Patient Compensation Funds

The Patient Compensation Funds (PCF) developed during the 1970's and 1980's as a general rule. They were brought into existence as a means of helping healthcare providers stem the ever increasing costs of medical malpractice insurance. The theory was that if a single entity covering most of the risks on an excess basis could pool large sums of premium type dollars to pay the losses on a larger or excess scale where economies of size would hold these costs in check. For many reasons the PCF's have largely failed or are simply self-perpetuating because they were under funded and can't be shut down. Some examples of problems are:

Pennsylvania PCF under funded by as much as $2 billion.

Pennsylvania PCF replaced by MCARE but still has ongoing liabilities

Florida PCF discontinued coverage in 1983 after assessing members hundreds of millions of dollars-Still working claims 22 years later

Indiana PCF charged inadequate rate and can only pay claims out of cash flow each year.

Indiana PCF has no funds to pay losses if it stops issuing coverage in future-self- perpetuating

South Carolina PCF estimated to be $30 million to $108 million difficiency

South Carolina PCF determined to have operational problems due to lack of controls.

Most PCF's were charging too little for large limits and only increased when disasters were imminent. Many times these PCF's were state agencies or quasi-state agencies and ran their operations not as insurance carriers but merely as payers of losses. The individuals handling the claims were clerks not claim adjusters with experience. In short they were not run as insurance company type entities and failed or are failing.

Allowing a PCF entity is a mistake in a state like Missouri whose problems are related to dramatic increases in claims severity as evidenced by a loss trend that at 11% per year is nearly twice the national average. There is every reason to believe that a stabilization fund will not be as successful as the one in Kansas as losses in Kansas are much less volatile than in Missouri. The presence of a stabilization fund in Missouri will make it a much less attractive market to the voluntary market as it limits premium income to a basic policy limit of $100,000 or $200,000 per claims which artificially restricts the premium volume insurers can expect to earn. It also might increase primary insurers costs if they become the collection point for the fund which will also serve to deter new market entrants.

The legislatures of the future will have to deal with the deficits of the past and many state funded benefits will have to be curtailed to make up these deficits. Starting a new PCF in this era might provide short term relief but it will fail if not properly operated and actuarially sound rates used.