SB 2656

Measure Title:	RELATING TO MEDICAL TORTS.
Report Title:	Medical Torts; Medical Malpractice Insurance; Claims in Excess of Liability Limits
Description:	Establishes the injured patients and families compensation fund to pay the portion of a medical tort claim that exceeds the liability limit of a health care provider's insurance coverage. Requires participating health care providers to have a minimum level of insurance coverage. Provides for assessment of fees and peer council review of claims paid.
Companion:	
Package:	None
Current Referral:	CPN, WAM
Introducer(s):	BAKER, Espero, Fukunaga, Ige, Taniguchi

Sort by Date		Status Text
1/25/2012	S	Introduced.
1/25/2012	S	Passed First Reading.
1/25/2012	S	Referred to CPN, WAM.
1/27/2012	S	The committee(s) on CPN has scheduled a public hearing on 02-07-12 9:30AM in conference room 229.

NEIL ABERCROMBIE
GOVERNOR

BRIAN SCHATZ
LT. GOVERNOR

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KEALI'I S. LOPEZ
DIRECTOR

TO THE SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

TWENTY-SIXTH LEGISLATURE
Regular Session of 2012

Tuesday, February 7, 2012
9:30 a.m.

TESTIMONY ON SENATE BILL NO. 2656 – RELATING TO MEDICAL TORTS.

TO THE HONORABLE ROSALYN H. BAKER, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department does not support this bill.

The purpose of this bill is add a new chapter in Title 24 to establish the injured patients and families compensation fund (Part I) and the injured patients and families compensation fund peer review council (Part II).

The fund would serve as a secondary source for the payment of a tort claim in excess of the liability limit for which the health care provider is insured, with coverage beginning July 1, 2013. Funding would be provided by health care provider fees based on various factors outlined in § -7. The fund would be managed by an 13-member board of governors administratively attached to the Insurance Division and staffed by Insurance Division personnel or by independent contractors. The Commissioner would be required to adopt rules establishing the fees approved by the board of governors; the

board of governors would be required to adopt rules providing for an automatic increase in the fees.

Appointed by the board of governors, the five-member peer review council would be required to review claims paid by the fund, private heath care liability insurers, or self-insurers and to make recommendations to the board of governors. Funding for the council would be provided by fees assessed on the fund and all private health care liability insurers.

The Insurance Division does not have staff with the expertise to operate the fund and to administer these claims. As currently drafted, the bill does not contain an appropriation for the hiring of contractors. The Department notes that this proposal sounds similar to the patient compensation fund, which was repealed in 1984.

We thank this Committee for the opportunity to present testimony on this matter and ask for your favorable consideration.

OFFICE OF INFORMATION PRACTICES

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To: Senate Committee on Commerce and Consumer Protection

From: Cheryl Kakazu Park, Director

Date: February 7, 2012, 9:30 a.m.
State Capitol, Room 229

Re: Testimony on S.B. No. 2656
Relating to Medical Torts

Thank you for the opportunity to submit testimony on S.B. No. 2656.

OIP takes no position on the substance of this bill. OIP is concerned, however, about the proposed section ___-8(b), beginning at bill page 10, line 19, which specifies that the funds records are government records under the Uniform Information Practices Act, "with the exception of confidential claims information, which shall be exempt from disclosure pursuant to section 92F-13."

This provision as written seems to state that the confidential claims information is not a government record subject to the UIPA, but is also subject to an unspecified exception to disclosure under the UIPA. A record that is subject to an exception to disclosure is still a government record, even though it need not be disclosed to a requester. If this Committee's intent is to make "confidential claims information" confidential, then OIP would suggest that the clause be replaced with "provided that confidential claims information shall be confidential."

OIP would further recommend that this Committee provide better guidance as to what it intends to make confidential. The phrase "confidential claims information" by itself leaves unclear whether it is intended to be limited to patient

information of the sort that would carry a significant privacy interest, or whether it is intended to cover all records relating to claims, which would likely be broader than necessary to protect patient privacy or health care providers' confidential business information.

Thank you for the opportunity to testify.

HAWAII MEDICAL ASSOCIATION
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Tuesday, February 7, 2012
9:30am
CR 229

To: COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Sen. Rosalyn H. Baker, Chair
Sen. Brian T. Taniguchi, Vice Chair

From: Hawaii Medical Association
Dr. Roger Kimura, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: **SB2656 RELATING TO MEDICAL TORT**

In Opposition

Chairs & Committee Members:

The Patient Compensation Fund models arose during the medical tort crisis of the 1970's and early 1980's. States who put these funds into statute, including Hawaii, soon found them fraught with problems ranging from increasing expenses to vulnerability to large lawsuits. The Hawaii plan established in 1979 or 1980 was no different, and was bankrupt and terminated by the legislature four years later. This was also the case in many other states enacting this legislation, including recent abandonment of Funds in Florida and Pennsylvania, and the contemplated closure of the South Carolina Fund. Those states that have been able to make Patient Compensation Funds work have accomplished this through the inclusion of protections to the Fund.

The bill before us, SB2656, is modeled after that of the Wisconsin Injured Patients and Families Fund. What is conspicuous in comparison of the two Funds is the absence of key protective measures in SB2656, namely the limitation on attorney's contingency fees (25 to 33% of the first $1,000,000, and 20% thereafter) and the $750,000 cap on non-economic damages. These limitations, in varying amounts, have been set up in virtually all of the successful state Funds, and have become generally accepted as a requirement for success.

A second problem with the proposed Patient Compensation Fund is the duplicity created between attorneys representing the defendant and a second set representing the fund. Past experience in Hawaii, as well as mainland funds, tells of conflict and disagreement between the plaintiff insurer and Fund attorneys, adding to increased costs for both sides, which all translate into increased costs for physicians.

Additional duplicity is also present in SB2656, in that the Peer Review Council established by this statute may be redundant with the function currently performed by Hawaii's Medical Claims Conciliation Panel.

In that the physician requirement to carry $1 million/$3 million in coverage under the Patient Compensation Fund is unchanged from that currently required, this cost to physicians remains as current. The additional assessment to the 3,000 actively practicing physicians in Hawaii to pay for the operation and compensation from the fund will result in a net increase in costs to this small population, resulting in an outcome contrary to the stated goal of the plan.
We appreciate the Senate's efforts to improve the liability issues of physicians, however it is our opinion this Patient Compensation Fund is not the vehicle with which to accomplish this goal. We are looking forward to a continued effort of all health care stakeholders to find a solution to this problem.

Thank you for this opportunity to testify.

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) REGARDING S.B. NO. 2656

Date: Tuesday, February 7, 2012
Time: 9:30 am

To: Chairperson Rosalyn Baker and Members of the Senate Committee on Commerce and Consumer Protection:

My name is Bob Toyofuku and I am presenting this testimony on behalf of the Hawaii Association for Justice (HAJ) regarding S.B. No. 2656, relating to Medical Torts.

S.B. No. 2656 establishes a patients compensation fund for medical mishaps. The proposed fund appears to be similar to the Wisconsin patients compensation fund that has performed successfully since its creation in 1975. Both the fund proposed by this bill and the Wisconsin fund operate on an excess basis and require physicians to maintain primary insurance with limits of $1 million per occurrence and $3 million per year. The fund does not replace primary insurance yet the cost of primary insurance in Wisconsin remained more affordable and obtainable there following adoption of the fund when compared to the nation as a whole. Whether a similar fund might have a similar effect in Hawaii may be worth exploring if it will assist doctors with the cost and availability of insurance. The answer, for all practical purposes, will be determined by MIEC and HAPI who together cover most individual physicians.

The most recent fund report (issued in 2011 for 2010) and a 2010 audit by the Wisconsin Insurance Commissioner show that the fund has performed well, except for 2008 – 2010 when the state raided the fund of $200,000,000 to offset general fund deficits. The Wisconsin fund has amassed a net equity of $133 million (after repayment of the funds taken by the state in 2009/2010). There are several significant factors that

should be recognized when considering a similar fund for Hawaii. Wisconsin has a significantly larger physician base to participate and contribute into its fund. As of December 2010, their fund had 14,960 participants. All physicians are required to participate with the exception of those who work for governmental entities and part-timers practicing no more than 240 hours a year (20 hrs./mo.). Assessments were $29 million for an average of approximately $2,000 per participant per year. Actual rates vary according to the insured (both individual doctors and large hospitals/groups are covered) and specialty such that higher risk groups pay more.

Perhaps the most critical period of any patient compensation fund is the initial start up phase while the fund builds sufficient capital to sustain long term viability. A larger base of participants may be helpful in contributing more funds and spreading risk. To some extent, luck is a factor if the fund does not have larger claims in its earlier years. The Wisconsin fund took several years to build sufficient assets (in part because it initially operated on a cash basis) and, we have been told, was lucky to avoid very large payments during its start up phase. It has been profitable for about the past 25 years. The fund switched from a cash to accrual basis after five years to provide greater stability in assessments and build reserves. Consideration might be given to limiting benefits (and hence the exposure of the fund) during the first five years to allow the fund to build reserves because of Hawaii's smaller physician population.

Unlike traditional insurance policies, the fund provides full coverage, has no policy limits and pays unlimited damages on behalf of its doctors so individual doctors do not have personal liability - - no matter how severe the injuries or death. The fund has paid individual claims as large as $34 million and routinely pays several claims in excess

of $5 million annually. Nonetheless, the fund has consistently remained solvent and maintained assessments at a rather modest rate for unlimited coverage.

Conventional wisdom would suggest that adding a requirement for excess coverage with unlimited benefits must be more expensive and will thus increase the overall cost to Hawaii doctors. The Wisconsin experience however seems contrary. There may be less obvious reasons for its success in Wisconsin that might also apply in Hawaii. For example, unlimited benefits for an individual doctor will undoubtedly eliminate the need for claims against multiple doctors in larger cases. A person with a $10 million claim for example, would have to assert claims against 10 doctors with $1 million policy limits in order to fully recover under our present situation. A Wisconsin-type fund could eliminate claims against 9 of the 10 doctors and thereby result in significant savings to the primary insurers. The absence of potential personal liability could also result in savings by eliminating settlements based primarily on the fear of losing personal assets. Effects like these are not readily apparent and further analysis of a patient compensation fund is worthy of further consideration.

Medical malpractice insurers, unlike automobile insurers for example, are highly secretive and protective of their data. There is a remarkable lack of public disclosure of claims data in Hawaii (and nationally in general) such that it is difficult for groups such as HAJ to present a more thorough analysis. There are two major insurers in Hawaii. HAPI is a private association and does not publicly report any claims data. MIEC, as we understand it, also does not have its rates regulated by the Insurance Division and does not report detailed claims data for Hawaii. Without sufficient data from insurers reliable

analysis is difficult if not impossible. At this point, only the insurers can determine whether a patient compensation fund will be helpful for the doctors or not.

Thank you very much for allowing me to testify regarding this measure. Please feel free to contact me should you have any questions or desire additional information.