Department of Planning and Budget
2004 Fiscal Impact Statement

1. **Bill Number** SB601

   House of Origin ☐ Introduced ☒ Substitute ☐ Engrossed

   Second House ☐ In Committee ☐ Substitute ☐ Enrolled

2. **Patron** Newman

3. **Committee** Courts of Justice

4. **Title** Medical professional liability insurance; state risk management plan

5. **Summary/Purpose:** The bill would provide professional medical liability insurance to physicians and sole community hospitals under the state's risk management plan under certain cases if they were not able to acquire adequate private insurance coverage. A physician qualifies to enter the risk management plan if he or she holds a valid medical license, participates in the Medicaid program or provides services at a "free clinic", participates in the Virginia Birth Related Neurological Injury Fund if eligible, and has active hospital privileges or participates in a quality assurance committee. The final requirement to qualify for the state plan is the physician was refused an insurance premium quote by a private insurer or received two quotes from private carriers that exceed 125 percent of the premium last paid by the physician or has a private carrier that became insolvent or stopped writing professional liability insurance in Virginia. A sole community hospital basically has the same requirements as a physician to qualify for the state plan except that it would qualify if it received two premium quotes from a private carrier that exceeds 110 percent of the premium last paid by the hospital.

   The physicians and hospitals that qualify would be required to pay premiums to cover all the costs of the risk management plan including the costs to administer the plan by the Division of Risk Management in the Department of the Treasury.

   Physicians and hospitals that choose to purchase coverage under the state plan would also have the option to purchase prior acts coverage or coverage for claims arising since the termination date of the last professional insurance policy providing coverage. Also, physicians who elect to retire, while covered under the state plan, would be entitled to purchase extended reporting period endorsement coverage for a period not to exceed 10 years from the date of retirement.

   The coverage under the state plan can be renewed for as long as the physician and hospital meet the requirements of the state plan.

   The bill has a second enactment clause that requires the Senate Committee on Rules to appoint a subcommittee of three members of the Senate to study the availability and affordability of professional liability insurance for physicians and hospitals in the Commonwealth. The Division of Legislative Services shall provide staffing and the subcommittee shall receive information and input from the Bureau of Insurance at the State

Corporation Commission, the Medical Society of Virginia, the Virginia Trial Lawyers Association, and the Virginia Hospital and Healthcare Association. The findings of the subcommittee shall report to the Chairman of the Senate Committee on Courts of Justice by December 1, 2004.

The bill also has an emergency enactment clause making the bill effective from its passage.

6. Fiscal Impact Estimates are preliminary: SEE ITEM 8.

6a. Expenditure Impact: This impact only shows the impact on the state budget.

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$2,077,000*	2.00	GF
2004-05	$464,000*	2.00	NGF
2005-06	$464,000*	2.00	NGF
2006-07	$464,000*	2.00	NGF
2007-08	$464,000*	2.00	NGF
2008-09	$464,000*	2.00	NGF
2009-10	$464,000*	2.00	NGF

*In any year where the fund has insufficient cash to pay claims, funding from a treasury loan would have to be used to cover the claims.

6b. Revenue Impact: SEE ITEM 8.

7. Budget amendment necessary: Yes, Item 290 in SB 29 to provide the initial funding for the program. Nongeneral fund appropriation must also be provided in Item 290 in SB 30. Also, the line of credit in Part 3, §3-2.03 in SB 30 must also be adjusted.

8. Fiscal implications: The bill would have a fiscal impact on the Commonwealth. The bill adds, under the state's risk management plan, liability coverage for physicians and community hospitals. The state's risk management plan primarily provides coverage for public entities, but this bill extends coverage to private individuals and private entities. Therefore, in order to provide such coverage the Department of the Treasury would have to set up a separate risk management plan. The current risk management plan is self-insured (except for the property insurance portion). Therefore, the department charges premiums to cover all of the costs of the plan. Including coverage for non-governmental entities requires such coverage to be segregated into a separate plan so that public funds are not mixed with private funds. This already occurs in the case of local government liability, which is segregated so that only local government premiums support the plan and not state funding.

With regard to the cost of the bill to the state, the risk management plan (hereafter "plan" references the risk management plan created by this bill) is impacted in two ways: administrative and programmatic. The Department of the Treasury will incur additional costs for staff and operating costs to handle the increased workload and to deal with the specialized nature of the insurance coverage provided. The following details the administrative costs.

Administrative Costs	FY 2004*	FY 2005	FY 2006
Claims Manager	$15,000	$89,000	$89,000
Eligibility Representative	$11,000	$65,000	$65,000
Operating Costs	$9,000	$50,000	$50,000
Insurance Consultant	$21,000	$125,000	$125,000
Actuary	$21,000	$125,000	$125,000
TOTAL	**$77,000**	**$454,000**	**$454,000**

***** *Due to the emergency clause, the FY 2004 fiscal impact includes funding for the months of May and June.*

The administrative costs of the plan include staffing for two additional positions within the department. This includes $89,000 for a claims manager ($70,000 annual salary and $19,000 for fringe benefits) for processing claims. The department also needs an eligibility representative at a cost of $65,000 per year ($50,000 salary and $15,000 for fringe benefits) to process applications and verify the eligibility of the physicians and hospitals that would apply for coverage. Another $50,000 is necessary annually for office expenses (rent, office supplies, and other related operating expenses) and information technology expenses.

The department will also have to contract with an insurance consultant to develop an application and verification process and an actuary to determine premiums based on claims experience and the financial stability of the risk management plan. Some of these administrative expenses are likely to go down in future years after some of the initial up-front activities necessary to initiate the plan have been completed. However, administrative expenses may be higher depending on the number of physicians and hospitals that actually choose coverage under the plan.

Initially, the Commonwealth will have to use its own funding to cover the initial administrative expenses of the plan until premiums are collected and the plan becomes self-supporting.

Programmatic Costs

The major cost to the state, at least initially, will be the programmatic expenses of the plan that includes legal costs and claims payments. Until the premium revenue is sufficient to cover the full costs of the program, the Commonwealth would have to use its own resources to cover such costs.

The legal expenses are difficult to estimate because medical malpractice cases are complex and have substantial legal costs associated with them. Furthermore, there is little information regarding the size of the pool to be insured and the number of claims to be handled each year. Assuming $200 an hour for a medical malpractice lawyer (on contract or on retainer), would cost $200,000 for 1,000 hours of work, but without knowing the number of claims that would be handled no estimate can be provided. The uncertainty of the legal costs can only be estimated as part of the funding needed to support the initial costs of the plan.

The initial estimate of upfront state funding for programmatic costs is $2.0 million. This amount is based on the fact that enough funding should be available to pay one significant claim and to cover legal costs. The current medical malpractice limit for damages is limited to $1.7 million under state law. Allowing for another $300,000 for legal costs and other claims totals $2.0 million. If for some reason the claim payments were higher or legal costs more substantial, then the state would have to cover those costs to ensure the plan has sufficient funding to cover its costs. However, the claims costs for the first year should not be significant since it generally takes a substantial period of time to settle a medical malpractice claim.

Impact on the State

State funding is impacted in two ways by the bill. First is the amount of initial funding that is necessary to begin to pay expenses of the plan until premium revenue is sufficient to cover those costs. This amount is expected to be $2,077,000 ($2,000,000 programmatic and $77,000 administrative) in FY 2004. This amount of funding must be funded from state resources in order to start the plan.

The second impact on the state could occur due to insufficient funding of premium revenue to cover all of the plan's expenses. The actual number of physicians and community hospitals to enroll in the plan is a significant unknown and indeterminable at this time. There are 14 community hospitals and thousands of physicians who could potentially enroll in the plan due to the criteria that a physician would only need a 25 percent increase in their premium to qualify. Therefore, with the size of the pool and thus the state's ultimate liability a significant unknown, the state would have to use its resources to make sure all the expenses of the plan are paid. If some or all of the physicians and community hospitals that are covered under the plan eventually end their coverage, for whatever reason, and the plan loses its base of premium revenue, the state will be responsible for all the expenses of the plan until all the claims are settled. Considering that the plan provides for prior acts coverage and extended coverage for up to 10 years after physicians retire, it is not possible to determine the state's total financial exposure of the plan at this time. However, any actuarially determined unpaid claims liability will be reported on the Commonwealth's balance sheet along with the appropriate footnote disclosure on the risks on the plan.

Assuming that the premium revenue, once it begins to be collected, is sufficient to cover all the costs of the plan, then the initial funding provided by the state can be repaid. Therefore, the first two to three years may have higher premiums in order to pay off the upfront costs.

The Department of the Treasury does have a line of credit authorized in the Appropriation Act in the amount of $15 million. The line of credit allows the agency to use general fund cash balances on a temporary basis. Since using the line of credit would cost the state interest on those balances and since it is designed to be an emergency reserve for the entire risk management program, it should not be used for the initial cost of starting a plan for physicians and community hospitals. However, since this bill expands the risk management

program and creates a potential cash flow shortfall for the state, the line of credit should be increased to cover any potential losses.

Premium Cost of the Plan's Coverage
According to information the Department of the Treasury has received, the initial plan may have about 60 physicians and one community hospital that qualify for coverage. Based on the initial estimate of upfront costs of nearly $2.1 million, the amount of premiums charged for the first year would likely match that amount. However, it is difficult to estimate the amount to be charged since the size of the insurance pool is not really known with any certainty and there is no claims history available to make an actuarial estimate. The total pool itself is likely to be extremely small making it hard to spread the risk. Therefore, it is likely that the premium level, especially in the first few years, will not likely be any more affordable than insurance provided through the private sector. The premium of each physician and community hospital will be based on claims history and other criteria the Department of the Treasury develops to determine risk to the overall pool.

9. **Specific agency or political subdivisions affected:** Department of the Treasury.

10. **Technical amendment necessary:** No.

11. **Other comments:** The bill provides no consideration for the claims experience of physicians that may be eligible for the risk management plan, providing only that as long as the physician's premium exceeds 125 percent of the last premium paid, then he or she is eligible.

West Virginia's Program
The State of West Virginia created a similar program within its risk management program in December 2001. Premium rates are required to be at least as high as any insurer with at least five percent of the market in the state.

During the fiscal year-ended June 30, 2003, the program insured 1,193 physicians, 15 hospitals, and 19 clinics. The program sustained an operating loss of nearly $2 million during the year on premium revenues of nearly $21 million. Program assets totaled nearly $56 million, which included a $24 million loan to the West Virginia Tobacco Settlement Fund. Current liabilities exceeded $42 million, including a loan from the State of West Virginia of $24.5 million. Long-term liabilities primarily consisted of estimated claims incurred but not reported of $16 million. At year-end, the program's unfunded liability totaled nearly $2.7 million.

Effective July 2004, newly passed legislation will end the program under the state's risk management program and all the insured physicians, hospitals and clinics will be transferred to a newly created physicians mutual insurance company. The West Virginia statute that makes the change states that the change is due to the state's determination that the state-run program is a substantial actual and potential liability to the state. The state legislature also found that a physicians mutual insurance company has been a successful mechanism in other

states. The company is a domestic, private, nonstock, nonprofit corporation, which has been incorporated and is in the process of becoming licensed. West Virginia has committed to providing the physicians mutual company with a $24 million capital loan.

Date: 02/13/04 / mst
Document: G:\Ga Sessions\2004 Session\Fis\Sb601S1.Doc

cc: Secretary of Finance