$250,000 and requires the Department of Insurance (Department) to pay for the administration of the Fund.
- Requires an annual surcharge in an amount fixed by the Superintendent of Insurance (Superintendent) to be levied on all medical malpractice insurance policies covering providers practicing in Ohio, collected by insurers and agents on the same basis as premiums, and deposited in the Fund.
- Specifies that a provider qualifies as a qualified provider if the provider's medical malpractice insurer files and maintains with the Department proof of the provider's financial responsibility, i.e., specified minimum amounts of medical malpractice insurance coverage, and pays the surcharge assessed on all providers and specifies the conditions that a provider's agents and employees must meet in order to qualify under the bill.
- Requires the Superintendent to adopt rules establishing criteria for determining whether a business arrangement of providers may qualify as a qualified provider.

- Authorizes the Superintendent to use money from the Fund to pay for legal services to aid in protecting the Fund against claims.
- Specifies the time in which claims for payment from the Fund that become final during certain periods in a calendar year must be computed and paid, requires the proration of the amount paid to each plaintiff if the Fund has insufficient funds to pay in full claims that become final during a particular period, and requires the payment of any amount left unpaid as a result of the proration before the payment of claims that become final during the following period.
- Provides for the discharge of an obligation to pay an amount from the Fund by payment in one lump sum, by periodic payments pursuant to agreement, through the purchase of an annuity payable to the plaintiff, or by a combination of those methods.
- Requires an unpaid settlement or judgment to be paid from the Fund and requires that the Fund be subrogated to the plaintiff's rights against the defaulting provider, provider's medical malpractice insurer, or both.

CONTENT AND OPERATION

Existing law--medical professional liability insurance plan: Joint Underwriting Association

Current Insurance Law provides that the Ohio Fair Plan Underwriting Association by action of its board of governors, with the approval of the Superintendent of Insurance, is authorized to enter into a contract with any association formed under a medical professional liability insurance plan created by authority of R.C. 3929.72 (see following paragraphs), in which the Ohio Fair Plan Underwriting Association will perform administrative services necessary or incidental to the operation of the medical professional liability insurance plan. Such a contract must provide that the Ohio Fair Plan Underwriting Association will be reimbursed for its actual expenses incurred in performing those services. Common expenses applicable both to the Ohio fair plan and to the medical professional liability insurance plan must be allocated between them on an equitable basis approved by the Superintendent of Insurance. (R.C. 3929.482(A).)

Existing R.C. 3929.72, not in the bill and repealed by the bill, creates a Joint Underwriting Association (JUA), to be effective with the plan of operation promulgated as described below, consisting of all insurers and corporations authorized to write and engaged in writing within Ohio, on a direct basis, prepaid

hospital service contracts; and liability insurance policies including insurers covering such perils in multiple peril package policies. Every such insurer, corporation, or association must be a member of the JUA and remain a member as a condition of its authority to continue to transact that kind of business in Ohio, notwithstanding other prohibitions or authorizations provided in the Revised Code. The participation in the JUA by any insurer or corporation required to participate in that association, does not constitute the writing of a line of insurance otherwise prohibited by the laws of Ohio. (Existing R.C. 3929.72(A).)

The JUA, pursuant to existing R.C. 3929.71 to 3929.85 and the plan of operation with respect to medical malpractice insurance promulgated as described below, have the power on behalf of its members to do the following (existing R.C. 3929.72(B)):

(1) Issue, or cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation. Coverages under those policies may be made available as primary or excess protection, provided limits of primary protection under one policy cannot exceed \$200,000 for each claim and \$600,000 for all claims in any year and limits of excess protection under one policy cannot exceed \$1 million for each claim and \$1 million for all claims in any year.

(2) Underwrite such insurance and adjust and pay losses with respect to that insurance, or appoint service companies or associations to perform those functions;

(3) Assume reinsurance from its members;

(4) Cede reinsurance.

Within 45 days following the creation of the association, the board of governors of the association must submit to the Superintendent of Insurance, for the Superintendent's review, a proposed plan of operation, consistent with R.C. Chapter 3929. The Superintendent may adopt this plan in a rule promulgated subject to R.C. Chapter 119. If the Superintendent does not adopt that plan within 15 days of such submission, the Superintendent must formulate a plan of operation consistent with R.C. Chapter 3929. The Superintendent, subsequent to the termination of the 15-day period, must establish that plan by rule in the minimum time permitted by R.C. Chapter 119.

The plan of operation must provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient providing of medical malpractice insurance, and must contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses

necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, administrative expenses, reasonable and objective underwriting standards, acceptance and cession of reinsurance, and the appointment of servicing carriers or the direct issuance of syndicate policies. Amendments to the plan of operation may be made by the board of governors of the association, subject to the approval of the Superintendent. The Superintendent may also make amendments to the plan of operation. The Superintendent must then amend the rule establishing the plan of operation pursuant to R.C. Chapter 119.

The plan of operation must require the issuance of a binder providing coverage for which the applicant tenders an amount equal to the annual premium as estimated by the association, that binder taking effect 15 days following the date of application, for a term and under conditions that are determined by the Superintendent. The Superintendent may alter that time requirement on a specific risk under conditions that the Superintendent finds appropriate. The association must cause all policies written to be separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium levels for each classification of risk, and performing loss prevention and other duties of the operation of the association. (Existing R.C. 3929.72(C).)

Existing R.C. 3929.71 to 3929.84 contain the provisions governing the Joint Underwriting Association.

Operation of the bill

The bill outright repeals R.C. 3929.482(A), as described above, and all of the existing provisions of law governing the Joint Underwriting Association¹ and replaces them with new provisions of law creating and governing the Patient's Compensation Fund.

Creation of Patient's Compensation Fund

The bill creates the Patient's Compensation Fund (hereafter, "Fund") in the state treasury. The Fund must be used solely to pay amounts in settlements and judgments of "medical claims" involving "providers" qualified under the bill (see "**Definitions**," below) that are in excess of \$250,000. The Department of Insurance (hereafter, "Department") must pay for the administration of the Fund. The Superintendent of Insurance (hereafter, "Superintendent") must collect the surcharge assessed on providers' malpractice insurance as described below under

¹ These provisions are found in R.C. 3929.71, 3929.72, 3929.721, 3929.73, 3929.75, 3929.76, 3929.77, 3929.78, 3929.79, 3929.80, 3929.81, 3929.82, 3929.83, and 3929.84.

"Annual surcharge" and deposit the money into the Fund. (New R.C. 3929.72(A).)

Payments from the Fund. The bill authorizes the Superintendent, upon application of both parties to nonbinding arbitration under R.C. 2711.21 (see **COMMENT 1**), to agree to disburse funds from the Fund towards the amount of a settlement in excess of \$250,000. The Superintendent cannot disburse any funds from the Fund unless the medical claim was asserted against a qualified provider. If the annual aggregate coverage for a qualified provider established under the bill as described below in "Minimum amount of insurance coverage" has been paid by or on behalf of the provider, all amounts that may subsequently become due and payable to a plaintiff during the year in which the annual aggregate was exhausted as a result of a judgment from a medical claim asserted against the provider must be paid from the Fund.

If a civil action asserts a medical claim against a qualified provider *after* the provider's annual aggregate coverage has been exhausted, the Superintendent may agree to disburse funds from the Fund pursuant to a settlement with the plaintiff. A qualified provider that has exhausted annual aggregate coverage has no right to object to the settlement, or refuse the Superintendent permission to settle the medical claim. (New R.C. 3929.72(B), (C), and (D).)

Annual surcharge

The bill requires an annual surcharge to be levied on all medical malpractice insurance policies covering providers practicing in Ohio. The Superintendent must fix the amount of the surcharge. An insurer or agent must collect money from the surcharge along with the insurance premium and pay the money to the Superintendent within 90 days after a policy's effective date for deposit to the Fund.

The Superintendent must calculate the actuarial risk posed to the Fund from judgments against qualified providers and the settlement of medical claims. The surcharge must be: (1) adequate to support the Fund, (2) a minimum of \$100, and (3) assessed uniformly on all providers practicing in the same specialty. (New R.C. 3929.79.)

Insurers and agents must collect the assessed surcharge on the same basis as premiums. The surcharge is due and payable to the Fund as described in the first paragraph, above. If the surcharge is not paid to the Fund, the medical malpractice insurer is responsible for the delinquency and is liable to the Fund for a penalty equal to 10% of the amount of the surcharge. If an insurer fails to pay the surcharges and penalties, the Superintendent may suspend the insurer's authority to

engage in the business of insurance in Ohio until the surcharges and penalties are paid. (New R.C. 3929.80.)

Qualifications of providers, agents, and employees

A provider is qualified for purposes of the bill's provisions if the provider's medical malpractice insurer does both of the following: (1) files and maintains proof of the provider's financial responsibility with the Department as described below in "**Minimum amount of insurance coverage**" and (2) pays the surcharge assessed on all providers as described above in "**Annual surcharge**." The agents and employees of a provider, while acting in the course and scope of their employment, are qualified if both of the following conditions are met: (1) the agents or employees are individually named or are members of a named class in the proof of insurance that is filed with the Department and (2) the assessed surcharge has been paid. (R.C. 3929.711(A) and (B).)

Except as described in the following paragraph, a provider, or an employee or agent of a provider, is qualified as described above as of either: (1) the day the Department receives the proof of insurance and surcharge or (2) the effective date of the medical malpractice insurance policy, if the Department receives the proof of insurance and surcharge not later than 90 days after the policy's effective date (R.C. 3929.711(C)).

If a medical malpractice insurer files proof of insurance and pays the surcharge on behalf of a provider more than 90 days but not more than 180 days after the effective date of a policy, the provider is qualified, contingent upon the insurer demonstrating to the satisfaction of the Department that the insurer both: (1) received the provider's premium and surcharge in a timely manner and (2) failed to forward the proof and surcharge in a timely manner. If an insurer files proof of insurance and pays a surcharge on behalf of a provider more than 90 days but not more than 180 days after the effective date of a policy, the Superintendent must impose on the insurer the following penalties: (1) 10% of the surcharge, if the proof of insurance is filed and surcharge paid more than 90 days but not more than 120 days after the effective date of the policy, (2) 20% of the surcharge, if the proof of insurance is filed and surcharge paid more than 120 days but not more than 150 days after the effective date of the policy, or (3) 50% of the surcharge, if the proof of insurance is filed and surcharge paid more than 150 days and not more than 180 days after the effective date of the policy. (R.C. 3929.711(D) and (E).)

A provider, and any agent or employee of the provider who is individually named or part of a named class in proof of insurance filed with the Department, is qualified as of the day the Department receives the provider's proof of insurance and surcharge and the penalty imposed as described in the preceding paragraph.

The Department must deposit in the Fund any money received as described in the preceding paragraph. (R.C. 3929.711(F) and (G).)

Within five business days after a medical malpractice insurer files proof of insurance and pays a surcharge on behalf of a provider, the Department must mail written notice to the provider stating that the provider is qualified for purposes of the bill's provisions. The notice must state the effective date. (R.C. 3929.712.)

Minimum amount of insurance coverage. In order for a provider to qualify for purposes of the bill, the provider's medical malpractice insurer must file proof with the Department that the provider maintains the applicable minimum amount of medical malpractice insurance coverage described in the next paragraph. The bill requires the Superintendent to adopt rules as to the nature of the proof required and any forms to be used. An insurer also may file proof of insurance covering the provider's agents and employees during the course and scope of their employment.

The minimum amounts of medical malpractice insurance coverage a provider needs to qualify are as follows: (1) a provider must maintain coverage of at least \$250,000 per occurrence and, except as provided in (2), below, \$750,000 in the annual aggregate, (2) if the provider is a hospital, home, or residential facility of not more than 100 beds, the hospital, home, or residential facility must maintain annual aggregate coverage of \$5 million or, if the provider is a hospital, home, or residential facility of more than 100 beds, the hospital, home, or residential facility must maintain annual aggregate coverage of \$7,500,000. (R.C. 3929.714.)

A provider employed by a hospital, home, or residential facility must establish proof of insurance separately from the hospital, home, or residential facility in order to qualify under the bill (R.C. 3929.715).

Business arrangement of providers. The bill requires the Superintendent to adopt rules under the Administrative Law establishing criteria for determining whether a partnership, association, corporation, or other business arrangement of providers may qualify as a qualified provider. The rules must include a requirement for these qualified business arrangements to maintain a minimum amount of medical malpractice insurance coverage as described above in "**Minimum amount of insurance coverage.**" A provider partnership, association, corporation, or other business arrangement seeking status as a qualified provider must provide all relevant information needed by the Superintendent. (R.C. 3929.713.)

Protection of Fund

The bill authorizes the Superintendent, using money from the Fund, as considered necessary, appropriate, or desirable, to purchase or retain the services of persons, firms, or corporations to aid in protecting the Fund against claims. The Superintendent must retain the services of counsel to represent the Department when a trial court's determination is necessary to resolve a claim against the Fund. When retaining legal services, the Superintendent must retain competent and experienced legal counsel licensed to practice law in Ohio to assist in litigation or other matters pertaining to the Fund. The Superintendent has sole authority for approving actions of the retained counsel and determining the reasonableness of any fee submitted to the Department by counsel. (New R.C. 3929.73.)

Claims for payment from Fund

The bill requires that claims for payment from the Fund that become final during the first six months of a calendar year be computed on the last day of June and paid not later than the following 15th day of July. Claims for payment from the Fund that become final during the last six months of the calendar year must be computed on the last day of December and paid not later than the following 15th day of January. If the balance in the Fund is insufficient to pay in full all claims that become final during a six-month period, the amount paid to each plaintiff must be prorated. Any amount left unpaid as a result of proration must be paid before the payment of claims that become final during the following six-month period. (R.C. 3929.74.)

The State Auditor must issue a warrant on the 30th day of June and the 31st day of December of each year in the amount of each claim submitted to the Auditor by the Superintendent against the Fund. The claim against the Fund must be in the form of a voucher prepared by the Superintendent after the Superintendent receives a certified copy of a final judgment against a qualified provider in an amount over \$250,000 or a certified copy of a settlement reached as described above in "*Patient's Compensation Fund*" and "*Payments from the Fund*" in an amount over \$250,000. (New R.C. 3929.75.)

An obligation to pay an amount from the Fund may be discharged as follows: (1) payment in one lump sum, (2) periodic payments pursuant to an agreement between the parties, subject to R.C. 2323.55 (see **COMMENT 2**), (3) through the purchase of an annuity payable to the plaintiff, or (4) any combination of the methods described in (1) to (3) in this paragraph (new R.C. 3929.76).

Notwithstanding the collection of the assessed surcharge as described in the last paragraph under "*Annual surcharge*," above, the Fund is not liable on any medical claim against a qualified provider for amounts in excess of the limits on

damages established under R.C. Title XXIII for medical claims asserted in civil actions (new R.C. 3929.77).

Subrogation

The bill provides that if a provider or the provider's medical malpractice insurer fails to pay a settlement or final judgment within 90 days, the settlement or judgment must be paid from the Fund, and the Fund must be subrogated to any and all of plaintiff's rights against the provider, the provider's medical malpractice insurer, or both, with interest, reasonable costs, and attorney's fees (new R.C. 3929.78).

Definitions

The bill defines the following terms for purposes of its provisions (new R.C. 3929.71):

Medical claim means any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. Medical claim includes the following: (1) a derivative claim for relief that arises from the medical diagnosis, care, or treatment of an individual and (2) a claim that arises out of the medical diagnosis, care, or treatment of any individual, resulting from acts or omissions in providing medical care or the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

Provider means a physician, podiatrist, hospital, home, or residential facility, an employee or agent of a physician, podiatrist, hospital, home, or residential facility, a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic.

Conforming changes

The bill deletes references to the Joint Underwriting Association under existing law and makes other conforming changes in R.C. 3929.85, 3931.01, 3955.05, 3960.06, and 4731.143.

COMMENT

1. Under R.C. 2711.21, not in the bill, upon the filing of any medical, dental, optometric, or chiropractic claim, if all of the parties to the claim agree to submit it to *nonbinding arbitration*, the controversy must be submitted to an arbitration board consisting of three arbitrators to be named by the court as follows: one designated by the plaintiff or plaintiffs, one designated by the defendant or defendants, and one designated by the court. In a claim accompanied by a poverty affidavit, the cost of the arbitration must be borne by the court. The arbitration proceedings are conducted in accordance with R.C. 2711.06 to 2711.16 insofar as they are applicable. Such proceedings must be conducted in the county in which the trial is to be held. If the decision of the arbitration board is not accepted by all parties to the claim, the claim must proceed as if it had not been submitted to nonbinding arbitration pursuant to R.C. 2711.21. The decision of the arbitration board and any dissenting opinion written by any board member are not admissible into evidence at the trial. Nothing in the above provisions can be construed to limit the right of any person to enter into an agreement to submit a controversy underlying a medical, dental, optometric, or chiropractic claim to binding arbitration.

2. R.C. 2323.55(B), not in the bill, provides that in any civil action upon a medical, dental, optometric, or chiropractic claim in which a plaintiff makes a good faith claim against the defendant for future damages that exceed \$50,000, upon motion of that plaintiff or the defendant, the trier of fact must return a general verdict and, if that verdict is in favor of that plaintiff, answers to interrogatories or findings of fact that specify both the past damages recoverable by that plaintiff and the future damages recoverable by that plaintiff. R.C. 2323.54 specify the procedures for the award of future damages in lump sum or in periodic payments.

HISTORY

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