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PATIENT COMPENSATION SYSTEMS EVOLVE— BUT ARE NO LESS WORRISOME

Legislation introducing a patient compensation system (PCS) has been proposed in states around the country over the past several years.

Proponents argue that the PCS legislation, at its core, will make it easier for patients to access compensation for a medical injury by removing medical professional liability (MPL) claims from the tort system. The stated goal has been to foster a “no-blame” non-confrontational indemnification process that will ultimately lead to lower costs for defensive medicine and perhaps, proponents argue, a direct reduction in MPL costs as well.

In theory, this structure offers lower barriers to filing a claim, since an attorney is not required. In addition, a claim that would not have been indemnified under the current tort system may qualify for indemnification under the PCS. Hence, multiple factors indicate that there will be more reported claims, and more indemnified claims,

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under these proposals which, contrary to proponents' views, may lead to higher MPL costs.

At the same time, PIAA and several of its members have expressed concern that such systems would deny adequate compensation to the most seriously injured patients. Furthermore, PIAA members feel that physicians' reputations may be tarnished by these additional claims, which they feel are not representative of the quality of healthcare being provided. State medical societies have also come out in opposition to PCSs. At its November 2016 meeting, which included testimony provided by PIAA, the American Medical Association voted to support state medical societies in opposing PCS legislation.

We have been following this process closely since the first PCS bill was introduced in the Florida House of Representatives during the 2012 session (see our prior article, First Quarter 2014, *Inside Medical Liability*, "Tort Overhaul: Patient Compensation System Legislation Raises More Questions than Answers," page 28). We are aware of four states that had an active bill during the 2016 legislative session: Florida, Georgia, Maine, and Tennessee. Other state legislatures have also explored the concept of a PCS, but as of the 2016 legislative session, we are not aware of any other states where bills have been introduced.

The concept has yet to gain enough support in any state to reach a House or Senate floor vote, but legislative committees have been evaluating the proposals. As is often the case with legislation, the proposals have evolved over time, presumably in an effort to address concerns regarding feasibility and lack of widespread support. This article will focus on what we believe to be some of the most significant aspects of the PCS legislation and how they have varied by state and changed over time.

Which claims are compensable?

Proponents of PCS legislation have argued that physicians oppose MPL claims because of the stigma associated with them. They argue that no physician wants to be told that he has done his job incorrectly, or that a patient's injury is the result of his actions. Hence, under the original PCS legislation, there would be no such thing as a doctor who "did something wrong," only that the doctor—or any doctor, for that matter—"could have done it better." At the same time, proponents sought to compensate a greater number of injured parties. Indeed, this stated goal was written into the first proposed legislation.

To accomplish both of these goals—removing the stigma associated with MPL, as well as compensating more patients—the first version of the PCS legislation defined medical injury using what we have termed an "avoidability standard." This standard defined events eligible for compensation as medical injuries that "could have been avoided." We argued at the time that this defini-

tion implied not just that a medical injury probably could have been avoided, but merely that it was possible, a broad standard for patient compensation.

In that regard, we agreed with proponents of the legislation that the number of compensated claims would increase significantly. In fact, in our prior article, we estimated that the number of claims could increase by as much as 840% under the legislation proposed in Florida at that time. However, proponents had argued that without the stigma associated with claims, physicians would decline to defend themselves, and that the resulting decrease in legal defense costs would offset the increase in indemnity payments. Our prior article differed with them on that point, arguing that the associated costs could increase significantly as well.

Proponents of the PCS legislation have attempted to address several of the concerns cited in opposition to their proposals. However, some changes to the legislation have spoken to its "presentability," rather than its functionality. For example, in response to concerns about cost, more recent versions of the proposed PCS legislation have not explicitly included the original version's goal of compensating a greater number of injured parties—but it's the more detailed mechanics of the legislation that must be addressed if the goal is cost containment. That said, the definition of a compensable medical injury has evolved in these more recent versions into something resembling a negligence standard, although a keen eye may notice several differences that, depending on their interpretation, may still result in compensating a broader range of injuries than the current tort system.

Other changes have made the implementation of certain aspects of the legislation more ambiguous, and that makes direct criticism of the proposed legislation more difficult. As an example, consider the proposed compensation schedule in Florida. The initial versions of PCS legislation stated that, "damage payments for each injury shall be no less than the average indemnity payment reported by the Physician Insurers Association of America or its successor organization for like injuries with like severity" (FL HB 1233 § 766.404 (4)(e)(2)). More recent iterations of PCS legislation in Florida state only that, "the chief compensation officer shall recommend to the Compensation Committee a compensation schedule for each type of

Table 1 Summary of Proposed Participants under 2016 PCS Legislation by State

State	Medical Providers	Choice of System	Insurers
Florida	Physicians only	Yes	Excluded
Georgia	Physicians only	No	Excluded
Maine	All medical providers	Yes	Included
Tennessee	Physicians only	No	Excluded



medical injury" (FL HB 1065 § 766.405 (4)(b)). We addressed some of our concerns about the use of the nationwide PIAA data in the Florida legislation in our prior article. Without reiterating them here, we will say that removing the reference to PIAA data does little to assure any of the parties that the schedule will be set in a way that is consistent with current levels of compensation in Florida, or in a manner that considers the PCS's solvency.

Impact on medical providers

The definition of a medical provider and which providers would be required to participate in the PCS vary among the versions of the legislation introduced in the various states and legislative sessions (Table 1). The widest net was cast in the 2012 version of the Florida bill, which stated that every medical provider in the state would be required to participate in the PCS. This meant that they would be required to pay premium amounts to the PCS and that any claims for medical misadventure would be handled within the PCS structure.

One of the most concerning arguments against the PCSs has been that they would deprive both patients and medical providers of their right to access the court system. To address this, the versions of the Florida legislation introduced subsequent to 2012 have stated that participation in the proposed PCS is at the medical provider's discretion; and the 2016 version further pares the scope, limiting participating providers to physicians only. The most recent version of each state's proposed PCS legislation lets providers choose whether to participate in the PCS or requires only physicians to participate. Hence the scope of providers who would be required to participate in the PCS, or at least be eligible to do so, has generally narrowed over time.

However, this distinction between physicians and other

providers could lead to unintended consequences. For example, in Florida, Georgia, or Tennessee, where the definition of medical providers subject to the proposed PCS includes only physicians, we can envision a system that incorporates the most costly elements of both the current tort system and the PCS. Consider a situation in which claims are brought against a hospital and at least one physician for the same underlying event. Here, it is possible that a plaintiff could recover both from within the current tort system as well as the PCS, potentially collecting twice the amount that he

would get today from the tort system alone. While we don't believe that this is the intent of PCS proponents, whether such a situation could in fact occur will depend on how courts interpret any enacted PCS legislation.

Even if plaintiffs were not permitted to recover from both systems, having two systems available for compensation would, in many cases, allow plaintiffs to choose the one more favorable to their situation. Table 2 shows four hypothetical claims. Before considering these examples, we'd like to stress that each of the values is merely hypothetical and the four claims shown should not be considered illustrative of any general comparison between the tort system and the various proposed PCSs. However, you will notice that we've assumed in creating this table that the standard of culpability is lower in the proposed PCS. While it is less clear that this is true in more recent versions of the proposed legislation than in its earlier forms, we believe this remains a likely result of any implemented PCS.

First, consider a claim such as number 1 in Table 2, which has the potential for a larger award under the current tort system than would be available from the PCS recovery schedule. In this sort of scenario, a plaintiff may bring his claim against the involved hospital, or

other institutional provider, to access that potentially higher indemnity payment. The more likely it is that such a claim will be indemnified, the more likely we believe its plaintiffs would be to seek recovery from the tort system instead of the PCS.

Now consider an alternate situation, in which the possible recovery is the same but negligence is less obvious (such as claim number 3). Under a scenario with these characteristics, a plaintiff might be more likely to file a request within the PCS. For

Table 2 Four Hypothetical Claims

	#1	#2	#3	#4
Tort System Recovery				
(A) Likelihood of Recovery	80%	80%	20%	20%
(B) Indemnity, if Recovered	\$1,000,000	\$200,000	\$1,000,000	\$200,000
(C) Expected Recovery; (A) × (B)	\$800,000	\$160,000	\$200,000	\$40,000
Patient Compensation System Recovery				
(D) Likelihood of Recovery	90%	90%	30%	30%
(E) Indemnity, if Recovered	\$750,000	\$250,000	\$750,000	\$250,000
(F) Expected Recovery; (D) × (E)	\$675,000	\$225,000	\$225,000	\$75,000
Tort System vs. PCS Comparison				
Larger Expected Recovery	Tort System	PCS	PCS	PCS

such a claim, the increased likelihood of compensation under the PCS outweighs what, in this case, is a lower compensation amount.

Finally, consider a medical event for which the possible recovery from the tort system is less than the amount set by the PCS recov-

ery schedule (such as claims number 2 and 4). Regardless of the extent of evidence for negligence, we can expect that any such claim will be filed within the PCS rather than the tort system. For such a claim, not only would recovery be more likely under the PCS, but the amount recovered would likely be greater as well. Consequently, the PCS makes possible recoveries that are larger, and also more likely. It is difficult to imagine anything but greater costs under such a system.

A cap on total claim payments

Three of the four currently proposed PCSs (in Florida, Georgia, and Maine) include a provision that would cap total costs. However, it is uncertain how costs (i.e., total payments made to patients plus the administrative expenses of the PCS) would be controlled. In other words, given that a defined amount of contributions is expected to cover both the expenses and payments of the PCS, what would happen if payments owed to injured patients exceed the total available from contributions?

Four possibilities appear to be most likely:

1. The state provides additional funds to offset any shortfall. The PCS would then increase surcharges for the next calendar year by an amount expected to be sufficient to reimburse the state, plus collect enough for the following year's costs.
2. A second scenario starts out like the first, but here, instead of the PCS making up for the shortfall (essentially, repaying a loan to the state), those who manage it are unwilling or unable to reimburse the state. In this case, the shortfall paid by the state is in effect paid by the taxpayers.
3. Injured patients may be refused indemnification after the annual disbursement set aside for patients has run out, or perhaps they will need to wait until the next year for their payment, which would presumably cause a further delay in payments for next year's claims.
4. The PCS compiles all requests for payment during a given year, and then apportions payments according to a pro rata share of the available funds based on the amount that each injured party would have otherwise received.

Each of these possibilities results in either a delay in claim payments, a reduction in the amount to be paid to each injured party, or an increase in premiums for the upcoming year sufficient to cover the

Table 3 Fiscal Summary of 2016 PCS Legislation By State

State	Cost Capping	Initial Premiums	Future Premiums
Florida	At total contributions	In bill	Board determined
Georgia	At total contributions	In bill	Board determined
Maine	Prior year cost plus inflation	Board determined	Board determined
Tennessee	None	In bill	Experience-based

shortfall. Any one of these possibilities could be financially significant for injured parties or medical providers.

Tennessee's 2016 PCS legislation provides for no such cap on total costs. Under this proposal, the contributions paid by providers would be adjusted annually based on the experience of each physician and the entire market in the previous year. Conceptually, this system more closely mirrors the existing tort system. However, under such a system, contributions would presumably have to be increased to cover any shortfall from the prior year. Such increases could be particularly significant in the first years of such a system, as the PCS legislation is implemented and interpreted.

There are two additional aspects of this approach that are worrisome, given the design of the PCS. First, in a system designed to indemnify more patients without reducing the payment amounts, this structure has the potential to increase MPL costs significantly. Since this version of the bill has no capping mechanism, should that cost increase come to fruition, physicians in Tennessee would need to contribute more, and perhaps significantly more, to the PCS than they pay to their insurers in the current tort system.

Second, the concept of a no-blame system in which physicians need not worry about applications filed against them comes under additional scrutiny under this cost structure. If a physician will be charged additional premium for having a "higher than average rate of compensation for medical injuries" (TN HB 546 § 29-26-307 (b)(2)(B)), then it would stand to reason that physicians would have a potent financial incentive to defend themselves against any application filed against them. 

Conclusion

The PCS legislation has evolved considerably over time and geography. As the 2017 legislative sessions get into full swing this winter and spring, we can expect additional changes as PCS legislation proponents push for a version of a PCS to be signed into law in one of a growing number of states that lobbyists are targeting.

For additional information on the Patient Compensation System or any of the current versions of the PCS legislation, please contact Susan Forray (susan.forray@milliman.com) or Eric Wunder (eric.wunder@milliman.com).