## IV. The Cost of Providing Malpractice Coverage

The cost of insurance or the funding or a state-run risk pool would vary substantially based on the statutory protections (if any) the State of California would adopt.

A. Statutory Immunity- Change in the Standard of Care

If state law made volunteer physicians immune for common negligence similar to the model adopted by Arizona, Oregon, Virginia, Washington and Wisconsin, then the cost of purchased insurance would be significantly less.

Arizona, for example, is a state that has statutory immunity for physician volunteers in which the physician would only be liable if he/she committed gross negligence. Therefore, the cost of insuring the volunteer is substantially less than if the volunteer would be liable for common negligence. The Mutual Insurance Company of Arizona (MICA) offers volunteer insurance coverage to retired physicians who wish to continue providing medical care.[75] According to Robin Charles of MICA, the policy only provides coverage to the physician when he/she provides care on a voluntary basis with or without direct remuneration. Guidelines have been established to limit the scope of practice and liability exposure: the volunteer retired physician must have a valid medical license or permit from the appropriate licensing board; services must be rendered on a volunteer basis with no financial compensation; services must be provided at an approved facility with liability coverage acceptable to MICA; the volunteer retired physician must have been a prior MICA insured physician before applying for this limited coverage policy and was issued a MICA extended reporting endorsement (tail coverage); and the applicant must have retired while insured with MICA. The physician is insured for $1,000,000 per occurrence; $3,000,000 aggregate. The cost of the insurance per year is

$100. Since the inception of the MICA program, there have been no losses or claims involving the retired physicians.

B. State Actor Immunity

If California considered volunteer physicians as "state actors" similar to the model adopted by Florida or Georgia, then there would be no cost to the state, but the professional liability risk exposure would increase. Since California currently does not purchase medical malpractice insurance for its physician employees, nor does it maintain a risk pool for professional liability claims, it would be difficult to assess a cost of liability for the "state actor" model.

Limited data is available from other states that have adopted the "state actor" model for physician volunteers. From our extensive research, we could find no evidence that those "state actor" immunity states maintain a self-insured risk pool for potential claims. As referenced earlier in this report, the state of Florida does maintain good data about its claims history. Florida reports that the Program's total patient visits for fiscal year 2006-07 was 290,026. In 2006-07, Florida reports nine claims were filed against the Volunteer Health Care Provider Program. Defense costs were just over $550,000. Settlement costs were $293,000.

In April, 2007, the State of Wisconsin proposed legislation that would make volunteer health care providers "state actors" when providing health care free of charge to patients of non-profit entities. In its fiscal analysis of the bill, the state's Division of Executive Budget and Finance concluded the fiscal effect of this bill is "Indeterminate". The financial analysis concluded, "If these volunteer health care providers were added to the department for liability purposes, and claims were made against them, the department's liability premiums would also increase. However, the amount by which the premiums will increase as a result of the bill cannot be estimated."[76]

There does not appear to be an identified methodology to determine the fiscal impact of a sovereign immunity model. Currently, the State of California maintains no data about the number of clinical physicians it employs in the state or the number of claims, or dollars expended in the defense/settlement/judgment of those claims.[77] The State of California does not maintain a risk pool/self insurance program for professional liability; nor does it purchase umbrella coverage for medical malpractice. The state's Attorney General is responsible for the defense of any claim brought by the state, and all costs, settlements or judgments associated with the claim are paid by the state agency or by the General Fund.[78] Therefore, it is not possible to determine what the additional cost to the state would be if physician volunteers would be deemed state actors when providing voluntary, uncompensated care.

C. Purchased Insurance

If California adopted legislation that would enable the state to purchase (or reimburse providers for) professional liability insurance premiums, similar to the model adopted by Washington, Minnesota and Kentucky, then there would be additional cost to the state.

Minnesota's Voluntary Health Care Provider Program has been summarized earlier in this report. As of 2008, $65,000 is appropriated annually to purchase malpractice insurance for the volunteer health care providers (nurses, dentists and physicians) enrolled in the program. The $65,000 premium payments are paid out of the revenue generated from health care providers' licensing fees. (The state's physician license fee is $192). There are 18,797 licensed physicians in Minnesota. In 2002, The Minnesota Joint Underwriting Association, on behalf of the state, contracted with a local medical malpractice carrier to provide $1,000,000 per occurrence/$3,000,000 aggregate coverage for volunteer physicians. The cost of a policy for each volunteer physician is $5,000 per year (the cost for dental malpractice insurance is $1,500 per year; nursing practice liability coverage is $500). There are currently 26 providers enrolled in the program.[79] (See Appendix 4.)[80]

In Kentucky, the state maintains a professional liability reimbursement program for volunteer physicians. Since Kentucky law provides immunity from civil liability to uncompensated volunteers that provide services to non-profit organizations unless the volunteer engages in willful or wanton conduct, the cost of professional liability insurance would be substantially less than in a state that does not have an immunity statute. For registered charitable health care providers approved by the state, premiums for the professional liability insurance policies are paid out of the state's General Fund. There are 25 clinics registered as Charitable Health Care Providers with the state. Professional liability premium reimbursement for those providers for fiscal year 2006-07 was just over $100,000. For the 2007-08 fiscal year, to date, the state has reimbursed the charitable providers $42,000.[81]

Similarly, state of Washington has an immunity statute. The cost for providing insurance to providers who have rendered more than 50,000 encounters will be approximately $145,000 this year.[82] [83]

Insurance plans and programs vary from state to state. In California, there appears to be several options for purchased liability insurance for volunteer physicians.

The first option is the individual physician policy where the state would either purchase liability insurance for the volunteer physician or reimburse the volunteer physician for the cost of his/her insurance premiums.

In 2003, an amended bill was introduced by Assembly Member Nakanishi proposing to create the Physicians and Surgeons Liability Insurance Pilot Program (PSLIPP), to be administered by the State Department of Health Services. (See Appendix 2.) Under the proposed legislation, up to 100 physicians and surgeons would be covered through the pilot program, which would purchase liability insurance for health care professionals volunteering in specific public or not-for-profit agencies. The volunteer physicians and surgeons would be eligible for waivers of license renewal fees, and the bill would be contingent on receiving sufficient private funding to pay the costs of both administering

the program and purchasing liability insurance. An analysis of the bill indicated that, depending on the number, location, specialty, and whether the physician is considered to be low or high risk by liability insurers, the cost of liability insurance would be $1.1 to $1.9 million.[84] The 100 physicians proposed to comprise this pilot program were 40 family and general practice physicians, 50 internal medicine physicians, and 10 obstetrics/gynecologist physicians. There is no other data maintained by the state or Assemblyman Nakanishi's office that provide information about how this estimate was derived. By all accounts, it appears that the then-current estimate of insurance costs was based on individual medical professional liability premiums for full time physicians.

Rates for malpractice premiums are determined utilizing a complex actuarial calculation. Rates are derived by an aggregate rate analysis that evaluates historical loss ratios (losses/premiums) to determine how much rates need to be charged overall to achieve a target loss ratio. The second part of the equation involves rate relativities. These are derived for each specialty based upon historical experience. [85] Data from two of the major malpractice carriers in California identify that insurance premiums in Southern California are significantly greater than Northern California premiums. Ranges for malpractice insurance premiums for coverage with limits of $1,000,000 per occurrence/$3,000,000 aggregate are as follows: Annual premiums for primary care range from $6,300 to $16,000 for Family Practice and $8,100 to $16,100 for Internal Medicine. Rates for specialty care (non-surgical) range from $7,000 to 16,100 for Infectious Disease and $8,100 to $25,500 for Ophthalmology. Rates for high risk specialties such as Obstetrics/Gynecology range from $35,000 to $77,000. General surgery rates range from $29,000 to $54,500. Commercial carriers do adjust for part-time status, which would reduce an individual premium up to 50%. [86] [87] [88]

Utilizing the range of professional liability premiums in the primary care and subspecialty areas, we estimate that individual malpractice premiums for physician volunteers providing low to mid risk medical care (non-surgical) on a part-time basis (less than 20 hours per week) would be in the range of $3,000 to $6,500 for primary care and $5,000 to $10,500 per physician per year for specialty care (non-surgical).

The second option to provide malpractice coverage for volunteer physicians is where the state would purchase or reimburse a clinic for the cost of purchasing a clinic professional liability policy. At least one major professional liability carrier in California, NORCAL Mutual Insurance Company, has a specialized policy for non-profit clinics. This program is managed through an exclusive broker arrangement. The program has specific eligibility requirements in order to be considered for evaluation of coverage. Premiums are based on numerous elements including: the type of visits and services being performed at the clinic, geographical location, retroactive date of coverage, limits of liability, etc.

The policyholder for this type of insurance is the non-profit clinic and the physicians providing care at the clinic are added to the clinic's policy. The policy has a single, shared per occurrence/aggregate limit. According to NORCAL, the minimum premium per clinic begins at $5,000, but annual premiums are generally in the $15,000-$20,000 range.[89] This clinic policy model is likely more cost effective than the individual physician model.

Many clinics in California that serve the medically indigent are FQHC or other non-profit clinics so that physicians who volunteer their services are immune from certain liability by the Federal Tort Claims Act (see discussion in Section II A, above). Professional liability carriers such as NORCAL also offer "wrap" coverage for professional and general liability claims not immune under the FTCA, provided coverage for such claims is not excluded.

There may be other types of professional liability insurance programs available to California volunteer physicians, such as the "encounter based" model offered in the state of Washington (see page 24, above). In order to arrive at an accurate dollar amount for the true cost of purchasing medical professional liability insurance for volunteer physicians, a formal request for proposal should be issued by the state that should specify the following: 1) the scope of practice volunteer physicians could provide under the

proposed state program; 2) the type of services provided by the volunteer physicians; 3) the type of settings volunteer physicians may practice (e.g., hospitals, non-profit clinics, private offices) and 4) specifications for coverage including: the amount of coverage requested (e.g., $1,000,00/$3,000,000), type of coverage requested (professional / general liability,) etc.

Given the restrictions placed on public entities pursuant to the California Public Contracts Code Section 10515(a), we did not retain the expertise of a commercial medical professional liability insurer to provide data for premium rates or specific malpractice insurance programs.* It would be better if the Medical Board would issue a formal Request for Information or Request for Proposal through its standard procurement processes. If professional liability premiums were competitively bid, the state would be in the best position to obtain the most favorable rates for coverage for volunteer physicians.

D. Revenue Generation

In order for the state to purchase malpractice liability, revenues could be generated by increased physician license fees. Several states (e.g., Minnesota) have utilized physician licensing fees to fund their purchased professional liability program for volunteers. California has one the highest medical license fee in the country at $805, so the easiest route to generating revenue for volunteer physician malpractice insurance may be the most difficult to implement.** Certainly, if every licensed physician was assessed an additional $50 to the biennial fee, over $3 million could be generated annually, which could easily pay for malpractice coverage for 150-200 clinics, utilizing the NORCAL non-profit clinic insurance data (see estimated costs on page 34, above) or provide

* California Public Contracts Code 10515. (a) No person, firm, or subsidiary thereof who has been awarded a consulting services contract may submit a bid for, nor be awarded a contract on or after July 1, 2003, for the provision of services, procurement of goods or supplies, or any other related action that is required, suggested, or otherwise deemed appropriate in the end product of the consulting services contract.

** The biennial fee will increase to $830 on January 1, 2009.

revenue to pay for approximately 450 individual physician premiums (see estimated costs on page 33, above).

Additional revenues could be generated by requiring those health care entities that register with the state in order to be an eligible site to receive volunteer physicians who are covered through the state program to pay a nominal annual fee, e.g. $200. Although this would be a limited source of revenue, it could generate some additional dollars. Similarly, the volunteer physicians could be required to pay a nominal fee (e.g., $200) toward their malpractice insurance benefit.

It is questionable whether assessing physician licensing fees is the most appropriate avenue to generate funds for this program. Most states pay for volunteer professional liability coverage out of their General Fund. In California, there may be current state program funding that could pay for an insurance coverage program for volunteer physicians. Health and Safety Code 12855, the Medically Underserved Account for Physicians, was established within the Health Professionals Education Fund for two purposes: 1) to provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program and 2) to provide funding for the Physician Volunteer Program. In 2008, SB 1379 appropriated additional $1 million of revenue to the Medically Underserved Account for Physicians to be used specifically for the Loan Repayment Program (and not for the Volunteer Physician Program). Nonetheless, this additional revenue to the loan repayment program may free up funds that could be used to pay for the professional liability coverage program for volunteer physicians consistent with the missions of the Physician Volunteer Program. Additionally, SB 1379 appropriated $10 million to be transferred to the Major Risk Medical Insurance Fund to be used to further that program. It may be appropriate for other revenue generated from health care service plan fines and administrative penalties (currently in the Managed Care Fund) be used to pay for a volunteer physician liability insurance program.

Grant opportunities, through organizations like the California Endowment, or other healthcare non profit organizations, could also present potential avenues for revenue

generation to pilot this program. Additionally, it my take a combination of funding sources from licensing assessments, state monies and granting opportunities to pay for professional liability coverage and program administration.

E. Program Administration

If a volunteer physician insurance program was developed in the state of California, it should not be administered by the Medical Board of California but by another branch of the state. (If administered by the Medical Board, there may be a perceived conflict of interest if the Board must determine whether to take disciplinary action against a licensee to whom it has provided medical malpractice insurance.) The Board could develop criteria for eligible health care entities and eligible health care providers and create a registration process that can be used to process insurance as well as to track statistical information. The best example of such a registration process (for the purchased insurance model) has been found in Minnesota and Washington states that request detailed information from the health care entity and the providers and requires annual or bi-annual information back from the health care entities about the quantity and type of free health care that is provided under the program. (See Appendix 4 and 5.)[90] [91] There would be some additional costs associated with administering such a program by the state. Once insurance rates are secured, and a registration process is established for clinics and physicians to participate in the program, administrative costs for the program should be relatively low.

**Appendix 2: History of Prior California Legislation Related to Liability Protections for Volunteer Physicians**

The following information was obtained from interviews with California Assembly staff regarding the successes, challenges, and lessons learned from previous bills.

Assembly Bill 621, first introduced on February 19, 2003, concerned a special license to qualifying retired health care professionals to practice in public agencies or institutions, at not-for-profit organizations, agencies, institutions, corporations or associations that provide health care to indigent patients in medically under-served or critical-need populations. This bill also would have exempted "those health care providers from liability for professional negligence or malpractice or any other civil damages for any act or omission resulting from the rendering of those services, with certain exceptions." This bill was amended (March 24, 2003) to cover only physicians and surgeons, and would exempt them from liability for "professional negligence or malpractice or any other civil damages for any act or omission resulting from those services, with certain exceptions."

An April 8 analysis (Pacheco, 2003) raises questions about who would bear the liability should negligence occur—the non-profit facility, the public health facility or other practitioners? How would the higher standard of liability be justified? Would this bill create two levels of medical care? Current laws authorize local government to insure and self-insure for tort claims against volunteer health professionals. The bill received support from the Civil Justice Association of California and the California Primary Care Association. Groups opposing this bill were the American Nurses Association of California, the Congress of California Seniors, and the Consumer Attorneys of California.

On April 21, 2003, the amended bill was introduced again by Assembly Member Nakanishi. This bill would create the Physicians and Surgeons Liability Insurance Pilot Program (PSLIPP), to be administered by the State Department of Health Services. Up to 100 physicians and surgeons would be covered through the program, which would

purchase liability insurance for these health care professionals volunteering in specific public or not-for-profit agencies. The bill would need to receive funding in the annual Budget Act. This bill was amended on April 24, 2003, to be funded privately. The program would also remain in effect until January 1, 2009. In a bill analysis (Gilman, 2003), it was noted that Washington State had a similar program. The bill was supported by the California Congress of Seniors and the California Primary Care Association. No opposition groups were on file.

The bill was amended in Assembly on May 6, 2003. The volunteer physicians and surgeons would be eligible for waivers of license renewal fees, and the bill would be contingent on receiving sufficient private funding to pay the costs of both administering the program and purchasing liability insurance. An analysis of the bill (Bain, 2003) indicated that, depending on the number, location, specialty, and whether the physician is considered to be low or high risk by liability insurers, the cost would range from $1.1 to $1.9 million. Through this program, 40 family and general practice physicians, 50 internal medicine, and 10 OB/GYNs would receive coverage. This analysis called for an amendment to require an evaluation of the PSLIPP.

The bill was amended on June 4, 2003, requiring the Department of Health Services to contract for an evaluation of the program, with the evaluation submitted to the Legislature by January 1, 2009. An analysis of the bill (Gilman, 2003) did not list any groups supporting or opposed to the bill. The bill was amended again on June 9, 2004. This text is listed below:

Division 3.4 CALIFORNIA ACCESS TO HEALTH CARE ACT

600. This division shall be known and may be cited as the California Access to Health Care Act.

601. The Legislature finds and declares that a significant portion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care. It is the intent of the Legislature that access to medical care for indigent residents be

improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of this state.

602. As used in this division, the following terms have the following meanings:

(a) "Contract" means an agreement executed under this division between a health care provider and a governmental contractor that authorizes the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor on a volunteer, uncompensated basis.

(b) "Governmental contractor" means a county health department, a hospital district, or a hospital owned and operated by a governmental entity.

(c) "Health care provider" or "provider" means any of the following:

(1) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(2) An entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(3) An employee or contractor of an entity under paragraphs (1) and (2) who is acting within the scope of employment or contract.

(d) "Low-income" means any of the following:

(1) A person who is eligible for Medi-Cal benefits under California law.

(2) A person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, as defined by the federal Office of Management and Budget.

(3) A patient or client of the governmental contactor who voluntarily chooses to participate in a program.

603. (a) A provider that executes a contract with a governmental contractor to deliver health care services on or after January 1, 2005, as an agent of the governmental contractor, is an agent for purposes of Division 3.6 (commencing with Section 810) while acting within the scope of duties pursuant to the contract, if the contract complies with the requirements of this division, regardless of whether the

individual treated is later found to be ineligible to receive health care services under the contract.

(b) A provider may not be named as a defendant in an action arising out of medical care or treatment provided on or after January 1, 2005, pursuant to the terms of a contract entered into under this division. The exclusive remedy for injury or damage suffered as a result of an action or omission of the provider or any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to Division 3.6 (commencing with Section 810).

(c) (1) Initial referral or assignment shall be made solely by the governmental contractor, and the provider shall accept all referred patients. However, the number of patients that a provider is required to accept may be limited by the contract, or when, in the provider's reasonable judgment accepting additional patients could endanger patient access or continuity of care.

(2) Patients may not be transferred to a provider based on a violation of subsection (c) of the federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. Sec. 1395dd).

(3) Any follow up patient care or hospital care, shall be subject to approval by the governmental contractor.

(4) The provider shall be subject to regular inspection by the governmental contractor.

(d) A governmental contractor that is also a health care provider is not required to enter into a contract under this division with respect to the health care services delivered by its employees.

604. A governmental contractor shall provide written notice to each patient, or the patient's legal representative, receipt of which shall be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to Division 3.6 (commencing with Section 810).

605. A governmental contractor engaging in a contract under this article shall establish a quality assurance program to monitor services delivered under contracts between the governmental contractor and a health care provider under this article.

606. This article applies only to act or omissions occurring on or after January 1, 2005.

At an Appropriations Committee Fiscal Summary (Cate, 2008), it was noted that the bill met the criteria to be placed on the Suspense file. The cost of purchasing liability insurance and conducting an evaluation during the duration of the pilot would be between $1.1 and 1.9 million in private funds. Assembly Member Nakanishi's office indicated that this private funding would be sought from the insurance industry and private foundations. A follow up summary from August 28 indicates that the bill does not give authority to expend funds once they are obtained. A history of the bill indicates that on November 30, "From Senate committee without further action."