

FINAL REPORT AND RECOMMENDATIONS
OF THE
OHIO MEDICAL MALPRACTICE COMMISSION

APRIL 2005

Commission Members

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

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

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

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

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

Wayne Wheeler, MD
Portsmouth, Ohio

Gerald Draper, Esq.
Roetzel & Andress LPA
Columbus, Ohio
(Member from inception of
Commission through June 2004.)

William Kose, MD
Rawson, Ohio

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

Hans Scherner, Esq.
Scherner Hanson & Cornwell LLC
Columbus, Ohio
(Member from July 2004 until
conclusion of Commission)

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.

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.

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Knowlton Constr. Co. (1990), 49 Ohio St.3d 193, thereby providing health care practitioners with access to affordable medical malpractice insurance and maintaining the provision of quality health care in Ohio.

(2) The General Assembly acknowledges the Court's authority in prescribing rules governing practice and procedure in the courts of this state as provided by Section 5 of Article IV of the Ohio Constitution.

SECTION 4. (A) There is hereby created the Ohio Medical Malpractice Commission consisting of nine members. The President of the Senate shall appoint three of the members, and the Speaker of the House of Representatives shall appoint three of the members. The minority leader of the Senate shall appoint one member and the minority leader of the House of Representatives shall appoint one member. The Director of the Department of Insurance or the Director's designee shall be the ninth member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one shall represent the Ohio State Bar Association, one shall represent the Ohio State Medical Association, and one shall represent the insurance companies in Ohio, and all of them shall have expertise in medical malpractice insurance issues.

(B) The Commission shall do all of the following:

(1) Study the effects of this act;

(2) Investigate the problems posed by, and the issues surrounding, medical malpractice;

(3) Submit a report of its findings to the members of the General Assembly not later than two years after the effective date of this act.

(C) Any vacancy in the membership of the Commission shall be filled in the same manner in which the original appointment was made.

(D) The members of the Commission shall by majority vote elect a chairperson from among themselves.

(E) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties.

SECTION 5. (A)(1) In recognition of the statewide concern over

(125th General Assembly)
(Amended Substitute Senate Bill Number 86)

AN ACT

To amend sections 2305.234, 3701.071, 4715.42, and 4731.295 of the Revised Code and to amend Section 2 of Sub. H.B. 221 of the 124th General Assembly to extend immunity from liability for services provided by volunteer health care professionals and workers to additional health care facilities and locations and to nonprofit health care referral organizations, to provide additional requirements for the immunity of a health care professional, to increase the maximum allowable income of individuals who may be served by volunteers having immunity from liability, and to change the effective date of the drug repository statute to January 1, 2004.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 2305.234, 3701.071, 4715.42, and 4731.295 of the Revised Code be amended to read as follows:

Sec. 2305.234. (A) As used in this section:

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section 2305.113 of the Revised Code.

(2) "Dental claim" has the same meaning as in section 2305.113 of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim for relief that arises out of a dental operation.

(3) "Governmental health care program" has the same meaning as in section 4731.65 of the Revised Code.

(4) "Health care facility or location" means a hospital, clinic, ambulatory surgical facility, office of a health care professional or associated group of health care professionals, training institution for health care professionals, or any other place where medical, dental, or other health-related diagnosis, care, or treatment is provided to a person.

(5) "Health care professional" means any of the following who provide

medical, dental, or other health-related diagnosis, care, or treatment:

(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(b) Registered nurses ~~;~~ ~~advanced-practice nurses~~; and licensed practical nurses licensed under Chapter 4723. of the Revised Code and individuals who hold a certificate of authority issued under that chapter that authorizes the practice of nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner;

(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code;

(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;

(e) Physical therapists, physical therapist assistants, occupational therapists, and occupational therapy assistants licensed under Chapter 4755. of the Revised Code;

(f) Chiropractors licensed under Chapter 4734. of the Revised Code;

(g) Optometrists licensed under Chapter 4725. of the Revised Code;

(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry;

(i) Dietitians licensed under Chapter 4759. of the Revised Code;

(j) Pharmacists licensed under Chapter 4729. of the Revised Code;

(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code;

(l) Respiratory care professionals licensed under Chapter 4761. of the Revised Code;

(m) Speech-language pathologists and audiologists licensed under Chapter 4753. of the Revised Code.

~~(5)~~(6) "Health care worker" means a person other than a health care professional who provides medical, dental, or other health-related care or treatment under the direction of a health care professional with the authority to direct that individual's activities, including medical technicians, medical assistants, dental assistants, orderlies, aides, and individuals acting in similar capacities.

~~(6)~~(7) "Indigent and uninsured person" means a person who meets all of the following requirements:

(a) The person's income is not greater than ~~one~~ two hundred ~~fifty~~ per cent of the current poverty line as defined by the United States office of management and budget and revised in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C.

9902, as amended.

(b) The person is not eligible to receive medical assistance under Chapter 5111., disability medical assistance under Chapter 5115. of the Revised Code, or assistance under any other governmental health care program.

(c) Either of the following applies:

(i) The person is not a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan.

(ii) The person is a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan, but the insurer, policy, contract, or plan denies coverage or is the subject of insolvency or bankruptcy proceedings in any jurisdiction.

~~(7)~~(8) "Nonprofit health care referral organization" means an entity that is not operated for profit and refers patients to, or arranges for the provision of, health-related diagnosis, care, or treatment by a health care professional or health care worker.

(9) "Operation" means any procedure that involves cutting or otherwise infiltrating human tissue by mechanical means, including surgery, laser surgery, ionizing radiation, therapeutic ultrasound, or the removal of intraocular foreign bodies. "Operation" does not include the administration of medication by injection, unless the injection is administered in conjunction with a procedure infiltrating human tissue by mechanical means other than the administration of medicine by injection. "Operation" does not include routine dental restorative procedures, the scaling of teeth, or extractions of teeth that are not impacted.

~~(8) "Nonprofit shelter or health care facility" means a charitable nonprofit corporation organized and operated pursuant to Chapter 1702. of the Revised Code, or any charitable organization not organized and not operated for profit, that provides shelter, health care services, or shelter and health care services to indigent and uninsured persons, except that "shelter or health care facility" does not include a hospital as defined in section 3727.01 of the Revised Code, a facility licensed under Chapter 3721. of the Revised Code, or a medical facility that is operated for profit.~~

~~(9)~~(10) "Tort action" means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or another agreement between persons or government entities.

~~(10)~~(11) "Volunteer" means an individual who provides any medical,

dental, or other health-care related diagnosis, care, or treatment without the expectation of receiving and without receipt of any compensation or other form of remuneration from an indigent and uninsured person, another person on behalf of an indigent and uninsured person, any ~~shelter or health care facility or location, any nonprofit health care referral organization,~~ or any other person or government entity.

~~(H)~~(12) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(B)(1) Subject to divisions ~~(E)~~(F) and ~~(F)~~(G)(3) of this section, a health care professional who is a volunteer and complies with division (B)(2) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision ~~at a nonprofit shelter or health care facility~~ to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct.

(2) To qualify for the immunity described in division (B)(1) of this section, a health care professional shall do all of the following prior to providing diagnosis, care, or treatment:

(a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence;

(b) Inform the person of the provisions of this section, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct;

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver under division (B)(2)(c) of this section shall state clearly and in conspicuous type

that the person or other individual who signs the waiver is signing it with full knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct.

(3) A physician or podiatrist who is not covered by medical malpractice insurance, but complies with division (B)(2) of this section, is not required to comply with division (A) of section 4731.143 of the Revised Code.

(C) Subject to divisions ~~(E)~~(F) and ~~(F)~~(G)(3) of this section, health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision ~~at a nonprofit shelter or health care facility~~ to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct.

(D) Subject to divisions (F) and (G)(3) of this section, a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other health-related diagnosis, care, or treatment by a health care professional described in division (B)(1) of this section or a health care worker described in division (C) of this section, unless the action or omission constitutes willful or wanton misconduct.

(E) Subject to divisions ~~(E)~~(F) and ~~(F)~~(G)(3) of this section and to the extent that the registration requirements of section 3701.071 of the Revised Code apply, a nonprofit shelter or health care facility or location associated with a health care professional described in division (B)(1) of this section or, a health care worker described in division (C) of this section, or a nonprofit health care referral organization described in division (D) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health

care professional or worker ~~in providing for or~~ nonprofit health care referral organization relative to the shelter or facility medical, dental, or other health-related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct.

~~(E)(F)~~(1) Except as provided in division ~~(E)(F)~~(2) of this section, the immunities provided by divisions (B), (C), and (D), and ~~(E)~~ of this section are not available to ~~an individual or to a nonprofit shelter~~ a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the ~~individuals~~ health care professionals or health care workers involved are providing one of the following:

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order entered by a court under division (B) of section 2951.02 of the Revised Code or imposed by a court as a community control sanction;

(b) Performance of an operation;

(c) Delivery of a baby.

(2) Division ~~(E)(F)~~(1) of this section does not apply to ~~an individual who provides, or a nonprofit shelter or health care facility at which the individual~~ when a health care professional or health care worker provides, medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency.

~~(F)(G)~~(1) This section does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or ~~nonprofit shelter or~~ health care facility or location.

(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which ~~an individual or a nonprofit shelter~~ health care professional, health care worker, nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical, dental, or other health-related diagnosis, care, or treatment.

(3) This section does not grant an immunity from tort or other civil liability to ~~an individual or a nonprofit shelter~~ health care professional, health care worker, nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers.

(4) This section does not affect any legal responsibility of a health care

professional or health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state.

(5) This section does not affect any legal responsibility of a nonprofit shelter or health care facility or location to comply with any applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety.

Sec. 3701.071. (A) As used in this section, "nonprofit:

(1) "Indigent and uninsured person" has the same meaning as in section 2305.234 of the Revised Code.

(2) "Nonprofit shelter or health care facility" has the same meaning as in section 2305.234 of the Revised Code means a charitable nonprofit corporation organized and operated pursuant to Chapter 1702. of the Revised Code, or any charitable organization not organized and not operated for profit, that provides shelter, health care services, or shelter and health care services to indigent and uninsured persons. "Nonprofit shelter or health care facility" does not include a hospital, as defined in section 3727.01 of the Revised Code, a facility licensed under Chapter 3721. of the Revised Code, or a medical facility that is operated for profit.

(B) A nonprofit shelter or health care facility operating in this state shall register on the first day of January each year with the department of health. The immunity provided by division (D)(E) of section 2305.234 of the Revised Code is not available to a nonprofit shelter or health care facility until the shelter or facility registers with the department in accordance with this section.

(C) A nonprofit shelter or health care facility operating in this state shall keep records of all patients who receive medical, dental, or other health-related diagnosis, care, or treatment at the shelter or facility. The department of health shall monitor the quality of care provided to patients at nonprofit shelters or health care facilities. The monitoring program may be conducted by contracting with another entity or through any other method authorized by law. The department may solicit and accept funds from private sources to fund the monitoring program.

Sec. 4715.42. (A)(1) As used in this section, "indigent and uninsured person;" "nonprofit shelter or health care facility;" and "operation" have the same meanings as in section 2305.234 of the Revised Code.

(2) For the purposes of this section, a person shall be considered retired from practice if the person's license has been surrendered or allowed to expire with the intention of ceasing to practice as a dentist or dental

hygienist for remuneration.

(B) The state dental board may issue, without examination, a volunteer's certificate to a person who is retired from practice so that the person may provide dental services to indigent and uninsured persons ~~at nonprofit shelters or health care facilities.~~

(C) An application for a volunteer's certificate shall include all of the following:

(1) A copy of the applicant's degree from dental college or dental hygiene school.

(2) One of the following, as applicable:

(a) A copy of the applicant's most recent license to practice dentistry or dental hygiene issued by a jurisdiction in the United States that licenses persons to practice dentistry or dental hygiene.

(b) A copy of the applicant's most recent license equivalent to a license to practice dentistry or dental hygiene in one or more branches of the United States armed services that the United States government issued.

(3) Evidence of one of the following, as applicable:

(a) The applicant has maintained for at least ten years prior to retirement full licensure in good standing in any jurisdiction in the United States that licenses persons to practice dentistry or dental hygiene.

(b) The applicant has practiced as a dentist or dental hygienist in good standing for at least ten years prior to retirement in one or more branches of the United States armed services.

(4) A notarized statement from the applicant, on a form prescribed by the board, that the applicant will not accept any form of remuneration for any dental services rendered while in possession of a volunteer's certificate.

(D) The holder of a volunteer's certificate may provide dental services ~~only on the premises of a nonprofit shelter or health care facility~~ and only to indigent and uninsured persons. The holder shall not accept any form of remuneration for providing dental services while in possession of the certificate. Except in a dental emergency, the holder shall not perform any operation. The board may revoke a volunteer's certificate on receiving proof satisfactory to the board that the holder has engaged in practice in this state outside the scope of the holder's certificate or that there are grounds for action against the person under section 4715.30 of the Revised Code.

(E)(1) A volunteer's certificate shall be valid for a period of three years, and may be renewed upon the application of the holder, unless the certificate was previously revoked under division (D) of this section. The board shall maintain a register of all persons who hold volunteer's certificates. The board shall not charge a fee for issuing or renewing a certificate pursuant to

this section.

(2) To be eligible for renewal of a volunteer's certificate, the holder of the certificate shall certify to the board completion of sixty hours of continuing dental education that meets the requirements of section 4715.141 of the Revised Code and the rules adopted under that section, or completion of eighteen hours of continuing dental hygiene education that meets the requirements of section 4715.25 of the Revised Code and the rules adopted under that section, as the case may be. The board may not renew a certificate if the holder has not complied with the appropriate continuing education requirements. ~~The nonprofit shelter or health care facility in~~ Any entity for which the holder provides dental services may pay for or reimburse the holder for any costs incurred in obtaining the required continuing education credits.

(3) The board shall issue to each person who qualifies under this section for a volunteer's certificate a wallet certificate and a wall certificate that state that the certificate holder is authorized to provide dental services pursuant to the laws of this state. The holder shall keep the wallet certificate on the holder's person while providing dental services and shall display the wall certificate prominently ~~in the nonprofit shelter or health care facility at~~ the location where the holder primarily practices.

(4) The holder of a volunteer's certificate issued pursuant to this section is subject to the immunity provisions in section 2305.234 of the Revised Code.

(F) The board shall adopt rules in accordance with Chapter 119. of the Revised Code to administer and enforce this section.

Sec. 4731.295. (A)(1) As used in this section, "indigent and uninsured person;" ~~"nonprofit shelter or health care facility,"~~ and "operation" have the same meanings as in section 2305.234 of the Revised Code.

(2) For the purposes of this section, a person shall be considered retired from practice if the person's license or certificate has expired with the person's intention of ceasing to practice medicine and surgery or osteopathic medicine and surgery for remuneration.

(B) The state medical board may issue, without examination, a volunteer's certificate to a person who is retired from practice so that the person may provide medical services to indigent and uninsured persons ~~at nonprofit shelters or health care facilities.~~ The board shall deny issuance of a volunteer's certificate to a person who is not qualified under this section to hold a volunteer's certificate.

(C) An application for a volunteer's certificate shall include all of the following:

(1) A copy of the applicant's degree of medicine or osteopathic medicine.

(2) One of the following, as applicable:

(a) A copy of the applicant's most recent license or certificate authorizing the practice of medicine and surgery or osteopathic medicine and surgery issued by a jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery.

(b) A copy of the applicant's most recent license equivalent to a license to practice medicine and surgery or osteopathic medicine and surgery in one or more branches of the United States armed services that the United States government issued.

(3) Evidence of one of the following, as applicable:

(a) That the applicant has maintained for at least ten years prior to retirement full licensure in good standing in any jurisdiction in the United States that licenses persons to practice medicine and surgery or osteopathic medicine and surgery.

(b) That the applicant has practiced for at least ten years prior to retirement in good standing as a doctor of medicine and surgery or osteopathic medicine and surgery in one or more of the branches of the United States armed services.

(4) A notarized statement from the applicant, on a form prescribed by the board, that the applicant will not accept any form of remuneration for any medical services rendered while in possession of a volunteer's certificate.

(D) The holder of a volunteer's certificate may provide medical services ~~only on the premises of a nonprofit shelter or health care facility~~ and only to indigent and uninsured persons. The holder shall not accept any form of remuneration for providing medical services while in possession of the certificate. Except in a medical emergency, the holder shall not perform any operation or deliver babies. The board may revoke a volunteer's certificate on receiving proof satisfactory to the board that the holder has engaged in practice in this state outside the scope of the certificate.

(E)(1) A volunteer's certificate shall be valid for a period of three years, unless earlier revoked under division (D) of this section or pursuant to section 4731.22 of the Revised Code. A volunteer's certificate may be renewed upon the application of the holder. The board shall maintain a register of all persons who hold volunteer's certificates. The board shall not charge a fee for issuing or renewing a certificate pursuant to this section.

(2) To be eligible for renewal of a volunteer's certificate the holder of

the certificate shall certify to the board completion of one hundred fifty hours of continuing medical education that meets the requirements of section 4731.281 of the Revised Code regarding certification by private associations and approval by the board. The board may not renew a certificate if the holder has not complied with the continuing medical education requirements. ~~The nonprofit shelter or health care facility in~~ Any entity for which the holder provides medical services may pay for or reimburse the holder for any costs incurred in obtaining the required continuing medical education credits.

(3) The board shall issue to each person who qualifies under this section for a volunteer's certificate a wallet certificate and a wall certificate that state that the certificate holder is authorized to provide medical services pursuant to the laws of this state. The holder shall keep the wallet certificate on the holder's person while providing medical services and shall display the wall certificate prominently ~~in the nonprofit shelter or health care facility at~~ the location where the holder primarily practices.

(4) The holder of a volunteer's certificate issued pursuant to this section is subject to the immunity provisions in section 2305.234 of the Revised Code.

(F) The board shall adopt rules in accordance with Chapter 119. of the Revised Code to administer and enforce this section.

SECTION 2. That existing sections 2305.234, 3701.071, 4715.42, and 4731.295 of the Revised Code are hereby repealed.

SECTION 3. (A) As used in this section, "health care professional," "health care worker," "indigent and uninsured person," "nonprofit health care referral organization," and "volunteer" have the same meanings as in section 2305.234 of the Revised Code, as amended by this act.

(B) The Ohio Medical Malpractice Commission created by Section 4 of Am. Sub. S.B. 281 of the 124th General Assembly shall have the following duties, in addition to the other duties provided by law for the Commission:

(1) To study the affordability and availability of medical malpractice insurance for health care professionals and health care workers who are volunteers and for nonprofit health care referral organizations;

(2) To study the feasibility of whether the state of Ohio should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and health care workers to utilize as volunteers in providing medical, dental, or other health-related diagnosis, care, or

treatment to indigent and uninsured persons;

(3) To study the feasibility of whether the state of Ohio should create a fund to provide compensation to indigent and uninsured persons who receive medical, dental, or other health-related diagnosis, care, or treatment from health care professionals or health care workers who are volunteers, for any injury, death, or loss to person or property as a result of the negligence or other misconduct by those health care professionals or workers;

(4) To study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law as amended by this act, as contained in section 2305.234 of the Revised Code.

(C) The Commission shall submit a report of its findings regarding all of the matters provided in division (B) of this section to the members of the General Assembly not later than two years after the effective date of this act.

(D) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties under this section.

SECTION 4. That Section 2 of Sub. H.B. 221 of the 124th General Assembly be amended to read as follows:

Sec. 2. Sections 3715.87, 3715.871, and 3715.872 of the Revised Code as enacted by ~~this act~~ Sub. H.B. 221 of the 124th General Assembly shall take effect ~~one year after the effective date of this section~~ on January 1, 2004.

SECTION 5. That existing Section 2 of Sub. H.B. 221 of the 124th General Assembly is hereby repealed.

SECTION 6. Sections 1, 2, 3, 4, 5, 6, and 10 of this act shall take effect ninety days after the effective date of this act.

SECTION 7. Section 2305.234 of the Revised Code is presented in this act as a composite of the section as amended by both Am. Sub. H.B. 95 and Am. Sub. S.B. 51 of the 125th General Assembly. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.

Speaker _____ *of the House of Representatives.*

President _____ *of the Senate.*

Passed _____, 20____

Approved _____, 20____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

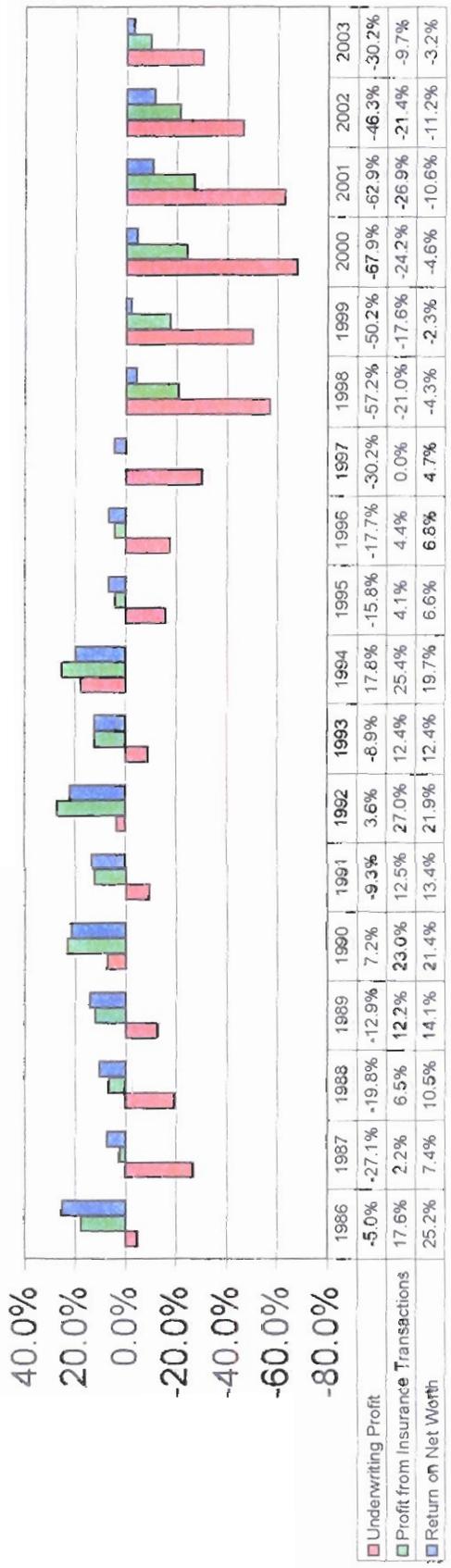
Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the
___ day of _____, A. D. 20___.

Secretary of State.

File No. _____ Effective Date _____

Ohio Medical Malpractice Insurance Profitability Measures



Source: NAIC Profitability Report

**Ohio Medical Malpractice Insurance
Physicians & Surgeons Rate Changes for the Top Five Insurers**

Company	2003 Direct Written Premium	2003 Market Share	2000 Rate Change	2001 Rate Change	2002 Rate Change	2003 Rate Change	2004 Rate Change	2005 Rate Change
The Medical Assurance Company	112,788,357	20.7%	9.6%	30.0%	43.6%	19.3%	8.6%	
The Medical Protective Company	106,941,441	19.6%	8.4%	6.3%	21.7%	27.5%	40.0%	13.0%
OHIC Insurance Company	81,014,009	14.9%	24.3%	28.0%	24.2%	17.0%	17.9%	
American Physicians Assurance Corporation	33,625,168	6.2%	14.9%	29.5%	29.0%	87.6%	9.1%	
The Doctors Company, An Interinsurance Exchange	29,616,791	5.4%	8.4%	14.9%	49.2%	18.0%	10.0%	6.9%
Total for Top Five Companies	363,985,766	66.7%	14.3%	20.5%	31.2%	27.4%	20.1%	11.7%
Total Ohio Industry	545,525,318	100.0%						
Cumulative Change for Top Five Companies			14.3%	37.7%	80.6%	130.2%	176.3%	208.6%

Ohio Department of Insurance
Med Mal Rate Changes 2000 to 2005

Most Recent Filing Effective Date: January 1, 2005
Exhibit Last Revised: January 3, 2005



Bob Taft, Governor
Ann Womer Benjamin, Director

2100 Stella Court, Columbus, OH 43215-1067
(614) 644-2658 www.ohioinsurance.gov

Ohio Department of Insurance Physician Medical Malpractice Insurance Survey

Executive Summary

The rising cost of malpractice insurance has significantly impacted Ohio physician behavior. Nearly 40 percent of the 1,359 respondents to the Ohio Department of Insurance survey said they have retired or plan to retire in the next three years due to rising insurance expenses. 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.

Ninety-six percent of the respondents had malpractice rate increases in 2004. The average annual premium for personal medical malpractice insurance paid by these Ohio physicians in 2004 was \$40,385, a 39 percent increase compared with 2003 expenses. On average, physician respondents paid 18 percent of their gross annual income in premiums.

Rates for insurance, however, vary from state to state and are very different within each state based on the specialty practice of the physician.

The Ohio Department of Insurance commissioned this survey of doctors to focus on how professional liability insurance rate increases have changed the way doctors practice medicine in Ohio and to learn doctors' preferences for solutions.

Anecdotal evidence has been presented in Ohio and across the country that a crisis has been developing due to the rapid premium increases. This study quantified the impact on physicians and patients and was large enough to show how Ohioans in different regions of the state and with varying medical needs are being affected.

The rising costs of malpractice insurance have significantly impacted physician behavior and doctors have closed their practices or are planning to do so.

More than 50 percent of the state's neurology and specialty surgeons responding to the survey are planning to retire in the next three years due to insurance rate increases. These specialties, along with obstetrics, are considered higher insurance risks and are charged the highest rates among physicians.

Ohio's patient population is already being impacted. In addition to the anticipated reduction in the number of physicians, the survey results show there has been a significant reduction in the services offered to Ohio patients. Sixty-six percent of physicians surveyed have turned down or referred high-risk procedure patients elsewhere.

The situation is critical in Southeast Ohio, where 95 percent of the survey respondents have turned down or referred patients who required high-risk procedures to other practitioners.



Accredited by the National Association of Insurance Commissioners (NAIC)

Consumer Hotline: 1-800-686-1526 Fraud Hotline: 1-800-686-1527 OSHIP Hotline: 1-800-686-1578

Forty-eight percent of OB/Gyn and family practice physicians in Northeast Ohio surveyed have stopped delivering babies due to insurance costs, and more than 50 percent of the osteopathic doctors in the state no longer deliver babies.

Insurance concerns have also affected where physicians will see patients. Physicians responding to the survey have reduced the number of patients they see in nursing homes (55 percent have cut back), home care settings (46 percent have cut back), and hospice settings (30 percent have cut back).

Northeast and Southeast Ohio have been hit particularly hard. Sixty percent of the survey group from Southeast Ohio report having cut their in-home visits, while 54 percent of physicians surveyed in Northeast Ohio say they have cut in-home care.

Physicians recognize a need for patients to have recourse when malpractice occurs. In the survey, they recommend the state of Ohio pursue remedies that focus first on determining the merits of a claim before it is filed in court.

Methodology

- This is the largest study of the impact of malpractice insurance rates conducted to date in the State of Ohio.
- 8,000 surveys were mailed to a random sample of Ohio physicians.
- 1,359 surveys were returned, for a 17 percent response rate.
- Comparisons among physicians' specialties, region of the state, age, and number of liability claims were conducted on every question.

Objectives

- To understand how medical malpractice insurance has impacted Ohio physicians' revenue, as well as physicians' willingness to perform certain procedures, invest in their practices, and continue to practice medicine in Ohio.
- To learn how medical malpractice insurance has impacted overall physician care, patient access to care and the patient experience.
- To determine physician interest in various proposed measures to stabilize medical malpractice insurance premiums.

Conclusions

1. The first conclusion is that the rising costs of malpractice insurance have significantly impacted physician behavior and doctors have closed or are planning to close their practices.

- We learned that nearly four out of 10 respondents said they have retired or plan to retire in the next three years due to rising insurance expenses. This finding is all the more sobering since just 9% of the respondents were over age 64.
- More specifically:
 - The percentage of doctor retirements is even higher in Northeast Ohio.
 - More than half of Ohio's neurologists and specialty surgeons responding to the survey plan to retire because of malpractice insurance rates. These specialties, along with obstetrics, are considered higher insurance risks and are charged the highest rates.

2. Second, rising premiums and the exodus of doctors have already negatively affected Ohio's patient population. In fact, a significant reduction in patient services has already occurred.

- For example, 66% of physicians surveyed have turned down or referred high-risk procedure patients elsewhere.
 - The situation is critical in Southeast Ohio, where 95% of physicians surveyed have declined or referred high-risk patients.
 - In addition, 48% of OB/GYN and family practice physicians in Northeast Ohio reported they have stopped delivering babies due to insurance costs.
 - Over half of Ohio's osteopathic doctors reported they no longer do deliveries.
- Also, high malpractice insurance premiums have influenced where physicians will see patients. Respondents indicated that
 - 55% have reduced the number of patients they see at nursing homes.
 - 46% have cut back the number of patients they see in home care settings.
 - And 30% see fewer patients in hospice settings.
 - The percentages are particularly high in Northeast and Southeast Ohio.
 - Physicians are minimizing patients in these settings because they consider them high-risk in terms of medical liability.

- Patient care has been impacted in other ways as well:
 - Nearly three-quarters of physician respondents say that they order more tests to better defend their decisions.
 - Physicians also report that they need to see more patients to remain financially viable, which results in longer waits for appointments and less time with each patient.
 - Finally, many doctors have cut their staff in response to malpractice insurance increases.

3. The third conclusion from the survey is that malpractice insurance premiums have risen dramatically and have strained office economics.

- 2004 rates went up for 96% of survey respondents, rising by an average of 39% over 2003. Well over a quarter of Ohio physicians responding paid more than \$50,000.
- On average, almost 20% of physicians' gross annual income – one dollar in five – goes to pay malpractice premium costs.
- Rates vary widely, both among states and within medical specialties. In Ohio, for example, OB/GYN physicians responding to the survey pay an average of 30% of their annual incomes – 50% more than the average physician – to malpractice insurers.

4. The survey's final conclusion deals with curative measures, steps we might take to remedy the current problem. Here we found that physicians, while recognizing the need for patient recourse when malpractice occurs, generally favor any proposed measure to address rising medical malpractice insurance costs.

- They are particularly supportive of a Medical Review Panel to screen medical liability cases, prior to court filing, to determine the merits of the cases. Almost nine physicians in 10 [88%] highly favor this proposal.

- Eighty percent of survey respondents highly favor the institution of a 60-day Mandatory Notice. This would require medical liability insurance companies to notify physicians well in advance if their policy were being cancelled or not renewed, or if they were receiving a significant premium increase. The Department spearheaded legislation (S.B. 187 effective 9/13/04) last year to implement this requirement.
- Finally, more than three doctors in four [76%] highly favor what is called Expert Witness Qualification Review. This would require the plaintiff to submit a “certificate of expert review” confirming that each medical expert witness is qualified to serve in that capacity. Legislation (H.B. 215 effective 9/13/04) was passed last year with the Department’s sponsorship requiring witnesses to be pre-certified as expert witnesses in their field by the Ohio State Medical Board.

Meeting Summary of the Ohio Medical Malpractice Commission
(As of April 27, 2005)

	Topic(s) Covered	Presenters
May 9, 2003	Inaugural meeting	
June 11, 2003	Ratemaking	<ul style="list-style-type: none"> • James Hurley, Chairperson, Medical Malpractice Sub-commission, American Academy of Actuaries • Jeffrey J. Smith, Vice President and Lead Reserving Actuary, The Medical Protective Company • John R. Pedrick, Chief Actuary, Property & Casualty Division, Ohio Department of Insurance
July 15, 2003	Ratemaking continued PCF Report	<ul style="list-style-type: none"> • John R. Pedrick, Chief Actuary, Property & Casualty Division, Ohio Department of Insurance • Robert J. Walling, FCAS, MAAA, Pinnacle Actuarial Resources, Inc.
August 5, 2003	Data Collection	<ul style="list-style-type: none"> • Doug Stephens, Director of Judicial and Court Services, Ohio Supreme Court • Diane Hatcher, Manager of Case Management Systems, Ohio Supreme Court • Lynne Mazeika, Lake County Clerk of Courts • Todd Bickle, Muskingum County Clerk of Courts • Peg Ising, Assistant Director, Property and Casualty Division, Ohio Department of Insurance
September 16, 2003	Medical Errors	<ul style="list-style-type: none"> • Thomas A. Dilling, J.D., Executive Director, State Medical Board of Ohio • Brian F. Keaton, M.D. FACEP, Attending Physician and EM Informatics of the Dept. of Emergency Medicine, Summa Health System • Andrew Thomas, M.D., Ohio Patient Safety Institute, The Ohio State University • Theresa M. Tonies, R.N., J.D., Risk Counsel, Barberton Citizens Hospital

Meeting Summary of the Ohio Medical Malpractice Commission
(As of April 27, 2005)

	Topic(s) Covered	Presenters
October 22, 2003	<p>OHIC Update</p> <p>Non-traditional Risk Arrangements</p> <p>Med Mal Filing Systems</p>	<ul style="list-style-type: none"> • Alan Berliner, Legal Counsel, OHIC Insurance Company • Norm Beal, Administrator, Ohio JUA • Susan Stanfield, Vice-President, Marsh USA, Inc. • Eric Nordman, Director of Research of the National Association of Insurance Commissioners
December 17, 2003	<p>Medical Protective Company Update</p> <p>Medical Review Boards</p>	<ul style="list-style-type: none"> • Phillip Troyer, Associate General Counsel, Medical Protective • Jennie Schlosser, Ohio Underwriting Manager, Medical Protective • Jorge Gomez, Commissioner, Wisconsin Department of Insurance • Thomas R. Rushton, Deputy Superintendent, New Mexico Department of Insurance • Cynthia D. Donovan, Deputy Commissioner, Financial Services Operations, Indiana Department of Insurance • Annette Gunter, Manager, Patients' Compensation Fund, Indiana Department of Insurance • Gerald S. Leeseberg, Esq., Leeseberg & Valentine
January 21, 2004	Interim Report	

Meeting Summary of the Ohio Medical Malpractice Commission
(As of April 27, 2005)

	Topic(s) Covered	Presenters
February 19, 2004	Alternative Compensation Funds Non-Meritorious Lawsuits	<ul style="list-style-type: none"> • Dr. B.L. Stalnaker, Florida Birth-Related Neurological Injury Compensation Association (NICA) • Sharon Payne, Assistant Director, Virginia Birth-Related Injury Fund • Almata Cooper, General Counsel, Ohio State Medical Association
March 5, 2004	Finalizing Interim Report	
March 25, 2004	Legal Reform Charitable Immunity	<ul style="list-style-type: none"> • Judge Tom Grady of the 2nd District Court of Appeals, Member and Co-chair of the Judicial Conference Civil Law and Procedure Committee • Bill Weisenberg, Ohio State Bar Association • Tim Maglione, Ohio State Medical Association • State Representative Bill Seitz, Chairman of the House Civil and Commercial Law Committee • Amy Rohling, Executive Director of the Ohio Association of Free Clinics
April 19, 2004	Joint Legislative/Commission Mtg. with Top 5 Medical Liability Carriers	<ul style="list-style-type: none"> • Timothy Kenesey, President & CEO, Medical Protective Company • Kevin Clinton, President & CEO, American Physicians • Devin F. O'Brien, Esquire, Sr. Counsel, The Doctors' Company • Paul Butrus, Vice Chairman, Pro Assurance, the parent company of Medical Assurance • Ray Mazzotta, President of OHIC Insurance Company

Meeting Summary of the Ohio Medical Malpractice Commission
(As of April 27, 2005)

	Topic(s) Covered	Presenters
May 24, 2004	<p>Patient Compensation Funds</p> <p>Attorney's Perspective on Medical Malpractice Cases</p>	<ul style="list-style-type: none"> • Bob Sanders, Milliman Consultants and Actuaries • Patrick F. Smith, Esq. • Peter H. Weinberger, Esq.
June 28, 2004	Health care access, recruitment, and retention	<ul style="list-style-type: none"> • Lois Margaret Nora, M.D., J.D., President and Dean of Northeastern Ohio Universities College of Medicine • John A. Brose, D.O., Dean of Ohio University College of Osteopathic Medicine • James Dougherty, M.D., FACEP, Medical Education Department of Akron General Hospital • J. Joseph Payton, D.O., Akron, Ohio • Andrew M. Thomas, M.D., M.B.A., Assistant Dean for Graduate Medical Education of the Ohio State University
August 24, 2004	<p>Medical Errors</p> <p>Data Collection Update</p> <p>Medical Malpractice Tail Coverage</p>	<ul style="list-style-type: none"> • Richard Boothman, Assistant General Counsel, University of Michigan Health Systems Legal Office • Peg Ising, Assistant Director, Property & Casualty Services, Ohio Department of Insurance • Joel Whitcraft, Actuarial Department, GE Medical Protective Company • J. Richard Ludgin, M.D., J.D., Board member of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) and Chairman of the AMC/NOMA Physician Advocacy Committee

Meeting Summary of the Ohio Medical Malpractice Commission
(As of April 27, 2005)

	Topic(s) Covered	Presenters
September 23, 2004	Charitable Immunity	<ul style="list-style-type: none"> • Sarah Kobliska, Board Member Free Clinics of Iowa and Founding Partner, Iowa Free Clinics Coalition • Mark Cruise, Executive Director, Virginia Association of Free Clinics • Amy Rohling, Executive Director, Ohio Association of Free Clinics
October 18, 2004	<p>Captives</p> <p>Medical Errors</p> <p>Final Report drafting</p>	<ul style="list-style-type: none"> • Raymond J. Marvar, Esq., Claims and Risk Management, Cleveland Clinic Health System • Mike D'Eramo, MaternOhio • Lloyd A. Jacobs, M.D., President, Medical College of Ohio
November 17, 2004	<p>Feasibility Study of Ohio Patient Compensation Fund</p> <p>Impact of Tort Reform</p>	<ul style="list-style-type: none"> • Robert Sanders, FCAS, MAAA, Milliman • Lucinda Finley, Esq., Professor of Law, State University of New York at Buffalo Law School • George Dikeou, Esq., Legislative Consultant, COPIC of Colorado • Richard S. Biondi, FCAS, MAAA, Consulting Actuary, Milliman • Devin O'Brien, Esq., Senior Counsel, The Doctors Company

Meeting Summary of the Ohio Medical Malpractice Commission
 (As of April 27, 2005)

	Topic(s) Covered	Presenters
December 13, 2004	<p>Texas Medical Malpractice Initiatives</p> <p>Reinsurance Overview</p> <p>Captives</p> <p>Discussion of Final Report</p>	<ul style="list-style-type: none"> • José Montemayor, Texas Commissioner of Insurance • Brian Engel, Senior Vice President of Benfield • Mitch Melfi, Senior Vice President and Chief Risk Officer for Catholic Health Initiatives
January 19, 2005	<p>Ohio Department of Insurance Medical Malpractice Closed Claims Study Summary</p> <p>Mediation</p> <p>Discussion of Final Report</p>	<ul style="list-style-type: none"> • Peg Ising, Assistant Director, Property & Casualty Services, Ohio Department of Insurance • Terry Wheeler, Co-Director of the Center for Dispute Resolution, Capital University Law School • Scot Dewhirst, Adjunct Professor of Law, Capital University Law School

Meeting Summary of the Ohio Medical Malpractice Commission
 (As of April 27, 2005)

	Topic(s) Covered	Presenters
February 28, 2005	State of the Current Medical Malpractice Market Medical Errors	<ul style="list-style-type: none"> • Ann Womer Benjamin, Director, Ohio Department of Insurance • Brian Phillips, Chief Information Officer, Ohio University College of Osteopathic Medicine • Dr. Martha Simpson, Associate Professor of Family Medicine, Ohio University College of Osteopathic Medicine
March 7, 2005	Discussion of Final Report Discussion of Final Report	

Meeting Summary of the Ohio Medical Malpractice Commission
 (As of April 27, 2005)

	Topic(s) Covered	Presenters
March 31, 2005	<p>Mediation and Specialized Courts</p> <p>Captives</p> <p>Discussion of Final Report</p>	<ul style="list-style-type: none"> • Doug R. Stephens, Director, Judicial and Court Services Division, Supreme Court of Ohio • Tom Hayden, Senior Vice President, Marsh Columbus • Jeff Kurz, Vice President, Marsh Columbus
April 5, 2005	<p>Medical Errors</p> <p>Discussion of Final Report</p>	<ul style="list-style-type: none"> • Dr. Nick Baird, Director of the Ohio Department of Health

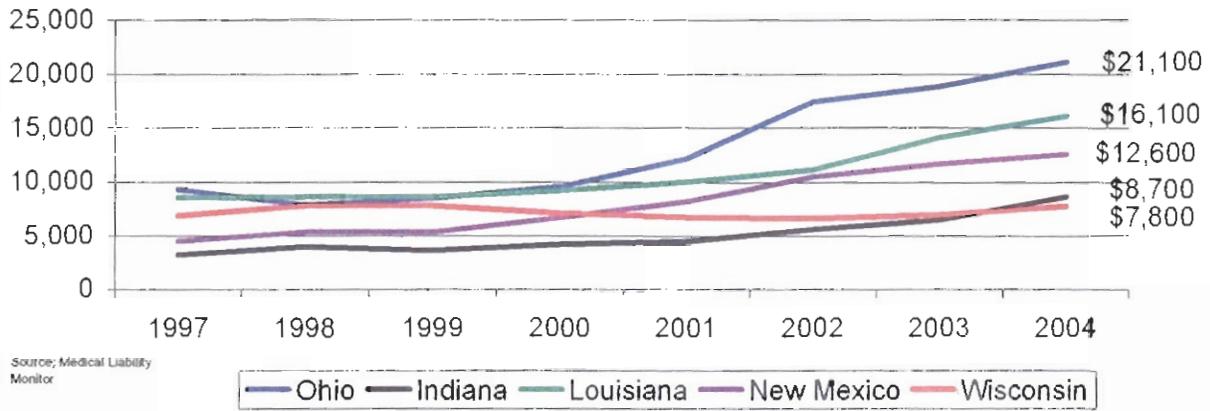
Meeting Summary of the Ohio Medical Malpractice Commission
 (As of April 27, 2005)

	Topic(s) Covered	Presenters
April 19, 2005	<p>Top Five Medical Liability Companies in Ohio Reflecting Tort Reform in Rate Filings</p> <p>Discussion of Final Report</p>	<ul style="list-style-type: none"> • John Pedrick, Interim Assistant Director, Office of Property & Casualty Services, Ohio Department of Insurance
April 27, 2005	Final Report Discussion	

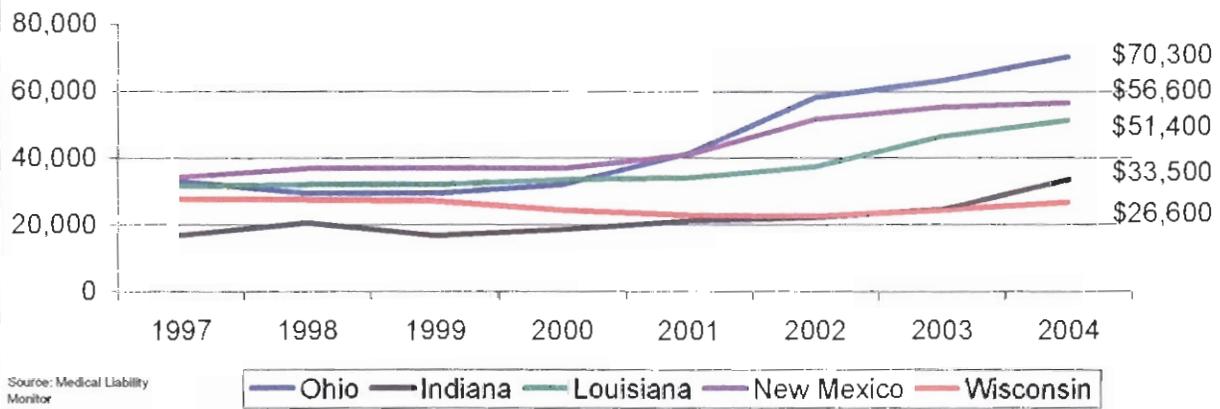
**Rate Comparison
Ohio v. PCF States (with PCF fees)**

Exhibit G

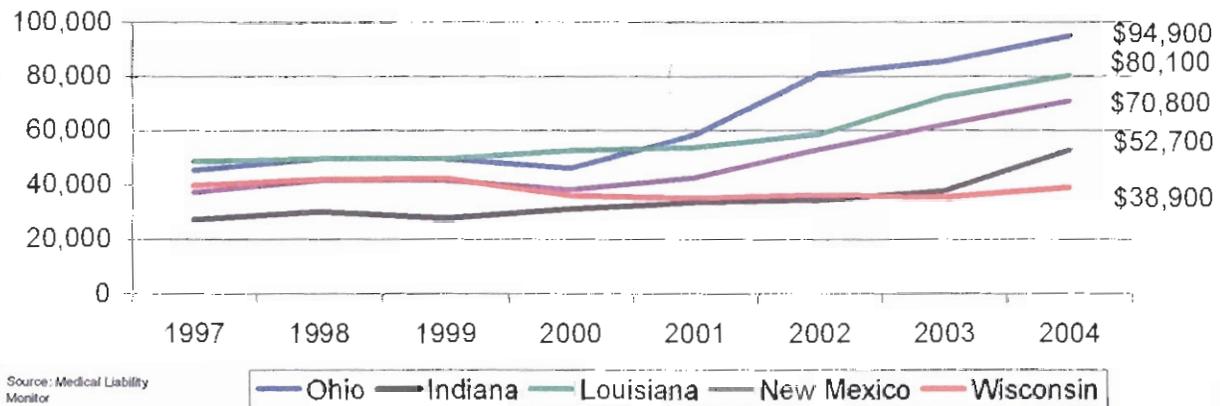
Internal Medicine Rates - Statewide Median



General Surgery Rates - Statewide Median

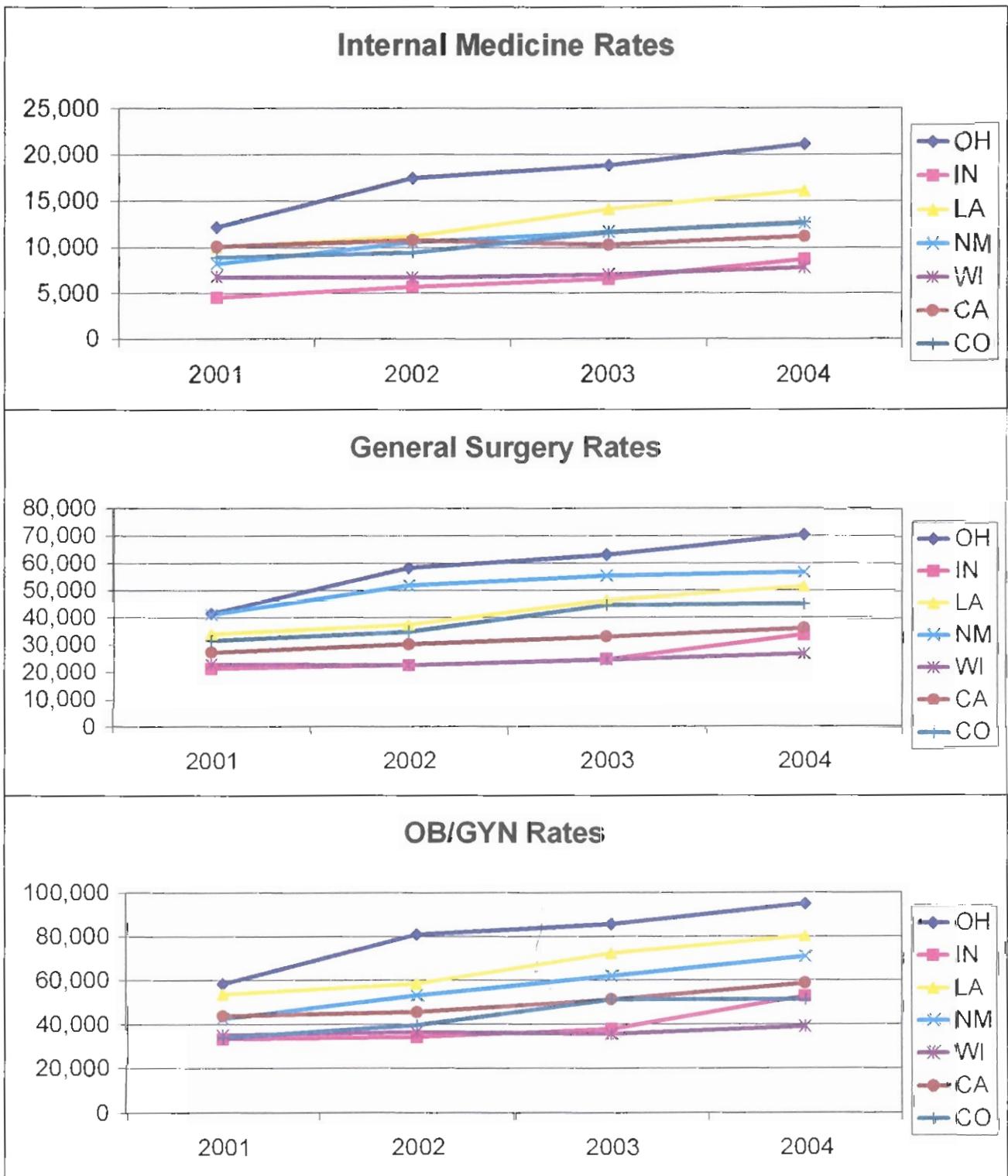


OB/GYN Rates - Statewide Median



Rate Comparison
Ohio v. AMA Non-Crisis States (with Tort Reform)

Exhibit H



Source: Medical Liability Monitor

Ohio Medical Liability Insurance
Premium, Losses, and Cost of Investigation and Defense
Top Five Insurers

	Premiums Earned	Costs for Payments to Claimants	Costs for Investigation and Defense	Costs for Claim Payments plus Investigation and Defense	Ratio of Total Claim Costs to Premium
Medical Protective Company					
2001	53,637,444	44,102,378	13,306,590	57,408,968	107.0%
2002	69,998,445	54,323,019	9,346,900	63,669,919	91.0%
2003	109,951,559	94,668,804	29,542,203	124,211,007	113.0%
3 Years	233,587,448	193,094,201	52,195,693	245,289,894	105.0%
Medical Assurance Company (including ProNational)					
2001	49,819,451	39,905,157	24,133,954	64,039,111	128.5%
2002	64,380,821	63,195,915	22,051,469	85,247,384	132.4%
2003	95,512,583	62,012,490	30,765,140	92,777,630	97.1%
3 Years	209,712,855	165,113,562	76,950,563	242,064,125	115.4%
OHIC Insurance Company					
2001	51,050,336	26,303,775	15,561,458	41,865,233	82.0%
2002	69,601,413	100,302,134	34,970,755	135,272,889	194.4%
2003	83,443,882	78,734,202	14,207,068	92,941,270	111.4%
3 Years	204,095,631	205,340,111	64,739,281	270,079,392	132.3%
American Physicians Assurance Corp.					
2001	19,817,613	46,230,911	13,959,104	60,190,015	303.7%
2002	29,328,053	42,860,164	7,003,599	49,863,763	170.0%
2003	30,978,017	35,101,039	10,872,776	45,973,815	148.4%
3 Years	80,123,683	124,192,114	31,835,479	156,027,593	194.7%
The Doctors Company - An Interinsurance Exchange					
2001	13,282,953	14,515,058	3,469,703	17,984,761	135.4%
2002	15,449,785	12,819,417	3,285,689	16,105,106	104.2%
2003	27,935,354	20,693,961	1,715,904	22,409,865	80.2%
3 Years	56,668,092	48,028,436	8,471,296	56,499,732	99.7%
Total for Top Five Companies					
2001	187,607,797	171,057,279	70,430,809	241,488,088	128.7%
2002	248,758,517	273,500,649	76,658,412	350,159,061	140.8%
2003	347,821,395	291,210,496	87,103,091	378,313,587	108.8%
3 Years	784,187,709	735,768,424	234,192,312	969,960,736	123.7%

- Notes: 1. These costs do not include expenses for company operations, in-house claims staff, commissions, and taxes paid to states, which represent an additional 25% of premium.
2. **Cost of Payments to Claimants** is known as Incurred Losses. It includes amounts paid during the year, reserves for claims that occurred during the year, and adjustments to reserves for claims from previous years.
3. **Investigation and Defense** costs are known as Incurred Defense and Cost Containment Expenses. They include amounts paid to defend policyholders, reserves for defense costs for claims that occurred during the year, and adjustments to reserves for defense costs for claims from previous years.
4. All figures are on a direct basis, i.e., they do not include reinsurance transactions.

Source: Annual Financial Statements, NAIC