

IN THE SUPREME COURT OF OHIO

MARY J. MANLEY,
Plaintiff-Appellee,
v.
NICHOLAS P. MARSICO, M.D., et al.,
Defendant-Appellant
And
EYE SPECIALISTS, INC.,
Defendant.

Case No. **06-1263**
On Appeal from the Clinton
County Court of Appeals,
Twelfth Appellate District
(Ct. App. No. CA2006-04-013)

**BRIEF OF *AMICI CURIAE*, THE OHIO HOSPITAL ASSOCIATION,
THE OHIO STATE MEDICAL ASSOCIATION,
AND THE OHIO OSTEOPATHIC ASSOCIATION,
IN SUPPORT OF APPELLANT NICHOLAS P. MARSICO, M.D.**

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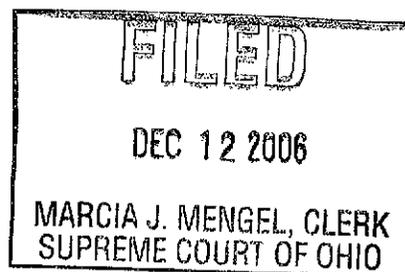


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STATEMENT OF FACTS

The relevant facts giving rise to the appeal pending before the Court are set forth in Defendant-Appellant's Merit Brief filed in the Ohio Supreme Court. Those facts are adopted by reference and incorporated herein.

INTEREST OF AMICI CURIAE

The issues presented in this appeal are of great importance to physicians, hospitals, and medical service providers throughout the State of Ohio. If the decision of the Twelfth District Court of Appeals is permitted to stand, the costs of frivolous medical negligence claims will continue to burden Ohio's health care system, the medical liability insurance market, and the millions of Ohio citizens that they serve. Civil Rule 10(D)(2) is the product of a lengthy legislative and judicial process aimed at curbing the costs of unsubstantiated medical negligence lawsuits while preserving the rights of plaintiffs to bring meritorious claims in Ohio's courts. The decision of the Twelfth District Court of Appeals directly undercuts Rule 10(D)(2)'s effectiveness by disallowing defendants the right to immediate appellate review of decisions by trial courts that have a direct impact on the cost—in time, reputation, and money—that the medical community is forced to incur defending against frivolous claims. As a result, physicians, hospitals and other providers of medical services throughout Ohio, as well as those who benefit from their services, will be directly affected by the decision of this Court.

The OHA is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. From its first major legislative undertaking involving the federal Harrison Narcotic Act, the OHA has provided a mechanism for Ohio's hospitals to come together and develop health care legislation and policy in the best interest of hospitals and their communities. The OHA is comprised of more than one hundred seventy (170) private, state and federal government hospitals and more than forty (40) health systems, all

located within the state of Ohio; these hospitals and health systems employ more than 240,000 employees. The total number of people working in Ohio hospitals, including physicians and volunteers is 303,000. The OHA's mission is to be a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

The Ohio State Medical Association ("OSMA") is a non-profit professional association founded in 1835 and is comprised of approximately 16,000 physicians, medical residents, and medical students in the State of Ohio. OSMA's membership includes most Ohio physicians engaged in the private practice of medicine, in all specialties. The OSMA strives to improve public health through education, to encourage interchange of ideas among members, and to maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The Ohio Osteopathic Association ("OOA") is a non-profit professional association, founded in 1898, that represents Ohio's 3,300 osteopathic physicians, thirteen member health care facilities accredited by the American Osteopathic Association's Healthcare Facilities Accreditation Program, and the Ohio University College of Osteopathic Medicine in Athens, Ohio. Osteopathic physicians make up eleven percent of all licensed physicians in Ohio and twenty-six percent of the family physicians in the state. OOA's objectives include the promotion of Ohio's public health and maintenance of high standards at all osteopathic institutions within the state.

ARGUMENT

PROPOSITION OF LAW:

A decision denying a motion to dismiss for failure to comply with Civil Rule 10(D)(2) is a final order pursuant to R.C. 2505.02 and is subject to appellate review upon its issuance.

Ohio Civil Rule 10(D)(2) requires an affidavit of merit to be filed with any complaint that contains a claim for medical negligence. The affidavit is necessary to establish the adequacy of the complaint with respect to any medical claim asserted. By requiring an affidavit of merit, Civil Rule 10(D)(2) serves as a safeguard against unsubstantiated claims and prevents medical service providers and their insurers from having to incur the costs of defending against frivolous lawsuits. However, unless questions concerning the application and enforcement of Rule 10(D)(2) are resolved with finality prior to a plaintiff's prosecution of a medical claim, the rule is powerless against the meritless claims it was designed to prohibit. As a result, a decision denying a motion to dismiss a complaint for failure to comply with Civil Rule 10(D)(2) is properly construed as a final order subject to appellate review immediately upon its issuance.

A. The Background and Purpose of Civil Rule 10(D)(2) Demand that a Court's Denial of a Rule 10(D)(2) Motion to Dismiss be Immediately Subject to Appellate Review

For more than a decade, the Ohio General Assembly has been concerned about the escalating costs associated with frivolous medical claims filed against Ohio's physicians, hospitals, and other health care providers. In an early effort to curb the filing of frivolous claims against medical providers, the General Assembly enacted Ohio Revised Code 2307.42. This statute required that every complaint alleging medical negligence be accompanied by an affidavit of plaintiff or plaintiff's counsel stating that medical records had been requested for review from each defendant. In *Hiatt v. Southern Health Facilities, Inc.* (1994), 68 Ohio St. 3d 236, this Court invalidated R.C. 2307.42's requirement that an affidavit be filed contemporaneously with

a complaint alleging medical negligence on the basis that the statute conflicts with Civil Rule 11: “Since the conflict involves the form and content of the complaint to initiate a medical malpractice case, it is a procedural matter and, therefore, Civ. Rule 11 prevails over the statute, R.C. 2307.42.” *Hiatt*, 68 Ohio St. 3d at 238.

In response, the General Assembly adopted House Bill 350 in 1996, which required a plaintiff asserting a medical claim to file with the court a certificate of merit similar to the affidavit of merit at issue in this case. *See* R.C. 2305.011 [repealed]. The purpose of the new statutory requirement was to “respond to issues raised by the holding of the Supreme Court in *Hiatt*,” and “[t]o recognize the salutary effect that the certificate of merit provisions [would] have in reducing insupportable, frivolous claims, as unequivocally demonstrated in the hearings before the General Assembly.” H.B. 350, Section 5, Paragraph (H)(4).

Hoping “to join the legislatures of other states that similarly have found certificate of merit provisions to be an effective response to the escalating costs and burden of frivolous medical...malpractice claims,” the General Assembly enacted House Bill 350 with the goal of providing defendants relief from the burdens associated with defending against unsubstantiated complaints of medical negligence. H.B. 350, Section 5, Paragraph (H)(5). However, because the statute amended the civil pleading requirements and purported to affect a change in the procedural rules of Ohio courts in a manner not dissimilar to its predecessor, R.C. 2305.011 was struck down in *State ex rel. Ohio Academy of Trial Lawyers v. Sheward* (1999), 86 Ohio St.3d 451, and repealed by the General Assembly in June 2001. *See McCleery v. Leech* (2003), 2003-Ohio-1875, ¶5 n.1.

Thus, recognizing the need for a formal amendment to the Civil Rules in order to effectuate its goal of minimizing the costs of defending against meritless medical liability claims,

the General Assembly enacted Section 3 of House Bill 215 in July 2005. Section 3 of that Bill included a request that this Court amend the Civil Rules to require plaintiffs who assert medical liability claims to file a “certificate of expert review.” In addition, the bill also included, among other things, a requirement that medical malpractice insurers annually provide the Ohio Department of Insurance with detailed information about each and every claim asserted against a risk located in Ohio, so that the state can better track the costs of such claims. *See* R.C. 2939.302. In response, this Court adopted the affidavit of merit requirement now contained in Civil Rule 10(D)(2).

It is evident from the legislative history preceding the adoption of Rule 10(D)(2) that the General Assembly has been dedicated, for more than a decade, to responding to the escalating costs associated with frivolous claims of medical negligence. Rule 10(D)(2) was adopted by this Court in light of its considered judgment and the considered judgment of the General Assembly that the problem of frivolous medical liability claims needed to be addressed—and to be addressed at the source. In addition to Ohio, twenty-four other states have adopted similar pleading requirements designed to mitigate the costs incurred by defendants, and consequently by consumers of medical services, as the result of frivolous and unsubstantiated medical claims.¹ Ohio’s first line of defense against such claims requires consistent enforcement of Rule 10(D)(2).

Now, however, Appellee asks this Court to remove the substance from the rule by rendering it unenforceable whenever a trial court denies a motion to dismiss for failure to

¹ As of the filing of this brief the following states, in addition to Ohio, have adopted some form of certificate or affidavit pleading requirement in conjunction with medical liability claims: Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New York, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Washington, and West Virginia.

comply. The negative consequences of such an approach are at least twofold: First, failing to identify such decisions properly as final orders strips the rule of its practical effectiveness and increases the likelihood that the costs of frivolous lawsuits will continue to plague the State and its citizens. Second, declaring a decision denying a motion to dismiss under Rule 10(D)(2) to be anything other than a final order undermines respect for the Civil Rules themselves by diminishing their enforceability.

The costs associated with medical malpractice defense are staggering. Recent data collected by the Ohio Department of Insurance (“ODI”), as well as research conducted by scholars and practitioners illustrates that those costs have a significant impact on insurance and health care costs for all Ohioans. According to a recent ODI report, which was based on data collected from medical malpractice insurers under House Bill 215’s mandatory reporting provisions, the average cost of simply investigating and defending a medical malpractice claim in Ohio, excluding the cost of any payment to the claimant, is \$24,443. Ohio Medical Liability Closed Claim Report (“OMLCCR”), November 2006, p. 3 (a copy of which is attached hereto as Exhibit A). Yet almost eighty percent (80%) of all claims reported resulted in no indemnity payment from the insurer to the claimant. *Id.* This means that in 2005, 4,005 out of 5,051 claims that closed did not result in any payment to the claimant.² That is, claims determined

² Consistent with the findings in the OMLCCR, a recent study in the New England Journal of Medicine revealed that a number of medical liability claims could be kept out of the judicial system with an effective screening mechanism. A random sample of medical malpractice claims found that three percent (3%) of the claims involved “no verifiable medical injuries,” thirty-seven percent (37%) “did not involve errors,” and claims involving no errors accounted for twenty-two percent (22%) of administrative costs. See David M. Studdert, Michelle M. Mello, et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 New Eng. J. Med. 2024-2033 (2006) (taken from abstract, which can be found online at <http://content.nejm.org/cgi/content/short/354/19/2024>).

ultimately to have no merit imposed upon Ohioans nearly one hundred million dollars (\$100,000,000) in defense costs alone.

What is more, it is precisely these defense costs that constitute an unusually large proportion of insurance expenses and play a significant role in the cost of premiums. According to the Insurance Information Institute (“III”), approximately forty percent (40%) of all medical malpractice insurance expenses nationally can be attributed to defense costs that do not include payouts to claimants. Note, *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 Vand. L. Rev. 1457, 1472 (2006) (citing Mitchell J. Nathanson, *It's the Economy (and Combined Ration), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 Penn St. L. Rev. 1077 (2004)).

As a result, merely having to defend against medical malpractice claims -- the vast majority of which never result in payment to the claimant -- imposes tremendous costs on insurance companies and self-insured entities, which ultimately are passed on to health care providers and Ohio's citizens. And although some claims that do not produce a payout may lack merit without being entirely frivolous, it is also true that the costs associated with defending against a claim are substantial regardless of the merits of that claim. Indeed, “the mere filing of claims significantly affects defense costs, independently of how often plaintiffs recover damages.” Note, *Lessons Learned from the “Laboratories of Democracy”: A Critique of Federal Medical Liability Reform*, 91 Cornell L. Rev. 1159, 1198 (citing Nathanson, *supra*).

Rule 10(D)(2)'s affidavit requirement was adopted precisely to minimize the losses suffered by Ohioans associated with the costs of defending against claims that lack merit. As the Ohio Medical Malpractice Commission (the “OMMC”) stated in its Final Report and

Recommendations (“Final Report”) (a copy of which is attached hereto without exhibits as Exhibit B) in April 2005, “claims, settlements and lawsuits generate costs for insurance companies, whether or not any money is paid out to the claimant.” OMMC Final Report p. 13. Citing the “considerable testimony” heard by the OMMC, the Final Report notes that “these costs [of defending against medical malpractice claims] drive premium increases,” and that “[t]he failure to mitigate these costs will impact a provider’s liability premium *regardless of the underlying merits of the lawsuits involved*” (emphasis added). *Id.* Based in significant part on these concerns, which may be gleaned from the OMMC’s Interim Report, the General Assembly enacted H.B. 215 requesting the adoption of Rule 10(D)(2)’s affidavit of merit requirement. *Id.*

A plaintiff can fail to comply with Rule 10(D)(2) in many ways other than mere failure to file the affidavit of merit. For instance if the contents of the affidavit are insufficient and the affiant has not, in fact, “reviewed all medical records reasonably available to the plaintiff concerning the allegations in the complaint,” or if the expert affiant is not a specialist “familiar with the applicable standard of care,” a plaintiff has failed to comply with the rule. *See* Civ. R. 10(D)(2)(a)(i) and (ii). Thus, the substance of the affidavit, as much as the filing requirement itself, is a necessary condition to proceeding with a claim of medical liability against a defendant. As a result, those cases in which a defendant moves the court to dismiss a claim for failure to comply with Rule 10(D)(2) will be varied and diverse.

When a plaintiff has failed to comply with Rule 10(D)(2) and the defendant moves for dismissal on that basis, the court ultimately decides whether or not the defendant must bear the substantial burden, financial and otherwise, of mounting a defense to an unsubstantiated claim of liability. Thus, the denial of a motion to dismiss on Rule 10(D)(2) grounds effectively operates as a judgment against the defendant in the amount of the costs of defending the action, which, as

discussed above, are substantial no matter what the merits of the claim. However, except where the terms of the rule actually have been met (i.e., where a proper affidavit of merit has been filed with the complaint), this scenario is precisely what the General Assembly intended to avoid—the inequitable distribution of power in medical malpractice claims wherein plaintiffs hold medical care providers hostage for the value of defending against the lawsuit despite the fact that the claims asserted lack any merit at all. A ruling that a trial court’s decision with respect to such motions to dismiss is not a final order subject to immediate appellate review restores the very inequity that the rule is designed to correct. And, as the General Assembly recognized in House Bill 215, that inequity has repercussions not just for medical liability defendants, but also for health care and insurance providers and consumers throughout the State.

In addition to the real economic costs associated with disallowing immediate appeal of a court’s decision on a Rule 10(D)(2) motion to dismiss, there are consequences for the enforceability and integrity of the Rule itself. Given that the bases for a Rule 10(D)(2) motion to dismiss will not always be a simple question of whether or not an affidavit was filed, some plaintiffs will be willing to assert meritless claims with a defective, incomplete, or otherwise inadequate affidavit of merit on the chance that getting past the trial court will virtually guarantee the plaintiff, at a minimum, nuisance value in the form of a settlement. This willingness to cut corners around the Rule will be enhanced if opportunistic plaintiffs know that defendants are facing upwards of \$25,000 in expenses so long as they get past the trial court on questions concerning the sufficiency of the affidavit of merit.

Encouraging disregard of the rule by rendering it unenforceable at particular stages of litigation does a disservice not only to the litigants, but also to respect for the Civil Rules themselves. Rendering a decision of the court unappealable in defeat of the purpose of the Civil

Rules undermines the authority of the Rules. On the other hand, if a trial court's decision on a Rule 10(D)(2) motion is properly regarded as a final order subject to appeal, then the requirements set forth under the Rule will be respected and the purpose of the rule—to eliminate the costs associated with the unnecessary defense of frivolous claims—will be effectuated without sacrificing in any respect the right of a plaintiff to pursue claims that are, in fact, adequate and at least potentially meritorious as defined by the Rule.

B. The Plain Text of Rule 10(D)(2) and the Ohio Revised Code Mandate that a Decision to Deny a Motion under Rule 10(D)(2) is a Final Appealable Order

When a trial court renders a decision denying a motion to dismiss for failure to comply with Civil Rule 10(D)(2), it has issued an order with respect to a provisional remedy of which there can be no meaningful adjudication after a final judgment in the case. This, according to R.C. 2505.02, is the very definition of a final order:

(B) An order is a final order that may be reviewed, affirmed, modified, or reversed, with or without retrial, when it is one of the following:

(4) An order that grants or denies a provisional remedy and to which both of the following apply:

(a) The order in effect determines the action with respect to the provisional remedy and prevents a judgment in the action in favor of the appealing party with respect to the provisional remedy.

(b) The appealing party would not be afforded a meaningful or effective remedy by an appeal following final judgment as to all proceedings, issues, claims, and parties in the action.

In addition, according to the Revised Code, a provisional remedy is an ancillary proceeding that includes, but is not limited to, a proceeding for preliminary injunction, attachment, suppression of evidence, etc., as well as a prima facie showing as required in various provisions of the Revised Code. *See* R.C. 2505.02(A)(3). Rule 10(D)(2) provides relief to defendants in medical

malpractice cases that is entirely consistent with the definitions of “provisional remedy” and “final order” set forth in the Revised Code.

Both the text and purpose of Rule 10(D)(2) demonstrate that a decision to deny a motion to dismiss on grounds of failure to comply therewith is a decision with respect to a provisional remedy. By its own terms, the rule requires an affidavit of merit “solely to establish the adequacy of the complaint....” Civ. R. 10(D)(2)(c). And although the affidavit is filed with the court, it is not admissible as evidence nor may it be used for purposes of impeachment—i.e., it addresses the threshold question of the adequacy of the complaint and nothing more. *Id.* Thus, like the requirement of a prima facie showing under the Revised Code, the affidavit of merit is reasonably understood as part of a proceeding ancillary to and distinct from the main action.

Even more, because the purpose of the rule is to prevent plaintiffs from pursuing medical claims that lack merit, it is properly characterized as a provisional remedy. If a court grants a motion to dismiss on Rule 10(D)(2) grounds, then the decision will affect an order of dismissal, with or without prejudice to re-filing depending on the order of the court. Where the court denies a motion to dismiss brought on Civ. R. 10(D)(2) grounds, such a decision operates as a final order as to the provisional relief that the rule provides to the defendant—i.e., being relieved of the burden of having to defend against a frivolous claim. Thus, by resolving the question of the sufficiency of the complaint, the court ultimately renders a decision granting or denying a provisional remedy to the defendant.

In addition, a decision denying a motion to dismiss under Rule 10(D)(2) amounts to a decision as to a provisional remedy that cannot be adjudicated equitably on appeal *after* final judgment. See R.C. 2505.02(B)(4). If a motion to dismiss is denied and the defendant is forced to wait until final judgment before being permitted to challenge the decision, the provisional

remedy provided for by Rule 10(D)(2) ceases to be “meaningful or effective” as used in R.C. 2505.02(B)(4)(b). This is because the rule requiring an affidavit of merit exists for the purpose of preventing defendants from having to defend against frivolous claims in the first place. Withholding appellate review of a trial court’s decision on a motion to dismiss under Rule 10(D)(2) until after final judgment renders the rule impotent and the courts powerless to grant a defendant the provisional remedy of not having to defend against the unsubstantiated claim.

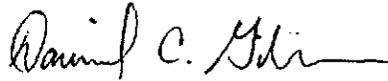
CONCLUSION

The failure to properly recognize a decision denying a Rule 10(D)(2) motion to dismiss as a final, appealable order runs contrary to Ohio law and defeats the purpose of the Rule in combating the costs associated with frivolous or otherwise unsubstantiated medical liability claims. Denying immediate appeal to a defendant under these circumstances severely undermines the ability of Ohio’s courts to effectuate the purposes of the Rule and to prevent insurers, health care providers, and consumers throughout the State from bearing the costs of frivolous claims. As an examination of the Revised Code and the text and purpose of Civ. R. 10(D)(2) reveals, a trial court’s decision in this context is a final order of the court, and any such decision is subject to appellate review immediately upon its issuance.

Simply put, if this Court reaches a contrary conclusion -- that denial of a motion to dismiss for failure to comply with Rule 10(D)(2) is not a final appealable order -- there is no meaningful remedy available to those defending themselves against frivolous or unsubstantiated medical claims.

For these reasons, *amici curiae* urge this Court to reverse the decision of the Twelfth District Court of Appeals and to hold that a decision denying a motion to dismiss for failure to comply with Civil Rule 10(D)(2) is a final order pursuant to R.C. 2505.02 and is subject to appellate review upon its issuance.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Brief of *Amici Curiae* was sent via regular U.S. mail, postage prepaid this 12th day of December 2006, to the following:

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APPENDIX

EXHIBITS

Ohio Medical Liability Closed Claim Report, November, 2006

Exhibit A

Final Report and Recommendations of the Ohio Medical
Malpractice Commission, April 2005

Exhibit B



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Ohio Medical Liability Closed Claim Report

November 2006

Ohio Medical Malpractice Closed Claim Report - 2005

I. Introduction

Pursuant to House Bill 215 and Ohio Administrative Rule 3901-1-64, the Department of Insurance hereby submits its first annual report to the General Assembly summarizing the Ohio medical liability closed claim data received by the Department for calendar year 2005.

II. Historical Overview

The Ohio Medical Malpractice Commission was created by legislation in 2003 to address the medical liability crisis in Ohio. That legislation, Senate Bill 281, also contained a comprehensive set of tort reforms aimed at reducing the costs of litigation and stabilizing the Ohio medical malpractice market.

While Senate Bill 281 contained a mechanism for collecting data on medical liability claims, testimony of the Department and county clerks before the Commission indicated difficulties and inefficiencies in obtaining reliable data with that system. As a result, the Commission recommended in its Interim Report the passage of legislation requiring more comprehensive data reporting.

Subsequently, the 125th General Assembly passed House Bill 215 enacting section 3929.302 of the Revised Code. All entities that provide medical malpractice insurance to health care providers located in Ohio, including authorized insurers, surplus lines insurers, risk retention groups and self-insurers, are required to report data to the Department regarding medical malpractice claims that close during the year. House Bill 215 authorized the Department to promulgate a rule outlining the procedures and reporting requirements. Ohio Administrative Rule 3901-1-64, which became effective on January 2, 2005, requires that each entity report the costs of defending medical liability claims and paying judgments and/or settlements on behalf of health care providers and health care entities.

House Bill 215 and Ohio Administrative Rule 3901-1-64 require the Department to prepare an annual report to the General Assembly summarizing the closed claim data on a statewide basis. They also stipulate that the data will be confidential and not subject to public record requests. As a result, this report summarizes data in order to maintain the confidentiality of the specific data filed by each reporting entity.

A copy of Ohio Revised Code 3929.302 and Ohio Administrative Rule 3901-1-64 are attached to this report as Appendices A and B.

III. Data Collection

A secured application on the Department's web site at www.ohioinsurance.gov captures the data elements required by Ohio Administrative Rule 3901-1-64,

Ohio Medical Malpractice Closed Claim Report - 2005

Medical Liability Data Collection. Data is due by May 1 for each medical, dental, optometric or chiropractic claim closed in the prior calendar year. A detailed user guide providing step-by-step instructions is located on the Department's web site at http://www.ohioinsurance.gov/agent/MLDC_UserGuide.pdf. Data collection methods from other states' insurance departments as well as input from the reporting entities were used in the development of this data reporting application.

IV. Description of Analysis

A claim is a demand for compensation due to alleged malpractice of a health care provider or facility. For the purposes of this report, and based on general practice, when an insurer or other insuring entity opens a file and begins to investigate the circumstances of a demand for compensation, a claim has occurred, whether or not a lawsuit is ever filed. When the file is closed for one of the many reasons detailed in this report, even when the claimant receives no payment, the claim is considered closed.

In this report, two primary pieces of data are analyzed:

- **Paid Indemnity:** The amount of compensation paid on behalf of each defendant to a claimant.
- **Allocated Loss Adjustment Expense (ALAE):** The expenses incurred by a reporting entity, other than paid indemnity, which relate to a specific claim, such as the costs of investigation and defense counsel fees and expenses. As a business practice, some of the reporting entities do not allocate loss adjustment expenses to a specific claim.

In this analysis, we organized and summarized the data to reflect the types of medical malpractice claims, the age and size of these claims, differences among regions of the state, differences among medical professionals, and several other categories.

This first annual report provides a one-year foundation in our analysis of medical malpractice claims in Ohio. Subsequent annual reports will build on this foundation, allowing trends to emerge.

V. Limitations of Analysis

The analysis is based entirely on historical closed claim data. That is, claims are reported to us and included in this analysis based on the year in which they reach a final outcome. Some arose from recent medical incidents, but most arose from incidents that occurred several years ago.

This report is not intended to be used to evaluate past or current medical liability insurance rates.

Ohio Medical Malpractice Closed Claim Report - 2005

In addition, this data does not reflect plaintiffs' attorney fees, which are not separately collected and cannot be broken out from this data or from any data available to the Department.

VI. Key Findings

Some important findings are evident in this first report. Greater detail is provided in the narrative describing the exhibits in Appendix C.

- **Total Claims:** A total of 5,051 claims were reported for 2005, by 91 entities. Authorized insurers¹ reported the majority of the claims, 3,325. Self-insured entities reported 1,516 claims; surplus lines insurers reported 172 claims; and risk retention groups reported 38 claims.
- **Indemnity Payments:** A large majority of medical malpractice claims resulted in no payment to a claimant. Four-fifths of the claims, 4,005, had no indemnity payments, while one-fifth of the claims, 1,046, closed with an indemnity payment. The total amount paid to claimants was \$281,764,938, an average of \$269,374 for those claims with an indemnity payment.
- **ALAE:** While most medical malpractice claims closed with no payments to claimants, almost all claims generated expenses for investigation and defense. The number of claims reported to have ALAE was 4,631. These expenses totaled \$113,194,565, an average of \$24,443 for claims with ALAE.
- **SB 281 Impact:** Twenty-four percent of the total claims, or 1,187, involved incidents that occurred after the enactment of SB 281, and therefore could have been subject to the revisions in Ohio tort law. However, none of these claims reached a trial or jury verdict, requiring separate detail of economic and non-economic damages. The average indemnity payment for these claims was \$171,299 and the average ALAE was \$9,044, well below the overall average figures for all claims. The larger claims subject to the provisions of SB 281 will likely take longer to close than those reported here for 2005.
- **Indemnity Payments and Age of Claim:** The amount paid to claimants increased with the age of the claim. Of the claims that closed with an

¹ Authorized (admitted) insurers are licensed to write business in the state; are subject to the Department's rate, policy form and solvency regulation; and are backed by the Ohio Insurance Guaranty Fund. Surplus lines insurers are not authorized and do not have guaranty fund backing, but are allowed to write policies for those doctors and hospitals that cannot obtain coverage from an authorized insurer. These companies must be on a list of accepted surplus lines insurers and are regulated for financial strength by their domiciliary state or country. Risk retention groups are permitted by federal law to cover the liability insurance risk of the group's members. These groups are not backed by the guaranty fund.

Ohio Medical Malpractice Closed Claim Report - 2005

indemnity payment, 188 closed within one year of being reported and had average paid indemnity of \$113,085. That figure rose to \$254,901 for 294 claims closing in their second year, and to \$326,435 for 287 closing in their third year. Sixteen claims closed seven or more years after being reported, having average paid indemnity of \$731,873.

- **ALAE and Age of Claim:** Allocated loss adjustment expense also increased with the age of the claim, starting with an average of \$6,076 for claims that closed in their first year, and rising to \$14,644 and \$36,104 for claims in their second and third years, respectively. For claims closing seven or more years after being reported, average ALAE was \$75,348.
- **Regional Comparisons:** Half of the claims, 2,561, came from Northeast Ohio. Of these, 492 had indemnity payments. More than half of the total amount paid to claimants arose from these claims, or \$149,129,183. This gave Northeast Ohio the highest average paid indemnity of \$303,108. The breakdown of average paid indemnity for the rest of Ohio, in descending order, is Southeast, \$268,075; Southwest, \$244,453; Central, \$242,354; and Northwest, \$224,235.
- **Specialty Comparisons:** When claims are broken down by specialty, Internal Medicine had the most at 287 with 41 of them resulting in paid indemnity averaging \$277,587. However, Orthopedic Surgery had the highest average paid indemnity of \$469,864 for 25 claims with payments, out of 163 reported claims.
- **Treatment Comparisons:** Injuries related to non-obstetric treatment, such as a failure or delay in treatment, produced the highest number of claims, 1,472, with 231 of these resulting in paid indemnity. Diagnosis-related incidents, such as failure to diagnose, delay in diagnosis, or misdiagnosis, produced 1,453 claims, with 234 having indemnity payments. Obstetrics-related claims totaled 245, with 239 of these involving birth injuries. Of these, 78 resulted in indemnity payments averaging \$567,625, the highest for any type of injury.

VII. Detailed Findings

This discussion corresponds to the exhibits attached as Appendix C. The reader is encouraged to review those exhibits for full details.

Claims by Outcome (Appendix C, Exhibits 1 and 2)

Reporting entities were asked to indicate the method of final disposition for each closed claim:

- Of the 5,051 claims that were closed in 2005, 79% closed with no indemnity payment. Included in this figure are five categories:

Ohio Medical Malpractice Closed Claim Report - 2005

- 64% of the claims closed when the claim or suit was abandoned or was dismissed without prejudice;
- 9% were dismissed by summary judgment or a directed verdict;
- 4% ended with a verdict for the defendant;
- 1% ended through a settlement;
- 1% ended with alternative dispute resolution.
- The remaining 21% of the claims closed with paid indemnity. Four categories of claims are included here:
 - 16% reached a settlement;
 - 3% used alternative dispute resolution;
 - 1% had a verdict for the plaintiff;
 - 0.3%² ended with a summary judgment or directed verdict for the plaintiff.

Another perspective is gained by grouping these outcomes together as follows:

- Claims that were dropped or dismissed without prejudice, and without an indemnity payment, form the largest group, 64%.
- Claims resulting in settlement are the next largest group, 18%. Of these, most had an indemnity payment.
- Claims with a summary judgment or a directed verdict comprise 10% of the total, with a large majority of these resulting in no indemnity payment.
- Claims that closed following alternative dispute resolution comprise 5% of the total, the majority of which resulted in indemnity payments.
- Finally, of the 5% of the claims that went to trial, most ended without indemnity payments.

This implies that claims ending with a settlement or through alternative dispute resolution were more likely to have indemnity payments to the plaintiff. Claims that ended with a trial or jury verdict were more likely to end in favor of the defendant.

Regardless of which of these outcomes applies, all categories of claims had expenses in the form of ALAE. That is, even though a claim may have closed without an indemnity payment, the claim was likely to generate investigation and legal expense. Exhibit 2 contains the details. Claims dropped or dismissed without prejudice had average ALAE of \$12,011. The 66 claims that reached settlement without an indemnity payment had the highest average ALAE, \$283,617.

Age of Claim (Appendix C, Exhibit 3)

This exhibit displays claims by age at the time of closing, and shows that average indemnity and average ALAE increased³ with the age of the claim. While claims

² Some of these breakdowns do not add up to 100% due to rounding. See Appendix C, Exhibits 1 and 2 for actual figures.

Ohio Medical Malpractice Closed Claim Report - 2005

that closed in their first year represent 23% of the total, they had the lowest average indemnity, \$113,085, and ALAE, \$6,076. These costs grew significantly as the claims aged. The oldest category, claims that closed at age seven or greater, had the highest average indemnity, \$731,873, and ALAE, \$75,348.

Claims by Size (Appendix C, Exhibit 4)

Of the 5,051 claims reported closed in 2005, only 21%, or 1,046, closed with an indemnity payment to a claimant. Of these, 65 claims, or 6%, had an indemnity payment greater than \$1 million. Indemnity payments for these claims totaled \$116,931,464, representing 41% of the total paid indemnity. Ninety-four claims with paid indemnity below \$1 million but at least \$500,000 represented 9% of the claims, but 24% of the total paid indemnity. This illustrates that 15% of the closed claims are associated with 65% of the total paid indemnity.

Claims by Insurer Type (Appendix C, Exhibit 5)

A total of 91 entities reported closed claim information to the Department. The reporting entities are categorized as authorized (admitted) insurance companies, surplus lines insurance companies, risk retention groups and self-insurers/captives. Of the 5,051 closed claims that were reported, 66% were reported by admitted insurance companies and 30% were reported by self-insurers/captives. Very few claims were reported as closed by surplus lines insurance companies or risk retention groups.

Claims by Region (Appendix C, Exhibits 6 & 7)

Claims were reported by county. However, an exhibit showing details by county would allow the reader to identify specific claims in those counties with very few claims reported in 2005, violating the requirement of confidentiality. In order to provide meaningful information regarding differences by location, we divided the state into five regions: Central, Northeast, Northwest, Southeast and Southwest. The counties within each region are show in Exhibit 5, while Exhibit 6 displays claim data for the regions.

More than half of the closed claims reported for 2005 were from the Northeast region. The Northeast region also had the largest average indemnity payment, while the Southwest region incurred the largest average allocated loss adjustment expense. Conversely, the Northwest region had the smallest average indemnity payment, while the Central region incurred the smallest average allocated loss adjustment expense.

³ While some age categories have values lower than younger age categories, this is likely due to the number of claims for just one year of data. Statistical tests for growth indicate that ALAE grew by approximately \$7,100 per claim per year, and paid indemnity grew by approximately \$55,000 per claim per year.

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Claims by Physician Specialty (Appendix C, Exhibit 8)

This exhibit shows the fifteen physician and surgeon specialties with the highest number of closed claims. All other specialties are grouped together as "Other" to maintain confidentiality. Internal Medicine had the most closed claims followed closely by Family Physicians & General Practitioners. An average of 15% of the claims against a physician or surgeon resulted in an indemnity payment.

Orthopedic surgery had the highest average paid indemnity, \$469,864, followed by Gastroenterology, \$447,727, and Neurology, \$409,722. The reader should be aware that one year of data is not sufficient to properly measure differences in costs by specialty. As additional years of data are gathered, this exhibit will become more informative.

Claims by Type of Injury (Appendix C, Exhibit 9)

The reporting entities identified the primary complaint or injury that led to the medical liability claim. Of the 5,051 claims reported as closed, 58% of the claims were closely split between two categories, Non-Obstetrical Medical Treatment and Diagnosis-Related. Non-Obstetrical Medical Treatment includes failure to treat, delay in treatment, and improper treatment. Diagnosis-Related includes failure to diagnose, misdiagnosis, and delay in diagnosis. Obstetrics-Related claims, including improper delivery method, improper management of pregnancy, and delay in delivery, had the highest average paid indemnity, \$389,591, and the highest average ALAE, \$90,965. These figures differ from those shown by physician and surgeon specialties because this exhibit includes all medical providers, including hospitals.

Birth Injury Claims (Appendix C, Exhibit 10)

Reporting entities identified whether the closed claim was due to a birth injury. Of the 5,051 claims reported, 239, or 5%, were identified as birth injury claims. Of these 239 birth injury claims, 33% resulted in an indemnity payment. The average indemnity payment of a birth injury claim was \$567,625, more than twice the overall average indemnity payment of \$269,374.

Severity of Injury (Appendix C, Exhibit 11)

Of the 5,051 claims reported as closed, 1,829 or 36% of the claims were due to the death of the injured party, with average paid indemnity of \$322,610. Injuries identified as "permanent grave" had average paid indemnity of \$914,418, more than three times the overall average indemnity payment. These include quadriplegia and brain damage, requiring lifelong dependent care.

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Age of Injured Person (Appendix C, Exhibit 12)

Of the 5,051 claims reported as closed, 71% of the claims were associated with adult claimants, age 18 to 64. Adults age 65 or greater were claimants in 20% of the claims. Infant and minor claimants represented 5% and 4% of the claims, respectively. Average indemnity payments for infants were the highest, \$571,685.

Gender of Injured Person (Appendix C, Exhibit 13)

For the 5,051 claims reported as closed, 57% of the claims reported the injured party as female and 43% reported the injured party as male. For both genders, approximately 20% of the claims resulted in an indemnity payment.

Location of Injury (Appendix C, Exhibit 14)

Reporting entities identified the location where the primary injury or complaint occurred that led to the medical liability claim. The greatest number of claims is due to incidents that occurred in the operating suite, followed closely by incidents that occurred in the medical professional's office. These two locations represent nearly 50% of the claims. While the largest average allocated loss adjustment expenses are due to injuries that occurred in the Obstetrics Department, the largest indemnity payments were made for injuries that occurred in the Recovery Room.

VII. Conclusion

This first annual report provides insight into the details of Ohio medical malpractice claims. Trends will emerge as additional years are included. Nevertheless, the data illustrates the following:

- Most of the claims closed without a payment to the plaintiff.
- Almost all of the claims had costs in the form of ALAE.
- Higher value claims tended to be older. Conversely, smaller claims closed faster.
- Northeast Ohio had the highest paid indemnity in total dollars, and in average dollars per claim, of any region in the state.
- Claims that went to trial were more likely to close with no indemnity payment, while those that settled or went through alternative dispute resolution were more likely to close with paid indemnity.
- Although 24% of total claims were subject to SB 281, insufficient data exists to draw any conclusions yet as to its impact.

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Appendix A

§ 3929.302. Collection and disclosure of medical claims data.

(A) The superintendent of insurance, by rule adopted in accordance with Chapter 119. of the Revised Code, shall require each authorized insurer, surplus lines insurer, risk retention group, self-insurer, captive insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, and any other entity that provides medical malpractice insurance to risks located in this state, to report information to the department of insurance at least annually regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in any of the following results:

- (1) A final judgment in any amount;
- (2) A settlement in any amount;
- (3) A final disposition of the claim resulting in no indemnity payment on behalf of the insured.

(B) The report required by division (A) of this section shall contain such information as the superintendent prescribes by rule adopted in accordance with Chapter 119. of the Revised Code, including, but not limited to, the following information:

- (1) The name, address, and specialty coverage of the insured;
- (2) The insured's policy number;
- (3) The date of the occurrence that created the claim;
- (4) The name and address of the injured person;
- (5) The date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic loss, noneconomic loss and, if applicable, punitive damages;
- (6) In the case of a settlement, the date and amount of the settlement;
- (7) Any allocated loss adjustment expenses;
- (8) Any other information required by the superintendent pursuant to rules adopted in accordance with Chapter 119. of the Revised Code.

(C) The superintendent may prescribe the format and the manner in which the information described in division (B) of this section is reported. The superintendent may, by rule adopted in accordance with Chapter 119. of the Revised Code, prescribe the frequency that the information described in division (B) of this section is reported.

(D) The superintendent may designate one or more rating organizations licensed pursuant to section 3937.05 of the Revised Code or other agencies to assist the superintendent in gathering the information, and making compilations thereof, required by this section.

(E) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting under this section or its agents or employees, or the department of insurance or its employees, for any action taken that is authorized under this section.

(F) The superintendent may impose a fine not to exceed five hundred dollars against any person designated in division (A) of this section that fails to timely submit the report required under this section. Fines imposed under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created under section 3901.021 [3901.02.1] of the Revised Code.

(G) Except as specifically provided in division (H) of this section, the information required by this section shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person.

(H) The department of insurance shall prepare an annual report that summarizes the closed claims reported under this section. The annual report shall summarize the closed claim reports on a statewide basis, and also by specialty and geographic region. Individual claims data shall not be released in the annual report. Copies of the report shall be provided to the members of the general assembly.

(I) (1) Except as specifically provided in division (I)(2) of this section, any information submitted to the department of insurance by an attorney, law firm, or legal professional association pursuant to rules promulgated by the Ohio supreme court shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information submitted is not subject to discovery or subpoena and shall not be made public by the department of insurance or any other person.

(2) The department of insurance shall summarize the information submitted by attorneys, law firms, and legal professional associations and include the information in the annual

report required by division (H) of this section. Individual claims data shall not be released in the annual report.

(J) As used in this section, medical, dental, optometric, and chiropractic claims include those claims asserted against a risk located in this state that either:

- (1) Meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 [2305.11.3] of the Revised Code;
- (2) Have not been asserted in any civil action, but that otherwise meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 [2305.11.3] of the Revised Code.

HISTORY: 150 v H 215, § 1, eff. 9-13-04; 150 v H 425, § 1, eff. 4-27-05.

The provisions of § 3 of H.B. 425 (150 v -) read as follows:

SECTION 3. The General Assembly hereby requests the Ohio Supreme Court adopt rules of professional conduct that require any attorney who provides representation to a person bringing a medical, dental, optometric, or chiropractic claim to file with the Department of Insurance or its designee under division (D) of section 3929.302 of the Revised Code a report describing the attorney fees and expenses received for such representation, as well as any other data necessary for the Department of Insurance to reconcile the attorney fee and expense data with other medical malpractice closed claim data received by the Department of Insurance pursuant to rules promulgated under section 3929.302 of the Revised Code. The General Assembly hereby requests that any rules adopted by the Ohio Supreme Court define medical, dental, optometric, and chiropractic claims in the same manner as section 3929.302 of the Revised Code and require the filing of a report with the Department of Insurance if the medical, dental, optometric, or chiropractic claim results in a final judgment or settlement in any amount or a final disposition of the claim resulting in no indemnity payment to the claimant.

Effect of Amendments

150 v H 425, effective April 27, 2005, inserted (I) and redesignated former (I) as (J).

Ohio Medical Malpractice Closed Claim Report - 2005

Appendix B

3901-1-64 Medical liability data collection.

(A) Purpose The purpose of this rule is to establish procedures and requirements for the reporting of specific medical, dental, optometric and chiropractic claims data to the Ohio Department of Insurance.

(B) Authority This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and 3929.302 of the Revised Code.

(C) Definitions

(1) "Medical, dental, optometric and chiropractic claims" include those claims asserted against a risk located in this state that either:

(a) Meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code, or

(b) Have not been asserted in any civil action, but that otherwise meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code.

(2) "Risk retention group" has the same meaning as in section 3960.02 of the Revised Code.

(3) "Surplus lines insurer" means an insurer that is not licensed to do business in this state, but is nonetheless approved by the department to offer insurance because coverage is not available through licensed insurers.

(4) "Self-insurer" means any person or persons who set aside funds to cover liability for future medical, dental, optometric or chiropractic claims or that otherwise assume their own risk or potential loss for such claims. "Self-insurer" includes captives.

(D) Each authorized insurer, surplus lines insurer, risk retention group, self-insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, or any other entity that offers medical malpractice insurance to, or that otherwise assumes liability to pay medical, dental, optometric or chiropractic claims for, risks located in this state, shall report at least annually to the superintendent of insurance, or to the superintendent's designee, information regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in:

(1) A final judgment in any amount,

(2) A settlement in any amount, or

(3) A final disposition of the claim resulting in no indemnity payment on behalf of the covered person or persons.

(E) The report required by division (D) shall include for each claim:

- (1) The name, address and specialty coverage of each covered person;
- (2) The insured's policy number, if applicable;
- (3) The date of the occurrence that created the claim;
- (4) The name and address of the injured person;
- (5) The date the claim was reported and the claim number;
- (6) The injured person's age and sex;
- (7) If the medical, dental, optometric, or chiropractic claim was filed with the court, the case number and the name and location of the court;
- (8) In the case of a judgment, the date and amount of the judgment and, if the judgment is subject to the itemization requirements in section 2323.43(B) of the Revised Code, a description of the portion of the judgment that represents economic loss, non-economic loss and punitive damages, if any;
- (9) In the case of a settlement, the date and amount of the settlement and, if known, the injured person's incurred medical expense, wage loss, and other expenses;
- (10) Any loss adjustment expenses allocated to the claim or, if known, the amount allocated to each covered person;
- (11) The loss adjustment expense, broken down between fees and expenses, paid to defense counsel;
- (12) The date and reason for final disposition, if no judgment or settlement, and the type of disposition;
- (13) Unless disclosure is otherwise prohibited by state or federal law, a summary of the occurrence which created the claim which shall include:
 - (a) The name of the institution, if any, and the location at which the injury occurred;
 - (b) The operation, diagnosis, treatment, procedure or other medical event or incident giving rise to the alleged injury;
 - (c) A description of the principal injury giving rise to the claim.

(F) Frequency The report(s) required by this rule shall be filed with the superintendent, or the superintendent's designee, on or before May 1 of each year, and shall contain information for the previous calendar year.

(G) Noncompliance Any person listed in division (D) that fails to timely submit the report required under this section shall be subject to a fine not to exceed \$ 500.00.

(H) Confidentiality Information reported to the superintendent or the superintendent's designee pursuant to this rule shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person, including any rating organizations or other agencies designated by the superintendent to gather and/or compile the information.

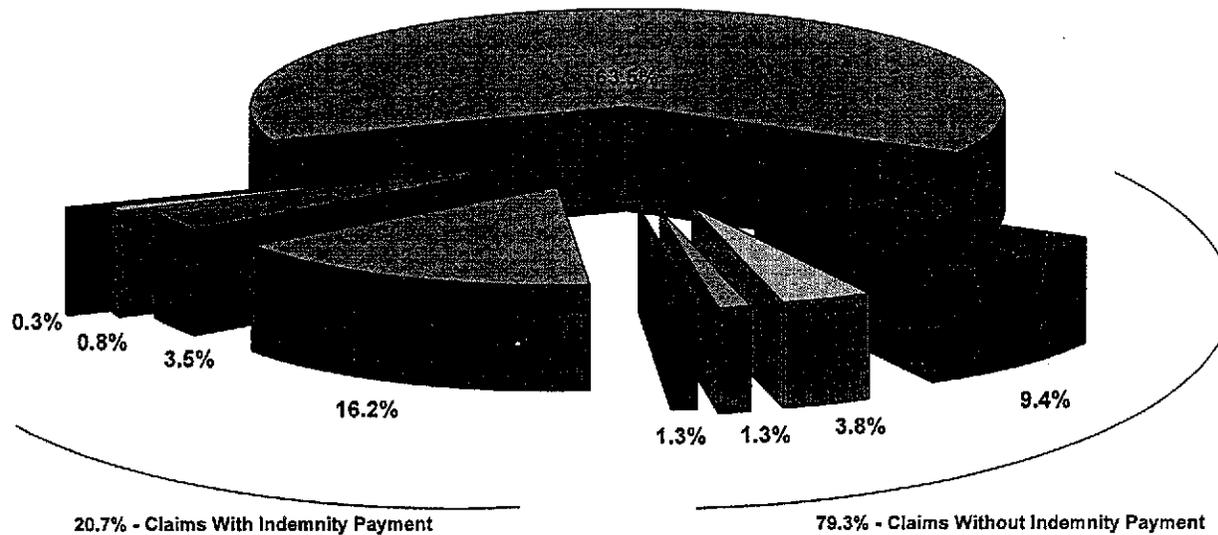
(I) The requirements of this rule do not apply to reinsurers, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

HISTORY: Eff. 01/02/2005
Promulgated Under: 119.03
Statutory Authority: 3901.041, 3929.302
Rule Amplifies: 3929.302
R.C. 119.032 review dates: 12/30/2008

Ohio Medical Malpractice Closed Claim Report - 2005

Appendix C

OHIO Closed Claims in 2005 Outcome of Malpractice Claims 5051 Closed Claims



- 63.5% Claim/Suit Abandoned Without Indemnity Payment, Including Dismissed Without Prejudice
- 9.4% Dismissed by Court - Summary Judgment/Directed Verdict - Without Indemnity
- 3.8% Disposed by Trial Verdict/Jury Verdict - Without Indemnity
- 1.3% Disposed by Settlement Agreement - Without Indemnity
- 1.3% Disposed by Alternative Dispute Resolution - Without Indemnity
- 16.2% Disposed by Settlement Agreement - With Indemnity
- 3.5% Disposed by Alternative Dispute Resolution - With Indemnity
- 0.8% Disposed by Trial Verdict/Jury Verdict - With Indemnity
- 0.3% Dismissed by Court - Summary Judgment/Directed Verdict - With Indemnity

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Final Disposition

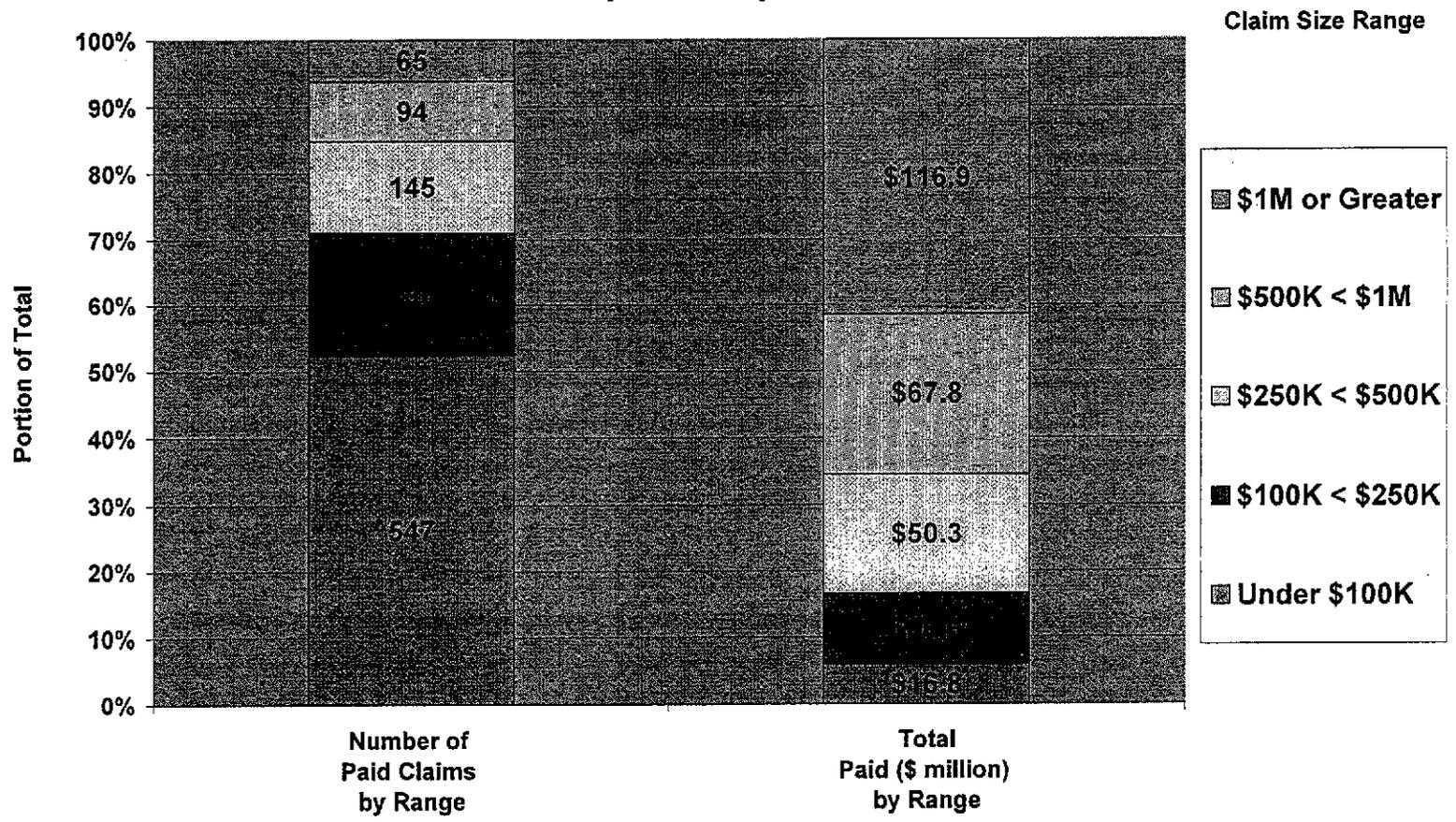
FINAL DISPOSITION DESCRIPTION	TOTAL CLAIMS	AVG	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Claim/Suit Abandoned Without Indemnity Payment, Including Dismissed Without Prejudice -- Without Indemnity	3208	63.5%	2993	\$35,950,032	\$12,011	0	\$0	\$0
Dismissed by Court -Summary Judgment/Directed Verdict -- Without Indemnity	473	9.4%	434	\$6,878,849	\$15,850	0	\$0	\$0
Disposed by Trial Verdict/Jury Verdict -- Without Indemnity	194	3.8%	191	\$13,178,053	\$68,995	0	\$0	\$0
Disposed by Settlement Agreement -- Without Indemnity	66	1.3%	51	\$14,464,484	\$283,617	0	\$0	\$0
Disposed by Alternative Dispute Resolution -- Without Indemnity	64	1.3%	64	\$230,660	\$3,604	0	\$0	\$0

FINAL DISPOSITION DESCRIPTION	TOTAL CLAIMS	AVG	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Disposed by Settlement Agreement -- With Indemnity	818	16.2%	680	\$29,637,547	\$43,585	818	\$200,300,256	\$244,866
Disposed by Alternative Dispute Resolution -- With Indemnity	175	3.5%	166	\$8,571,532	\$51,636	175	\$55,421,480	\$316,694
Disposed by Trial Verdict/Jury Verdict -- With Indemnity	39	0.8%	39	\$3,719,130	\$95,362	39	\$24,284,263	\$622,673
Dismissed by Court -Summary Judgment/Directed Verdict -- With Indemnity	14	0.3%	13	\$564,279	\$43,406	14	\$1,758,940	\$125,639
TOTALS and AVERAGES:	5051	100.0%	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Age of Claim

AGE IN YEARS	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Less Than 1	1165	936	\$5,687,478	\$6,076	188	\$21,260,009	\$113,085
1 But Less Than 2	1585	1483	\$21,716,580	\$14,644	294	\$74,940,826	\$254,901
2 But Less Than 3	1248	1209	\$43,649,696	\$36,104	287	\$93,686,788	\$326,435
3 But Less Than 4	572	545	\$19,328,165	\$35,465	151	\$40,996,457	\$271,500
4 But Less Than 5	286	277	\$12,056,208	\$43,524	63	\$25,421,292	\$403,513
5 But Less Than 7	153	148	\$8,269,970	\$55,878	47	\$13,749,597	\$292,545
7 or Greater	42	33	\$2,486,469	\$75,348	16	\$11,709,970	\$731,873
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
By Size of Payment

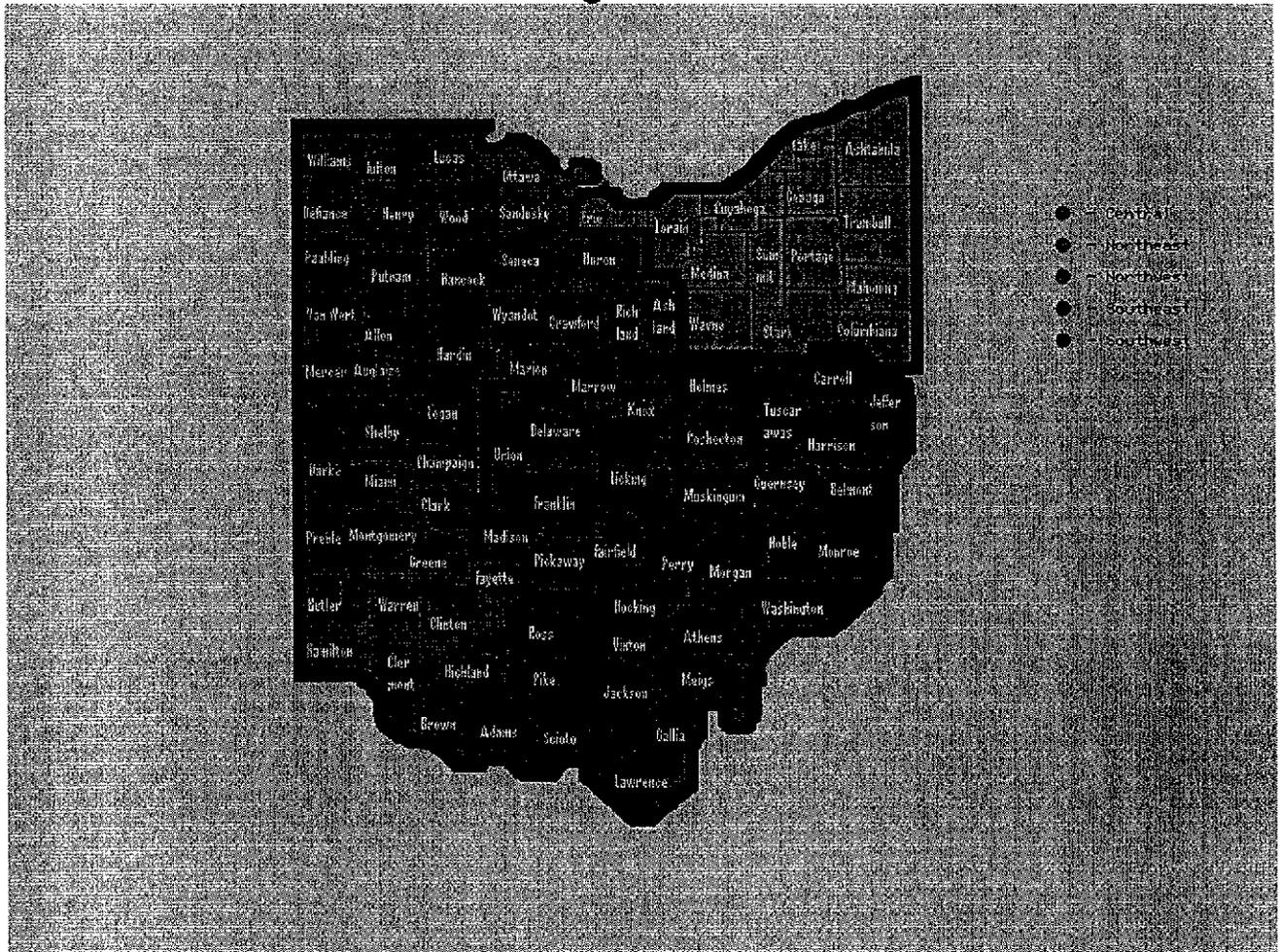


OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Insurer Type

Appendix C, Exhibit 5

INSURING ENTITY TYPE	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Insurance Company - Authorized/Admitted	3325	3139	\$66,631,466	\$21,227	596	\$167,097,194	\$280,364
Insurance Company - Surplus Lines	172	139	\$3,395,231	\$24,426	32	\$7,538,146	\$235,567
Risk Retention Group	38	34	\$419,734	\$12,345	4	\$1,787,500	\$446,875
Self Insurers (Captives)	1516	1319	\$42,748,134	\$32,410	414	\$105,342,098	\$254,450
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

Closed Claims 2005 Regions



The counties displayed on the map include the following:

Central:

Delaware, Fairfield, Franklin, Licking, Madison, Pickaway, Union

Northeast:

Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Wayne

Northwest:

Allen, Ashland, Auglaize, Crawford, Defiance, Fulton, Hancock, Hardin, Henry, Huron, Knox, Logan, Lucas, Marion, Mercer, Morrow, Ottawa, Paulding, Putnam, Richland, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood, Wyandot

Southeast:

Adams, Athens, Belmont, Carroll, Coshocton, Gallia, Guernsey, Harrison, Hocking, Holmes, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Tuscarawas, Vinton, Washington

Southwest:

Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Warren

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Region

Appendix C, Exhibit 7

STATE REGION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Central	616	539	\$10,284,732	\$19,081	116	\$28,113,006	\$242,354
Northeast	2561	2383	\$53,265,564	\$22,352	492	\$149,129,183	\$303,108
Northwest	771	711	\$15,208,661	\$21,391	174	\$39,016,878	\$224,235
Southeast	217	192	\$3,905,565	\$20,341	51	\$13,671,845	\$268,075
Southwest	878	798	\$30,421,862	\$38,123	212	\$51,824,026	\$244,453
Unknown	8	8	\$108,182	\$13,523	1	\$10,000	\$10,000
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Physician Specialty

PHYSICIAN SPECIALTY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Internal Medicine	287	276	\$6,210,226	\$22,501	41	\$11,381,077	\$277,587
Family Physicians\General Practioners	264	250	\$5,744,996	\$22,980	48	\$13,283,157	\$276,732
Emergency Medicine	215	201	\$4,349,156	\$21,638	17	\$6,490,516	\$381,795
Obstetrics/Gynecology	215	202	\$5,913,695	\$29,276	56	\$15,572,665	\$278,083
Surgery - General	212	207	\$5,000,652	\$24,158	34	\$8,909,498	\$262,044
Surgery - Orthopedic	163	157	\$2,982,683	\$18,998	25	\$11,746,604	\$469,864
Radiology	160	157	\$2,209,833	\$14,075	18	\$4,152,999	\$230,722
Anesthesiology	103	95	\$2,111,428	\$22,226	22	\$6,216,350	\$282,561
Neurology	92	89	\$1,114,780	\$12,526	9	\$3,687,500	\$409,722
Cardiovascular Disease	89	87	\$2,139,088	\$24,587	9	\$2,440,000	\$271,111

PHYSICIAN SPECIALTY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Gastroenterology	59	56	\$1,335,731	\$23,852	11	\$4,924,999	\$447,727
Surgery - Plastic	42	41	\$601,418	\$14,669	8	\$2,354,900	\$294,363
Pediatrics	37	35	\$628,742	\$17,964	5	\$1,455,000	\$291,000
Urology	37	36	\$550,606	\$15,295	6	\$2,022,161	\$337,027
Ophthalmology	36	35	\$606,999	\$17,343	11	\$3,060,000	\$278,182
Other	438	414	\$7,944,683	\$19,190	59	\$22,398,771	\$379,640
TOTALS and AVERAGES:	2449	2338	\$49,444,715	\$21,148	379	\$120,096,197	\$316,877

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Injury

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Medical Treatment, Non-Obstetrical (Failure to Treat, Delay in Treatment, Improper Treatment, etc.)	1472	1371	\$25,877,007	\$18,875	231	\$57,938,197	\$250,815
Diagnosis-Related (Failure To Diagnose, Misdiagnosis, Delay In Diagnosis, etc.)	1453	1361	\$31,763,943	\$23,339	234	\$76,470,035	\$326,795
Surgery-Related (Delay in Surgery, Improper Performance of Surgery, etc.)	903	847	\$17,304,405	\$20,430	148	\$52,788,979	\$356,682
Other (No Listed Category Applies)	253	206	\$3,596,540	\$17,459	47	\$8,676,742	\$184,612

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Obstetrics-Related (Improper Delivery Method, Improper Management of Pregnancy, Delay in Delivery, etc.)	245	233	\$21,194,790	\$90,965	81	\$31,556,854	\$389,591
Safety & Security-Related (Falls, Failure To Ensure Safety, Failure to Protect From Assault)	177	138	\$2,409,208	\$17,458	104	\$5,727,692	\$55,074
Patient Monitoring-Related (Failure to Monitor, etc.)	176	153	\$4,373,382	\$28,584	82	\$27,109,676	\$330,606
Blood-Related (Wrong Blood Type, Contaminated Blood, etc.)/Medication-Related (Failure to Order, Wrong Medication, Wrong Dosage, etc.)	168	148	\$3,406,511	\$23,017	49	\$12,154,146	\$248,044
Breach of Confidentiality/Communication-Related (Failure To Instruct, Failure to Obtain Consent, etc.)	68	63	\$1,314,823	\$20,870	21	\$2,683,277	\$127,775

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Equipment-Related (Improper Use of Equipment, Improper Maintenance, Equipment Failure/Malfunction, etc.)	60	49	\$741,891	\$15,141	27	\$2,113,023	\$78,260
Anesthesia-Related (Improper Choice, Improper Administration, etc.)	41	35	\$733,711	\$20,963	11	\$3,483,762	\$316,706
Policies & Procedures-Related (Failure To Follow, Negligent Credentialing, etc.)/Supervision-Related (Supervision of Residents, Nurses, etc.)	33	25	\$462,386	\$18,495	11	\$1,062,554	\$96,596
Unknown	2	2	\$15,970	\$7,985	0	\$0	\$0
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Birth Injury

Appendix C, Exhibit 10

BIRTH INJURY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
No	4810	4406	\$91,655,313	\$20,802	968	\$237,490,192	\$245,341
Yes	239	223	\$21,523,283	\$96,517	78	\$44,274,747	\$567,625
Unknown	2	2	\$15,970	\$7,985	0	\$0	\$0
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Severity

SEVERITY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Death	1829	1738	\$43,308,095	\$24,918	342	\$110,332,470	\$322,610
Emotional	131	109	\$1,583,637	\$14,529	25	\$914,249	\$36,570
Permanent Grave	134	129	\$4,597,568	\$35,640	25	\$22,860,458	\$914,418
Permanent Major	584	547	\$18,670,981	\$34,133	122	\$82,061,240	\$672,633
Permanent Minor	400	370	\$6,585,258	\$17,798	96	\$14,784,023	\$154,000
Permanent Significant	588	560	\$23,094,629	\$41,240	105	\$31,528,265	\$300,269
Temporary Low Significance	211	180	\$1,300,671	\$7,226	21	\$130,705	\$6,224
Temporary Major	527	455	\$7,184,366	\$15,790	159	\$13,201,445	\$83,028
Temporary Minor	645	541	\$6,853,392	\$12,668	151	\$5,952,084	\$39,418
Unknown	2	2	\$15,970	\$7,985	0	\$0	\$0
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Age

Appendix C, Exhibit 12

AGE RANGE	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Adult (Ages 18-64)	3566	3264	\$63,229,386	\$19,372	621	\$162,966,569	\$262,426
Senior (Age 65+)	986	902	\$19,154,778	\$21,236	259	\$36,619,343	\$141,387
Infant (Less than 1 year old)	271	255	\$23,201,638	\$90,987	96	\$54,881,741	\$571,685
Minor (Ages 1 to 17)	206	190	\$7,076,216	\$37,243	62	\$24,029,978	\$387,580
Unknown	22	20	\$532,547	\$26,627	8	\$3,267,308	\$408,414
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Gender

GENDER	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Female	2860	2613	\$66,510,458	\$25,454	605	\$146,591,383	\$242,300
Male	2189	2016	\$46,668,138	\$23,149	441	\$135,173,556	\$306,516
Unknown	2	2	\$15,970	\$7,985	0	\$0	\$0
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

OHIO
2005 Closed Claims
ALAE and Indemnity Payments by Location

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Operating Suite (Includes Pre-Op & Operating Rooms)	1198	1118	\$23,045,820	\$20,613	211	\$71,343,692	\$338,122
Medical Professional's Office	1163	1106	\$19,470,653	\$17,605	205	\$50,293,484	\$245,334
Emergency Room/Emergency Department	751	677	\$16,296,345	\$24,071	105	\$25,292,623	\$240,882
Patient's Room, Including Patient Bathroom or Inpatient Areas Not Otherwise Specified	512	447	\$9,716,343	\$21,737	136	\$25,372,765	\$186,564

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Obstetrics Department (Labor & Delivery, Recovery & Post-Partum)	270	249	\$21,455,207	\$86,165	87	\$42,535,644	\$488,915
Radiology (Includes Mammography, CT, MRI, Radiation Therapy & Nuclear Medicine)	210	198	\$3,062,131	\$15,465	37	\$6,031,793	\$163,021
Other (No Listed Location Applies)	207	165	\$4,082,820	\$24,744	40	\$8,978,882	\$224,472
Outpatient/Ambulatory Care Areas or Facilities	151	138	\$2,426,547	\$17,584	35	\$10,667,951	\$304,799
Nursing Home (Includes Assisted Living, Extended Care & Long-Term Care)	149	137	\$2,995,918	\$21,868	57	\$4,786,254	\$83,969

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Critical Care Unit (ICU/CCU/NICU)	144	136	\$3,145,980	\$23,132	25	\$10,147,476	\$405,899
Special Procedure Room (Includes Cardiac Cath Lab, EEG, Dialysis, Endoscopy, Sleep Lab, etc.)	89	78	\$2,558,195	\$32,797	26	\$4,257,090	\$163,734
Patient's Home	53	51	\$1,329,821	\$26,075	15	\$5,614,000	\$374,267
Ancillary Services (Includes Laboratory, Pharmacy, and Blood Bank)	41	34	\$817,947	\$24,057	17	\$6,350,827	\$373,578
Physical Therapy Dept.	23	22	\$305,304	\$13,877	13	\$1,232,250	\$94,788

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Mental Health (Includes Psychiatric and Drug & Alcohol Addiction)	21	15	\$403,466	\$26,898	6	\$915,000	\$152,500
Recovery Room (Post-Anesthesia Care Unit)	18	17	\$442,225	\$26,013	5	\$2,678,641	\$535,728
Facility Support Areas (Including Administrative Areas, Hallways, Elevators, Cafeteria, Gift Shop & Public Restrooms)	16	9	\$115,642	\$12,849	8	\$121,969	\$15,246
Hospice Area or Facility	10	9	\$307,507	\$34,167	7	\$308,007	\$44,001
Unknown	2	2	\$15,970	\$7,985	0	\$0	\$0
TOTALS and AVERAGES:	5051	4631	\$113,194,565	\$24,443	1046	\$281,764,938	\$269,374

FINAL REPORT AND RECOMMENDATIONS
OF THE
OHIO MEDICAL MALPRACTICE COMMISSION

APRIL 2005

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I. INTRODUCTION

Overview

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

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.