

PUBLIC MEDICAL MALPRACTICE INSURANCE: AN ANALYSIS OF STATE-OPERATED PATIENT COMPENSATION FUNDS

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INTRODUCTION

During the past three decades, medical malpractice insurance has experienced periodic crises of lack of available coverage and/or increased price of coverage.¹ One solution in some states has been the implementation of public medical malpractice insurance plans, the most common type being Patient Compensation Funds (PCFs).² By definition, PCFs offer insurance for medical malpractice liability that exceeds the specified threshold amounts covered by the insured provider's primary insurance policy or qualified self-insured plan.³

The underlying rationale for public provision or reliance on private insurers other than stock companies is that the for-profit sector is an unreliable source of medical malpractice liability coverage. Faced with a few high loss claims, it is difficult for insurers to know whether

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1. See generally Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 *NEW ENG. J. MED.* 2281 (2003); David M. Studdert et al., *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283 (2004).

2. Frank A. Sloan, *Public Medical Malpractice Insurance* (Report of The Pew Charitable Trusts Project on Med. Liability in Pa., Mar. 2004), <http://medliabilitypa.org/research/files/sloan0304.pdf>. Although some states call these funds by different names, for purposes of our study, the general term "Patient Compensation Fund," or PCF, will be used to identify these types of public funds.

3. See *id.*; PINNACLE ACTUARIAL RES., INC., FINAL REPORT ON THE FEASIBILITY OF AN OHIO PATIENTS' COMPENSATION FUND (May 1, 2003), <http://www.ohioinsurance.gov/legal/REPORTS/FinalReportOhioPatientComp.pdf>.

the change is a random occurrence or represents a true shift in claiming patterns. As a result, for-profit firms may either raise premiums substantially or exit from the market entirely. The public or non-profit organizational forms, including PCFs, in principle, provide a more stable form of affordable coverage. Since much of the volatility in losses stems from losses at the high end of the claims distribution, PCFs may, by focusing on high loss claims, stabilize an otherwise very unstable medical malpractice insurance market.

State-operated PCFs represent one of several public policy options for addressing the dual problems of lack of available coverage and affordable coverage.⁴ Although they have existed for nearly three decades, relatively little is known about their performance. This study addresses two related issues. The first is essentially descriptive: How do these PCFs operate and what have been their successes and failures? The second is prescriptive: What role should these organizations play as states look to solutions to their medical malpractice crises?

As of early 2004, the following nine states had created PCFs: Indiana (1975),⁵ Kansas (1976),⁶ Louisiana (1975),⁷ Nebraska (1976),⁸ New Mexico (1978),⁹ New York (1986),¹⁰ Pennsylvania (1975, 2002),¹¹ South Carolina (1976),¹² and Wisconsin (1975).¹³ Florida had a PCF, but the program closed in 1983, having underpriced coverage.¹⁴

4. Sloan, *supra* note 2, at 4.

5. *Id.*; Tanya Albert, *Indiana Doctors Face Big Hit for Liability Fund*, AM. MED. NEWS, Sept. 8, 2003, at <http://www.ama-assn.org/amednews/2003/09/08/prl20908.htm>.

6. Kansas Health Care Stabilization Fund, Home Page, at <http://www.hcsf.org/> (last visited Jan. 22, 2005).

7. State of Louisiana, Louisiana Patient Compensation Fund, at <http://www.lapcf.state.la.us/> (last visited Nov. 1, 2004).

8. American Tort Reform Association, Medical Liability Reform, at <http://www.atra.org/show/7338> (last visited Feb. 10, 2005).

9. N.M. PUB. REGULATION COMM'N, ANNOTATED REPORT 2001.

10. N.Y. STATE DEP'T OF INS., THE STATUS OF THE PRIMARY AND EXCESS MEDICAL MALPRACTICE MARKET AND THE FUTURE NEED FOR THE MEDICAL MALPRACTICE INSURANCE ASSOCIATION: REPORT TO THE GOVERNOR AND THE LEGISLATURE BY THE SUPERINTENDENT OF INSURANCE (1997).

11. RANDALL R. BOVBJERG & ANNA BARTOW, UNDERSTANDING PENNSYLVANIA'S MEDICAL MALPRACTICE CRISIS (Report of The Pew Charitable Trusts Project on Med. Liability in Pa., June 2003), <http://medliabilitypa.org/research/report0603/UnderstandingReport.pdf>.

12. S.C. LEGISLATIVE AUDIT COUNCIL, A REVIEW OF THE MEDICAL MALPRACTICE PATIENTS' COMPENSATION FUND (Jan. 2000), <http://www.state.sc.us/sclac/Reports/2000/pcf.pdf>.

13. OFFICE OF THE COMM'R OF INS., STATE OF WIS., WISCONSIN PATIENT COMPENSATION FUND, <http://oci.wi.gov/pcf.htm> (last modified June 30, 2004).

14. See FRANK A. SLOAN ET AL., INSURING MEDICAL MALPRACTICE 123 (1991).

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Nonetheless, Florida was still paying claims as of April 2003.¹⁵ Wyoming's legislature passed a statute creating a PCF, but it was never formally created in practice.¹⁶

Data for our study came from several sources: literature reviews, Internet searches, and a survey of all nine PCFs from research that we conducted during late 2003 and early 2004. We spoke with representatives at each of the PCFs by telephone (seven states) or by in-person interview (two states). During the interviews, we requested additional material, which was provided by some PCFs. To fill in missing data, we performed Internet searches to obtain publicly available material that provided financial data and other information about these PCFs.

II. MOTIVATIONS FOR CREATING A PCF

Eight of the nine PCFs (all except New York) were created in the mid-1970s in response to the first medical malpractice insurance crisis, which was precipitated by a withdrawal of insurers from markets in many states.¹⁷ Although withdrawal of insurers and premium increases were widespread, only a handful of states adopted PCFs, and these tended to be states not typically identified as states suffering the greatest medical malpractice crisis.¹⁸

PCFs are often implemented as part of more general tort reform, which includes in different combinations: limits on non-economic damages, limits on attorney contingent fees, modification of the collateral source rule, creation of physician-sponsored medical malpractice insurance companies, Joint Underwriting Associations (JUAs) for medical malpractice insurance, and other statutory changes. Judging from the survey responses, the importance of the PCF in relation to the entire reform package varied. For example, in Indiana, the introduction of a PCF was minor relative to the cap on total damages enacted at the same time. By contrast, in Wisconsin, the PCF seems to have been a much more important part of the reform package.¹⁹ The risk assumed by PCFs is sensitive to other laws that were adopted, in

15. FLA. INS. COUNCIL, THE GOVERNOR'S SELECT TASK FORCE ON HEALTHCARE PROFESSIONAL LIABILITY INSURANCE (Jan. 2003), available at www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf.

16. Telephone Interview with Charlie Hartman, Wyoming Insurance Department (July 16–17, 2003); Tom Morton, *Panel Dumps State Malpractice Insurance Idea*, CASPER STAR TRIB., Oct. 28, 2003, <http://www.casperstartribune.net/articles/2003/10/28/news/wyoming/dbebb5ab96666b3de06f89390f947e99.txt>.

17. See generally Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629 (1985).

18. *Id.*

19. *Id.*; OFFICE OF THE COMM'R OF INS., *supra* note 13.

particular, limits on total or non-economic loss, which had the effect of placing at least a partial ceiling on the PCF's exposure to loss.²⁰

The interviews revealed two major motivations for forming PCFs: (1) providing physicians and hospitals with affordable and reliable medical malpractice insurance coverage by covering losses at the higher end of the distribution of losses, thereby reducing volatility; and (2) providing adequate compensation for injured patients in the state. The first goal was of primary interest to providers. The second was of interest to the trial bar.

In contrast to other statutory changes, PCFs have generally been supported by medical and hospital associations and groups representing plaintiffs and defendants in medical malpractice litigation, probably because they served both of the above goals. The motivation for trial lawyer support has been to assure ample compensation for medical injuries. In Pennsylvania, several persons we interviewed emphasized trial lawyer support of the existing system. There were some exceptions, namely, the medical community in Pennsylvania and trial attorneys both in Louisiana and Indiana.

In general, PCFs are much the same as they were at inception. Over the years, the PCFs have accomplished the following: (1) increased the amount of primary insurance the provider must have to be eligible for PCF coverage, resulting in changes to the level at which the PCF begins coverage; (2) increased the level of limits on damages for those states with such limits; (3) implemented new methods of monitoring PCF activities; and (4) moved toward funding PCFs on a fully reserved rather than on a pay-as-you-go basis (although Pennsylvania retains the pay-as-you-go method).

III. CHARACTERISTICS OF PCFS

A. *Mandatory Versus Voluntary Coverage*

PCFs in a few cases require the participation of providers.²¹ The case for requiring coverage is to expand the base of enrollment and avoid adverse selection of bad risks into the PCF.²² On the other hand, the case for being voluntary is to provide coverage as a last re-

20. See generally, e.g., RICHARD S. BIONDI & ARTHUR GUREVITCH, MILLIMAN USA, PROJECTED EFFECT OF CAPPING NON-ECONOMIC DAMAGES ON PENNSYLVANIA PHYSICIAN PROFESSIONAL LIABILITY COSTS (2003), www.wsma.org/Milliman_Report.pdf.

21. See *infra* app. A, tbl. 1.

22. PINNACLE ACTUARIAL RES., INC., PRELIMINARY REPORT ON THE FEASIBILITY OF AN OHIO PATIENTS' COMPENSATION FUND (Feb. 2003), http://www.ohioinsurance.gov/legal/Reports/Prelim_Patient_Compensation_Report_03-03-03.pdf; PINNACLE ACTUARIAL RES., INC., *supra* note 3.

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sort, much like a JUA.²³ Only three of the PCFs were mandatory: Kansas, Pennsylvania, and Wisconsin. One PCF representative commented that the mandatory nature of the PCF is a critical aspect of its success for the following three reasons: (1) it establishes a wide premium base, facilitating loss projections and rate-making; (2) it provides a uniform level of coverage across the state, assuring that injury victims will be able to receive compensation as determined by the court; and (3) it provides primary insurers with an upper limit of liability exposure.

B. Funding

With one exception described below, the PCFs have always been funded from assessments on providers and investment returns, not from state subsidies.²⁴ Providers pay assessments either directly to the PCF or as part of the premium paid to primary insurers. While eight of the PCF states have not used public funds in the past, one state was considering, as of late 2003, taking a loan from a different state fund to cover part of its unfunded liability. Assessments are generally structured as a fraction of the premium paid for primary coverage. PCFs do vary surcharges by specialty, either reflecting physicians' primary insurance classification (as in Pennsylvania)²⁵ or establishing a few specialty-based risk classes (e.g., four in Wisconsin).²⁶ Like JUAs, PCFs often have the authority to assess insured physicians retroactively to cover unanticipated losses.²⁷

In New York, the state has subsidized the purchase of private excess insurance for physicians since 2000.²⁸ The New York program in its current form is strictly a public subsidy program. Physicians are able to choose the private insurer for the excess layer, but they are encouraged to use the same insurer as they use for their primary coverage so that claims management and potential legal defense can be coordinated.²⁹ In a fundamental sense, the New York program differs from the others in that there is no public provision of insurance.

23. COUNCIL OF STATE GOVERNMENTS, *MEDICAL MALPRACTICE CRISIS: TRENDSALERT* (May 2003), available at <http://www.csg.org/NR/rdonlyres/ek7ao3dfatxrcgh656amm6vnlw2owndpku4rp3xhss32rzeche5ggb4j4mbwdozh4zsobfboqxysz3bnp5corc6trae/Medical+Malpractice+%28May+Revised%29.pdf>.

24. See generally U.S. DEP'T OF HEALTH & HUMAN SERVS., *REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE* (1987).

25. Christopher J. Conover et al., *Excess Coverage and the Medical Malpractice Crisis: A Study of Pennsylvania* (Nov. 22, 2004) (unpublished manuscript, on file with the authors).

26. OFFICE OF THE COMM'R OF INS., *supra* note 13.

27. SLOAN ET AL., *supra* note 14, at 14.

28. See N.Y. STATE DEP'T OF INS., *supra* note 10.

29. See *id.* at 10; *infra* app. A, tbl. 1.

There is, however, public involvement in funding and in premium regulation.³⁰

PCFs differed on whether or not assessments reflected prior claims experience of the provider. Four PCFs had the authority to take action in response to adverse claims, whether by removing providers from the PCF or attaching an experience-rated increase to the annual surcharge.³¹ In a fifth case, the Kansas Board of Governors received lists of providers with high claims frequency, and the Board was vested with the authority to eliminate providers from PCF coverage (this has only happened once, as it is a difficult process).³²

Three states have incorporated experience-rating into their assessments.³³ South Carolina providers are charged a higher rate based on the number of claims against them.³⁴ Louisiana identifies providers with high numbers of cases, and then attaches a specific percentage increase to the assessment.³⁵ In the last rate package sent to providers, New Mexico included an experience-rating system for the first time.³⁶ Depending on the number of claims a provider has received (one, two, three, or more than four), there is a standardized increase in the surcharge.³⁷ For those with a high claims frequency, this can result in an additional 100% surcharge on top of the normal annual assessment.³⁸ The 2002 PCF statute in Pennsylvania included the concept of experience-rating, but this provision has not been implemented to date.³⁹ Wisconsin uses a peer review process to monitor physicians with a high number of claims.⁴⁰

PCFs differ according to whether they reserve for anticipated losses or operate on a pay-as-you-go basis. Pay-as-you-go financing is a common practice among social insurance programs, such as Social Security and Medicare. In the Social Security program, for example,

30. *Id.*

31. See generally State of Louisiana, *supra* note 7; N.M. PUB. REGULATION COMM'N, *supra* note 9; N.Y. DEP'T OF INS., *supra* note 10; BOVBJERG & BARTOW, *supra* note 11; S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12.

32. Kansas Health Care Stabilization Fund, *supra* note 6.

33. N.M. PUB. REGULATION COMM'N, *supra* note 9, at 30; S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 11; STATE OF LA., RATE MANUAL: LOUISIANA'S PATIENT COMPENSATION FUND 12 (2004), <http://www.lapcf.state.la.us/rateman/2004/PCF%20Rate%20Manual%202004.doc>;

34. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 11.

35. STATE OF LA., *supra* note 33, at 12.

36. N.M. PUB. REGULATION COMM'N, *supra* note 9, at 30.

37. *Id.*

38. *Id.*

39. University of Pennsylvania Health System, Medical Malpractice, The CAT Fund & Act 135, at <http://www.uphs.upenn.edu/legal/malp.html> (last visited Oct. 31, 2004).

40. OFFICE OF THE COMM'R OF INS., *supra* note 13.

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premium taxes from current employees and employers pay for retirement benefits of retired workers.⁴¹ The implicit contract is that while younger persons subsidize the benefits of older persons, their benefits will in turn be subsidized by others when they become age-eligible.⁴²

Pennsylvania operates a pay-as-you-go system, as did South Carolina until recently, and Wisconsin and Louisiana in their early histories.⁴³ When a provider pays an annual assessment in these states, the provider does not buy coverage for the current year's medical malpractice claims, but rather pays for losses incurred in previous years that have just become due.⁴⁴ In such instances, the providers subject to annual assessments effectively are the holders of reserves for the PCF and each year's assessment is more properly viewed as a claim on these reserves rather than a true premium for coverage. This arrangement has the political advantage of requiring lower payouts in the initial years, thereby affording providers immediate relief from high malpractice premiums.⁴⁵ The downside, however, is that as claims come due, the annual increases in PCF assessments typically rise much faster than the annual increase in traditional premiums under a loss-reserving approach.⁴⁶

Other states use standard loss reserving principles, including Kansas,⁴⁷ New Mexico,⁴⁸ and Wisconsin.⁴⁹ In Wisconsin, a state in which the PCF maintains reserves at a relatively high level,⁵⁰ the Governor recently proposed to tap \$200 million from the fund in order to subsidize Medicaid.⁵¹ Louisiana has a statutory requirement that surpluses must be a specified percentage of assessments.⁵² In New York, since

41. SOC. SEC. ADMIN., SOCIAL SECURITY: UNDERSTANDING THE BENEFITS (Mar. 2004), <http://www.ssa.gov/pubs/10024.pdf>.

42. *Id.*

43. BOVBJERG & BARTOW, *supra* note 11, at 2; OFFICE OF THE COMM'R OF INS., *supra* note 13.

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44. Alfred E. Hofflander et al., Report on the Medical Malpractice Insurance Delivery System in Pennsylvania (Nov. 2001) (unpublished manuscript, on file with the authors) (funded by the Pennsylvania Trial Lawyers Association).

45. BOVBJERG & BARTOW, *supra* note 11, at 19; ALFRED E. HOFFLANDER & BLAINE F. NYE, MEDICAL MALPRACTICE INSURANCE IN PENNSYLVANIA (1985); CONOVER et al., *supra* note 25, at 10.

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46. See Hofflander et al., *supra* note 44.

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47. See generally Kansas Health Care Stabilization Fund, Surcharge Rating System Information, at <http://www.hcsf.org/ratingpage.htm> (last visited Jan. 22, 2005).

48. N.M. PUB. REGULATION COMM'N, *supra* note 9, at 30.

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49. OFFICE OF THE COMM'R OF INS., *supra* note 13.

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50. OFFICE OF THE COMM'R OF INS., STATE OF WIS., WISCONSIN INSURANCE REPORT (2001), http://oci.wi.gov/ann_rpt/bus_2001/bus_2001.pdf.

51. WIS. HOSP. ASS'N, 2003-2005 STATE BUDGET: IMPACTS ON WISCONSIN HOSPITALS (Apr. 18, 2003), http://www.wha.org/pubArchive/position_statements/pp2003issuesummary.pdf.

52. State of Louisiana, *supra* note 7.

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there is no public insurer, it is up to the private insurers to maintain adequate reserves for losses.⁵³

When actuarial evaluations are performed, the recommendations are not always followed.⁵⁴ The New Mexico Department of Insurance recently completed an actuarial study concluding that the state's PCF was underfunded by nine million dollars, but the state medical society recommended no increase in physician contributions.⁵⁵ This problem is not limited to the public sector, however. A survey of private primary malpractice insurers revealed much the same picture; insurers said that they had overridden their actuaries' recommendation at least once in the previous five years.⁵⁶ Reasons may differ between the two groups, with private insurers more worried about losing market share and PCFs responding to political rather than competitive pressures.

C. Organizational Form and Monitoring

PCFs are public organizations, created by state law and organized as either a state agency or a trust fund.⁵⁷ Because PCFs are public organizations, they plausibly lack incentive to exploit their dominant market position by charging monopoly-level premiums. Nor are they driven by the profit motive to engage in risky financial decisions that may lead to insolvency. Yet, as very small and self-financed organizations, they may easily escape public scrutiny, at least for several years, even from stakeholders, potentially making them less accountable.

1. PCF Boards

Responsibility for PCF performance resides with PCF boards. Boards may be either self-perpetuating or appointed.⁵⁸ The main advantage of a self-perpetuating board is that board composition is less subject to outside political influence. However, such boards may be less accountable to the public and to stakeholders. South Carolina had a self-perpetuating board, until recently.⁵⁹ There was very little turnover, and the board did not provide effective oversight.⁶⁰ In Wisconsin, board members are appointed.⁶¹ In practice, membership on the board is diverse, including faculty members from universities and

53. N.Y. STATE DEP'T OF INS., *supra* note 10, at 10.

54. See Kansas Health Care Stabilization Fund, *supra* note 6.

55. N.M. Med. Soc'y, Council Minutes (Jan. 11, 2003).

56. See SLOAN ET AL., *supra* note 14, at 157.

57. PINNACLE ACTUARIAL RES., INC., *supra* note 3, at 4.

58. PINNACLE ACTUARIAL RES., INC., *supra* note 22, at 11.

59. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 13, at 3.

60. *Id.* at 13.

61. OFFICE OF THE COMM'R OF INS., *supra* note 50.

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an actuary.⁶² The board determines annual assessments and monitors PCF investments.⁶³ In Kansas, the Board of Governors for the PCF is responsible for reviewing claims, setting assessments, and making recommendations on staffing.⁶⁴ New Mexico has a unique supporter called the Medical Legal Liaison Panel, composed of representatives from the medical and legal communities, which discuss potential changes to the PCF.⁶⁵ By incorporating these two different constituencies, any changes that are passed do not favor one group to the detriment of the other. If the Panel does not agree on the suggested reforms, then the proposed reforms do not make it through the legislature.⁶⁶

2. *Organizational Location of PCFs*

A key decision is whether or not to house the PCF in the state Department of Insurance. Such departments potentially offer expertise, and economies of scale may be realized by combining PCF administration with administration of other programs. One PCF indicated that an advantage of being housed in the Department of Insurance is that the Department has responsibility for other aspects of medical malpractice insurance, such as conducting solvency and policy form regulation activities.

The alternative is to establish a separate state agency, which may tend to insulate the PCF from political considerations affecting the Insurance Department more generally. In some states, there has been controversy about whether PCFs are really insurers or, alternatively, are risk pools that are not subject to traditional insurance principles governing such activities as loss reserving and premium setting.⁶⁷ Since bureaucracies that interact with a larger number of interest groups are less likely to be beholden to any one group,⁶⁸ an independent state agency may be more influenced by the provider community than a PCF located within an Insurance Department.

62. *Id.*

63. *Id.*

64. Kansas Health Care Stabilization Fund, Members of the Board of Governors and Staff Members of the Health Care Stabilization Fund, at http://www.hcsf.org/board_and_staff.htm (last visited Jan. 22, 2005).

65. N.M. PUB. REGULATION COMM'N, *supra* note 9, at 14.

66. *Id.*

67. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 12; Hofflander et al., *supra* note 44, at 13.

68. See generally Richard C. Elling, *Administering State Programs: Performance and Politics*, in *POLITICS IN THE AMERICAN STATES: A COMPARATIVE ANALYSIS* 267 (Virginia Gray et al. eds., 7th ed. 1999).

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At the time of our interviews, seven PCFs were located in the state Department of Insurance. Some states have moved their PCFs out of the Department of Insurance. For example, in Louisiana, oversight of the PCF was transferred from the Department of Insurance to the Office of the Governor in the early 1990s; the PCF indicated that this was done to give the PCF more stability. Following the move, the PCF's staffing and budget increased appreciably. The Kansas PCF separated from the Insurance Department in 1995, partially to give health providers greater control of PCF activities.⁶⁹ Although the Department of Insurance continues to be very involved in managing the PCF in South Carolina, Department representatives were removed from the PCF Board due to mismanagement of the PCF that necessitated supervision by the legislature.⁷⁰ Currently, the Department plays an important role in supervising the PCF, but does not have representation on the Board.⁷¹

3. *External Review*

Another mechanism for overseeing PCF activities is periodic external review of the PCF. Such reviews are useful, especially in light of inadequacies of financial performance in the past. In South Carolina, an initial audit by the state's Legislative Audit Council found that the PCF was inadequately funded.⁷² The findings from the first audit prompted legislative action to modify Board oversight and to increase the required primary layer of coverage. A follow-up audit in January 2004 concluded that the PCF's funding had improved.⁷³ The PCFs in Louisiana and Kansas also are subject to periodic legislative audits.⁷⁴ In New Mexico, an external evaluation is required every other year.⁷⁵ The evaluators work with the actuaries to examine different aspects of the PCF finances and meet with the Medical Legal Liaison Panel to discuss findings.⁷⁶ Wisconsin requires a legislative audit every three years by the state Legislative Audit Bureau.⁷⁷

69. See Kansas Health Care Stabilization, Who Runs the Health Care Stabilization Fund, at <http://www.hcsf.org/general3.htm> (last visited Jan. 22, 2005).

70. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 12.

71. *Id.*

72. See *id.* at v.

73. See generally S.C. LEGISLATIVE AUDIT COUNCIL, FOLLOW-UP: A REVIEW OF THE MEDICAL MALPRACTICE PATIENT'S COMPENSATION FUND (Jan. 2004), http://www.state.sc.us/sclac/Reports/2000/pcf_follow-up.pdf.

74. Kansas Health Care Stabilization Fund, *supra* note 6, at 11; State of Louisiana, *supra* note 7, at 12.

75. N.M. PUB. REGULATION COMM'N, *supra* note 9, at 3.

76. *Id.*

77. OFFICE OF THE COMM'R OF INS., *supra* note 13, at 10.

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4. Use of Actuarial Advice

In addition to external reviews, actuarial studies are done for all PCFs, primarily on an annual basis.⁷⁸ The studies monitor the financial state of the PCF, determine the level of reserves, suggest the surcharge needed for the PCF to be actuarially sound, and make other financial recommendations. The recommendations of actuaries, however, are not always followed.⁷⁹

D. Coverage

Eight of the nine PCFs provide excess medical liability coverage for hospitals and physicians. New York does not cover hospitals.⁸⁰ Some states offer PCF coverage to other providers, such as dentists, chiropractors, podiatrists, nursing homes, and HMOs. The PCFs reported varying levels of interest from those providers that are not covered by the PCFs. Some states use the existence of a PCF as a recruitment tool to attract doctors to the state, even highlighting its existence in recruiting materials.⁸¹

1. Required Primary Coverage

Coverage limits provided by the PCFs differ, as do the primary limits required of the health providers. As of early 2004, required limits of primary coverage ranged from \$100,000 in Louisiana to \$1.3 million in New York. These coverage requirements have been updated over time. For example, in Nebraska, the primary coverage requirement increased from \$100,000 to \$200,000 in 1987.⁸² In 2004, another increase was being considered.⁸³ South Carolina recently increased its primary limits from \$100,000 to \$200,000.⁸⁴ Pennsylvania periodically increased its primary coverage requirement with its initial PCF, called the Medical Professional Liability Catastrophe Loss (CAT) Fund, and plans to require increases in the upcoming years until the Medical Care Availability and Reduction of Error (MCARE) Fund, the successor to the CAT Fund, is dissolved in 2009.⁸⁵ Indiana and Kansas

78. See *infra* app. A, tbl. 1.

79. SLOAN ET AL., *supra* note 14, at 6; Kansas Health Care Stabilization Fund, *supra* note 6, at 11.

80. N.Y. STATE DEP'T OF INS., *supra* note 10, at 10.

81. See Aurora Health Care, Physician Services & Recruitment, at <http://www.aurorahealthcare.org/jobs/phys-recruit/index.xasp> (last modified Dec. 8, 2004).

82. NEB. MED. ASS'N, THE NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT: A SYNOPSIS 4, www.nol.org/home/NDOL/brochure/b_medmal.pdf (last modified Sept. 14, 2001).

83. *Id.*

84. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 2.

85. See generally University of Pennsylvania Health System, *supra* note 39.

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have also increased primary coverage requirements since establishing their PCFs.⁸⁶

2. *Limits of PCF Coverage*

Similar to the varying amount of primary level requirements, coverage provided by the PCF also varies from \$500,000 per occurrence in Pennsylvania to unlimited medical expenses per occurrence provided by four PCFs (Louisiana, New Mexico, South Carolina, and Wisconsin).⁸⁷ Some PCF limits are indexed, adjusting the non-economic damages limit annually, while other limits remain fixed until specifically updated by the state legislature.

The upper limit on liability for PCFs may also be governed by a statutory limit on total or non-economic loss that applies to all medical malpractice losses. In Nebraska, the limit only applies to providers participating in the PCF.⁸⁸ Caps on damages are controversial, not only in the context of PCFs.⁸⁹ Some PCF states included limits on liability as part of the original design of the PCF. Such limits have been challenged in the courts, often successfully.⁹⁰

Many respondents to our survey maintained that limits on liability are a necessary condition for the PCF's success. Indiana had a limit on total damages. For participants in Nebraska's PCF, there was a \$1.75 million cap on economic and non-economic damages. The following four states had limits on non-economic damages: Wisconsin, Louisiana, New Mexico, and Kansas. South Carolina, Pennsylvania, and New York did not have caps for medical malpractice, but Pennsylvania did limit the liability of its PCF. One PCF respondent remarked that it is as important to implement policies to improve patient safety as it is to reduce exposure to large awards by implementing caps. However, this view was not widespread.

86. See generally Albert, *supra* note 5; see also Kansas Health Care Stabilization Fund, *supra* note 6, at 11.

87. See *infra* app. A, tbl. 1.

88. NEB. MED. ASS'N, *supra* note 82, at 1.

89. See generally JOINT LEGISLATIVE AUDIT & REVIEW COMM'N, VA. GEN. ASSEMBLY, REVIEW OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM (2003), <http://jlarc.state.va.us/Reports/Rpt284.pdf>; Patricia H. Born & W. Kip Viscusi, *The Distribution of the Insurance Market Effects of Tort Liability Reforms*, in BROOKINGS PAPERS ON ECON. ACTIVITY: MICROECONOMICS 55 (1988).

90. See generally Tanya Albert, *Tort Reform Challenges Yield Mixed Results*, AM. MED. NEWS, Aug. 9, 2004, at 12.

3. Joint Underwriting Associations

During the same time period that PCFs were created, many states established JUAs to provide a “market of last resort” for those health providers that could not obtain primary coverage at a reasonable rate. Five of the nine states had distinct JUAs. New Mexico and New York did not have a JUA, and South Carolina and Nebraska made little distinction between the PCF and JUA. In South Carolina, eighty percent of physicians were covered by the JUA (a percentage that has been maintained for many years), and participation in the JUA required participation in the PCF. The JUA and PCF pooled their funds, and defended claims jointly.

E. Claims Management, Loss Prevention, and Patient Safety

Claims management consists of all activities, including legal representation, related to lowering the total potential payment from a specific claim. Loss prevention includes activities conducted to reduce the probability that a potential grievance results in the filing of a claim. Patient safety includes all activities undertaken to reduce harm to patients, including but not limited to use of financial incentives to deter injuries.

Except for New York, where the PCF only funds the purchase of private excess insurance, the PCF is not the only insurer in a case.⁹¹ For this reason, among others, claims management is a complex process. On one hand, having many decisionmakers can greatly increase the complexity of claims resolution. On the other hand, the PCF has a financial stake in the outcome, and thus may have a role in the resolution process.

Some PCFs were passive participants in claims management activities. Primary insurers generally oversaw claims management. However, several PCFs had their own claims functions to monitor claims that penetrated the PCF layer so that they were prepared to assist with settlement discussions or trials. Wisconsin, New Mexico, Kansas, and Pennsylvania closely monitored claims filed through their claims staff. In Wisconsin, prior to involving the PCF in the defense of a claim, the primary insurer has a statutory obligation to defend the PCF.⁹² If the PCF feels that the primary insurer is not acting with the best interests of the PCF in mind, then it can bring a “bad faith” case against the insurer.⁹³ This has only happened once, but the PCF con-

91. N.Y. STATE DEP'T OF INS., *supra* note 10, at 10.

92. OFFICE OF THE COMM'R OF INS., *supra* note 50, at 14.

93. *Id.*

tinues to monitor potential bad faith cases.⁹⁴ After the primary insurer tenders the claim to the PCF, it is the responsibility of the PCF to manage the defense of the claim.⁹⁵

In South Carolina, the close relationship between the PCF and JUA resulted in a different division of responsibilities.⁹⁶ The JUA managed legal defense and claims, and when the claim reached the PCF limit, the PCF was asked to tender money for the claim. Three states did not provide claims management.

In Pennsylvania, there is considerable controversy about the PCF's role in claims management.⁹⁷ Many hospitals interviewed in Pennsylvania said that PCF involvement has delayed settlements and thereby resulted in higher payouts.⁹⁸ Similar views were expressed by brokers and primary insurers.

None of the PCFs actively offered loss prevention. However, one PCF (Pennsylvania) stated that the organization would offer such assistance if it were requested. None of the PCFs offered formal guidance for patient safety issues, leaving this practice to the individual providers and primary carriers. Wisconsin had a Risk Management Committee, which was available to provide patient safety guidance to PCF participants.⁹⁹ Pennsylvania imposed very specific patient safety requirements (e.g., mandatory reporting and process standards) that are viewed by some providers as being an important component of improving the patient safety climate even though the PCF itself has a hands-off role in promoting patient safety. In New York, there was a mandatory risk management requirement for all recipients of the PCF subsidy.

E. PCF Staffing

Among the nine PCFs, there was a great deal of variation in staffing levels. Authorized staff sizes ranged from zero in New York to fifty-five in Pennsylvania. Expressing staffing as the ratio of paid losses in 2002 to the number of authorized staff at the interview date, ratios ranged from \$1.1 million to \$5 million. Paid loss data were only available for five of the nine PCFs.¹⁰⁰ Some low staffing levels may reflect the fact that other organizations have taken over some functions (e.g.,

94. *Id.*

95. *Id.*

96. S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 31.

97. Conover et al., *supra* note 25, at 10.

98. *Id.*

99. OFFICE OF THE COMM'R OF INS., *supra* note 13, at 54.

100. *See infra* app. A, fig. 1 (Paid Claims per PCF Staff Member).

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premium collection and claims handling). In some cases, there is a large staffing component that manages the PCF. In cases where there is no dedicated staff, the Department of Insurance personnel set aside different percentages of their workday to focus on PCF responsibilities. Staffing levels did not change much from 2001 to 2003, with PCFs fairly constant in their staffing budget and specific needs. None of the PCFs reported difficulty in filling positions, with one respondent commenting that the PCF has a good reputation and individuals have gone to work at the PCF because of this reputation. Another respondent commented that many insurers viewed the PCF as a “training base” for future employees. The PCF was a good place to learn the business, and staff often moved on to the private sector due to higher salaries and better career advancement opportunities.

In terms of the type of staff employed, PCFs hired their own attorneys and also contracted out defense work for claims that reached trial. For example, in Wisconsin, the PCF contracted with different defense counsel for each case. For their actuarial needs, PCFs also reported a mixture of in-house staff and contractors. Reports were typically completed on an annual basis. Nebraska has a review conducted by the actuary on staff and then supplements this report with an external actuarial study.

IV. HOW SUCCESSFUL HAVE THE PCFs BEEN?

Since the overarching objective of the PCFs was to improve the affordability and availability of medical malpractice insurance in the states, the main question is whether or not such insurance has become more available and affordable because of the presence of a PCF. Although all PCFs share this common goal, there is considerable heterogeneity among PCFs. Thus, it is also important to gauge whether certain design features have contributed to the PCF’s success or lack thereof.

A. *Trends in Losses*

The notion that medical malpractice insurance is more available and affordable because of the presence of PCFs cannot be conclusively demonstrated with available data or data that could be assembled at reasonable cost. In a general sense, private insurance was available in all states with PCFs; but in South Carolina, virtually all insurance was issued by the JUA and the PCF. Also, hospitals differ from physicians in that they are subject to much higher losses. Thus, even in Pennsylvania, where the PCF limits on coverage were low, the perception was that the limits work for physicians, where they effec-

tively serve as excess coverage. The limits did not work for hospitals where very similar limits effectively serve as a working layer between primary and additional excess coverage, which is often desired by these facilities.

On cost of coverage, premiums have increased dramatically in some states, including some states with PCFs, but the increases are probably for many reasons beyond the control of PCFs. Based on available data on losses paid by PCFs during 1998–2002, expressed in 2002 dollars using the general Consumer Price Index, there was considerable variation in recent trends in losses among the five PCF states for which trends could be measured.¹⁰¹ Kansas experienced a decrease in paid losses.¹⁰² Pennsylvania had a slight increase.¹⁰³ South Carolina experienced the largest percent increase by far, with Louisiana and Wisconsin in between Pennsylvania and South Carolina.¹⁰⁴

Using data from the National Practitioner Data Bank (NPDB), trends in claims frequency are very similar between PCF and non-PCF states.¹⁰⁵ Since PCF payments were not included in the NPDB data, it was not possible to calculate mean total severity of loss or total losses incurred by private and public insurers in PCF states.

B. Opinions of the PCFs Themselves

Perhaps not surprisingly, when asked whether the PCF serves a useful role in their state, all respondents answered “yes.” No PCF had direct evidence to demonstrate that availability and affordability were improved, but they provided the following types of arguments. First, as excess insurers, the PCFs reduced the volatility of losses experienced by other private medical malpractice insurers. Second, PCFs have made their states more attractive to primary insurers by limiting their exposure to high losses, even in states without statutory limits on liability. Such limits are considered helpful in achieving market stability. Third, compared with private insurers, PCFs have low administrative expense. Although not explicitly stated, this may not only reflect lean staffing and state salary scales, but also differences in risk-bearing between PCFs and private insurers. In contrast to private insurers, in states with mandatory participation in PCFs, the PCF has the ability

101. See S.C. LEGISLATIVE AUDIT COUNCIL, *supra* note 12, at 16; *infra* app. A, fig. 2 (Normalized Paid Claims 1998–2002).

102. *Id.*

103. *Id.*

104. *Id.*

105. See *infra* app. A, fig. 3 (Medical Malpractice Payment Reports by Year: PCF States and Non-PCF States).

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to assess providers retroactively to cover overruns. In the latter sense, at least, lower cost is not necessarily an advantage.

We asked the PCFs whether the market could have been served better by using a private excess carrier. Private excess coverage was available in all states, but the majority of PCFs added that such coverage was at a high cost. Hospitals were typically more inclined to investigate obtaining excess coverage; however, in South Carolina hospitals self-insure. There was no excess market in South Carolina since the PCF covered all damages above the \$200,000 primary coverage limit. In Pennsylvania, the PCF provided excess coverage for physicians, but many hospitals obtained excess coverage above the MCARE limit. Private excess insurers have generally required a substantial buffer between the MCARE limit and where their coverage begins. Much of this can be attributed to business decisions, such as not wanting to be exposed to lower layers, but at least some appears to be motivated by concerns about the complications that ensue when the hospital and PCF do not see eye-to-eye on whether to settle or go to trial on a particular claim.

The Wisconsin PCF gave several reasons for its success. The reasons in descending order of importance were as follows: mandatory participation; mandatory primary insurance for providers; effective communication between the PCF and the agency that licenses providers to monitor error-prone providers; and limits on liability for non-economic damages and wrongful death. In New York, the existence of the excess program was given as one of five reasons that insurance has remained available in that state and a surge in premiums has been avoided.

Theoretically, the existence of a PCF may reduce incentives for loss prevention defined as improving patient safety, reducing the probability that a claim is filed, and managing claims to reduce the amount of indemnity, legal fees, and other expenses incurred by defendants. State-sponsored excess coverage also creates a moral hazard for primary insurers. Without a PCF, a primary insurer should defend claims up to the point at which the last dollar spent on prevention equals the saving in payments to claimants. An insurer with foresight is also likely to assess the effect of its current defense strategy on future claims.¹⁰⁶ When a PCF exists, however, the primary insurer's incentive to fight large claims may be substantially reduced because savings from effort it expends near the dollar threshold of excess cov-

106. See generally Barry Nalebuff, *Credible Pretrial Negotiation*, 18 RAND J. ECON. 198 (1987); Holger Sieg, *Estimating a Bargaining Model with Asymmetric Information: Evidence from Medical Malpractice Disputes*, 108 J. POL. ECON. 1006 (2000).

erage will accrue not to itself, but to the PCF or to all insured providers in the state as a group.¹⁰⁷

The majority of PCFs did not impose surcharges on insureds based on the individual insured's loss experience, which could moderate this effect. By contrast, private excess carriers do engage in experience-rating.¹⁰⁸ Having a poor loss history is likely to be a disadvantage in the market for excess insurance and this will likely translate into higher premiums.

In practice, the PCFs and others we interviewed saw little relationship between having a PCF and patient safety, loss prevention, and claims management. They viewed PCFs as primarily passive financial intermediaries. In their view, they did not promote patient safety, loss prevention, and claims management or do anything to lessen the incentives for insureds to engage in these activities. Some PCFs considered these activities responsibilities of primary insurers rather than responsibilities of private excess insurers or PCFs. The latter just handle money.

C. *Opinions of Brokers, Private Excess Insurers, and Hospitals*

Brokers and private excess insurers were less enthusiastic about the PCF concept overall, but indicated that some of the states with PCFs were attractive to private insurers. In some states, public PCFs could be seen as competitors of private excess insurers. The presence of a PCF would "crowd out" demand for private excess insurance.

An important exception was Pennsylvania. In one sense, these respondents stated that Pennsylvania's PCF was in a different market since the private excess insurers only provided coverage at much higher losses. A private excess insurer of a hospital might begin coverage at a loss of \$10 million per occurrence. By contrast, Pennsylvania's MCARE limits were \$500,000 to \$1 million. We only interviewed hospitals in Pennsylvania.¹⁰⁹ In that state, several hospitals raised administrative issues about MCARE, including difficulties in coordinating defense strategies when several insurers, including MCARE, were involved in the defense of a case. Another problem in Pennsylvania was the state PCF's high level of unfunded liabilities. Some brokers cited other administrative concerns, such as inconsistent messages from the staff, claims handling problems, changing rules, and lack of coordination between the physician and hospital sides of

107. HOFFLANDER & NYE, *supra* note 45, at xiv.

108. See generally NEIL DOHERTY & KENT SMETTERS, MORAL HAZARD IN REINSURANCE MARKETS (Nat'l Bureau of Econ. Research, Working Paper No. 9050, 2002).

109. See N.Y. STATE DEP'T OF INS., *supra* note 10, at 10.

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the business.¹¹⁰ There was a consensus that MCARE should be abolished. On the other hand, we heard from several brokers and excess insurers that PCFs in the other states had a neutral and, more commonly, a positive influence on the attractiveness to offshore markets. In some cases, there was no direct familiarity with the state since the PCF wrote all of the excess insurance business. Based on these responses, it appears that Pennsylvania's problems do not generalize to other PCFs.

V. STATE MEDICAL LIABILITY REPORT CARDS

One other crude indicator of how the PCF states are faring relative to other states comes from state report cards prepared by NORCAL Mutual Insurance Company, based on a variety of indicators, including average patient payment, patient payment frequency, total patient payments, average delay of patient payments, physician and consumer cost burdens, and various measures of market structure.¹¹¹ Grades and points were assigned based on a state's ranking on ten such indicators. We found that the average ranking for PCF states was lower than in non-PCF states and their grade point average was slightly higher, suggesting their overall malpractice climate was somewhat "better."¹¹² This hardly counts as definitive evidence, but is generally consistent with the subjective impressions provided by our respondents.

VI. IS THERE A ROLE FOR PCFs?

State governments operate PCFs. Public sponsorship has an important advantage: assuring availability of coverage. Like JUAs and unlike private insurers, PCFs do not withdraw from the market during crisis periods.¹¹³ Demand for private excess coverage by primary medical malpractice insurers is directly related to the volatility of loss.¹¹⁴ Because private excess insurance covers large, infrequent losses, it is itself volatile in terms of availability and premiums. By contrast, a PCF can keep excess coverage available because its decision to supply coverage is not guided by prospective rates of return. Excess coverage primarily relies on offshore insurers, which have an

110. *Id.*

111. Measures of market structures include leading company market share and number of A-rated competitors.

112. See *infra* app. A, tbl. 2.

113. This is because they are public programs.

114. See generally Thomas J. Hoerger et al., *Loss Volatility, Bankruptcy, and the Demand for Reinsurance*, 3 J. RISK & UNCERTAINTY 221 (1990).

incentive to shift funds to other sectors when the medical malpractice line becomes unprofitable.¹¹⁵

With the exception of New York, financing generally comes entirely from premiums paid by physicians, hospitals, and investment income. Thus, rather than call it a public provision, it is more accurate to say that PCFs offer a statutorily sanctioned mechanism for providers to pool risk. In this sense, if the groups responsible for financing PCFs want to keep them, and no other major distortions can be identified, there is a strong case for retaining them. However, there are other statutorily sanctioned mechanisms, most importantly risk retention groups, which are private organizations and also perform the risk pooling function. PCFs do not reduce medical liability exposure, unless they undertake specific loss prevention actions. Rather, they transfer costs to a different funding mechanism.¹¹⁶

VII. PUBLIC POLICY OPTIONS

When considering what to do with PCFs, states face three options: phase out the PCF (as is scheduled to occur in 2009 in Pennsylvania), modify the PCF, or continue the status quo. As one PCF respondent commented, "if it's not broke, why fix it?" But the question remains whether the PCFs are "broke," and if so, how to resolve the situation and bring the private insurers back into the state market to provide affordable coverage. When asked about ways to reform and modify the PCF, respondents focused on tasks that proved to be problematic in their workdays, such as streamlining internal operations, improving communication, and improving other technical aspects of the PCF, rather than focusing on larger structural changes. Some respondents proposed larger reforms such as changes in primary limits and having a better sense of surcharges that are actuarially sound.

The decision for states is whether the PCF concept is sound and makes a contribution to availability and affordability of medical malpractice insurance. If the answer to this question is "yes," then several questions about PCF design follow.

VIII. ARE PCFS WORTH HAVING?

Our conclusion is that PCFs may be worth having if they are designed correctly. Crises in availability and in premiums tend to be serious when they occur. But the disruptions tend to be quite limited

115. William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in *HEALTH LAW HANDBOOK 15* (Alice Gosfield ed., 2003).

116. PINNACLE ACTUARIAL RES., INC., *supra* note 3, at 10.

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in duration. At the time of our survey, we found no evidence that private excess insurance was unavailable in any PCF state, unless the PCF had crowded out such private coverage. Thus, the issue is whether states wish to have the PCF in reserve as a “back-up” plan in the event that coverage goes away. Because this can happen so quickly, it may be preferable to have the PCF already in place, with the kinks worked out, rather than attempt to create this mechanism on the fly in the heat of a crisis.

Should PCFs be retained by the states that have them and should the concept be adopted by other states? There are several reasons for and against the retention or adoption. On the plus side, if the stakeholders want to have them, why should others object? Except in New York, no public funds are being used.¹¹⁷ If enrollment in the PCF is voluntary, the PCF is just another competitor in the marketplace. PCFs can be designed to look like a private insurer. Finally, PCFs have several purported advantages, including reductions in volatility of claims and seemingly low administrative costs. Reduced volatility makes states more attractive to primary insurers.

In terms of the drawbacks, it may be politically impossible to craft a PCF of optimal design. It may be more difficult for a public agency to deal with physicians and other providers with bad loss records. If the PCF acts as a financial intermediary, it may be seen as unduly passive and apathetic toward promoting patient safety and other worthwhile objectives. Conversely, if the PCF does not act cooperatively with other insurers, PCFs may impose an added transactions cost. In cases in which the PCF acts prudently, by maintaining adequate reserves to cover anticipated losses, political pressures (for example, those stemming from a large budget deficit), may lead to tampering with loss reserves. Wisconsin’s experience is a case in point.¹¹⁸ By limiting its role to subsidizing purchase of excess insurance, the New York program avoids these negatives.¹¹⁹ However, it also avoids the plus of stakeholder financing of the program.

Although it is possible to design an effective PCF, the “proof of pudding” is in successful implementation. Historical evidence is useful in describing possible practical barriers to successful program implementation.

117. See *infra* app. A, tbl. 1.

118. Wis. HOSP. ASS’N, *supra* note 51, at 14.

119. N.Y. STATE DEP’T OF INS., *supra* note 10, at 14.

IX. DESIGNING AN EFFECTIVE PCF

If PCFs are to be retained and/or states are to adopt them, how should they be designed? In the end, design may be more important than whether or not a PCF exists.

A. There Are Arguments for Both Mandatory and Voluntary Participation

Voluntary insurance markets are vulnerable to adverse selection if premiums do not precisely match risk. Primary medical malpractice insurance is not usually experience-rated.¹²⁰ Compulsory participation in a PCF can avoid adverse selection, which is otherwise likely to occur if high-loss physicians or hospitals are able to obtain coverage at average rates. However, requiring low-risk participants to subsidize high-risk participants may be viewed as unfair. An alternative perspective is that the PCF should serve as an insurer of last resort. If so, adverse selection is anticipated, and the PCF provides a mechanism for pooling losses among high-risk providers, possibly supplemented by contributions from all insurers in the same fashion as is routinely done with state guaranty funds in many other lines of insurance. The downside of the state guaranty fund model is that evidence from the property and casualty market suggests that it may be subject to moral hazard.¹²¹ Also, a voluntary PCF may usefully offer patient safety and loss prevention programs, which presumably would benefit providers who have incurred large losses in the past. Thus, the ultimate judgment as to whether mandatory participation is a desirable feature depends on the state's objective in establishing the PCF.

B. PCF Coverage Limits Should Clearly Position the PCF as an Excess Insurer

Because most statutes have not established upper limits on liability, health care providers remain vulnerable to very high dollar claims. Philadelphia juries, for example, commonly award amounts exceeding one million dollars.¹²² The amount of private excess coverage purchased in states with PCFs is unknown. In Pennsylvania, the presence of a PCF has not eliminated hospital demand for private excess cover-

120. See Sloan, *supra* note 2, at 38.

121. James G. Bohn & Brian J. Hall, *The Costs of Insurance Company Failures*, in *THE ECONOMICS OF PROPERTY-CASUALTY INSURANCE* 139 (David F. Bradford ed., 1998).

122. BOVBIERG & BARTOW, *supra* note 11, at 26.

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age.¹²³ A PCF's limit on liability should be sufficiently high so as to position it as an excess insurer. Covering losses in the mid-range of losses, as in Pennsylvania, serves no useful purpose. Entities seeking higher levels of loss protection must obtain such coverage from private sources. Problems in both availability and in the price of coverage from the private sector are most likely at the high end of the loss distribution. Liability limits should be indexed so as to obviate the need for legislative action to change limits.

C. From the Standpoint of a PCF, Having Statutory Limits on Liability Is Useful

Establishing limits on non-economic and total loss for medical malpractice is one of the most popular options among insurers and potential defendants more generally.¹²⁴ A general evaluation of caps is beyond the scope of this analysis. For an excess insurer, whether private or public, having caps is useful for loss control. Pennsylvania has no caps, but the PCF has an established upper limit on payment. Although such limits also reduce risk to the PCF and ultimately to the premium payers, having a limit on coverage but not on non-economic or total loss has meant that providers, especially hospitals, have sought excess coverage from private insurers, thus making the PCF a working layer.

D. PCFs Should Offer Some Incentives for Injury Deterrence

This may be done in several alternative ways. One is to experience rate premiums, which is done by some PCFs and all private excess insurers. A problem with the use of experience-rating for high losses is that such losses tend to occur infrequently. Thus, an experience-rated system may be excessively punitive since past losses may not be predictive of future losses. On the other hand, refraining from experience-rating at all goes too far in the other direction, completely eliminating the potential deterrent effect.

Rather than completely rely on experience-rating, PCFs might offer premium discounts to providers who have. As of early 2004, no PCF offers such discounts, although risk management training is required of participants in New York's PCF. Given the lack of empirical evidence establishing that such programs achieve savings, especially for the range of losses that PCFs typically cover, PCFs should proceed

123. HOSP. & HEALTHSYSTEM ASS'N OF PA., PROFESSIONAL LIABILITY COVERAGE IN PENNSYLVANIA: FINDINGS OF STATEWIDE SURVEY (May 2002), http://www.haponline.org/downloads/Liability_Srvy0502FINAL.pdf.

124. BIONDI & GUREVITCH, *supra* note 20, at 8.

cautiously in implementing explicit financial incentives to adopt such programs.

E. Avoid Pay-As-You-Go Financing

This approach has practical appeal in that policyholders can enjoy benefits currently without incurring the associated costs. The advantage of postponing the cost obligation is particularly attractive in an unpredictable, "long-tail" line, such as medical liability insurance; it helps solve short-term crises in availability of excess coverage without imposing the immediate pain of high premium assessments. In the first few years, losses tend to be low because most claims have not yet been resolved, allowing assessments to be low as well.¹²⁵ Later, however, losses mount, and PCFs often must raise premiums sharply, incurring the wrath of premium-payers and precipitating political pressures for reform.¹²⁶ Several states have used pay-as-you-go financing in the past, but only Pennsylvania has retained it.¹²⁷ Even recognizing the short-term political benefit, pay-as-you-go financing almost assures a future financial crisis. Thus, there is a strong case for setting aside reserves at the time the claim is filed.

Since it seems prudent for insurers to loss reserve, why would legislatures in some states have eschewed the practice? One reason, suggested by Professors Hofflander and Nye,¹²⁸ is that the pay-as-you-go approach simplifies administration. Instead of having to compute reserves and invest those funds prudently, the PCF assumes that providers are aware of the liability accruing and are holding "reserves" of their own.¹²⁹ Reserves held by public agencies are also vulnerable to exploitation for unrelated purposes.¹³⁰ The most important explanation, however, is politics. Failure to reserve attracts political support for a PCF because excess coverage seems inexpensive in the PCF's initial years. When the unfunded liability from past policy years eventually becomes due and payable, it is easy to label the malpractice system "out of control" instead of confronting the design flaws in the PCF.¹³¹

125. ALFRED E. HOFFLANDER ET AL., REPORT ON THE MEDICAL MALPRACTICE INSURANCE DELIVERY SYSTEM IN PENNSYLVANIA 3 (2001); BOVBJERG & BARTOW, *supra* note 11, at 19; CONOVER ET AL., *supra* note 25, at 23.

126. BOVBJERG & BARTOW, *supra* note 11, at 19; HOFFLANDER & NYE, *supra* note 45, at 31; CONOVER ET AL., *supra* note 25, at 23.

127. BOVBJERG & BARTOW, *supra* note 11, at 19; CONOVER ET AL., *supra* note 25, at 4.

128. HOFFLANDER & NYE, *supra* note 45, at 31.

129. *Id.*

130. WIS. HOSP. ASS'N, *supra* note 51, at 14.

131. *See generally* HOFFLANDER ET AL., *supra* note 125.

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However, the countervailing arguments appear stronger, and apply equally to public agencies and private insurers. First, the objective of insurance is to protect policyholders against loss. If there is substantial insolvency risk, health care providers remain vulnerable. Second, insurers have a comparative advantage in loss reserving. Unlike actuaries, health care providers do not possess the requisite data or expertise to make such projections.

F. On Balance, Public Provision Is a Better Alternative than Public Subsidization

New York's program is unique in subsidizing insurance purchased from sources other than providers.¹³² Public subsidies of private insurance may have succeeded in a state such as New York with a history of extensive regulation of insurance premiums and insurer solvency.¹³³ In a less regulatory environment, subsidies run the risk of adding to existing demand for insurance and ultimately to medical malpractice premiums. Also, a policy of subsidizing persons with high incomes may be objectionable on equity grounds.

X. CONCLUSION

Compared to major tort and insurance reforms, PCFs have received virtually no attention by scholars. With an exception or two, they are not a major focus of public policy debate either. Because they are small organizations and there have been lengthy periods in which medical malpractice markets are quiescent, they have not attracted much scrutiny. Given a lack of quantitative evidence, our evaluation depended on qualitative evidence. Yet PCFs address the fundamental issues of medical malpractice that have led to reoccurring crises in the availability of medical malpractice insurance coverage and in its premiums for such coverage. As such, PCFs represent a potentially effective policy instrument when designed correctly.

132. N.Y. STATE DEP'T OF INS., *supra* note 10, at 10.

133. *Id.*

APPENDIX A

TABLE 1: SUMMARY OF MAJOR PCF PROVISIONS

State	Enabling Legislation	Financial Structure	Participation	Eligibility (Phys/Hosp)	Required Primary Coverage	Coverage Limits	Funding Approach	Reserves Authorized?
IN	Burns Ind. Code Ann. § 34-18-1-1 - 18-2	Separate Trust Account	Voluntary	Phys/Hosp	Phys: \$250K/ \$750K Hosp: \$250K/\$.5M or \$7.5M	\$1.25M per occurrence	Decided using actuarial principles, collected by primary insurer	Yes
KS	K.S.A. § 40-3401 - 3419	State Treasury Trust	Mandatory	Phys/Hosp	\$200K/\$600K	Purchaser's option of \$100K/\$300K, \$300K/\$900K, or \$800K/\$2.4M	Decided using actuarial principles, collected by primary insurer	Yes
LA	La. R.S. § 40:1229.41 - 49	State Treasury Fund	Voluntary	Phys/Hosp	\$100K/\$300K	\$500K & future medical expenses - primary coverage	Decided using actuarial principles, collected by primary insurer	Yes, but surcharge must be reduced if fund exceeds \$15 million in excess of the required 50% of exposures
NE	R.R.S. Neb. § 44-2801 - 2855	Trust Account	Voluntary	Physicians	Phys: \$200K/ \$600K Hosp: \$200K/\$M	\$1.75M for economic and non-economic damages	Assessments as percentage of underlying premiums through insurer	Yes
NM	N.M. Stat. Ann. § 41-5-1 - 29	State Treasury Trust	Voluntary	Phys/Hosp	\$200K/\$600K	Unlimited medical & \$600K economic & non-economic	Decided using actuarial principles, collected by primary insurer	Yes
NY	N.Y. C.L.S. Ins. § 5502	Excess Liability Pool	Voluntary	Physicians with hospital privileges	\$1M/\$3M	\$1M per occurrence	State Fund	Not Applicable
PA	40 P.S. § 303.101 - 910 P.L. 154, No. 13	State Treasury Fund	Mandatory	Phys/Hosp	Phys: \$500K/\$1.5M Hosp: \$500K/ \$2.5M	\$500/\$1.5M	Based on primary premium collected by insurer	No

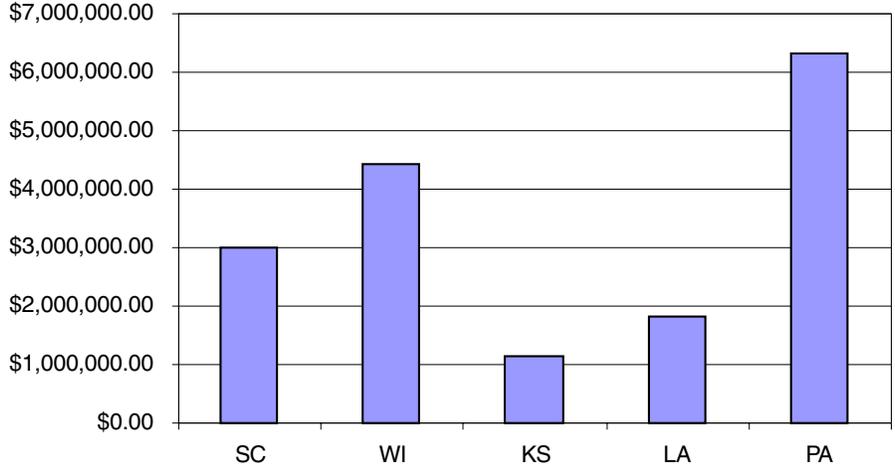
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State	Enabling Legislation	Financial Structure	Participation	Eligibility (Phys/Hosp)	Required Primary Coverage	Coverage Limits	Funding Approach	Reserves Authorized?
SC	S.C. Code Ann. § 38-79	State Treasury Fund	Voluntary	Phys/Hosp	\$200K/\$600K	Unlimited medical & non-economic	Annual member fees and assessments	Yes
WI	Wis. Stat. § 655.27	Trust Fund	Mandatory w/ Exceptions	Phys/Hosp	\$1M/\$3M	Unlimited (limits on non-economic damages & wrongful death)	Assessments determined by board billed to H.C. providers	Yes

The vast majority of PCFs include other health professions.
 Source: Sloan, *supra* note 2; based on PINNACLE ACTUARIAL RES., *supra* note 22 (produced for the Ohio Department of Insurance by Robert J. Walling, FCAS, MAAA of Pinnacle Actuarial Resources, Inc.)(thanks to Justin Sadowsky of Columbia Law School for updating this table).

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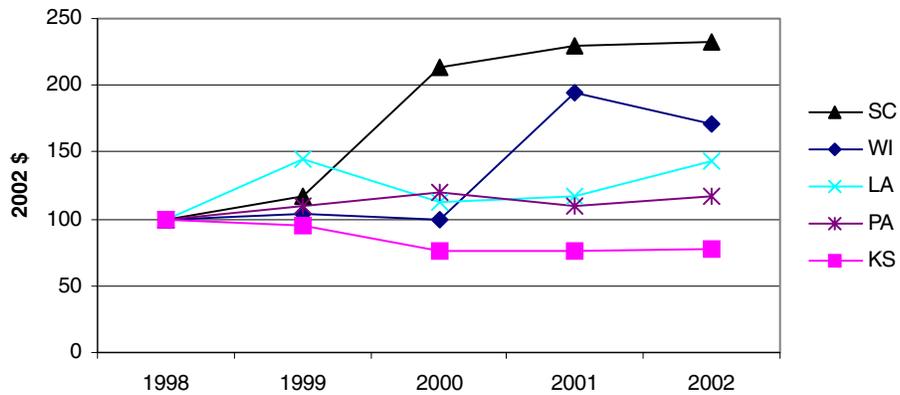
FIGURE 1: PAID CLAIMS PER PCF STAFF MEMBER



Sources:

All staffing data were received from conversations with PCF representatives in South Carolina, Wisconsin, Kansas, Louisiana, and Pennsylvania. The 2002 paid claims data for Wisconsin, Kansas, Louisiana, and Pennsylvania came from information provided by the PCFs. Data for South Carolina came from the Follow-up Audit report¹³⁴ conducted by the South Carolina Legislative Audit Council. We then calculated the ratio of paid claims to individual staff member. South Carolina staffing includes the JUA since the JUA and PCF share many duties.

FIGURE 2: NORMALIZED PAID CLAIMS 1998-2002



134. S.C. LEGISLATIVE AUDIT COUNCIL, FOLLOW-UP: A REVIEW OF THE MEDICAL MALPRACTICE PATIENTS' COMPENSATION FUND (Jan. 2004), http://www.state.sc.us/sclac/Reports/2000/PCF_Follow-up.pdf/.

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Paid claims data were translated into 2002 dollars using the Consumer Price Index. Next, we normalized paid claims to \$100 in 1998 and calculated the increases/decreases across the 1998–2002 time period. Paid claims data for Wisconsin, Kansas, Louisiana, and Pennsylvania came from information provided by the PCFs. Data for South Carolina came from the legislative audit report (January 2000) and the follow-up legislative audit report (January 2004) conducted by the South Carolina Legislative Audit Council. South Carolina jointly reports PCF and JUA paid claims.

Sources:

South Carolina: South Carolina Legislative Audit Council, January 2000, Follow-up Audit, January 2004.¹³⁵

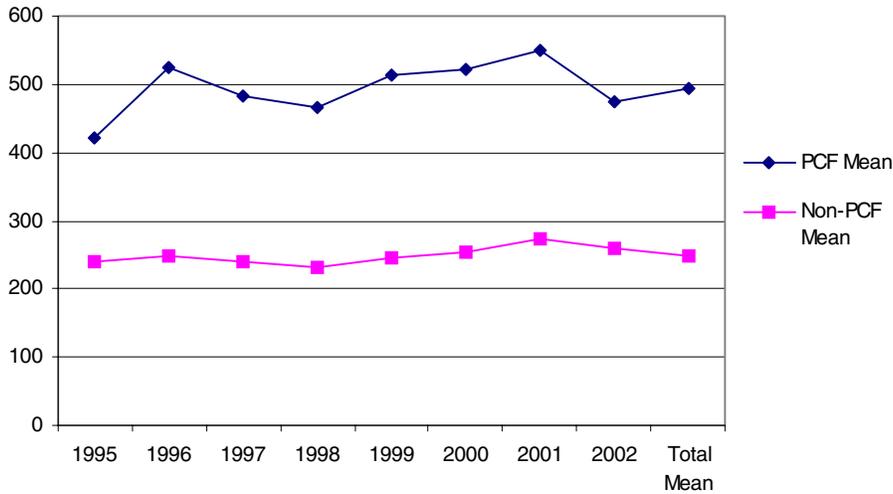
Wisconsin: 2002 Functional and Progress Report to the Legislature (page 6), provided by Wisconsin PCF.

Louisiana: Information provided by the Louisiana PCF.

Pennsylvania: Medical malpractice claims data provided by MCARE.

Kansas: Information provided by Kansas PCF.

FIGURE 3: MEDICAL MALPRACTICE PAYMENT REPORTS BY YEAR
PCF STATES AND NON-PCF STATES



Sources:

Figure 3 was compiled using data from the 1999–2002 *Annual Reports* of the U.S. Department of Health and Human Services’ Division of Practitioner Data Banks.¹³⁶

135. *Id.*

136. DIV. OF NAT’L PRACTITIONER DATA BANKS, U.S. DEP’T OF HEALTH & HUMAN SERVS., 2002 ANNUAL REPORT tbl. 7, http://www.npdb-hipdb.com/pubs/stats/2002_NPDB_Annual_Report.pdf; 2001 ANNUAL REPORT tbl. 7, http://www.npdb-hipdb.com/pubs/stats/2001_NPDB_Annual_Report.pdf; 2000 ANNUAL REPORT tbl. 7, http://www.npdb-hipdb.com/pubs/stats/2000_NPDB_Annual_Report.pdf; 1999 ANNUAL REPORT tbl. 7, http://www.npdb-hipdb.com/pubs/stats/1999_NPDB_Annual_Report.pdf.

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TABLE 2: MEDICAL LIABILITY REPORT CARD 2000, PCF
STATES VS. NON-PCF STATES

State	Rank	Grade	GPA
<i>Average PCF State</i>	19.7	C	2.3
Indiana	8	B	3.0
Kansas	17	C	2.6
Louisiana	25	C	2.2
Nebraska	2	B	3.3
New Mexico	11	C	2.8
New York	51	F	0.5
Pennsylvania	43	D	1.0
South Carolina	15	C	2.6
Wisconsin	5	B	3.1
<i>Average Non-PCF State</i>	27.4	C	2.0

Note: the highest assigned grade was B and the lowest was F. The highest GPA was 3.6 and the lowest was 0.5.

Source: NORCAL Mutual Insurance Company, January 6, 2003.