NEBRASKA DEPARTMENT OF INSURANCE
MEDICAL MALPRACTICE EXCESS LIABILITY FUND

Nebraska's Hospital-Medical Liability Act

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Housekeeping

- Continuing Education
  - 1 hour of Continuing Legal Education
    - Activity Number: 267353

- If you need the PowerPoint or any help during the presentation,
  - Message AJ Raaska (AJ.Raaska@Nebraska.gov)
  - She will be monitoring the chat

- Stay For The Poll At The End

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TODAY'S CLE

- Brief history of the Nebraska Hospital-Medical Liability Act
- Excess Liability Fund basics
- Steps to qualify and renew
- Changes to underlying limits beginning 1/1/2025

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REASONS FOR THE HOSPITAL-MEDICAL LIABILITY ACT

- Neb. Rev. Stat. §§ 44-2801 to 44-2855, enacted in 1976
  - At the present time (1976) and under the system in effect too large a percentage of the cost of malpractice insurance is received by individuals other than the injured party.
    - National medical malpractice insurance crisis, insurers exited the market and premiums skyrocketed.
  - It is in the public interest that competent medical and hospital services be available to the public in Nebraska at reasonable costs.
    - Cap on damages = lower malpractice insurance costs = more health care providers in Nebraska and lower costs for patients.
  - It is in the public interest that prompt and efficient methods be provided for eliminating the expense as well as the useless expenditure of time of physicians and courts in nonmeritorious malpractice claims and for efficiently resolving meritorious claims.
    - The Act provides a Medical Review Panel process (rarely used, typically waived by the plaintiff).

DOLLAR AMOUNTS THROUGH HISTORY

- **Cap on Damages:**
  - 1976 to 1984: $500,000
  - 1985 to 1992: $1,000,000
  - 1993 to 2003: $1,250,000
  - 2004 to 2014: $1,750,000
  - **2015 to present: $2,250,000**

- **Underlying Limits:**
  - 1976 to 2004:
    - $100,000/$300,000 for physicians and CRNAs
    - $100,000/$1,000,000 for hospitals
  - 2004 to 2025:
    - $500,000/$1,000,000 for physicians and CRNAs
    - $500,000/$3,000,000 for hospitals
  - **Beginning 1/1/2025:**
    - **$800,000/$3,000,000 for all health care providers**

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EXCESS LIABILITY FUND BASICS

- By statute, the Department of Insurance administers the Fund.
- Participation is voluntary.
- Participation is limited to physicians, CRNAs, entities providing medical services by physicians or CRNAs, and hospitals.
- Two actions required to qualify:
  1. Submit proof of financial responsibility (private market insurance from an insurer licensed in Nebraska, in the amounts required by statute)
  2. Pay the surcharge, currently set at 50% of the premium for the underlying coverage.
- If the alleged malpractice occurred before the health care provider became Fund qualified, there is no Fund coverage. Even if the provider uses a claims-made policy to qualify for the Fund. Neb. Rev. Stat. § 44-2824(4).
- If a health care provider is Fund qualified, the Nebraska Hospital-Medical Liability Act is the exclusive remedy, and damages are capped at $2.25M.

IMPORTANT DEFINITIONS FOR "HEALTH CARE PROVIDERS"

§ 44-2803. Health care provider, defined.

- Health care provider means: (1) A physician; (2) a certified registered nurse anesthetist; (3) an individual, partnership, limited liability company, corporation, association, facility, institution, or other entity authorized by law to provide professional medical services by physicians or certified registered nurse anesthetists; (4) a hospital; or (5) a personal representative as defined in section 30-2209 who is successor or assignee of any health care provider designated in subdivisions (1) through (4) of this section.

§ 44-2804. Physician, defined.

- Physician shall mean a person with an unlimited license to practice medicine in this state pursuant to the Medicine and Surgery Practice Act or a person with a license to practice osteopathic medicine or osteopathic medicine and surgery in this state pursuant to sections 38-2029 to 38-2033.

FUND COVERAGE FOR EMPLOYERS AND EMPLOYEES OF "HEALTH CARE PROVIDERS"

§ 44-2821(2) "If a health care provider shall qualify under the act, the patient's exclusive remedy against the health care provider or his or her partner, limited liability company member, **employer, or employees** for alleged malpractice, professional negligence, failure to provide care, breach of contract relating to providing medical care, or other claim based upon failure to obtain informed consent for an operation or treatment shall be as provided by the act unless the patient shall have elected not to come under the provisions of the act."

- For physicians or CRNAs, individual qualification is required, even if they are "employees" of a hospital or other qualified entity.
- A hospital may submit qualification documents and pay the surcharge for employed physicians and CRNAs, along with the hospital itself.
  - Those physicians and CRNAs will have their own separate qualification (with separate insurance limits and separate surcharge payments).

MEDICAL MALPRACTICE INSURANCE INDUSTRY TERMINOLOGY

- **"Occurrence"** policies cover losses that occur during the policy period.
  - Homeowners, auto, and health insurance are examples of insurance written on an occurrence basis.
- **"Claims-made"** policies cover claims that are made during the policy period, even if they are based on events that occurred prior to the first day of the policy period.
  - Most medical professional liability coverage is written on a claims-made basis.
  - Claims-made policies typically have a **"retroactive date,"** which limits the look-back period for occurrences.
- **"Tail"** coverage can be added to a claims-made policy to cover claims that get reported after the policy period ends.
  - Tail coverage is sometimes referred to as an "extended reporting endorsement."

FUND QUALIFICATION IS IMPORTANT, BUT REMEMBER PATIENTS CAN OPT OUT

- If the health care provider failed to qualify for the Fund, the patient can sue under common law and the Hospital-Medical Liability Act does not affect the case.
- If the health care provider qualifies for the Fund, for claims of malpractice, professional negligence, failure to provide care, breach of contract relating to providing medical care, or failure to obtain informed consent for an operation or treatment, the Hospital-Medical Liability Act provides the exclusive remedy *unless* the patient:
  - (a) elected not to be bound by the Act and
  - (b) filed such election with the Director of Insurance in advance of any treatment, act, or omission upon which any claim or cause of action is based, and
  - (c) notified the health care provider of election as soon as is reasonable under the circumstances that the patient has so elected.

RESIDUAL MALPRACTICE AUTHORITY

- § 44-2837 creates the Residual Malpractice Insurance Authority (RMA).
  - The RMA is similar to Nebraska's residual funds for workers' compensation and auto insurance, providing an "insurer of last resort" for health care providers the private market is unwilling to cover.
  - Premiums are not competitive with the private market.
- If a health care provider has been declined by at least two insurers, he or she is eligible for the RMA.
  - "If the application is accepted, the coverage shall be issued at the rates established by the Nebraska Department of Insurance." 210 Neb. Admin. Code Ch. 32 § 008.
  - Premium rates are based on accepted actuarial principles and accepted practices in the insurance industry.
- As a condition for participating in the RMA, the health care provider must also maintain qualification in the Excess Liability Fund.
- https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/residual1.pdf (link to RMA application form)

STEPS TO QUALIFY

To qualify for the Fund, a health care provider “or such health care provider’s employer, employee, partner, or limited liability company member” must:

1. Purchase malpractice coverage from an insurer or the residual fund and file proof of coverage with the Department of Insurance.
   - Coverage for physicians, CRNAs, and their employers, employees, partners, or limited liability company members:
     - $500,000 per occurrence/$1,000,000 aggregate
   - Coverage for hospitals and their employees:
     - $500,000 per occurrence/$3,000,000 aggregate
   - *These amounts are changing as of 1/1/2025 (discussed in later slides)*

2. Pay the surcharge to the Department of Insurance.
   - Surcharge is set every year, currently at 50% of the premium for the “underlying” coverage.

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NEW IN 2023: ONLINE PAYMENT PORTAL

- In response to stakeholder feedback, the Department implemented an online payment portal for Fund surcharge premiums.
- Now both steps for Fund qualification can be completed online.
  - STEP ONE: Use the **online portal** to pay the surcharge premium, which is a percentage (currently 50%) of the premium reflected on your Certificate of Insurance. Save your receipt as a PDF.
  - STEP TWO: Email your Certificate of Insurance and PDF receipt to **doi.nelf@nebraska.gov**
- **Submitting your certificate and proof of payment together in an email results in a quicker turnaround for your qualification letter.**
  - Matching payments to Certificates of Insurance can be a challenge because dollar amounts may not match (lump sum payments for more than one provider) or names may not match (payments from an entity other than the named insured). Submitting the proof of payment with the certificates avoids these matching problems.
- Questions can be sent to **doi.nelf@nebraska.gov** or contact Emma Covalt at 402-471-4651.

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POSTING NOTICE

- Every provider qualified under the Act “shall post and keep posted in his or her waiting room or other suitable location a sign of a size and type to be prescribed by the director stating: (name of health care provider) has qualified under the provisions of the Nebraska Hospital-Medical Liability Act. Patients will be subject to the terms and provisions of that act unless they file a refusal to be bound by the act with the Director of Insurance of the State of Nebraska.”
  - The statutes do not address posting for telemedicine, so the DOI advises qualified health care providers who interact with patients exclusively through telemedicine to post notice on the electronic equivalent of a waiting room or patient information page. The “other suitable location” would be through the same method of communication used to provide telemedicine.

- Posting notice is not required *to qualify for the Fund*, but posting notice is required of every health care provider covered by the Fund.

A REMINDER ABOUT RENEWALS

- Private insurers can “backdate” or make coverage effective as of any date they choose. Fund qualification is not the same as private market coverage—statutes control.
- Neb. Rev. Stat. § 44-2824(5)
  - Once qualified, failure to renew or continue qualification in the manner provided by law and regulations results in no Fund coverage.
- Neb. Rev. Stat. § 44-2829(3)
  - Surcharge is due within 30 days after submitting proof of financial responsibility, payable annually.
- Neb. Rev. Stat. § 44-2829(5)
  - If annual surcharge is not paid within 30 days, qualification is suspended until the annual premiums are paid.
  - The Department will give written notice of the suspension in a letter, mailed at least 30 days before the suspension becomes effective.

RENEWAL: EXPIRATION AND SUSPENSION

- The consequence for failing to provide renewed proof of financial responsibility within 30 days is harsher than the consequence for failing to timely pay the surcharge.
- 210 Neb. Admin. Code Ch. 32 § 006
- § 006.01 If the Department does not receive renewed **proof of financial responsibility** on or before the date the policy expires, the Fund will send a notice advising that if proof is not received within 30 days, the **qualification expires** on the date the expiring proof of responsibility terminates.
  - Department staff does not have the ability to waive the 30-day deadline.
- § 006.02 If the Department does not receive the required **surcharge payment** within 30 days of the provider submitting proof of financial responsibility, the Fund will send notice that qualification will be **suspended** 30 days after the notice is mailed.
  - This gives a grace period for providers to correct any surcharge calculation errors.

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CHANGES COMING IN 2025

- Statutory changes effective for *coverage issued or renewed 1/1/25 or later*.
- Prior underlying coverage requirements:
  - Coverage for physicians, CRNAs, and their employers, employees, partners, or limited liability company members:
    - $500,000 per occurrence/$1,000,000 aggregate
  - Coverage for hospitals and their employees:
    - $500,000 per occurrence/$3,000,000 aggregate
- New coverage requirements:
  - Coverage for physicians, CRNAs, and their employers, employees, partners, or limited liability company members:
    - $800,000 per occurrence/$3,000,000 aggregate
  - Coverage for hospitals and their employees:
    - $800,000 per occurrence/$3,000,000 aggregate

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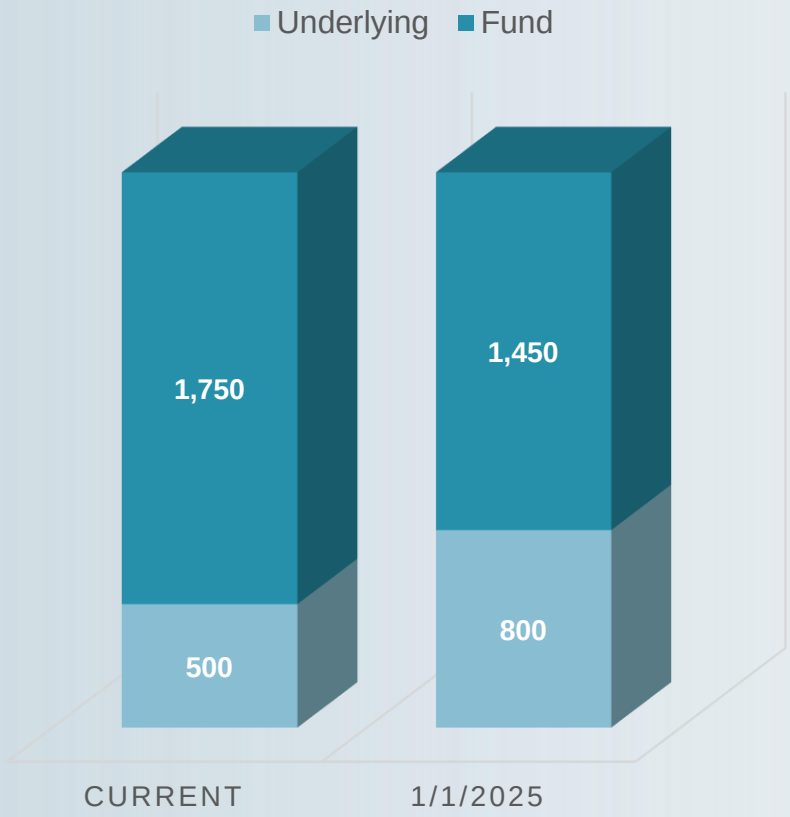
UNDERLYING AND FUND COVERAGE, BEFORE AND AFTER 1/1/2025

PER OCCURRENCE



- Increased underlying limit means more private market coverage per claim.
- Shifting more risk to the underlying layer is intended to result in lower surcharge payments and long-term financial stability for the Fund.

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2025 CHANGES FOR AGGREGATE

- Aggregate refers to the total amount paid for all claims and is a limit on coverage.
- Physicians and CRNAs will increase from $1M to $3M aggregate.
- Hospitals were already at $3M and will stay at $3M aggregate.
  - At $500,000 per occurrence, it currently would take 6 large claims to exhaust a hospital's aggregate.
  - At $800,000 per occurrence after 1/1/2025, it will take 3.75 large claims to exhaust a hospital or physician/CRNA's aggregate.
- The Fund does not "drop down" to provide first-dollar coverage or defense costs if a health care provider exhausts its aggregate.
- If hospitals wish to purchase "backup" or "umbrella" coverage for the risk that they will exhaust their aggregate, that additional coverage does not affect the $800,000 limit on each health care provider's private (underlying) insurance contribution per claim.

FAQ: WHEN DOES THE NEW LIMIT BECOME EFFECTIVE?

- **The new limits will be implemented at renewal during 2025.**
  - Until 12/31/2024, renewals will be at the current limits:
    - For physicians, qualified entities, and nurse anesthetists: $500,000/$1,000,000
    - For Hospitals and Surgical Centers: $500,000/$3,000,000
  - On 1/1/2025 and after, renewals will be at the new limits:
    - Any policy issued or renewed on or after 1/1/2025 must provide coverage limits of $800,000/$3,000,000. These limits apply to all types of health care providers.
    - This means that prior to a provider's renewal in 2025, the $500,000 per-occurrence limit still applies.

See Neb. Rev. Stat. §§ 44-2824(1)(a) (per-occurrence and aggregate coverage amounts), 44-2831.01 (effective date for changes to underlying limits).

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FAQ: DO I LOOK TO THE DATE OF OCCURRENCE OR DATE OF CLAIM?

- **The limits on the policy responding to the loss will apply.**
  - If you have occurrence coverage (Residual Malpractice Authority coverage is always on an occurrence basis), the limits on the policy covering the occurrence apply.
  - If you have claims-made coverage (almost all private market coverage is claims-made), the limits on the policy in effect when the claim was reported apply.

See Neb. Rev. Stat. §§ 44-2824(2) (qualification "shall be either on an occurrence or claims-made basis and shall be the same as the insurance coverage provided by the insured's policy"), 44-2831.01(4) (the increases in coverage requirements "shall apply to policies issued or renewed and risk-loss trust years that commence on or after January 1, 2025").

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FAQ: WHAT ABOUT TAIL COVERAGE?

- **Will existing tail policies need to be amended?**
  - No. For tail coverage issued on or before 12/31/2024, the $500,000 limits that applied when the coverage was issued will continue to apply.
    - The premium for tail coverage is paid once at the inception of the endorsement or policy and is not paid again, so in order to avoid imposing a higher limit than underwriters anticipated, the $500,000 limit will stay in place for the life of tail coverage issued on or before 12/31/2024.
  - If the insurer issues an extended reporting endorsement or tail coverage on or after 1/1/2025, the $800,000 underlying coverage limit applies.

See Neb. Rev. Stat. §§ 44-2824(2) (qualification "shall be the same as the insurance coverage provided by the insured's policy"), 44-2831.01(4) (the increases in coverage requirements "shall apply to policies issued or renewed and risk-loss trust years that commence on or after January 1, 2025"), 44-2824(3) ("The director shall have authority to permit qualification of health care providers who have retired or ceased doing business if such health care providers have primary insurance coverage under subsection (1) of this section.").

ONLINE RESOURCES

- https://doi.nebraska.gov/insurers/property-and-casualty
  - Contact Information
  - Online payment portal
  - FAQ document with embedded links to statutes and regulations
  - Statutes and regulations
  - List of admitted medical malpractice carriers
  - Guidance for out-of-state providers using telemedicine to treat patients in Nebraska
  - Residual Fund Application
  - Annual surcharge determinations
  - Annual reports

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QUESTIONS?

Provider Qualification Process:

- Emma Covalt
  (402) 471-4651

Claim Information:

- Laura Arp
  (402) 318-4814

Other Questions:

- Cheryl Wolff
  (402) 471-4607

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