

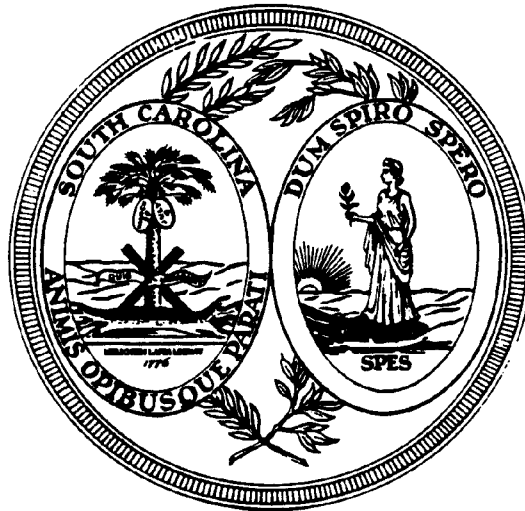
LAC

Report to the General Assembly

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January 2000

# A Review of the Medical Malpractice Patients' Compensation Fund



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# Legislative Audit Council

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A Review of the  
Medical Malpractice  
Patients' Compensation  
Fund

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# Synopsis

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As requested by members of the General Assembly, we conducted an audit of the Medical Malpractice Patients' Compensation Fund (PCF). The requesters were concerned about the fund's solvency and whether the state would be liable in the event of a default. A July 1999 informal opinion from the Attorney General's office concluded that the state should not be liable for claims made against the PCF. However, we found that the PCF operates with a high level of risk.

- ❑ The PCF has not maintained adequate reserves to pay future claims. A Department of Insurance report estimated that the PCF had a minimum \$30 million reserve deficiency as of June 30, 1999. In addition, the PCF's methods for establishing reserves are inadequate and have resulted in a pattern of reserve deficiencies.
- ❑ Membership in the PCF is voluntary. If faced with large or repeated assessments, many PCF members might opt to obtain their malpractice insurance from the private market.
- ❑ The PCF has unlimited claims liability; there is no limit on the amount of an award for which the PCF could be responsible. Only one other state, Wisconsin, has an excess malpractice fund with unlimited liability.
- ❑ The PCF is not subject to oversight by the South Carolina Department of Insurance. The majority of its board and all of its members are healthcare providers who may have inadequate expertise in issues related to insurance. To ensure they operate in a responsible manner, other insurance entities in South Carolina regularly file reports with and are examined by the Department of Insurance.

We also reviewed the purpose of the PCF and recommend that the General Assembly examine whether there is a continuing need for the fund. The private malpractice insurance market should be able to furnish malpractice coverage to healthcare providers. If the General Assembly determines there is a continuing need for the PCF, action should be taken to lower its risk and improve its management.

We found that the PCF does not have adequate management controls to ensure the proper administration of the fund.

- The PCF does not have adequate written policies and procedures to ensure consistency and continuity of administration.
- The PCF routinely grants retroactive coverage to members after a claim is filed.
- The PCF does not adequately verify information received from the primary insurer about claims.
- The PCF does not have appropriate controls to ensure the accuracy of key information about claims in its computer database.
- The PCF does not have appropriate controls to ensure that it is informed of pending claims.
- The PCF does not report claims payments to the National Practitioner Data Bank in a timely manner.

We also reviewed the operations of the PCF for compliance with state law and found the following:

- The PCF has violated the Freedom of Information Act (FOIA) with its claims committee voting practices, use of proxies for voting and quorums, discussion of confidential matters in open session, and lack of minutes for committee meetings.
- The PCF has violated the Administrative Procedures Act (APA) by not promulgating regulations to establish board policy for fund membership and administration.
- The PCF's executive director also works for the Medical Malpractice Joint Underwriting Association (JUA), a private organization, as part of his state job. We could identify no provision in state law that would authorize a state employee to work on state time for a private organization.

We also reviewed information about funds similar to the PCF in other states. Although healthcare providers in most states obtain malpractice insurance through the private market, we identified seven other active state programs that offer excess malpractice coverage to healthcare providers. Although it is difficult to compare malpractice insurance rates, evidence indicates that South Carolina providers pay less than providers in other states for excess malpractice coverage. Historically, the number of reported medical malpractice awards in South Carolina has been low compared to other states, but South Carolina's incidence is rising.



# Introduction and Background

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## Audit Objectives

Members of the General Assembly requested that we conduct an audit of the Medical Malpractice Patients' Compensation Fund (PCF). They were concerned about the fund's solvency and whether the state would be liable to pay claims against healthcare providers in the event of default. They also asked us to review the need for the fund and determine if there are similar funds in other states. Our specific objectives are listed below.

- Review the background and history of South Carolina's system for medical malpractice insurance.
- Determine whether the PCF is managed to ensure solvency and assess the effects if the PCF were to become insolvent.
- Determine the fiscal and other impacts that would occur in the absence of the PCF.
- Determine whether the PCF has adequate management controls over fund administration.
- Determine whether the PCF's management and board operations are in compliance with law and regulation.
- Compare South Carolina's system for medical malpractice insurance with systems used in other states.

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## Scope and Methodology

We reviewed the operations of the Patients' Compensation Fund and assessed its performance in relation to state law, similar programs in other states, and good management practice. We did not review the operations of the South Carolina Medical Malpractice Joint Underwriting Association (JUA), although its existence and role in the medical malpractice system were examined as relevant. Our review focused on FY 96-97 through FY 98-99. In addition, we considered the PCF's entire claims payment history because it is used to determine the level of reserves needed.

We used the following sources of data.

- PCF member and claims records.
- PCF financial records.
- PCF board minutes, contracts, and correspondence.
- Actuarial and other financial reports relating to the PCF.
- Laws and reports about medical malpractice in other states.

We conducted interviews with PCF officials and officials with other South Carolina state agencies. We also talked with officials in other states who administer funds similar to the PCF. We identified problems with the reliability of the PCF's reports and computerized records, so we verified from other sources data that was critical to our audit objectives.

We reviewed the PCF's management controls over fund membership, the payment of claims, and the determination of the appropriate level of reserves. We used a random nonstatistical sample to review paid claims. This audit was conducted in accordance with generally accepted government auditing standards.

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## Background

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In the 1970s, the availability and affordability of medical malpractice insurance reached a crisis point. In much of the nation, private insurers were raising rates and withdrawing from the market. As a result, the South Carolina General Assembly acted to ensure that healthcare providers could obtain adequate and affordable medical malpractice insurance. In 1975 the General Assembly authorized the creation of the Medical Malpractice Joint Underwriting Association (JUA) to provide basic malpractice coverage with limits of \$100,000 per occurrence and \$300,000 annually. The JUA was to begin operation when the S.C. Department of Insurance declared the existence of an emergency due to the unavailability of medical malpractice insurance at a reasonable cost. The JUA became operational in 1975.

The South Carolina Medical Malpractice Patients' Compensation Fund (PCF) was created by Act 674 in 1976 and began operations in 1977. The PCF provides unlimited coverage for malpractice claims that exceed the basic \$100,000/\$300,000 limits. Although there is no longer a crisis in the availability of private insurance, most healthcare providers in the state still obtain their insurance through the JUA and PCF.

Unlike the JUA, which is a nonprofit corporation whose members are the insurance companies authorized to sell malpractice insurance, the PCF is a state agency. The PCF is governed by a board whose 13 members are appointed by the Governor. Healthcare providers have a majority on the PCF board. By statute, the board is to include three physicians, two dentists, two hospital representatives, two insurance representatives, two attorneys and two consumer members. The PCF functions as a payment mechanism for any malpractice award that exceeds \$100,000. It does not hire attorneys to defend claims; rather, it relies on the basic insurance company to defend its cases.

There is no legal requirement that South Carolina healthcare providers obtain malpractice insurance. However, most physicians carry this insurance. All healthcare providers licensed in South Carolina are eligible to become members of the PCF, provided they have basic insurance in the amount of \$100,000/\$300,000. As of June 30, 1999, the PCF had 8,372 members, of whom 5,466 were physicians. This represents 79% of the approximately 6,900 nongovernmental physicians whose primary offices are in the state. The remaining members of the PCF were dentists, nurses, hospitals, professional associations, and others (see Table 1.1).

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**Table 1.1: Patients' Compensation Fund Members as of June 30, 1999**

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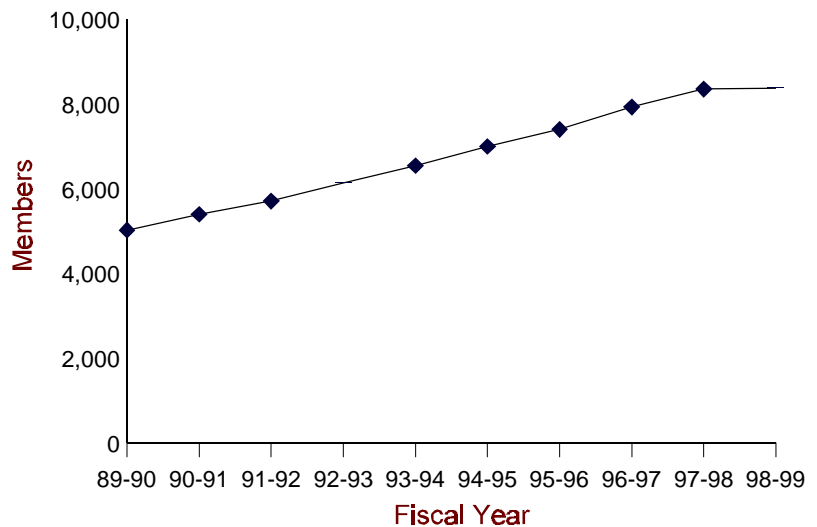
Type of Provider	Members	Percent
Physicians	5,466	65.3%
Dentists and Oral Surgeons	1,217	14.5%
Professional Associations	1,002	12.0%
Nurse Practitioners, Nurses, and CRNAs	398	4.7%
Physicians Assistants	131	1.6%
Podiatrists	60	0.7%
Hospitals	25	0.3%
Other	73	0.9%
<b>TOTAL</b>	<b>8,372</b>	<b>100.0%</b>

The PCF does not receive state appropriations; it is funded solely by member fees. In FY 98-99, the PCF collected \$10.9 million in member fees and paid out \$11.8 million in claims. The PCF has three state employees, and its operating expenses for FY 98-99 were \$291,545. The State Treasurer's office invests the PCF's funds. As of June 30, 1999, the PCF's cash balance was \$19.3 million.

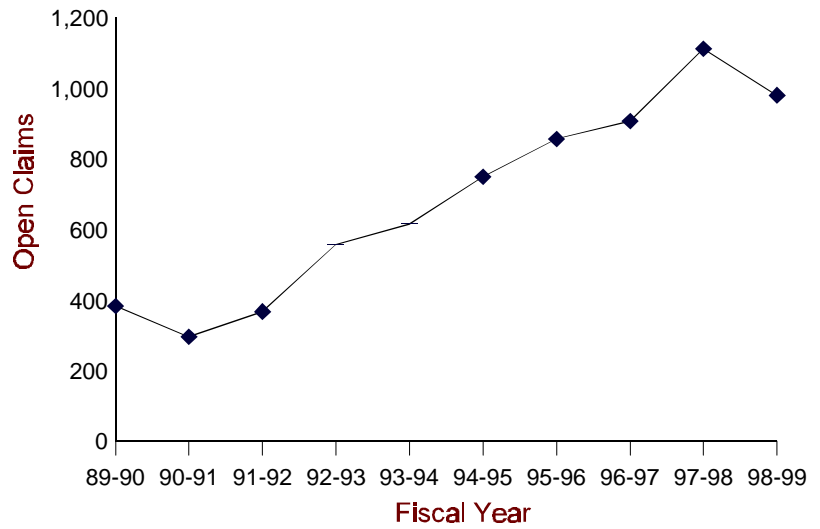
## Increase in Claims Activity

Over the last ten years, the PCF's level of activity has greatly increased. The number of PCF members has increased by 67% and the number of open claims has more than doubled (see Graphs 1.1 and 1.2). Also, since it began in 1977, the PCF has paid a total of \$81 million to settle 243 claims. More than half of these payments, \$45.6 million for 124 claims, have been made in the last four years (see Graph 1.3). Medical malpractice claims have what is called a "long tail." It is common for claims to be reported several years after the incident occurred, and it may take several more years for claims to be resolved.

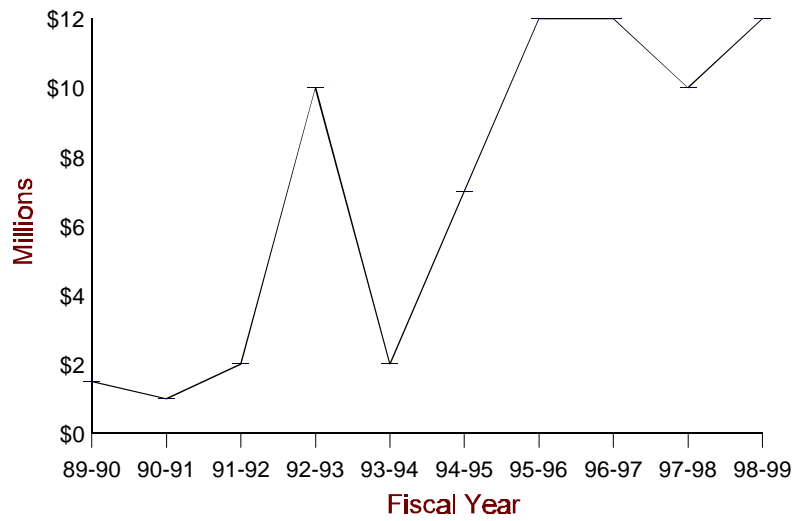
**Graph 1.1: PCF Membership  
FY 89-90 Through FY 98-99**



**Graph 1.2: PCF Open Claims  
FY 89-90 Through FY 98-99**



**Graph 1.3: PCF Claims Payments  
FY 89-90 Through FY 98-99**



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**Chapter 1**  
**Introduction and Background**

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# Liability, Risk, and Purpose of the PCF

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One objective of our review was to determine whether the PCF is managed to ensure solvency and assess the effects if the PCF were to become insolvent. We obtained the assistance of the Department of Insurance in analyzing the PCF's reserves and the assistance of the Attorney General's office in determining state liability.

Overall, we conclude that the state should not be liable for claims against the PCF. However, the PCF has not maintained adequate reserves and operates with a high level of risk. In addition, since the private market can provide medical malpractice insurance coverage, the need for continuation of the PCF should be examined.

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## State Liability

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We were asked to determine the state's liability if the PCF were to become insolvent or were unable to pay its claims. It does not appear that the state is liable for claims made against the fund. However, amending state law to add a provision addressing the state's liability would help to ensure that the state is not responsible for the PCF's claims.

The PCF is a state agency. Its board members are appointed by the Governor, and its employees are state employees. However, the PCF receives no state appropriation. Claims made against the fund are paid from fees collected from healthcare providers.

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An informal opinion from the Attorney General's office concludes that the state "should not be liable" for claims against the PCF.

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Section 38-79-420 of the S.C. Code of Laws states that, "The Fund is liable only for payment of claims against licensed healthcare providers . . ." An informal opinion from the Attorney General's office dated July 20, 1999, concludes that the state "should not be liable" for claims made against the PCF. However, having a specific provision ". . . spelling out that the State is immune from suit for recovery (of) any money in excess of the Fund would further ensure that the State is immune from liability under the circumstances." According to a Department of Insurance analysis, the PCF does not have adequate reserves (see p. 8), which increases the likelihood that the fund may be unable to pay its claims.

The statute creating the Pennsylvania's Medical Professional Liability Catastrophe Loss Fund contains language which addresses the state's liability. The statute (40 Pa. Cons. Stat. §1301.701) states, "No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth."

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## Recommendation

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1. The General Assembly may wish to consider amending §38-79-420 of the South Carolina Code of Laws to include a provision specifying that the state is not liable for claims against the Patients' Compensation Fund.
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## PCF Reserves and Risk

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According to a Department of Insurance (DOI) analysis, as of June 1999, the PCF had a minimum \$30 million deficiency in its reserves. In addition, its method for establishing reserves is inadequate and has resulted in a pattern of deficiencies.

We requested the assistance of DOI in reviewing the adequacy of the PCF's reserves and the methodology for determining the reserves. The DOI conducted its analysis in a manner consistent with the examination of a private insurance company. The DOI used two different methodologies to estimate the PCF's liabilities. These methods produced reserve estimates for the PCF that ranged from \$49 million to \$127 million. As of June 1999, the PCF had a cash balance of \$19 million, resulting in a minimum \$30 million estimated deficiency.

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As of June 1999, the PCF had a cash balance of \$19 million, resulting in a minimum \$30 million estimated deficiency.

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In addition, the DOI compared the loss reserve estimates established by the PCF from FY 86-87 through FY 97-98 with the total paid claims. For example, in FY 91-92, the PCF estimated that the amount needed to pay all current open claims and claims not yet reported would be slightly over \$15 million. However, since FY 91-92, the PCF has paid a total of over \$46 million on closed claims that occurred through FY 91-92, a difference of \$31 million. Table 2.1 shows PCF reserve estimates and actual paid claims for FY 86-87 through FY 94-95.



**Table 2.1: Comparison of PCF Reserve Estimates to Paid Claims**

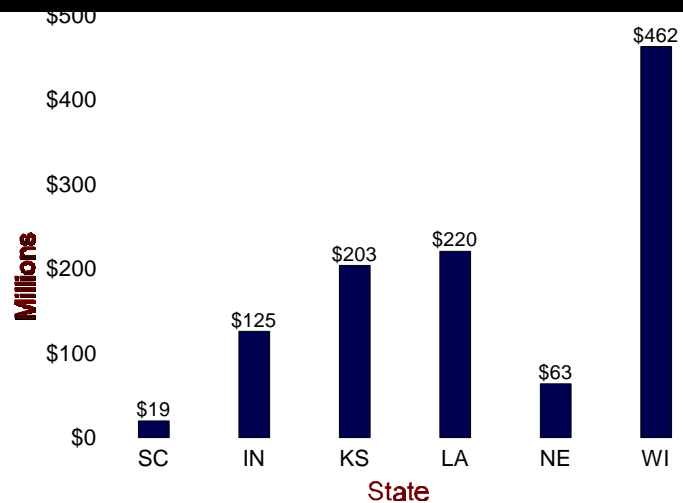
Fiscal Year <sup>1</sup>	PCF Reserve Estimate	Paid Claims <sup>2</sup>	Deficiency
86-87	\$19,009,000	\$15,437,443	(\$3,571,557)
87-88	\$20,807,000	\$21,865,267	\$1,058,267
88-89	\$18,721,000	\$23,337,859	\$4,616,859
89-90	\$17,461,500	\$28,829,276	\$11,367,776
90-91	\$15,250,000	\$31,783,308	\$16,533,308
91-92	\$15,025,000	\$46,103,590	\$31,078,590
92-93	\$11,551,908	\$42,311,257	\$30,759,349
93-94	\$13,912,500	\$42,818,757	\$28,906,257
94-95	\$13,300,000	\$44,056,641	\$30,756,641

- 1 Table does not include most recent fiscal years because many pending claims have not yet been settled.
- 2 Claims paid after that year for incidents that occurred during that year or earlier.

Source: S.C. Department of Insurance.

Of the six other states that furnished information about reserves, five maintain reserves which are significantly higher than South Carolina's (see Graph 2.1 and p. 33).

**Graph 2.1: Claims Reserves in States with Excess Medical Malpractice Funds<sup>1</sup>**



- 1 Pennsylvania does not maintain reserves and operates on a pay-as-you-go basis. As of 12/31/98, the fund has an estimated unfunded liability of \$2 billion.

Source: State funds shown. Date of reserve amount varies from June 1998 to June 1999.

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## PCF Reserve Methodology

The PCF's executive director and the PCF's consulting actuary do not consider the methods used by DOI to be valid for an entity like the PCF. The consulting actuary has stated that "substantial judgment" must be used in setting the PCF's reserves. According to the consulting actuary, using DOI's methods would result in excessive reserves being maintained by the PCF.

PCF officials stated that the PCF is not an insurance company but rather a risk pool. However, since July 1, 1993, the PCF's financial auditors have considered the PCF to be an "insurance enterprise" for accounting purposes. The PCF provides a service similar to that of a private insurance company. The PCF takes the losses of a few members and spreads them over a much larger population. The PCF considers itself a self-insurer for its member healthcare providers.

Because the PCF does not consider itself an insurance company it does not consider it necessary to maintain reserves at a level equal to that of a private insurance company. Instead, the PCF operates primarily on a pay-as-you-go basis. PCF officials stated that the PCF was intended to be a high-risk operation. According to PCF management, the PCF is able to maintain low reserves because of its ability to assess its members and to spread claim payments over several years. In addition, according to PCF officials, the PCF is not the sole source of excess claim payments. If the PCF were to become insolvent, South Carolina healthcare providers may be sued individually for the full amount claimed.

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The PCF does not consider it necessary to maintain reserves at a level equal to that of a private insurance company.

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Section 38-79-450 of the South Carolina Code of Laws allows the PCF to make ". . . deficit assessments upon the determination by the Board that insufficient money is available to meet the Fund's liabilities." The PCF made its first deficit assessment in 1998. It assessed members 100% of their yearly fee, effectively doubling the cost of PCF coverage for 1998. Also, §38-79-480 allows the fund to pay claims in increments of \$100,000 per year. The PCF has not used this provision to date, choosing instead to pay the total amount of the claim due at the time of the settlement.

Traditional insurance companies estimate the amount needed to pay current and future liabilities, and charge premiums to policyholders that are sufficient to generate the reserves needed to pay these liabilities. These reserves also generate investment income, which can provide added assurance against insolvency and ultimately reduce policyholder rates. In a pay-as-you-go system, members pay for claims after they have occurred. Little provision is made for future liabilities and less investment income is generated because reserves are not maintained.

The PCF's current members may be paying for claims, and face possible assessments, for incidents that occurred years ago and were caused by healthcare providers who are no longer members of the PCF.

Early members of the PCF paid much lower rates than current members. Until 1999, the PCF charged lower fees for long-term members. For example, between 1992 and 1996, PCF members with four or more years of membership paid only 10% of the Joint Underwriting Association (JUA) rate while first year members paid 100% of the JUA rate. Also, the PCF gave members a 55% refund of their fees in 1991 and a 20% refund in 1992.

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## Increased Risk

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Since FY 95-96, the PCF's claim payments have significantly increased. More than half of the \$81 million paid by the fund, \$45.6 million, has been paid in the last four years. As of June 8, 1999, the PCF has 14 claims with court awards which were being appealed. The amount under appeal was over \$24 million.

The PCF's reliance on the assessment feature and the ability to spread out claims payments is a riskier approach than maintaining an adequate level of reserves for the following reasons:

### **Participation in the PCF Is Voluntary**

PCF members may withdraw from the PCF as long as they are current on all fees and assessments (see p. 30). It is possible that members may withdraw from the fund if the PCF is forced to make large or repeated assessments as a result of insufficient funds. We found one other state, Pennsylvania, whose excess malpractice fund also operates on a pay-as-you-go basis. However, participation is mandatory in Pennsylvania's fund.

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There is no cap on the amount of an award for which the PCF could be responsible.

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### **The PCF Has Unlimited Liability**

The PCF's liability is unlimited. There is no cap on the amount of a malpractice award for which the PCF could be responsible. Of the seven other states with funds similar to the PCF, all but one, Wisconsin, have a cap on the fund's liability. However, Wisconsin, unlike South Carolina, requires mandatory participation in the fund.

The PCF's liability is also increased because South Carolina (along with Louisiana) has the lowest primary insurance limits of any of the seven states with funds similar to South Carolina's. The PCF provides coverage for amounts in excess of \$100,000 per incident and \$300,000 aggregate. These limits have remained unchanged since 1977. In other states, the attachment point (above which the fund provides coverage) ranges from \$200,000 to \$1 million (see p. 34).

### **The PCF Does Not Maintain Reinsurance**

The PCF does not maintain reinsurance. Reinsurance is designed to lessen the impacts of large claims by paying the amount of any award above a certain level. For example, the state's Insurance Reserve Fund (IRF), which provides medical malpractice coverage for state-employed healthcare providers, purchases reinsurance to pay for any claims award exceeding \$250,000 up to the state tort liability cap of \$1.2 million.

### **The PCF Discounts its Reserves**

In estimating its reserve needs, the PCF reduces the amount of the reserves by the amount of interest it estimates it will earn on its reserves. This is called discounting. In South Carolina, private insurance companies are not allowed to discount their reserves. In addition, the PCF has not maintained a cash balance equal to its reserve estimates. Therefore, it is unlikely the PCF would be able to generate the projected interest income used to discount its reserves.

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## Oversight of the PCF

The PCF is not subject to oversight by the Department of Insurance. In contrast, private insurance companies are required to file an annual statement with the Department of Insurance and are subject to an examination by the DOI at least once every five years. If the department finds that the company has taken actions that are hazardous to the policyholders or the public, it can place the company under administrative supervision. The Medical Malpractice Joint Underwriting Association is subject to an annual examination by the DOI. The state's Insurance Reserve Fund is also subject to review by the DOI.

The majority of the PCF board is comprised of healthcare providers who may not have the necessary expertise in insurance issues. While there are currently two insurance industry representatives on the PCF board, the law was amended in 1997 to remove the insurance commissioner as ex officio chairman.

Greater oversight of the PCF could reduce the likelihood of insolvency. In addition, it could result in better claims management and improve the PCF's response to the public.

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## Recommendations

2. If the General Assembly determines there is a continuing need for the Patients' Compensation Fund (see p. 14), it should consider amending §38-79-470 to make the PCF subject to the same oversight by the Department of Insurance as other insurance entities. This would include requiring the department to conduct a periodic examination of the fund.
3. If the General Assembly determines not to require the Patients' Compensation Fund to be accountable to the Department of Insurance, as recommended above, it should consider other statutory changes to decrease the PCF's risk. These could include:
  - Amending §38-79-440 to make participation in the fund mandatory for healthcare providers who want to have medical malpractice coverage in excess of the basic limits.
  - Amending §38-79-420 to place a cap on the fund's liability.
  - Amending §38-79-420 to raise the \$100,000/\$300,000 primary insurance limits.

4. The Patients' Compensation Fund should take action to reduce its risk of insolvency. The fund should consider increasing its level of reserves, obtaining reinsurance, and eliminating the discounting of reserve estimates.

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## Need for Continuation of the PCF

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The private insurance market should be able to provide sufficient and affordable malpractice insurance.

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We were asked to determine whether other states have funds similar to the PCF. In most states, private insurers are the only providers of medical malpractice coverage. We found that the private insurance market in South Carolina should be able to provide sufficient and affordable medical malpractice insurance. In South Carolina there is no legal requirement that healthcare providers carry malpractice insurance. Whether the PCF should exist to provide excess insurance to the state's healthcare professionals should be examined.

The PCF benefits healthcare professionals by providing coverage at lower rates than private insurance. However, these rates have been too low to establish adequate reserves (see p. 8). In addition, the PCF provides a benefit to healthcare professionals that is not available to members of other professions, such as attorneys or contractors, who also need liability coverage.

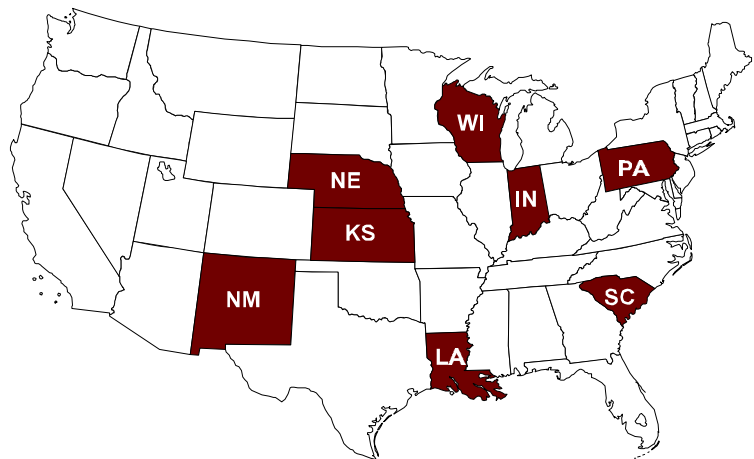
The medical malpractice crisis that led to the creation of the JUA and PCF no longer exists (see p. 3). In 1998, 82 companies reported writing medical malpractice insurance in South Carolina. However, private insurers cover only a small minority of in-state physicians.

Only seven other states, none in the southeast, have active excess insurance funds (see map and p. 33). North Carolina authorized the creation of a healthcare excess liability insurance fund in 1976, but the fund was never implemented. According to a North Carolina official, after the law was passed, the private insurance market improved and the fund was not needed. Florida has an excess insurance fund that still exists; however, the fund stopped issuing new policies in 1983.

In the absence of the PCF, it is likely that the price paid by healthcare providers for insurance would rise. The PCF's rates for excess insurance appear to be among the lowest in the nation (see p. 35). However, it is unclear how much of an impact the elimination of the PCF would have on the overall cost of medical care or the effect it would have on the cost to consumers. A 1995 federal General Accounting Office report cited studies showing that the cost of medical malpractice insurance amounted to approximately 1% of total healthcare costs.

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**Map 2.1: States With Funds Similar to the PCF**



If the cost of medical malpractice insurance were to rise significantly, these costs could be passed on to consumers and the availability of healthcare could be affected. However, because of inadequate reserves, the PCF's rates may also rise significantly in coming years.

According to a PCF official, the PCF exists primarily to serve the state's healthcare providers. It is possible that, at times, the best interest of the healthcare provider may not be the best interest of the state's citizens. Physicians may see it in their best interest to fight all malpractice claims, even those that are legitimate, in order to keep their medical malpractice rates low.

Terminating the PCF would have little impact on state government. An informal opinion from the Attorney General's office indicates that the state should not be liable if the PCF were to become insolvent. The PCF receives no state-appropriated funds; claim payments and operating expenses are paid from fees collected from member healthcare providers. However, the state provides some services to the PCF at no cost. For example, the State Treasurer's office invests the fund's money and prints the checks for the PCF. The Comptroller General's office provides some accounting services to the PCF.

The existence of the PCF also results in lost tax revenue for the state. Private insurance companies pay premium taxes on their premiums. For medical malpractice insurance the tax rate is 1.25% of net premiums. Because the PCF is a state agency, it does not pay premium taxes. We estimate that the state would have collected approximately \$175,000 in premium taxes in FY 98-99 if the coverage were provided through private insurers.

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Discontinuing the PCF would not prevent South Carolina healthcare providers from forming their own company to provide medical malpractice coverage.

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Discontinuing the PCF would not prevent South Carolina healthcare providers from forming their own company to provide medical malpractice coverage. The Doctor's Company is a company formed in California in 1976 as a result of the medical malpractice crisis. The company is physician owned and was ". . . founded by doctors for doctors." The company currently has over 20,000 policyholders across the U.S. We identified 48 insurance carriers in the United States that are owned or controlled by healthcare providers. However, if the state's healthcare providers were to form their own company, they would have to maintain adequate reserves and pay state premium taxes.

Terminating the PCF would not result in its immediate end. The PCF would still need to exist to handle claims currently open, as well as claims that will be reported in future years for incidents that occurred prior to its year of termination. As noted above, Florida closed its PCF in 1983, but the fund is still paying on claims that occurred prior to that date. The South Carolina PCF currently has over 900 open claims.

It is also likely that the PCF would still have to assess healthcare providers to pay for claims that have yet to be reported for the years during which coverage was provided. According to a Department of Insurance analysis, the PCF has a minimum \$30 million loss reserve deficit. Florida has had several assessments and refunds of fees since it ceased offering coverage in 1983.



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## Recommendation

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5. The General Assembly may wish to examine whether there is a continuing need for the Medical Malpractice Patients' Compensation Fund. If the PCF were to be discontinued, provisions should be made for the resolution and payment of all outstanding claims.
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## Issue for Further Study — Medical Malpractice Joint Underwriting Association

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As discussed above, most healthcare providers purchase their primary malpractice coverage (\$100,000/\$300,000) from the Medical Malpractice Joint Underwriting Association (JUA) and their excess coverage from the PCF. Although we did not review the JUA, we noted that the need for its continued existence may need to be reviewed.

The JUA began in 1975 when the S.C. Department of Insurance declared the existence of an emergency due to the unavailability of malpractice insurance at a reasonable cost. The JUA is a non-profit corporation whose members are the insurance companies authorized to sell medical malpractice insurance coverage. The JUA is subject to the periodic examination of its operations and reserves by the Department of Insurance.

In general, joint underwriting associations are designed to be a residual market, providing coverage to individuals or companies who cannot obtain their primary insurance coverage from private insurance companies. Although there is no longer a crisis in availability of private insurance, most healthcare providers in the state still obtain their primary insurance through the JUA. Its existence hinders the ability of private companies to compete in the medical malpractice insurance market.

While the Department of Insurance can declare an emergency which will result in the creation of a JUA, there is no specific provision in state law allowing the department to periodically review the need for a JUA or declare the emergency over and terminate the JUA.

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## Recommendation

6. The General Assembly may wish to review the statutes (§38-79-10 *et seq.* of the South Carolina Code of Laws) establishing the Medical Malpractice Joint Underwriting Association to determine if the Department of Insurance should conduct a periodic review of the need for the JUA.

# Management Controls

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We were asked to review the PCF's management. We reviewed the PCF's controls over fund administration and found that the controls are not adequate. The fund does not have adequate policies and procedures and lacks appropriate controls over claims payments.

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## Policies and Procedures

The Patients' Compensation Fund does not have adequate written policies and procedures. We obtained some written policies, but PCF staff were unable to determine when they were drafted or adopted. The PCF's policies and procedures consist of an outline of some of the agency's operations. They do not contain detailed procedural information. For example, there are inadequate policies for the approval of basic insurers, verification of primary coverage, and notification of members of their rights and responsibilities. The policies do not provide adequate controls for verifying claims information provided by the basic insurer, ensuring the accuracy of database information, or reporting claims to the National Practitioner Data Bank (NPDB) (see pp. 21, 25).

Section 1-23-140 (a) (2) of the South Carolina Code of Laws requires that state agencies "adopt and make available for public inspection a written policy statement setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the agency." Written procedures provide a system of operating controls. Complete written policies would help ensure that the PCF handles matters relating to membership and claims in a consistent manner and in compliance with legal requirements. Written policies are also necessary to ensure continuity of action when staff turnover occurs. The absence of written policies may result in inconsistent actions and inadequate controls over the PCF's resources.

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## Recommendation

7. The Patients' Compensation Fund should comply with S.C. Code §1-23-140 and develop and implement written policies and procedures necessary to protect the agency's resources and ensure appropriate management controls.

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## Controls Over Claims Payments

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The PCF does not have adequate controls over the payment of claims. We reviewed a random sample of 50 of the 100 paid claims from FY 96-97 through FY 98-99. Although we found no evidence that the PCF paid claims for periods when a member was not covered, the PCF has a practice of granting retroactive coverage to its members. Also, the PCF does not adequately verify the accuracy of claims information provided by the primary insurer.

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## Retroactive Coverage

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The PCF routinely grants retroactive coverage to members after a claim is filed. According to PCF staff, prior to 1986 many members did not receive renewal notices for their professional associations because of a decision by the PCF board not to send separate notices. As a result, on July 15, 1987 (12 years ago), the PCF's board made a decision to grant retroactive coverage to those providers identified as having an unintentional gap in their coverage. The board directed notices to be sent to these providers offering coverage if they had intended to be covered, and if they responded within 30 days. However, agency staff stated that they could not identify all members with gaps in their coverage at that time and therefore, decided to grant coverage as they became aware of unintentional gaps.

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We identified 61 cases where retroactive coverage was granted to PCF members since January 1988.

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The PCF has continued to provide retroactive coverage. For example, in December 1997 the PCF was notified of a claim filed against a professional association which had not had coverage since 1983. After receiving notification of the claim, the PCF sent a letter stating, "If you *intended* to have continuous coverage . . . and failed to renew as a result of your not receiving a renewal notice, please notify the PCF in writing of your intent" [Emphasis Added]. The PCF has also granted retroactive coverage when they had documentation showing that they had sent a renewal notice to the member.

We identified a total of 61 cases where retroactive coverage was granted to PCF members since January 1, 1988. Eleven of the cases involved individual physicians and 50 were professional associations. There were 27 claims filed against these providers with accident dates occurring during the period that the member did not have coverage. In 21 of these cases, the retroactive coverage was given to the provider after the claim was reported to the PCF.

The PCF has paid a total of \$1,375,000 for these claims. In addition, five of the claims are still open. In one case resulting in a payment of \$1,025,000, the doctor was granted retroactive coverage by a 5–4 vote of the PCF board. The rest of the providers were granted coverage administratively.

The PCF director stated they do not consider granting retroactive coverage a problem because South Carolina has “joint and several liability” in lawsuits. This means that if there is more than one defendant in a lawsuit, each defendant is equally responsible for the total amount of any judgement or settlement. For example, if there are four co-defendants and only one has insurance coverage, that defendant’s insurance company could be liable for the entire judgement. According to the PCF director, as long as one co-defendant has PCF coverage, the liability of the PCF does not increase by insuring others. However, some providers could avoid having their malpractice awards investigated by the South Carolina Board of Medical Examiners by dividing claims payments between themselves and their professional association (see p. 25).

Granting retroactive coverage to members when a claim is filed against them is an inappropriate practice. It could reduce the incentive for providers to pay fees and obtain coverage, and is unfair to members who pay their fees in a timely manner. If its renewal notification process is not adequate, the PCF should strengthen the system of member notification instead of granting retroactive coverage.

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## Verification of Claims Information

The PCF does not adequately verify information about claims received from the primary insurer. The PCF does not have written policies for verification of accident dates and settlement amounts. In our review of claims, we saw cases where the PCF had incorrect accident dates or settlement amounts.

According to the agency director, all accident dates are verified with the suit papers. Settlement amounts or judgements are verified with the copy of the court award or a signed release. These items should be kept in the claim file. However, the PCF has no policy to require that these items be in the claim files. In our review, we found that suit papers were only present in 2 (4%) of the 50 paid claim files. We found court awards or signed releases in 19 (38%) of the files. In one case the primary insurer notified the PCF that their

portion of a claim was \$450,000. The primary insurer later requested an additional \$50,000 because they had reported the settlement amount incorrectly.

By not verifying accident dates with the actual suit papers, the PCF may have paid claims for periods when a member was not covered. In addition, the PCF may pay an incorrect settlement amount.

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## Recommendations

8. The Patients' Compensation Fund should no longer grant retroactive coverage to members.
9. The Patients' Compensation Fund should develop and implement a policy of verifying all information received from the primary insurer with the appropriate court documents.

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## Information Controls

The PCF does not have adequate controls to ensure the accuracy of claims information. We found that the PCF database contains incomplete and incorrect data about paid claims. Also, the PCF has given incorrect information to the actuary who estimates the appropriate level of fund reserves. In one instance, two paid claims in the total amount of \$600,000 were omitted from the PCF's claims database. In other cases, claims were recorded with the wrong accident year. Table 3.1 shows examples where the actual accident date was different from the date given to the actuary.

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**Table 3.1: Examples of Incorrect Accident Dates Submitted to the PCF's Actuary**

Claim #	Actuary's Accident Date	Actual Accident Date
326	Jun-87	Jun-78
802	May-68	May-86
1215	Dec-89	Dec-87
1761	Sept-94	Sept-91
3184	Dec-95	Dec-94

Some of the PCF's errors were caused by incorrect information entered into the computerized claims database, while others can be attributed to incorrect information manually compiled by PCF staff. The PCF is in the process of implementing an automated claims information system. However, they have not implemented appropriate controls to ensure that key information, such as accident date and amount paid, is correctly recorded in the system. In addition, the new system does not have adequate security controls; any system user can change information in the database. Further, PCF staff have not received software training that would allow them to use the system effectively. They depend on a computer consultant to solve even the simplest of system problems.

Accurate information about paid claims, including the amount of payments and the accident dates, is critical to establishing estimates of reserves needed for future claims. Without accurate information about paid claims, the PCF is less likely to establish appropriate reserves.

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## Recommendation

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10. The Patients' Compensation Fund should institute appropriate controls for entering data in its computer system and appropriate security controls for system access. Also, the PCF should ensure that staff using the information system have received adequate training.
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## Notification of Claims

The PCF has no controls to ensure that it is notified of claims in a timely manner. PCF members are required by law to notify the PCF within five days of receipt of a claim. However, the primary insurer is the one who ordinarily notifies the PCF. In reviewing a sample of 50 paid claims, we found that most claims were reported to the PCF within two weeks of the primary insurer receiving them; however, in 7 cases (14%) the PCF was not notified of the claim until one year or more after the primary insurer received the notification. Lack of timely notification can affect the adequacy of the PCF's reserves.

South Carolina Code §38-79-480 (1) states “. . . the provider shall within five days of receipt of summons and complaint . . . give notice to the Board of the action.” The law does not provide for penalties if the member does not report a claim to the PCF within the specified time period. Also, the PCF director stated they prefer that the primary insurance company, instead of the provider, notify the fund.

Other states with excess medical malpractice funds similar to the PCF have various ways of ensuring that they receive claims reports. In Kansas, state law requires the plaintiff in the action to serve a copy of the petition upon the board. Pennsylvania law requires the primary insurer to notify the fund; if the primary insurer does not notify the fund, the insurer is responsible for paying the total judgement. Wisconsin has a legal requirement that the fund be named and served in an action.

It is possible that a claim could reach judgement without the PCF having knowledge of it. According to the executive director, in the late 1970s there was a case where a court judgement was awarded before the PCF was notified of the claim. The judgement exceeded the limits of primary coverage by \$50,000. The board, on the advice of the director, decided to pay the claim. If the PCF does not have knowledge of pending claims, the ability to establish appropriate member fees to ensure adequate reserves is diminished.

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## Recommendations

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11. The General Assembly should consider enacting legislation to require the primary insurer to promptly notify the Patients' Compensation Fund of pending claims. The law should include penalties, such as denial of coverage, if the fund is not notified.
  12. In the absence of statutory change, the fund should develop and implement policies to ensure that providers notify the fund of pending claims.



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## Reporting of Claims Payments

The PCF does not report claims payments to the National Practitioner Data Bank (NPDB) in a timely manner. The PCF reported all claims payments in our sample to the NPDB; however, 13 (34%) of the 38 reports were submitted after the 30-day time limit. The PCF does not have adequate written policies and procedures for reporting claims to the NPDB, and the PCF does not use a consistent date as the claim payment date. An official at the PCF stated that the date used may be the voucher date, the check date, the date the payment was mailed, the date the check cleared the bank, or the date the JUA processed their payment.

Federal law (42 U.S.C. §11131) requires that each person, entity, or insurance company which makes a payment for the benefit of a healthcare professional to settle or satisfy all or part of a claim for medical malpractice, must report specific information to the NPDB. Reports must be submitted within 30 days of the date the payment was made regardless of whether all appeals are exhausted. The payment date reported should be the date that appears on the payment check.

Not reporting claims payments to the NPDB carries penalties. Any person or entity who fails to report information on a payment required to be reported is subject to a civil penalty of up to \$10,000 for each such payment involved.

An official at the South Carolina Board of Medical Examiners stated that they receive a report from the NPDB prior to each board meeting. This information is reviewed at each board meeting and payments greater than \$200,000 are usually investigated to determine any questions of licensing or credentialing. If the information is not reported in a timely manner, licensing questions may not be appropriately addressed.

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## Recommendation

13. The Patients' Compensation Fund should implement a complete written policy for reporting payments to the National Practitioner Data Bank. The PCF should use the check date as the payment date when filing NPDB reports and ensure the reports are sent within 30 days.

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**Chapter 3**  
**Management Controls**

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# Compliance Issues

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As part of our review of the Patients' Compensation Fund's management, we reviewed PCF operations for compliance with state law. We found that the PCF has not always conducted business in compliance with the Freedom of Information Act and the Administrative Procedures Act. Also, the fund's executive director works for a private organization as part of his state position. This may not be authorized by state law.

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## Freedom of Information Act (FOIA)

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The Freedom of Information Act (S.C. Code §30-4-10 *et seq.*) provides guidance on how public agencies' business is to be conducted. Violators of the act may be guilty of a misdemeanor. The PCF has not always conducted business in compliance with the FOIA.

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## Claims Committee Voting

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The PCF claims committee does not comply with the law in the way it approves claims payments. The five-member PCF claims committee approves each malpractice claim payment. According to the PCF director, the claims committee does not meet often; instead, it takes action by a system of polling. The claims committee members individually fax or telephone their approval of each payment to the PCF office. This method is not authorized by law.

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Since the committee's method of voting violates state law, the validity of its actions could be questioned.

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State law requires public bodies, such as the PCF and its committees, to meet collectively to conduct their business. South Carolina Attorney General's opinions have affirmed the requirement that members of a public body, such as the claims committee, must convene in a meeting, either in person or by telephone, to discuss or act upon a matter over which they have supervision, jurisdiction, advisory power, or control. The opinions have specifically disallowed the practice of voting by polling, whether in writing or by telephone.

The PCF claims committee approved payment of 50 claims in FY 98-99 for over \$11.7 million. Since the committee's method of voting violates state law, the validity of its actions could be questioned.

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## Use of Proxies for Board Meetings

The PCF board allows members to send proxies to board meetings. A member who submits a proxy is counted as present for the meeting, and the board member designated as proxy can vote for the absent member. However, according to Attorney General's opinions, unless there is specific statutory authorization, a board cannot use proxies to obtain a quorum at meetings or for votes. The PCF's statutes do not provide authorization for the use of proxies.

Without a quorum, the board cannot legally act. According to §38-79-430, "The affirmative vote by a majority of the quorum present at a duly called meeting . . . is required to exercise any function of the board." A May 1984 Attorney General's opinion stated ". . . any action taken at . . . [a] meeting, absent a quorum, would be void."

On eight occasions (21% of its meetings) from July 1988 through June 1999, the PCF board met without having a quorum; at six of these meetings, the board counted proxies to obtain a quorum. The board's actions at these meetings were few, but included approval of the PCF's budget.

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## Use of Executive Sessions

The PCF board does not go into executive sessions to discuss claims, although some claims information is confidential. Generally, information about closed claims is public and information about open claims is confidential. The claims committee provides the board with a report of its action taken, and the board may discuss individual claims in open session.

The Freedom of Information Act provides a process for a board to go into executive session to discuss confidential matters. This allows public bodies to protect the confidentiality of information entrusted to them. A review of the PCF's minutes for 1987 through April 1999 revealed only one occasion when the board went into executive session, although the board routinely received claims reports with information about open cases. The executive director stated that they have removed identifying information from claims reports; however, this information was in the reports until 1997. Also, board members may ask questions about individual claims.

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## Committee Minutes

The committees of the PCF board do not routinely record minutes of their meetings. A review of the board's minutes did not find any minutes of standing committee meetings since 1989, although some committees, such as operations, met frequently. S.C. Code §30-4-90 provides that all public bodies shall keep written minutes of all of their public meetings, and these minutes shall be available to the public.

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## Conclusion

The PCF board has not followed the FOIA in conducting its business. According to the executive director, the claims committee could not function in approving claims settlements if it had to have a meeting. Some board members cited the inconvenience of procedures for conducting public meetings. However, we could identify no provision that would exempt the PCF from the law. According to S.C. Code §30-4-110, "any person or group of persons who willfully violates the provisions . . . shall be deemed guilty of a misdemeanor" and subject to fines or imprisonment.

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## Recommendations

14. The Patients' Compensation Fund claims committee should conduct business in compliance with the FOIA. If necessary, the PCF should obtain guidance from the Attorney General's office in implementing appropriate procedures.
15. The Patients' Compensation Fund should discontinue the use of proxies for obtaining a quorum or voting.
16. The Patients' Compensation Fund board should go into executive session to discuss claims or other confidential matters.
17. The Patients' Compensation Fund should record minutes of all committee meetings and make the minutes available to the public.

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## Administrative Procedures Act (APA)

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In the absence of regulations, board policy and actions could be challenged.

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The PCF has not promulgated regulations through the Administrative Procedures Act (APA) to establish policy for fund membership and administration. The board's 1981 regulations are outdated and not in compliance with the APA. In addition, the fund's written policies and procedures are inadequate (see p. 19). Without regulations, board policy on issues such as fund membership does not have the authority of law. This could affect the fund's solvency.

S.C. Code §1-23-110 *et seq.*, effective in 1977, establishes the process that agencies must follow to promulgate regulations. The board did not follow these procedures when its regulations were established in 1981. Since that time, changes have been made to the PCF statutes that are not reflected in the regulations. For example, when the regulations were implemented, the fund could not exceed \$6 million, and the regulations state that after four years of membership, members shall pay only the assessments required for the fund to reach the \$6 million level. This regulation is obsolete, as there is now no limit on the amount in the fund. Also, the regulations provide for the use of proxies to obtain a quorum and for voting. These provisions do not comply with law (see p. 28).

In 1990, the board passed some amendments to the regulations so that they would conform to statutory changes. However, according to the executive director, the Attorney General's office advised the PCF that they had to go through the APA process to amend the regulations. The PCF decided not to amend the regulations. We could not find documentation of this decision.

The board's policies on whether fund members may withdraw their membership without affecting their coverage for prior years could be important if the PCF levies increased charges and assessments, and members consider obtaining their malpractice coverage in the private market. The executive director stated that if a member withdraws after having paid his fees and assessments for a given year, his coverage for prior years would remain in effect. However, if he withdraws without paying an assessment, he would lose coverage not just for that year, but for all prior years in which he paid his fees. However, the board has not issued regulations about this issue. Also, we could find no evidence that the board officially adopted this policy. In the absence of regulations, board policy and actions could be challenged.

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## Recommendation

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18. To establish agency policy for membership and administration of the Patients' Compensation Fund, the PCF board should promulgate regulations in compliance with S.C. Code §1-23-110 *et seq.*
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## Executive Director's Employment

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The executive director of the PCF also works for the Joint Underwriting Association (JUA), a private organization that covers most healthcare providers in South Carolina for primary malpractice insurance (see p. 2). According to the executive director, he performs two functions for the JUA. He is employed as a consultant on the JUA's claims, and he also acts as the JUA's manager. His work as the JUA's manager may not comply with state law.

The JUA pays the executive director \$85 per hour for his claims consulting; he reported that he earned \$25,500 in 1998 for his consulting. As part of his consulting contract, the JUA also provides him with a car for his use. The executive director stated that he does this work in hours that he is not working for the PCF.

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We could identify no provision in law that would authorize a state employee to work on state time for a private organization.

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The executive director said that he also works as the JUA's manager. He coordinates and administers the contracts that the JUA has with other organizations. These include an insurance company that administers the JUA's policies and medical associations that provide risk management services. He also advises the JUA board. The executive director is not paid by the JUA for his management services, and he does it as part of his state position. He does not keep records of the time he spends on JUA activities, but he estimated that he spends 20% of his PCF time working for the JUA. The JUA's offices are adjacent to the PCF offices.

Although the PCF board voted in 1986 to "offer the Executive Director's services to the JUA in an administrative and advisory capacity," the board may not have the authority to do that. The executive director is a full-time state employee whose position is to manage the PCF. His state position description does not mention any job responsibilities relating to the JUA. We could identify no provision in state law that would authorize a state employee to regularly work on state time for a private organization, whether or not he is paid. Managing the JUA does not appear to be part of the mission of the PCF.

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## Recommendations

19. The executive director of the Patients' Compensation Fund should discontinue his work managing the Joint Underwriting Association as a part of his PCF position.
20. If the Patients' Compensation Fund board wishes the executive director to continue managing the JUA as part of his state position, they should consult the Attorney General's office to determine whether this could be authorized by state law.

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## Board Composition

The Patients' Compensation Fund board has two vacancies and several members with expired terms. Seven of the eleven current members of the PCF board are serving with terms that have expired; two in 1996, one in 1997, and four in 1999. Five of the current board members have served on the board since the PCF was established 22 years ago.

One of the PCF board's two positions for consumer members has been vacant for 12 years — since 1987. The board has taken no action to promote the appointment of a new consumer member. The Governor appoints the members of the PCF board. According to the executive director, it is not the board's practice to notify the Governor of vacancies or expired terms.

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## Recommendation

21. The Patients' Compensation Fund should ensure that the Governor's office is made aware of board vacancies and expired terms.



# Other States' Medical Malpractice Funds

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## Funds Similar to the PCF in Other States

Healthcare providers in most states obtain malpractice insurance through the private market. We identified only seven other states with active programs that offer excess medical malpractice coverage to healthcare providers. These states are Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Wisconsin (see Table 5.1). Two additional states, North Dakota and Wyoming, have provisions for a fund in their statutes, but no fund exists.

South Carolina is the only southeastern state with an active state-run fund for malpractice insurance. Officials in the other southeastern states indicated that medical malpractice insurance is provided solely by the private market. Some of those interviewed stated there was a problem with the availability and affordability of medical malpractice insurance a decade or more ago, but the problems were solved without state involvement. In 1976 the North Carolina Legislature created a Medical Compensation Fund, but it was never funded and the law was repealed in 1997.

The seven state funds vary in structure and provisions. Four of the funds, including the PCF, operate as a separate state agency. The others are housed under each state's department of insurance. Each of the funds requires that participants carry primary coverage. Primary coverage is the amount of coverage that a provider must obtain from another insurer. The amounts of this coverage have to be exceeded before the state funds make any payments on a claim. In most situations, the insurer who provides primary coverage is responsible for the defense of the claim, which reduces the claims expenses for the excess coverage funds.

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South Carolina is the only southeastern state with an active state-run fund for malpractice insurance.

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South Carolina's fund has the broadest coverage of all the funds. South Carolina and Louisiana require the lowest amounts of primary coverage. The South Carolina PCF and Wisconsin's fund both provide unlimited excess coverage. This means that regardless of the amount of a judgement or settlement they will pay the claimant the full amount over existing primary coverage. However, Wisconsin requires \$1 million/\$3 million primary coverage, and South Carolina requires \$100,000/\$300,000 primary coverage. Due to the lower primary limits, the South Carolina PCF has a potentially higher liability. The state of Wisconsin also has a statutory cap on liability for wrongful death and non-economic damages claims. South Carolina does not have any limitations on the amount of liability.

**Chapter 5**  
**Other States' Medical Malpractice Funds**

**Table 5.1: State Funds Providing Excess Malpractice Insurance**

State Fund	Administrative Structure	Participation Requirements	Providers Eligible <sup>1</sup>	Number of Participants <sup>2</sup>	Primary Coverage Required <sup>3</sup>	Maximum Fund Coverage
<b>South Carolina</b> Medical Malpractice Patients' Compensation Fund	Separate State Agency	Not mandatory	MDs, Nurses, Hospitals, Podiatrists, Dentists, and Other HCPs.	8,400	\$100,000/\$300,000	Unlimited
<b>Indiana</b> Patient's Compensation Fund	Medical Malpractice Division of The Department of Insurance	Not Mandatory	MDs, Nurses, Hospitals, Podiatrists, Dentists, and Other HCPs.	25,000–28,000	\$250,000/\$750,000 <sup>4</sup>	\$1 Million
<b>Kansas</b> Health Care Stabilization Fund	Separate State Agency	Mandatory	MDs, Nurses, Hospitals, DOs, Podiatrists, Dentists, and Other HCPs.	10,000	\$200,000/\$600,000	\$800,000/ \$2.4 Million
<b>Louisiana</b> Patient's Compensation Fund	Separate State Agency	Not Mandatory	MDs, Nurses, Hospitals, Podiatrists, Dentists, and Other HCPs.	12,000	\$100,000 <sup>5</sup>	\$400,000 + future medical expenses
<b>Nebraska</b> Excess Liability Fund	Division of the Department of Insurance	Not Mandatory	MDs, Nurses, Hospitals, DOs, and Other HCPs.	3,000	\$200,000/\$600,000 <sup>6</sup>	\$1.05 Million
<b>New Mexico</b> Patient's Compensation Fund	Division of the Department of Insurance	Not Mandatory	MDs, Nurses, Hospitals, DOs, Podiatrists, and Other HCPs.	2,700	\$200,000	\$400,000 + future medical expenses
<b>Pennsylvania</b> Medical Professional Liability Catastrophe Loss Fund	Separate State Agency	Mandatory	MDs, Nurses, Hospitals, DOs, Podiatrists, and Other HCPs.	35,000	\$400,000/ \$1.2 Million <sup>7</sup>	\$800,000/ \$2.4 Million
<b>Wisconsin</b> Patients Compensation Fund	Under The Office of The Commissioner of Insurance	Mandatory	MDs, Nurses, Hospitals, DOs, and Other HCPs.	12,000	\$1 Million/\$3 Million	Unlimited

- 1 Those providers listed are explicitly stated in law, other HCPs may include: Ambulatory Care Centers, Birth Centers, Chiropractor, Midwives, Nursing Homes, Occupational Therapist, Optometrist, Pharmacist, Physical therapist, Physician assistant and other healthcare organizations as defined by law. A DO is a doctor of Osteopathy. Nurses indicates that some type of nurse is covered.
- 2 Approximate number of annual participants.
- 3 Where there are two numbers, the first is the limit for each occurrence and the second is the aggregate limit for one year.
- 4 Hospital, HMO, health facility higher aggregate.
- 5 \$125,000 if self-insured.
- 6 Hospitals (\$200,000/\$1Million).
- 7 Hospitals (\$400,000/\$2Million).

Source: State funds listed.

## Costs of Coverage

Although it is difficult to compare malpractice insurance rates, evidence indicates that South Carolina providers pay less than providers in other states for the excess coverage offered by the PCF. We obtained rate information for two specialities from the other seven state funds that provide excess malpractice coverage (see Table 5.2).

The varying coverage and rate structure of each fund make it difficult to compare rates. Rates differ for each speciality and type of provider; a state has no average overall rate that can be used for comparison. Several states establish rates as a percentage of primary insurance premiums and others set a flat fee. The amount of coverage provided varies, as some states have limits on the fund's liability and others do not. The fund's policy on accumulating reserves to pay future claims and whether coverage is provided on an occurrence or claims-made basis can also affect rates. Occurrence policies cover the member as long as they had coverage at the time of the incident, while claims-made coverage requires the member to have coverage at the time the claim is filed. One must assess the value of these features when comparing the affordability of different funds.

**Table 5.2 : Other States' Rates for Excess Malpractice Coverage for Two Specialities<sup>1</sup>**

FY 99-00		
State	Internal Medicine	OB/GYN
South Carolina	\$1,008	\$5,225
Indiana	\$1,803	\$15,326
Kansas	\$991	\$5,956
Louisiana <sup>2</sup>	\$3,080	\$11,119
Nebraska	\$130	\$635
New Mexico	\$4,476	\$15,543
Pennsylvania <sup>3</sup>	\$4,253	\$21,613
Wisconsin	\$2,531	\$15,186

- 1 Rates are for maximum coverage provided. If coverage is claims-made, the mature rate is taken.
- 2 Rates listed are for occurrence coverage; mature claims-made coverage is available for an Internist for \$2,833 and an OB/GYN for \$10,232.
- 3 Rates listed are the average rates for the 5 territories of the state.

Source: State funds listed.

The PCF's rates used for comparison are occurrence rates. The rates of the PCF are a percentage of the prevailing JUA rates. As of June 1, 1999, the PCF charge was equal to 110% of the JUA rate for all providers. The fee for a provider specializing in internal medicine is \$1,008 and an OB/GYN is \$5,225 (see Table 5.2). Though other states, such as Nebraska, have lower rates for excess medical malpractice coverage, the coverage of the PCF is broader. The PCF coverage starts at \$100,000 and is unlimited; Nebraska's coverage begins at \$200,000 and is capped at \$1.25 million. Wisconsin, which also provides unlimited liability coverage, charges providers a flat fee based on their specialty. Wisconsin's coverage starts higher than South Carolina's — at \$1 million. This year Wisconsin's fees are \$2,531 for an internist and \$15,186 for an OB/GYN, more than double what the South Carolina PCF charges.

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## Paid Claims Experience

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The number of reported medical malpractice awards in South Carolina has been low compared to other states, but the incidence has been rising. The National Practitioner Data Bank (NPDB) provides claims information by state. Insurers and self-insureds must submit a malpractice payment report to the NPDB when a malpractice payment is made.

The NPDB ranks each state, including the District of Columbia, from 1 to 51, with the state ranked 1 having the lowest occurrence of malpractice claims. According to the NPDB's cumulative data for the period of September 1, 1990, to December 31, 1998, South Carolina ranked number 4 for the number of malpractice payments per 1,000 physicians and nurses, and number 1 for the number of claims per 1,000 dentists. For this period, S.C. had 9.69 paid claims per 1,000 physicians, 5.09 per 1,000 dentists, and .05 per 1,000 nurses. The cumulative average for the NPDB was 20.75 claims for each 1,000 physicians, so South Carolina's incidence has been almost half the national average. In reviewing other states with excess malpractice funds, only two had better rankings. Wisconsin ranked number 2 for physician claims, and Indiana ranked number 3 for nurse claims.

For the same period, South Carolina's mean payment for malpractice claims was \$134,540, and the median payment was \$70,000. The average mean and median payments reported to the NPDB were \$167,031 and \$61,220, respectively. South Carolina's median payment in 1998 was \$75,000 which ranked 8<sup>th</sup> out of 51 with 1 being the lowest. Comparative payment information for excess malpractice funds is shown in Table 5.3. For FY 96-97 and FY 97-98, the number of claims and amounts paid for the South Carolina PCF are among the lowest of the funds.

**Table 5.3: Claims for Excess Malpractice Funds**

State	FY 97-98		FY 96-97	
	Number of Claims Paid	Amount Paid	Number of Claims Paid	Amount Paid
South Carolina	25	\$9,917,941	25	\$11,545,691
Indiana <sup>1</sup>	139	\$64,501,022	119	\$56,713,853
Kansas	66	\$12,834,705	41	\$13,653,618
Louisiana	165	\$64,976,879	151	\$61,984,567
Nebraska <sup>1</sup>	11	\$2,860,428	11	\$3,324,598
New Mexico	Not available	Not available	Not available	Not available
Pennsylvania <sup>1</sup>	624 <sup>2</sup>	\$269,836,617	616 <sup>2</sup>	\$268,321,044
Wisconsin	24	\$18,718,458	16	\$34,679,277

1 Claims data is for calendar years 1997 and 1998.

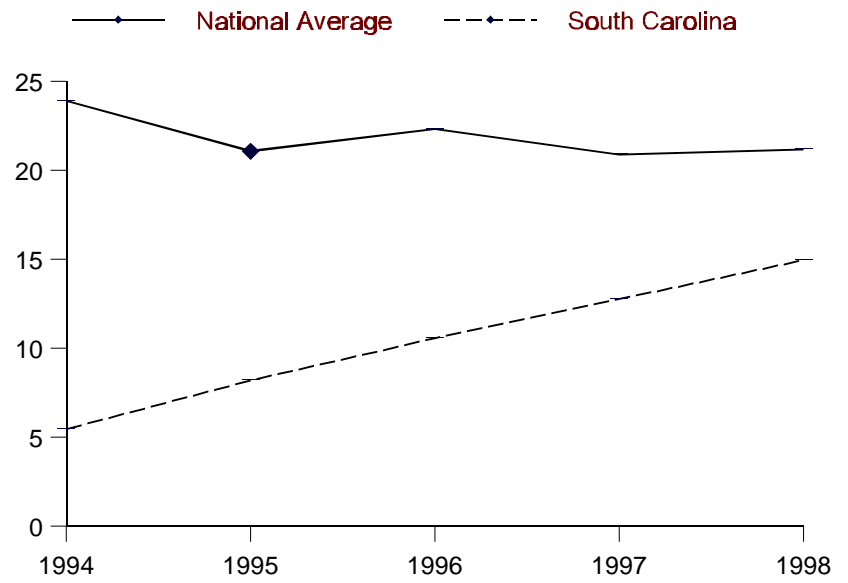
2 Figure represents the number of healthcare providers with claims paid against them, not the number of claims paid.

Source: State funds listed.

South Carolina's incidence of claim payments appears to be rising (see Graph 5.1). Data from 1994 – 1998 shows that the number of reports per 1,000 physicians has increased each year. The NPDB average does not show the same yearly increase. In 1998 there were 15 states with a lower claims rate.

If this trend continues, it will be increasingly important for the PCF to establish adequate reserves and reduce its risks.

**Graph 5.1: Malpractice Payment Reports Per 1,000 Physicians**



Source: National Practitioner data bank (NPDB) Annual Report 1998.

# Agency Comments

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**Appendix A**  
**Agency Comments**

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C. Tucker Weston, MD  
Chairman of the Board

**South Carolina Medical Malpractice  
PATIENTS' COMPENSATION FUND**

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C. Tucker Weston, MD

January 7, 2000

George L. Schroeder, Director  
Legislative Audit Council  
400 Gervais Street  
Columbia, SC 29201

Dear Mr. Schroeder:

This is the South Carolina Medical Malpractice Patients' Compensation Fund's response to the Legislative Audit Council's December, 1999 report A Review of the Medical Malpractice Patients' Compensation Fund.

The primary thrust of the LAC Report is that the Medical Malpractice Patients' Compensation Fund (PCF) and the Medical Malpractice Liability Insurance Joint Underwriting Association (JUA) should be discontinued since affordable coverage is available through private insurance companies.

Apparently LAC has not done an Economic Impact Study of the affect of the discontinuation of the PCF and the JUA. Coverage with private insurance companies will be both expensive and limited. The cost of coverage could be more than double the PCF/JUA costs and the maximum coverage will be \$1,000,000/\$3,000,000. The limited coverage will increase the health care provider's personal exposure and increase preventive or defensive testing of patients thereby substantially increasing health care costs of the general public.

In the mid seventies the General Assembly created the PCF as well as the JUA and provided the state's health care providers with the best liability coverage at the lowest cost in the United States. The General Assembly also gave the health care providers the responsibility for funding and operating these organizations. The PCF and the JUA have been very successful due to the fact that health care providers are responsible for their funding and their operation. Nothing has changed that would prevent the PCF and the JUA from continuing to provide the best coverage at the lowest cost in the future.

The following is the PCF and the JUA's response to the recommendations and conclusions contained in the LAC Draft Report:

## **LAC Report: LIABILITY, RISK & PURPOSE OF PCF**

### **State Liability**

**An informal opinion from the Attorney General's Office concluded that the state should not be liable for claims made against the PCF.**

### **Reserve & Risk**

**The PCF has not maintained adequate reserves to pay future claims. A Department of Insurance analysis estimates that the PCF has a minimum reserve deficiency of \$30 million. Also, the PCF methods of establishing reserves are inadequate and have resulted in a pattern of reserve deficiencies. The PCF has substantially less in reserves than funds in other states.**

PCF Response: The PCF's statutes clearly gives the PCF health care members sole responsibility for the PCF funding with no provision for any funding from the state or any other sources.

The PCF is a state risk pool and not an insurance company. The LAC compares it to insurance company standards in this report. This is not an appropriate comparison since the PCF is not subject to the insurance company statutes. The PCF's statutes clearly state that the PCF Board of Governors has the responsibility of determining the sufficient level of funding necessary to pay the PCF's liabilities. This was not the case for the first ten years of the PCF's operation when the General Assembly determined the PCF level of funding and the amount of the fees necessary to generate this fund. Act No. 674 of 1976 (PCF enabling legislation) Section 5 makes provision of a \$4 million limit of PCF funding with an assessment of members when the PCF funds reached the level of \$3.5 million. This section also provided for surcharges (fees) based on the Joint Underwriting Association's premium level. Act No. 55 of 1979 raised the limit of PCF funding to \$6 million with a member assessment when the funding reached \$5 million. This act also discontinued member fees after four years of membership. Act No. 443 of 1986 removed the statutory funding provisions and provided that all PCF members would pay annual membership fees. It also gave the PCF board the authority to determine that the PCF had sufficient money available to meet the fund's liabilities. This provision has been in place since May 28, 1986 to the present time. During this thirteen year period the PCF board has adjusted fees upward five times and downward five times and made no change in the fee level in three years. The board made an assessment in 1998 in addition to an upward fee adjustment in that year. The board utilizes the services of a consulting actuary to assist it in determining the level of funding needed to meet the fund's liabilities. The PCF's consulting actuary was the Department of Insurance Chief actuary when he began working for the PCF in 1989 under a state dual employment contract. The consulting actuary resigned from the South Carolina Department of Insurance in 1997 and he is currently the Chief Property and Casualty Actuary for the Insurance Department of the State of Hawaii, an actuarial consultant for the states of Oklahoma and Florida. He is also an actuarial consultant for another South Carolina risk pool, the Second Injury Fund and the Department of Consumer Affairs for insurance premium rate filing with the Department of Insurance. The PCF consulting actuary states that the Department of Insurance review for LAC is not appropriate in that improper methods were utilized to reach inaccurate conclusions.

The PCF board believes that it has made the necessary fee adjustment and member assessment to have sufficient money to pay the PCF liabilities.

## **LAC Report: CLAIMS RESERVES IN OTHER STATES**

**S.C. IN KS LA NE WI**  
Millions \$19 \$125 \$203 \$220 \$63 \$462

**The PCF has primarily operated on a pay-as-you-go basis because it has the authority to assess its members if necessary. However, this approach is riskier than maintaining adequate reserves.**

PCF Response: While the PCF has the same mission of payment of health care providers excess liabilities it is quite different from any of the other state funds. Even though the Indiana and Wisconsin PCF legislation were copied by South Carolina there are a great many fundamental differences in their legal responsibilities. Both of these states have mandatory health care membership in their fund and both funds are the sole source the claimants have for the collection of their excess claims. The PCF is not the sole source of excess claim payment and South Carolina health care providers may be sued for the full amount claimed. The cost of the sole source method is considerable more expensive as indicated by the reserves in these funds.

## **LAC Report: PARTICIPATION IN PCF IS VOLUNTARY.**

**If faced with large and repeated assessments, many members might opt to obtain their malpractice insurance from the private market. Pennsylvania's excess malpractice fund operates on a pay-as-you-go basis, but fund membership is mandatory.**

PCF Response: The LAC's recommended funding levels would result in large and repeated assessments. Since the private insurance companies doing business in Pennsylvania have the sole fiscal responsibility for the Pennsylvania fund, they must consider pay-as-you-go to be the appropriate method of funding.

## **LAC Report: THE PCF HAS UNLIMITED LIABILITY.**

**There is no limit on the amount of an award for which the PCF could be responsible. Wisconsin has the only other state excess malpractice fund and it has mandatory membership.**

PCF Response: The non-mandatory PCF has prospered for over twenty years providing unlimited protection for South Carolina health care providers. Wisconsin like South Carolina does not have a liability cap for its' health care providers, however it is the sole source of payment to the claimants and the Wisconsin fund costs are almost three times the PCF costs.

## **LAC Report: THE PCF DOES NOT MAINTAIN REINSURANCE.**

**Reinsurance is designed to lessen the impact of large claims by paying the amount of any award above a certain level. The state's Insurance Reserve Fund carries reinsurance.**

PCF Response: The cost of reinsurance for private insurance companies is the reason the PCF was created. The PCF provides unlimited protection much cheaper than the costs of reinsurance. The state's Insurance Reserve Fund has limited liabilities of \$1 million yet its reinsurance is so expensive that its rates are higher than the unlimited PCF/JUA costs.

**LAC Report: THE PCF IS NOT SUBJECT TO OVERSIGHT BY ANY REGULATORY BODY.**

**Other insurance entities in South Carolina regularly file reports with and are examined by the South Carolina Insurance Department to insure they operate in a responsible manner. The majority of the PCF board and all PCF members are health care providers who may have inadequate expertise in issues related to insurance.**

PCF Response: The Department of Insurance regulates all insurance companies operating in South Carolina, however the Department of Insurance does not regulate other state agencies including state funds such as the PCF.

The PCF statutes provides PCF oversight from the State Auditor, the State Comptroller General and the State Treasurer. The State Budget and Control Board provides oversight and services to the PCF through the Office of State Budget, the Office of Information Resource Management, the Office of General Services, the Office of Human Resource Management, the Office of Insurance Services, the Office of Research and Statistical Services, the State Accident Fund and the State Retirement System.

**LAC Report: NEED FOR THE PCF**

**We reviewed the need for the PCF and examined whether the fund is still needed. The private malpractice insurance market should be able to furnish malpractice coverage to health care providers.**

PCF Response: The General Assembly considered health care to be vital to our citizens when it created the PCF's and JUA's enabling legislation and it considered them to be necessary after the private insurers returned to South Carolina. South Carolina health care providers have indicated their preference for the PCF and the JUA by their continuing support. The LAC report indicates that the private insurers are the only parties concerned by the PCF's and JUA's low costs for coverage that is far superior to the coverages available from these insurers. The PCF is directly responsible for the payment of millions to injured patients with no cap or limit as to the amount to be paid.

**LAC Report: FOR FURTHER STUDY OF NEED FOR THE JUA**

JUA and PCF Response: The General Assembly created the JUA by way of Joint Resolution with the JUA having a life span of two and one half years. The need for the JUA's continued existence was considered by the General Assembly at the end of the two and one half years and the joint resolution was extended for a year. The General Assembly continued to consider the need for the continued operation of the JUA periodically until it enacted Act No. 199 of 1983 which provided "That this act shall take effect upon approval by the Governor and shall expire upon the determination by the General Assembly that the South Carolina health care providers have no need for the Joint Underwriting Association."

A comprehensive study of the need for the JUA was made by the Joint Legislative Insurance Study Committee chaired by Senator Edward E. Saleeby. The committee determined that while medical malpractice insurance was available in South Carolina through private insurance companies, the cost of coverage was not affordable and the committee recommended the continued operation of the JUA. Ms. Mary Lou Price in Senator Saleeby's office was the director of the Joint Legislative Insurance Study Committee at the time the JUA study was made and she is attempting to locate the records of this study. Senator Saleeby and Ms. Price are a source of confirmation of the results of the study in the event the records cannot be located. The South Carolina Dental Association, the South Carolina Hospital Alliance, and the South Carolina Medical Association all feel very strongly that the JUA is needed by South Carolina health care providers and that it should be continued.

**LAC Report: The PCF does not have adequate written policies and procedures.**

PCF Response: The PCF's written procedures were developed over twenty-two years of operation of the fund and have adequately served the needs of providing all of the services involved in the PCF operations. The Board of Governors, at the recommendation of the PCF Operations Committee approves all of the administrative procedures.

**LAC Report: The PCF routinely grants retroactive coverage to members after a claim is filed.**

PCF Response: The PCF Board of Governors formally reviews requests for retroactive coverage and has granted retroactive coverage when the basis of the requests were valid. Most of these requests involved failure of the PCF to furnish renewal notices to professional associations. In no instance has the PCF incurred additional expense through claim payments for any of the retroactive coverage granted by the PCF. No requests for retroactive coverage were adopted administratively.

**LAC Report: The PCF does not adequately verify information received from the primary insurer about claims. Proper documentation of accident dates and settlement amounts is needed to verify coverage and payments made from the fund.**

PCF Response: The PCF verifies the information from the basic insurer before payment is made by way of a written request from the primary insurer along with copies of the recommendations of the defense attorneys, verification of the date of accident is furnished by the JUA by way of a copy of the form used to establish claims involving lawsuits and by copies of the lawsuit from other primary insurers. Proper documentation of settlements are furnished by primary insurers by way of court orders of dismissal of the suit and a copy of the release signed by the claimant. This verification fully serves the intended purpose of determining if the PCF owes and pays the appropriate amount on all claims.

**LAC Report: The PCF does not have appropriate controls to insure the accuracy of key information about claims in its computer database.**

PCF Response: The Legislative Audit Council auditor obtained the PCF's entire database including all claims data. The auditor was informed that the claims database was incomplete and that the PCF was in the process of manually keying claims data from the Claims Log into the database with the help of temporary keying personnel and that the PCF had not had time to verify the accuracy of the claims data. The claims database was approximately 85% complete at this time. An audit system will be implemented at the completion of the transfer to the database.

**LAC Report: The PCF does not have appropriate controls to insure that it is informed of pending claims.**

PCF Response: The primary insurers are very helpful in assisting the member health care providers to report the potential claim to the PCF. The great majority of claims are reported on a timely basis and no problems have resulted from any delayed reporting. This is not a critical issue and does not warrant action against the member health care providers who are the only parties responsible for the notification of potential claims.

**LAC Report: The PCF does not report claims payments to the National Practitioner Data Bank in a timely manner.**

PCF Response: The federal law provides for a \$10,000 fine for the filing of a late report of claim payment to the National Practitioner Data Bank and the PCF is very careful to make reports on a timely basis. The PCF has never had a complaint or a fine from the Data Bank for late reporting.

**LAC Report: COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT AND THE ADMINISTRATIVE PROCEDURES ACT.**

PCF Response: Freedom of Information Act. The Attorney General's office reviewed the question of the PCF's violation of FOIA and has advised that the FOIA allows disclosure of the PCF claims report and the decision to release the report is one for the PCF board and its legal counsel to make. The Claims Committee Report is submitted as a record of the committee's actions during each quarter.

Proxies are not utilized by the PCF committees and the Board was not aware that a statutory provision for their use was necessary. The Board will not utilize proxies unless it has the authority to do so.

PCF Response: Administrative Procedures Act. The PCF is in the process of establishing regulations in compliance with the APA and will have them in place as soon as possible.

**LAC Report: The PCF executive director works for the Medical Malpractice Joint Underwriting Association (JUA), a private organization as part of his state job.**

PCF Response: The PCF Director has performed the same duties for the PCF and JUA during their entire existence. The first ten years as an employee of the South Carolina Department of Insurance and the last fourteen years as the Director of the PCF. The Boards of the PCF and the JUA as well as the Chief Commissioner of the South Carolina Department of Insurance approved of this method of administering the PCF and the JUA. The Budget and Control Board's Office of Human Resources were formally notified in writing as was the Joint Legislative Agency Head Salary Commission. None of these organizations found any problems with this arrangement.

**LAC Report: Seven of the eleven current PCF board members are serving with expired terms. One consumer member position has been vacant since 1987. Five of the current board members have served since the PCF began in 1977.**

PCF Response: This is the largest number of board members serving after their six years had expired, however, since the inception of the PCF there have been numerous delays in the reappointment or replacement of the members whose terms had expired. In some instances the organization responsible for recommending the reappointment or replacement of a board member whose term had expired failed to make timely recommendations to the Governor and in other instances the Governor did not make timely reappointment or appointments for the members with the expired terms. The 1987 consumer member was appointed to the PCF board and before attending a PCF board meeting was appointed to a different board by the Governor and no replacement was appointed. The PCF will ensure that the Governor's Office is made aware of board vacancies and expired terms.

## **LAC Report: MEMBERS AND CLAIMS PAYMENTS**

### **PCF Membership**

**Over the last ten years, the PCF's activity has greatly increased. The number of PCF members increased to 8,372 as of June 30, 1999. The number of open claims more than doubled during this period, from 382 in FY89-90 to more than 900 in FY98-99.**

PCF Response: The increase in PCF membership has been consistently increased each year due to the cost differential between the PCF/JUA and private insurance companies as well as the broad unlimited coverage that was provided. The increase in claims frequency has increased in proportion to the increase in members with the exception of 1997 and 1998 when approximately four hundred breast implant suits were filed.

## **LAC Report: PCF CLAIMS PAYMENTS**

**The PCF's claims payments have been rising. Since it began in 1977, the PCF has paid a total of \$81 million to settle 243 medical malpractice claims. More than half of this amount, \$45.6 million, has been paid in the last four years.**

PCF Response: The severity of PCF claims has increased over the past five or six years due to the change in the jury pool from registered voters to licensed drivers along with the increased costs of health care for the past injury care of claimants. It is not unusual for a claimant to present medical expenses in excess of \$1 million and if a court award is made the amount of the award will reflect these expenses. The courts have provided some relief to these expenses that are incurred by Medicaid patients and are limiting the allowed expenses to the amount actually paid by Medicaid which is usually a fraction of the amount billed by the health care providers.

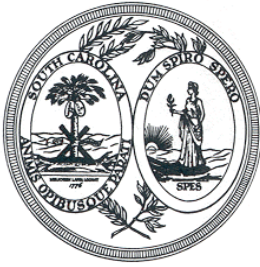
There are not enough of the multimillion dollar awards or payments to constitute a trend.

In summary, many health care providers, attorneys, insurance agents and members of the general public who served on the PCF Board of Governors as well as the Department of Insurance, the Attorney General's Office, the Comptroller's Office, the Treasurer's Office and numerous Budget and Control Board subdivisions have worked closely in the operation of the PCF since its inception. Their combined efforts along with the support of the state's entire medical community have resulted in a successful method of providing affordable coverage that is beneficial to the citizens of this state.

Respectfully submitted,



Calvin L. Stewart  
Executive Director



**South Carolina  
Department of Insurance**

1612 Marion Street  
Columbia, South Carolina 29201

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**JIM HODGES**  
Governor

**ERNST N. CSISZAR**  
Director of Insurance

January 10, 2000

**VIA HAND DELIVERY - TO BE PICKED UP**

George Schroeder, Director  
Legislative Audit Council  
Suite 315  
1331 Elmwood Avenue  
Columbia, South Carolina 29201

Dear Mr. Schroeder:

This letter is to inform you that the South Carolina Department of Insurance has no comments on Chapter 2 of the Audit of the Patients' Compensation Fund.

Yours very truly,

A handwritten signature in black ink, appearing to read "Ernst N. Csiszar".

Ernst N. Csiszar

ENC/cjh

G:\WP\PCFAUDIT.LTR



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This report was published for a total cost of \$510; 200 bound copies were printed at a cost of \$2.55 per unit.