APPENDIX A

Committee Charges

BILL RATLIFF

Lieutenant Governor of Texas
President of the Senate

The Capitol
Austin, Texas 78711-2068
512-463-0001 • Fax: 512-936-6700

State Senator
District 1

September 13, 2001

The Honorable Jane Nelson
Texas Senate
Capitol Extension, Room E1.804
Austin, Texas 78701

Dear Jane:

It is my pleasure to appoint you Chair of the Senate Special Committee on Prompt Payment of Health Care Providers.

As you know, many doctors, their staff, and their patients across the Lone Star State are unduly burdened as a result of delays in payment from insurance companies for treatment the doctors have provided. I have charged this committee with evaluating the effectiveness of existing state law and agency rules designed to ensure prompt payment of health insurance claims to providers by insurance companies. The committee should assess the level of industry compliance with current law and the necessity of additional enforcement measures. Further, you should determine the factors affecting the timeliness of reimbursements and make necessary recommendations to improve the process.

Please submit to my office a copy of your proposed work plan, including the number and locations of hearings you anticipate holding. In an effort to minimize costs, hearings outside of Austin should be limited to the minimum required to obtain sufficient public input on these issues.

Attached is a copy of the committee membership and charge. Please do not hesitate to contact me if I may be of assistance to you as you carry out your duties.

Yours very truly,

Bill Ratliff

William R. Ratliff
Lieutenant Governor of Texas

WRR/ml

Attachment

cc: The Honorable Rick Perry, Governor of Texas
The Honorable James E. "Pete" Laney, Speaker, Texas House of Representatives
Mrs. Patsy Spaw, Secretary of the Senate
Interim Committee Distribution List

BILL RATLIFF
Lieutenant Governor of Texas
President of the Senate

The Capitol
Austin, Texas 78711-2068
512-463-0001 • Fax: 512-936-6700

State Senator
District 1

July 30, 2002

The Honorable Jane Nelson
Chairman
Senate Special Committee on Prompt Payment
of Health Care Providers
Capitol Extension, Room E1.804
Austin, Texas 78701

Dear Jane:

As you know, testimony presented to the Senate Special Committee on Prompt Payment of Health Care Providers has led to the discussion of the impact of rising medical malpractice insurance costs on patient access to health care. The growing evidence that such costs are forcing physicians to curtail or abandon their practices, leaving patients with reduced access, warrants additional study.

Therefore, I am adding an additional charge to the ongoing work of the committee. The committee shall evaluate the effectiveness of existing state law and agency rules relating to the current medical professional liability system. The committee should assess the causes of rising malpractice insurance rates in Texas, including the impact of medical malpractice lawsuits, and their impact on access to health care. Based on that assessment, the committee should determine the need for corrective action and make recommendations as necessary.

Instructions previously given to you regarding interim studies will apply to this charge. Please let me know if I may be of assistance as you carry out these additional duties.

Yours very truly,

Bill Ratliff

William R. Ratliff
Lieutenant Governor of Texas

WRR/ls/nbm

cc: The Honorable Rick Perry, Governor of Texas
The Honorable James E. "Pete" Laney, Speaker, Texas House of Representatives
Members of the Senate Special Committee on Prompt Payment of Health Care Providers
Mrs. Patsy Spaw, Secretary of the Senate
Interim Committee Distribution List

APPENDIX B.1.

Overview of TDI Rules on Disclosure of Coding, Bundling and Fee Schedule Information

Overview of TDI Rules on Disclosure of Coding, Bundling and Fee Schedule Information

Source: Texas Department of Insurance

The new rules, effective October 9, 2002, deal with contracting provisions affecting HMOs and insurers or preferred provider benefit plans relating to coding, bundling and fee schedule information. The rules require that, upon request from a provider, a carrier must provide provider-specific information in a level of detail that a reasonable person with sufficient training, experience, and competence in claims processing can determine the contractual payment amount.

- The information must include:
  - a provider-specific summary and explanation of all methodologies that will be used to pay claims submitted in accordance with the contract;
  - a fee schedule;
  - any applicable coding methodologies, bundling processes, and down coding policies, and
  - any other applicable policy or procedure used in paying claims.

- Carriers must provide the information:
  - under existing contracts, within 30 days after receiving a request; or,
  - under new contracts or renewals, along with other contractual materials.

- Providers receiving information under the new rules are prohibited from
  - using or disclosing the information for any purpose other than practice management or billing activities, and
  - using the information to misrepresent the level of services actually performed when submitting a claim under the contract.

- A request may be made by any reasonable and verifiable means, such as e-mail or facsimile. Insurers may provide the information using any reasonable method that is accessible by the provider, including e-mail, computer disks, paper, or access to an electronic database.

- If information is held by a source outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the insurer must explain the procedure by which the provider may access the external source.

- An insurer that cannot provide the required information due to copyright laws or a licensing agreement may provide a summary as long as it is sufficient to allow the provider to determine the contractual payment.

- Information required to be provided under the rules may be amended, revised, or substituted only upon written notice to the provider at least 60 calendar days prior to the effective date of the change.

- TDI provided carriers 90 days from the effective date of the rules to meet the new requirements.

- The information provided pursuant to these rules does not constitute verification that the service provided is a covered benefit. The rules are not intended to dictate the types of practices, policies or procedures that relate to or affect the claims payment process an insurer may elect to employ.

APPENDIX B.2.

Overview of the Claims Process

Overview of the Claims Process

Source: Texas Department of Insurance

The claims process begins after a patient goes to a provider (a physician, hospital, or other provider of medical services):

- The provider asks the patient for an insurance identification card to verify coverage and the type of health plan (group or individual). The provider determines if it is a member of the plan's preferred provider network. This information determines how and when the claim is paid.

- If the patient has no health coverage, the provider bills the patient for the full amount.

- If the provider is "in-network" (is a member of the plan's preferred provider network), the provider collects the co-pay and the deductible or coinsurance amount. This information is typically noted on the patients's insurance identification card, if applicable (most carriers provide enrollee ID cards, though it is not currently required by statute or rule). The provider then submits the claim to the carrier for any additional amounts owed in accordance with the provider's contract with the carrier.

- If the provider is "out-of-network," the provider bills the patient for the services provided. The patient then files a claim with the carrier for reimbursement. In some cases, the provider bills the carrier directly through an assignment of benefits by the patient.

- Providers use the UB-92 (institutional provider) and HCFA-1500 (non-institutional provider) billing statements to submit claims.

- Providers submit claims in paper or electronic form. Carriers process paper and electronic claims differently. It is anticipated that implementation of provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in 2003 will result in increased standardization of electronic claims filing and payment.

<u>Contracted provider claims</u>:

- When the carrier receives a contracted claim, it determines if it can pay the claim.

- State prompt pay statutes and rules come into play for contracted claims that satisfy the requirements for a "clean claim." Clean claim elements are defined by rule and include appropriately noticed additional elements and attachments. The prompt pay statutes and rules provide that carriers will process clean claims through one of the following means within 45 days of receipt:

    - Pay the correct amount owed in accordance with the contract;
    - Deny the claim with a written explanation to the provider;
    - Notify the provider that the claim will be audited, and pay 85 percent of the

contracted rate for the claim; or
- Submit a deficiency notice to the provider stating that the claim is not clean.

- The statutory 45-calendar day timeline does not begin until the carrier receives the claim. Problems arise when a provider cannot establish when or if a claim was received by the carrier.

- If the carrier fails to pay the claim correctly or timely, improperly denies the claim, or does not follow the audit procedure, the carrier owes the provider a contract penalty or billed charges. In these instances, the carrier is also subject to an administrative penalty for prompt pay violations. If the claim is deficient (a clean claim element or attachment is missing), and the carrier fails to provide the deficiency or pay the claim, only an administrative penalty applies.

- If a carrier decides to audit a claim, the audit must be completed within 180 days. The carrier collects the additional information necessary to evaluate whether the claim should be paid and the amount owed. Requests for information often involve sources other than the physician or provider. Once the necessary information is received, the carrier determines whether the claim is covered. If the claim is covered the carrier pays the remaining 15 percent of the contracted rate for the claim to the provider. The additional payment must be made within 30 days of completion of the audit. If the claim is not covered, the carrier requests a refund of the 85 percent of the contracted rate for the claim previously paid to the provider. The refund is due thirty days after written notification or exhaustion of any applicable subscriber or patient appeals.

<u>Non-contracted provider claims</u>:

- Fee-for-service (indemnity plans) and PPOs: When there is no contractual relationship between the provider and the insurer, the insured may make an assignment of benefits to the physician or provider. This includes instances in which an insured in a fee-for-service or indemnity plan makes an assignment of benefits to a physician or provider, or if an insured in a preferred provider plan receives services from a non-network provider and makes an assignment of benefits. The insurer must pay all benefits payable under the policy within 60 days after receipt of proof of loss.

- HMOs: If an HMO enrollee receives services from a non-network physician or provider through a referral or emergency services from a non-network physician or provider (no referral needed), the HMO must make payment to the non-network physician or provider within 45 days after receiving the claim. The claim must include documentation reasonably necessary to process the claim and must be for covered services.

- In situations where the enrollee or insured does not make an assignment of benefits or an authorization of payment to the physician or provider, the HMO or insurer will directly reimburse the enrollee or insured. The physician or provider can then obtain payment from the enrollee or insured.

APPENDIX B.3.

Summary of State Laws and Selected 2001 State Legislation

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
AL Law 27-1-17 Section 21.54.020 Amended by HB 164 (2001) *Applies to HMOs, insurers, health service corporations and health benefit plans*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of Electronic "Clean Claim":** The transmission of data for purposes of payment which contains substantially all of the required data elements necessary for accurate adjudication without obtaining additional information from the provider of the service or from a third party in an electronic data format specified by the insurer's, health service corporation's, or health benefit plan's published filing requirements. **Definition of "Clean Claim":** A claim which contains substantially all of the required data elements necessary for accurate adjudication without obtaining additional information from the provider of the service of from a third party. In no event shall an insurer, health service corporation, or health benefit plan require that the health care provider submit information or data elements in excess of those required on the standard health claim form or the standard electronic health insurance claim format designated by section 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.	1.5% per month The commissioner of insurance may assess an administrative fine. The fines will be up to $1,000 for each day that the claim or claims remained unpaid, not to exceed $100,000 per violation.	Amends current law to allow carriers to deny a claim if a provider receives a request for additional information and fails to timely submit such information. After the submission of requested information from a provider, the claim shall be paid, denied, or settled within 90 days.
AK Law HB 113 (2001) Signed by Governor: 6/25/01 *Applies to insurers*	30 days for "clean claims" **Definition of "Clean Claim":** A claim that does not have a defect, impropriety, or circumstance requiring special treatment that precludes timely payment on the claim.	15% per annum	

* States vary on whether this penalty applies when there is a processing delay, or when there is a delay only where payment is due.

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
AR Law Rules and Regulations 43, and HB 2449 (2001) (23-66-215) *Applies to insurers, HMOs and risk retention groups*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the carrier's standard claim form with all required fields completed in accordance with the health carrier's published claim filing requirements.	12% per annum	Deadline to notify party that more time is needed for processing: 15 days
AZ Law Sections 20-3101 and 20-3102 HB 2600 (2000) *Applies to health care insurers*	30 days for "clean claims" **Definition of "Clean Claim":** A written or electronic claim for health care services or benefits that may be processed without obtaining additional information from the health care provider or from a third party, except in cases of fraud.	Interest on claim at rate that is equal to legal rate.	Deadline to request additional information: 30 days Payment deadline after receipt of additional information: 30 days
CA Law CA Health & Safety Code 1371 Amended by AB 1455 (2000) *Applies to health care service plans*	45 working days for an HMO or 30 working days for a health service plan unless claim is "contested" **Definition of "Contested":** When insurer has not received a completed claim and all information necessary to determine payer liability for the claim.	15% per annum Upon a final determination by the director of the Department of Managed Health Care that a health care service plan has engaged in an unfair payment pattern, the director may require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371.	Deadline to notify that a claim is contested: 45 working days for an HMO or 30 working days for a health service plan

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
CA Law CA Insurance Code Sec. 10123.13 Amended by AB 2537 (2000) *Only applies to insurers issuing group or individual policies of disability insurance that covers hospital, medical or surgical expenses*	30 working days unless claim is "contested" **Definition of "Contested":** When insurer has not received a completed claim and all information necessary to determine payer liability for the claim.	10% per annum	Deadline to notify that a claim is contested: 30 working days. Payment deadline after receipt of information: 30 days
CO Law S.B. 13 (2002) CO Revised Statutes 10-16-106.5 *Applies to insurers*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. (The Colorado Insurance Department also occasionally cites the 60-day timeframe established in an older regulation - Regulation 4-2-7. The penalties established in the regulation are: penalty of no more than $20 if claim is $100 or less, and of 8% annual interest if claim is more than $100).	10% per annum Carrier must pay an amount equal to 3% of total claim for all claims unsettled after 90 days, starting on the 90th day	
CT Law CT Gen. Statutes 38A-816 Amended by SB 694 (2001) *Applies to insurers*	45 days if there is no deficiency in the information needed for processing a claim	15 % per annum, in addition to penalties which may be imposed	Deadline to request additional information: 30 days Payment deadline after receipt of additional information: 30 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
DE Law Regulation 81, Delaware Commissioner of Insurance *Applies to insurers*	30 days	If the carrier does not make prompt payment, the commissioner of insurance may award interest in an amount equal to prime interest rate plus three percent and impose fines.	
FL Law Section 641.3155 *Applies to HMOs*	40 days 20 days for electronically submitted claims (30 for an electronic pharmacy claim) **Definition of "clean claim":** For no institutional providers: A claim submitted to the HMO designated locations that consists of the HCFA 1500 data set, or its successor, and has all mandatory entries. For institutional providers: A claim submitted to the HMO designated locations that consists of the UB-92 data set, or its successor, and has all mandatory entries.	12% per annum	Deadline to notify that claim is contested: 40 days (20 for electronically submitted claims) Claim must be paid or denied within 120 days of receipt (90 for electronically submitted claims)
FL Law 627.6131 (applies to insurers)	40 days 20 days for electronically submitted claims (30 for an electronic pharmacy claim) **Definition of "clean claim":** For non-institutional providers: A claim submitted to the HMO designated locations that consists of the HCFA 1500 data set, or its successor, and has all mandatory entries. For institutional providers: A claim submitted to the HMO designated locations that consists of the UB-92 data set, or its successor, and has all the mandatory entries.	12% per annum	Deadline to notify that claim is contested: 40 days (20 for electronically submitted claims Claim must be paid or denied within 120 days of receipt (90 for electronically submitted claims)
GA Law O.C.G.A. Sec. 33-24-59.5 *Applies to insurers*	15 working days for undisputed claims or undisputed portions of a claim	18% per annum	Deadline to notify subscriber of reasons for failing to pay claim: 15 days Payment deadline after receipt of additional information: 15 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
HI Law H.R.S. Section 431-13 103(a)(11)(F) and 431-13-108 *Applies to accident and sickness insurance providers and HMOs*	30 days if claim is not in dispute Repealed effective 07/01/02 Note: Section 431-13-108, which expressly concerned uncontested electronic claims, was repealed effective 7-01-02, pursuant to a repeal provision in the original 1999 bill.	No provision	
HI Bill HB 202 (2001) Amends 431-13 Passed House: 3/6/01 Passed Senate: 4/10/01 Carried over: 5/14/01 SB 171 (2001) Passed Senate: 3/6/01 Passed House: 4/2/01 Carried over: 5/14/01 *Applies to HMOs*	15 days for electronic "clean claims" 30 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim where the following conditions are met: (1) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract; (2) claim has no material defect or impropriety; (3) there is no dispute regarding the amount claimed; and (4) the entity has no reason to believe that the claim was submitted fraudulently.	Any interest that accrues in a sum of at least $2 on a delayed claim shall be automatically added by the entity to the amount of the unpaid claim due the provider. The commissioner may suspend the accrual of 15% interest per annum under current law if the commissioner of financial institutions determines that the failure to pay was the result of a major disaster or of an unanticipated major computer system failure.	
IL Law 215 ILCS 5/357.9 *Applies to insurers, HMOs, managed care plans, health care plans, PPOs, third party administrators, independent practice associations, and physician- hospital organizations*	30 days	9% per annum	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
IN Law 27-8-5-19 *Applies to insurers*	45 days (after insurer receives all information required to determine liability under the terms of the policy)	No provision	
IN Law SB 311 (2001) 5-10-8 Signed by Governor: 5/07/01 *Applies to insurers and HMOs providing state employee health benefits*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim submitted by a provider for payment under a health benefit plan that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.	At a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and accruing from the date of overpayment. Other Fines: (1) If the insurer or HMO has paid at least 85 percent but less than 95 percent of all clean claims received during the calendar year in compliance with this chapter, a fine of up to $10,000. (2) If the insurer or HMO has paid at least 60 percent but less than 85 percent of all clean claims received during the calendar year in compliance with this chapter, a fine of at least $10,000 but not more than $100,000. (3) If the insurer or HMO has paid less than 60 percent of all clean claims received during the calendar year in compliance with this chapter, a fine of at least $100,000 but not more than $200,000.	
IA Law SB 500 Signed by Governor: 4/24/2001 *Applies to insurers*	30 days for "clean claim" **Definition of a "Clean Claim":** A properly completed paper or electronic billing instrument containing all reasonably necessary information that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.	10% per annum	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
KS Law HB 2005 (2000) *Applies to Medicare Supplemental Insurers*	30 days for "clean claims" **Definition of "Clean Claim":** A claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this act.	1% per month	Deadline to request additional information: 30 days Payment deadline after receipt of additional information: 15 days
KY Law SB 279 (2000) 304.17A-700 through 304.17A-730 *Applies to insurers*	30 calendar days for "clean claims" (60 days for "clean claims" involving organ transplants) **Definition of "Clean Claim":** A properly completed billing instrument, paper or electronic, that does not involve coordination of benefits for 3rd party liability, preexisting condition investigations, or subrogation. For institutional providers, a clean claim consists of: (1) UB-92 data set or its successor submitted on the designated paper or electronic formats as adopted by the National Uniform Billing Committee (NUBC); (2) entries stated as mandatory by the NUBC; and (3) any state-designated data requirements determined and approved by the KY State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service. For dentists, a clean claim consists of the form and data set approved by the ADA. For all other providers, a clean claim consists of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee. For pharmacists, a clean claim consists of a universal claim form and data set approved by the National Council on Prescription Drug Programs.	12% per annum for claims that are paid between 31 and 60 days from the date that the claim was received 18% per annum for claims that are paid between 61 and 90 days from the date that the claim was received Department of Insurance can also assess fine of $1,000 per day or 10% of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid. If the commissioner determines the insurer has willfully and knowingly violated Act or has a pattern of repeated violations, the commissioner may fine insurer up to $10,000.	Deadline to acknowledge claim: 48 hours for electronic claims 20 days for non-electronic claims Deadline to request additional information: 30 days Payment deadline after receipt of additional information: 30 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
LA Law R.S. 22:250.31-250.37 *Applies to "Health Insurance Issuers" defined as insurance companies and HMOs*	25 days for electronic claims 45 days for non-electronic claims submitted within 45 days 60 days for non-electronic claims submitted after 45 days Deadlines apply to claims upon which a correctly completed uniform claim form is furnished.	1% of amount due and 1% of unpaid balance for each 25 days that claim remains unpaid	
ME Law Title 24-A, Sections 2436, 2436A and 4222-B Sections 4222-(undisputed claims) Signed by the Governor on March 28, 2002 *Applies to insurers*	30 days **Definition of "undisputed claim":** Any claim that received prior authorization from an HMO. For non-institutional providers, any claim filed with and HMO submitted on a federal Health Care Financing Administration from that has no defect or impropriety, does not lack request substantiation documentation for non-contracted providers and suppliers, and does not present particular circumstances requiring special treatment that prevent timely payment. For institutional providers, in absence of a contractual definition, any claim that is properly and accurately complete, consists of the requisite data set, and contains entries deemed mandatory by a national uniform billing committee.	1.5% per month A. Up to $500 per claim for each day a claim is processed beyond the 30-day limit. A penalty imposed under this paragraph may not exceed a total of $5,000 for each separate violation. B. Up to $500 per day for any health maintenance organization that fails to respond to the superintendent's inquiries in a timely manner. A penalty imposed under this paragraph may not exceed $7,500 per inquiry. C. Up to $500 per day for any person that fails to cooperate with the superintendent's investigations. A penalty imposed under this paragraph may not exceed a total of $10,000 except that a person who violates the law 5 times within a 5-year period may be penalized an additional $50,000.	Deadline to request additional information: 30 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
MD Law Insurance Code 15-1005 *Applies to insurers, HMOs and MCOs*	30 days	1.5% per month simple interest for claims that are paid between 31 and 60 days from the date the claim was received 2% per month for claims that are paid between 61and 120 days from the date the claim was received 2.5% per month for claims that are paid after 120 days from the date the claim was received	
MA Law Ch. 176G sec. 6 HB 4525 (2000) *HMOs*	45 days	1.5% per month, not to exceed 18% per year	
MI Law MCL 500.2006 *Applies to insurers*	60 days	12% per annum	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
MI Law SB 938 (2000) Sections 400.111a and 111b Introduced 5/3/01. Passed Senate 12/13/01. Passed House 2/28/02. *Only applies to HMOs participating in Medicaid*	45 days after receipt of the claim by the health plan for "clean claims" 45 days or within the industry standard time frame for paying the claim, whichever is sooner, for pharmaceutical clean claims **Definition of "Clean Claim"**: A claim that (1) identifies the health professional or health facility that provided treatment or service, including a matching identifying number; (2) identifies the patient and plan; (3) lists the date and place of service; (4) is for covered services; (5) is certified pursuant to section 111b(17) (a provider shall certify that a claim for payment is true, accurate, prepared with the consent of the provider and does not contain deceptive or misleading information) and has the identifying information required under section 111b(21) (provider shall identify each attending, referring, or prescribing physician, dentist, or other practicing practitioner); (6) if necessary, substantiates the medical necessity and appropriateness of the care provided; (7) if prior authorization is required for certain patient care or services, includes any applicable authorization number; and (8) includes additional documentation based upon services rendered as reasonably required by health plan.	12% per annum	30 days for plan to notify provider of any defect in claim. A health provider shall have 30 days after receipt of a notice that a claim or a portion of a claim is defective within which to correct the defect. The health plan shall pay the claim within 30 days after the defect is corrected.
MN Law SB 2767 (2000) *Section 62Q.75* *Applies to health plans and TPAs*	30 calendar days for "clean claims" **Definition of "Clean Claim":** A claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section.	1.5% per month	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
MS Law H.B. 683 (amends current law) Signed by Governor 4/11/02 *Applies to insurers and HMOs* Effective: January 1, 2003	(Effective 1/1/03) 25 days for "clean claims" submitted electronically. 35 days for "clean claims" submitted by paper. **Definition of a "clean claim":** A claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim is NOT : (a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim; (b) Claims which are submitted fraudulently or that are based upon material misrepresentations; (c) Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or (d) Claims submitted by a provider more than 30 days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.	If the claim is not denied for valid and proper reasons by the end of the applicable time period, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of 1-1/2% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than $1.00, such amount shall be credited to the account of the person or entity to whom such amount is owed. **Administrative Penalties:** (1) If the commissioner finds that the insurer, during any calendar year, has paid at least 85%, but less than 95%, of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not to exceed $10,000. If the commissioner finds that the insurer, during any calendar year, has paid at least 50%, but less than 85%, of all clean claims received from all providers during that year in accordance with the provision of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount of not less that $10,000 nor more than $100,000. If the commissioner finds that an insurer, during any calendar year, has paid less than 50% of all clean claims received from all providers during that year in accordance with provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not less than $100,000 nor more than $200,000. In determining the amount of any fine, the commissioner shall take into account hthccommissionercommissioner	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
MS Law **(continued)**		whether the failure to achieve the standards in subsection (1)(h) of this section were due to circumstances beyond the control of the insurer. The insurer may request an administrative hearing to contest the assessment of any administrative penalty imposed by the commissioner pursuant to this subsection within 30 days after receipt of the notice of assessment. (2) Examinations to determine compliance with subsection (1)(h) of this section may be conducted by the commissioner or any of his examiners. The commissioner may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the insurer examined. (3) Nothing in the provisions of subsection (1)(h) of this section shall require an insurer to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance. (4) An insurer and a provider may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (1)(h) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the insurer to the provider. If the express written agreement is silent as to ant interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (1)(h)3 of this section shall apply. (5) The commissioner may adopt rules and regulations necessary to ensure compliance	Any claim resubmitted with supporting information must be paid within 20 days of receipt.

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
		with this subsection.	

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
MO Law HB 328 (2001) Sections 376.383 Signed by Governor: 7/6/2001 *Applies to health carriers*	45 days	1% per month If a health carrier fails to pay, deny or suspend the claim within 40 processing days, and has received, on or after the 40th day, notice from the health care provider that the claim has not been paid, denied or suspended, the health carrier must, in addition to monthly interest due, pay to the claimant per day an amount of 50 percent of the claim but not to exceed 20 dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. The penalty must not accrue for more than 30 days unless the claimant provides a second written or electronic notice on or after the 30 days to the health carrier that the claim remains unpaid and that penalties are claimed to be due. Requires the Director of the Department of Insurance to monitor health carrier compliance on or after January 1, 2002. Compliance will be defined as properly processing and paying 95 percent of all claims received in a given calendar year. The director may assess an administrative penalty in addition to the penalties of up to 25 dollars per claim for the percentage of claims found to be in noncompliance, but not to exceed an annual aggregate penalty of 250,000 dollars, for any health carrier deemed to be not in compliance.	Payment deadline after receipt of additional information: 10 days
MT Law 33-18-232 *Applies to insurers*	30 days	18% per annum from the date the commissioner determines delay became unreasonable	Deadline to request additional information: 30 days

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
NV Law 695C.185 Amended by **SB 99** (2001) *Applies to HMOs*	30 days	A rate of interest equal to the prime rate at the largest bank in Nevada, as determined by the commissioner of financial institutions, on January 1 or July 1, immediately preceding the date on which the payment was due, plus 6%. The commissioner of insurance may require HMO to provide evidence demonstrating substantial compliance, including payment within 30 days of at least 95% of approved claims or at least 90% of the total dollar amount for approved claims. If the HMO is not in substantial compliance with requirements, the commissioner may require the HMO to pay an administrative fine in an amount to be determined by the commissioner.	Deadline for notifying the subscriber of its request for information: 20 days Payment deadline after all additional information is received: 30 days
NH Law Section 126-A: 12 RSA 126-A, RSA 415 And RSA 420 Amended by SB 383/ HB 1240 (2000) *Applies to insurers offering health benefit plans (also partially applies to the department of health and human services for services rendered to Medicaid recipients*	15 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.	1.5% per month The commissioner of insurance may assess an administrative fine up to $5,000 per violation, not to exceed $100,000 against any insurer or may suspend or revoke the license or certificate of authority of any insurer after determining that the insurer has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer.	Deadline to notify provider/ certificate holder of reason for denying/ pending the claim and if additional information is necessary: 15 calendar days

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
NJ Law Sections 17:48-8.4 17:48H-33.1 *Applies to organized delivery systems and hospital service corporations*	30 days or the Medicare standard, whichever is earlier, for electronic claims 40 days for non-electronic claims Deadlines apply if : (1) The claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health benefits plan contract or policy; (2) The claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding; (3) There is no dispute regarding the amount claimed; (4) The payer has no reason to believe that claim has been submitted fraudulently; and (5) The claim requires no special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy.	10% per annum	Deadline for notifying that claim is contested : 30 days Deadline for payment after additional information is received: 30 days or the Medicare standard, whichever is earlier, for electronic claims, and 40 days for non-electronic claims
NM Law Section 59A-2-9.2 *Applies to HMOs*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim from a participating provider that: (a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system; (b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; or (c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within 30 days if electronic or 45 days is submitted manually.	1.5% per month	Deadline to notify that insurer is not liable for claim or that additional information is necessary: 30 days for electronic claim 45 days for non-electronic claims
NY Bill New York Insurance Code, 3224-A *Applies to HMOs*	45 days	A rate of interest at the rate set by the Commissioner of Taxation or 12%, whichever is greater. Penalty of up to $500 for each violation (Sections 109)	Deadline for notifying subscriber of its request for information: 30 days Payment deadline after all additional information is received: 45 days

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
NC Law NC G.S. Sec. 58-3-100 *Applies to insurers not covered by Section 58-3-225*		The commissioner of insurance may impose a civil penalty if an insurer fails to acknowledge a claim within 30 days after receiving notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgment of the claim shall be made to the claimant or his legal representative, advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of a settlement; or shall be a written denial of the claim.	
NC Law Section 58-3-225 HB 1340 (2000) *Applies to health benefit plans, including HMOs*	30 calendar days	18% per annum	Deadline to notify of denial of claim or of contested status: 30 calendar days Payment deadline after receipt of additional information: 30 calendar days
ND Law 26.1-36-37.1 *Applies to insurers*	15 business days unless claim is "contested" No definition of "contested"	No provision	Payment deadline after receipt of additional information: 15 business days

Prompt Pay: Summary of State Laws and Selected State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
OH Law 3901.38 Amended by SB 4 (2001) *Applies to third-party payers*	30 days if no additional supporting documentation is necessary.	18% per annum (effective 7/24/02) ‡ For a first offense (series of violations that taken together constitutes a consistent pattern or practice of violating the subsection 3901.3811(A)), the superintendent may levy a fine of not more than $100,000. For a second offense that occurs on or earlier than 4 years from the first offense, the superintendent may levy a fine of not more than $150,000. For a third or additional offense that occurs on or earlier than 7 years after a first offense, the superintendent may levy a fine of not more than $300,000.	Deadline to request additional supporting documentation to establish payer responsibility or that relates to a pre-existing condition: 30 days Payment deadline if additional supporting documentation is necessary: 45 days, not including the number of days between the request for additional information and receipt of that information: 45 days Deadline to give notice of material deficiencies in the claim related to diagnosis, treatment or provider identification: 15 days
OK Law 63 Sec. 2514 *Applies to HMOs*	45 day prompt payment of claims **Definition of "Clean Claim":** A claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment.	10% per annum	Payment deadline after receipt of additional information: 90 days
OK Law 36 Sec. 1219 Amended by S 192 (2001) *Applies to insurers and HMOs*	45 days for "clean claims" **Definition of "Clean Claim":** A claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment.	10% per annum	Deadline to request additional information: 30 days Deadline to deny or pay the claim after receipt of additional information: 45 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
OR Law Section 743.866 & 748.868 SB 894 (2001) Signed by Governor: 7/5/2001 *Applies to insurers*	30 days for "clean claims" Law requires the director of the Department of Consumer and Business Services to adopt a definition of "clean claim" and to consider the definition of "clean claim" used by the federal department of health on human services for the payment of Medicare claims.	12% per annum	
PA Law Title 32, Section 154.18 P.L. 682, No. 284 (Insurance Co. Law of 1921) *Applies to insurers and managed care plans*	45 days for "clean claims" **Definition of "Clean Claim":** A claim which has no defect or impropriety (includes lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim)	10% per annum	
RI Law Sections: 27-41-64, 27-18-61, 27-19-52 & 27-20-47	30 days for electronic "claims" 40 days for non-electronic "claims" **Definition of "Claim":** (i) A bill or invoice for covered services; (ii) a line item of service; or (iii) all services for one patient or subscriber within a bill or invoice.	12% per annum	
SD Law Section 58-12-19 & 58-12-20 S 231 (2001) Signed by the Governor: 3/3/01 *Applies to health insurers and HMOs*	30 days for electronic "clean claims" 45 days for non-electronic "clean claims" **Definition of "Clean Claims":** A claim for which there is no need for additional information to determine eligibility or adjudicate the claim. The term, clean claim, does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law or a claim for which fraud is suspected.	No provision	Deadline to request additional information: 30 days

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
TN Law HB 1192 (2000) Sections 56-7-109 (amends current law) Signed by Governor 4/9/02. Applies to health insurance entities, including HMOs Effective: July 1, 2002	21 calendar days for electronic "clean claims" 30 calendar days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim received by a health insurance entity for adjudication, and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this act. A clean claim includes resubmitted paper claims with previously identified deficiencies corrected, but does not include a duplicate claim (when the duplicate is filed within 30 days of the original claim) or any claim submitted more than 90 days after the date of service.	1% per month If the commissioner of the department of commerce and insurance finds a health insurance entity has failed during any calendar year to properly process and pay a certain percentage of claims, he/she may levy the following penalties: Up to $10,000 if a health insurance entity failed to process and pay 95% of all clean claims; Up to $100,000 if a health insurance entity failed to process and pay 85% of all clean claims; Up to $200,000 if a health insurance entity failed to process and pay 60% of all clean claims.	Deadline to notify provider that additional information is necessary: 21 calendar days for electronic claims 30 calendar days for non-electronic claims
TX Law *Article 3.70-3C, Section 3A* *Applies to preferred providers*	45 days or within payment deadline specified by written agreement between insurer and provider	18% per annum and reasonable attorney fees (Article 21.55) Also see "Other Deadlines"	Insurer must pay damages if insurer delays payment following its receipt of all information requested and required for a period exceeding the period specified in applicable statutes or for more than 60 days
TX Law Vernon's TX Ins. Code Chapter 20A.18B Will be repealed 6/01/03, and replaced by Sections 843.336-843.46 *Applies to HMOs*	45 days for "clean claims" (If HMO intends to audit a claim, it must pay 85% of claim within 45 days.) 21 days for electronic prescription benefits claims (If prescription benefit claim is electronically adjudicated and electronically paid, and the HMO or its designated agent authorizes treatment, claim must be paid no later than 21 days after treatment is authorized.) **Definition of "Clean Claim":** completed claim, as determined under TX DOI rules, submitted by a physician or provider for medical care or health care services under a health care plan.	In addition to any other penalty or remedy authorized, administrative penalty of up to $1000 for each day the claim remains unpaid may be imposed. 18% per annum and reasonable attorney fees (Article 21.55)	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
UT Law 31A-26-301.6 Amended by S.B. 124 (amends current law) Signed by Governor 3/26/02 *Applies to insurers* Effective: May 1, 2002	30 days Amends current law to clarify the scope of claims subject to the law. The law is amended to apply to claims for first party benefits made by a person who is: (a) named or defined as an insured under the terms of an insurance policy; (b) described as a covered person under the terms of a policy of health care insurance; or (c) named, defined, or described. Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured.	For first 90 days, multiply: (1) The total amount of the claim; (2) The total number of days the response or the payment; and (3) .1% For 91 or more days, add: (1) The late fee for the first 90 days; and (2) multiply the total amount of the claim; the total number of days the response or payment was late beyond the initial 90 days and the rate of interest set in accordance with section 15-1-1	Deadline to request additional information: 30 days
VT Law Title 18, chapter 221, section 9418 *Applies to health plans*	45 days	12% per annum	Payment deadline after receipt of additional information: 45 days
VA Law Chapter 34, Title 38.2-3407.15 *Applies to carriers*	40 days for "clean claims" **Definition of "Clean Claim":** A claim that has no material defect or impropriety (including lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim.	Legal rate of interest. (38.2-3407.1)	Deadline to request additional information: 30 days.
WA Law WAC 284-43-320 *Applies to carriers*	30 days for 95% of monthly volume of "clean claims" 60 days for 95% of monthly volume of all claims **Definition of "Clean Claim":** A claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.	1% per month	

Prompt Pay: Summary of State Laws and Selected 2001 State Legislation			
State Law or Bill #	**Processing Deadline/ Type of Claim**	**Penalty for Late Processing/Payment ***	**Other Deadlines**
WV Law HB 2486 (2001) Section 33-43-1, et seq. Signed by Governor: 5/02/01 *Applies to insurers*	30 days for electronic "clean claims" 40 days for non-electronic "clean claims" **Definition of "Clean Claim":** A claim that (a) has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (b) with respect to which an insurer has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with the act.	10% per annum	Deadline: An insurer has 30 days to request additional information, and then, after receiving information from this first request, may ask for certain additional information within 15 days. Payment deadline after receipt of additional information: 30 days
WI Law 628.46 *Applies to insurers*	30 days	12% per annum	
WY Law 26-15-124 *Applies to insurers*	45 days Deadline does not apply if there is any question as to the validity or the amount of the claim and the question is referred to the WY state medical peer review committee for adjudication.	10% per annum	

APPENDIX B.4.

Texas Department of Insurance HMO and PPO Performance Trends

TEXAS DEPARTMENT OF INSURANCE

HMO and PPO COMPLAINTS RECEIVED
2000 - 2002 (to date)

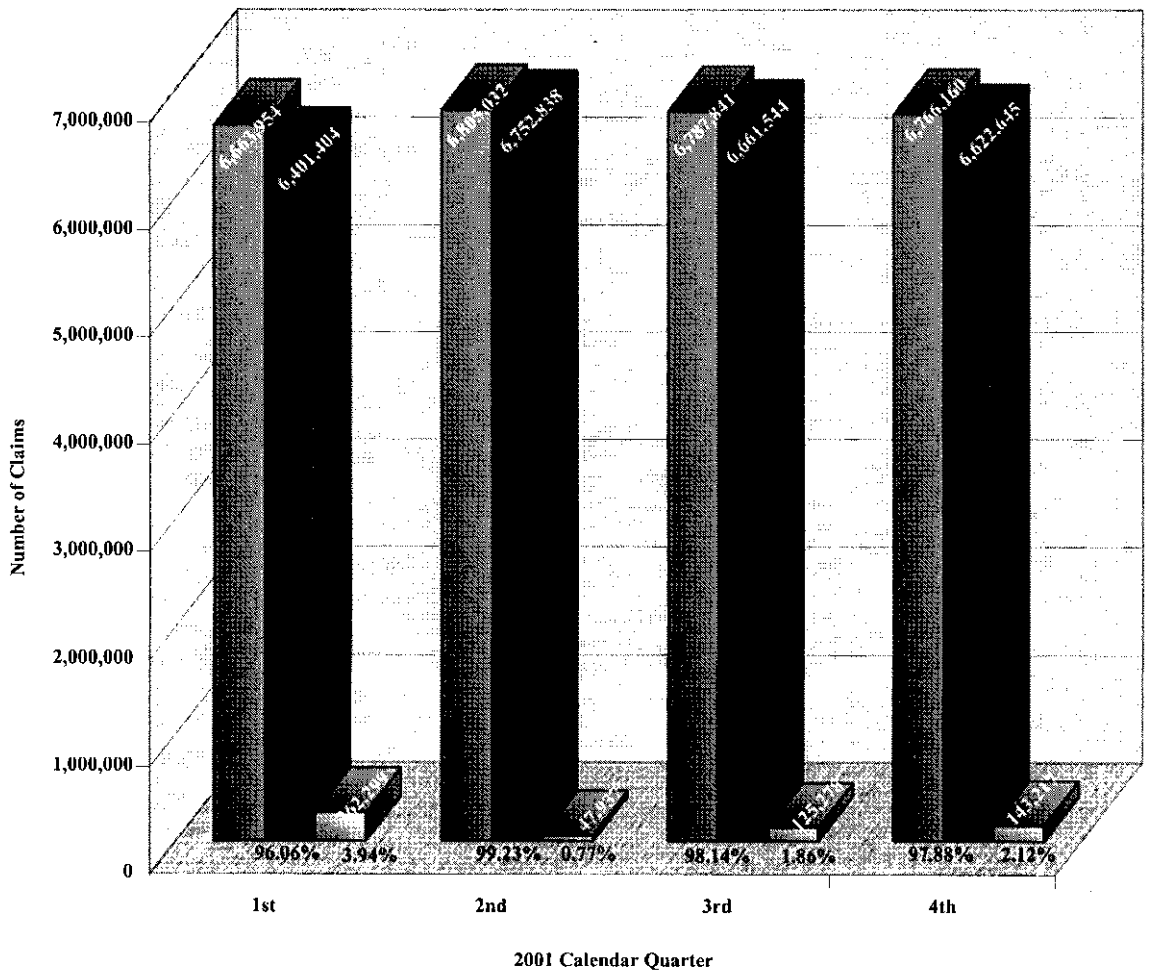
	Calendar Year/Percentage					
	2000	**Percentage**	**2001**	**Percentage**	**2002***	**Percentage**
HMO						
Total complaints received	5,829		8,276		5,307	
Total provider complaints received	2,972	51%	5,522	67%	3,642	69%
Justified provider complaints received	1,933	65%	3,457	63%	1,910	52%
PPO						
Total complaints received	3,159		4,221		3,783	
Total provider complaints received	2,001	63%	3,238	77%	3,147	83%
Justified provider complaints received	752	38%	1,130	35%	753	24%

* Received through 11/4/2002

Overall, the number of complaints TDI received from providers as a percentage of all complaints against HMOs and PPOs has increased.

A complaint is justified if there is an apparent violation of a policy provision, contract provision, TDI rule or Texas statute, or there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice. Some examples of a justified complaint include the complainant has a reason to be dissatisfied with how the claim was handled; the amount paid was less than it should have been; the claim was denied when it should have been paid; or, the claim was not handled timely. The percentage of justified complaints from providers has decreased.

Clean Claims Payment History
First, Second, and Third Company Groups



Includes Companies in All Groups Requested:

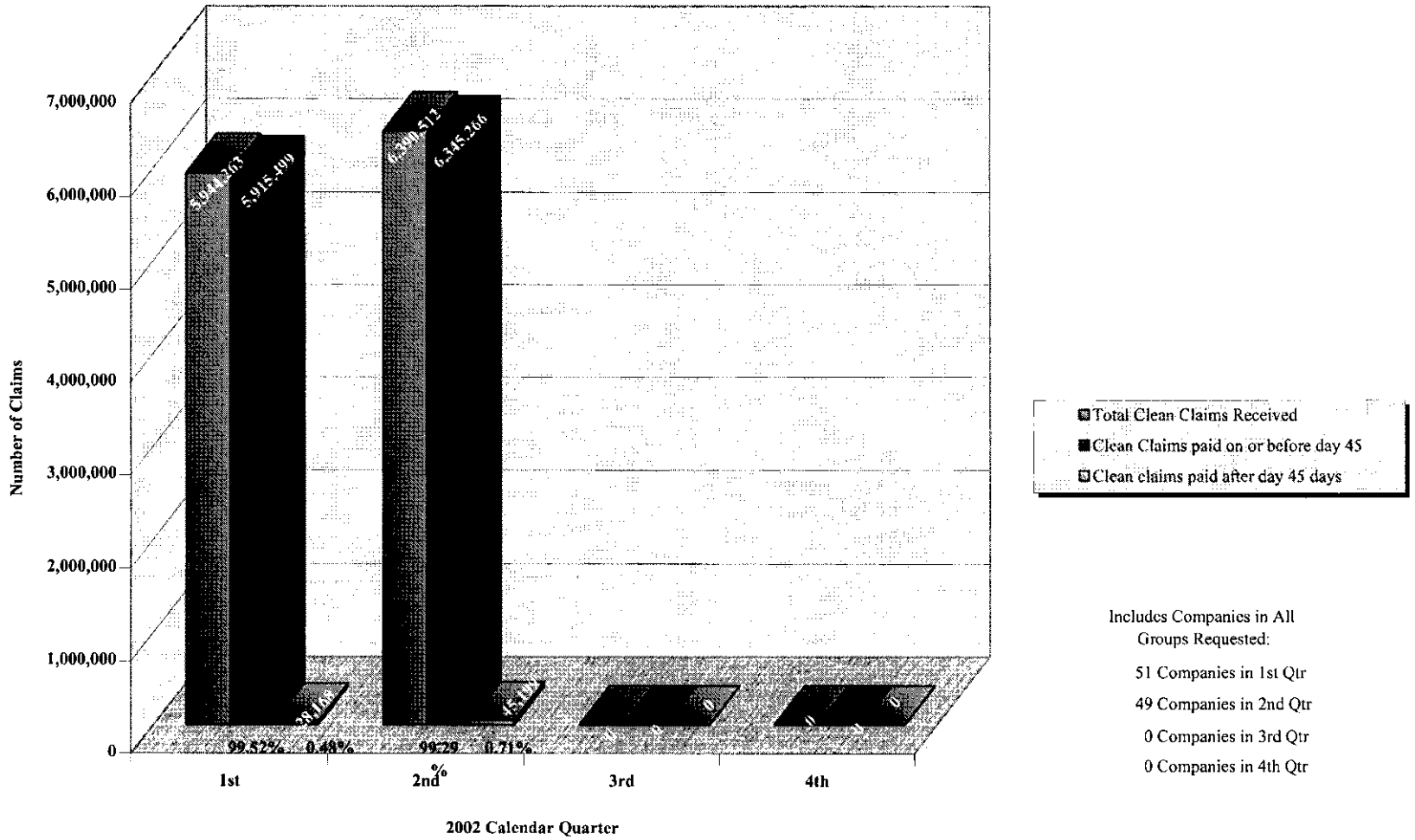
23 Companies in 1st Qtr

40 Companies in 2nd Qtr

52 Companies in 3rd Qtr

51 Companies in 4th Qtr

Clean Claims Payment History
First, Second, and Third Company Groups



Includes Companies in All Groups Requested:

51 Companies in 1st Qtr

49 Companies in 2nd Qtr

0 Companies in 3rd Qtr

0 Companies in 4th Qtr

APPENDIX B.5.

Texas Department of Insurance Provider Ombudsman Project - Restitution Paid

Texas Department of Insurance -
Provider Ombudsman Project - Restitution Paid

As of 11/4/2002

Carrier	Number of Physicians	Restitution Paid	Number of Providers	Restitution Paid	Total Number of Entities Paid	Total Restitution Paid	Administrative Penalties
Alta Health & Life Insurance Company	1	$22.45	3	$8,483.48			$416,666.66
Great-West Life & Annuity Insurance Co.	4	$776.80	19	$101,296.28			$541,666.68
One Health Plan of Texas, Inc.	39	$5,369.55	55	$352,597.54			$541,666.66
Subtotal - Great-West	**44**	**$6,168.80**	**77**	**$462,377.30**	**121**	**$468,546.10**	**$1,500,000.00**
Blue Cross and Blue Shield of Texas	402	$129,191.88	173	$2,569,303.24			$1,500,000.00
Rio Grande HMO, Inc.	163	$62,476.96	39	$204,265.23			included above
Southwest Texas HMO, Inc.	161	$84,970.16	36	$207,317.16			included above
Texas Gulf Coast HMO, Inc.	865	$1,014,038.68	160	$2,226,439.84			included above
Subtotal - BCBS	**1,591**	**$1,290,677.68**	**408**	**$5,207,325.47**	**1,999**	**$6,498,003.15**	**$1,500,000.00**
CIGNA Healthcare of Texas, Inc.	209	$21,399.07	1,744	$1,113,999.42			$1,250,000.00
CIGNA Delegated Entities	299	$205,185.77	67	$6,993.45			
Connecticut General Life Insurance Co.	752	$133,587.77	1,418	$840,474.89			included above
Subtotal - CIGNA	**1,260**	**$360,172.61**	**3,229**	**$1,961,467.76**	**4,489**	**$2,321,640.37**	**$1,250,000.00**
Humana Health Plan of Texas, Inc.	506	$50,485.50	238	$1,039,487.10			$1,250,000.00
Humana Insurance Company	100	$27,371.01	72	$249,448.22			included above
Employers Health Insurance Company	1,125	$304,756.73	123	$488,522.27			included above
Subtotal - Humana	**1,731**	**$382,613.24**	**433**	**$1,777,457.59**	**2,164**	**$2,160,070.83**	**$1,250,000.00**
Unicare Life & Health Insurance Co.	**224**	**$264,700.77**	**50**	**$271,758.00**	**274**	**$536,458.77**	**$1,250,000.00**
Sierra Health and Life Insurance Co. Inc.	308	$49,178.72	37	$73,928.18			$1,250,000.00
Texas Health Choice, L.C.	664	$137,396.44	80	$738,319.97			included above
Subtotal - Sierra Health/Texas Health Choice	**972**	**$186,575.16**	**117**	**$812,248.15**	**1,089**	**$998,823.31**	**$1,250,000.00**
United Healthcare Insurance Company	19	$3,348.45	9	$65,605.25			$1,250,000.00
United Healthcare of Texas, Inc.	261	$67,853.39	64	$471,496.35			included above
Subtotal - United	**280**	**$71,201.84**	**73**	**$537,101.60**	**353**	**$608,303.44**	**$1,250,000.00**
Aetna Life Insurance Company	1,907	$682,925.60	226	$2,786,753.47			**$1,150,000.00**
The Prudential Insurance Co. of America	722	$372,498.68	165	$1,775,726.75			included above
Aetna U.S. Healthcare Inc.	668	$269,985.15	51	$819,393.87			included above
Aetna U.S. Healthcare Inc. of North Texas	476	$149,845.02	78	$961,124.94			included above
Prudential Health Care Plan, Inc.	920	$363,835.45	180	$3,368,664.02			included above
Subtotal - Aetna	**4,693**	**$1,839,089.90**	**700**	**$9,711,663.05**	**5,393**	**$11,550,752.95**	
Subtotal - Aetna Delegated Entities	**287**	**$51,147.33**	**523**	**$6,804.44**	**810**	**$57,951.77**	
Subtotal - Aetna payments for MSM restitution	**476**	**$149,845.02**	**78**	**$961,124.94**	**554**	**$1,110,969.96**	
TOTAL FOR AETNA GROUP	**5,456**	**$2,040,082.25**	**1,301**	**$10,679,592.43**	**6,757**	**$12,719,674.68**	**$1,150,000.00**
GRAND TOTAL - ALL GROUP 1 COMPANIES*	**11,558**	**$4,602,192.35**	**5,688**	**$21,709,328.30**	**17,246**	**$26,311,520.65**	**$10,400,000.00**
Aetna Letter of Credit Payments**				$10,303,417.00			

*Some physicians and providers may have received restitution from more than one carrier, therefore reducing the total number of physicians and providers paid. Also, the total number of physicians and providers has been adjusted based on subsequent reports.

**Aetna US Healthcare of North Texas is subject to an additional $600,000 fine if certain MSM Letter of Credit payments are not made throughout 2002.

Texas Department of Insurance -
Provider Ombudsman Project - Restitution Paid

As of 11/4/2002

Carrier	Number of Physicians	Restitution Paid	Number of Providers	Restitution Paid	Total Number of Entities Paid	Total Restitution Paid	Administrative Penalties
April 1 Consent Orders							
Amil International Insurance Company, Inc.	149	$31,492.34	35	$15,050.28	**184**	**$46,542.62**	$150,000.00
Central Reserve Life Insurance Company	1,216	$203,072.76	203	$454,673.44	**1,419**	**$657,746.20**	$550,000.00
Continental General Insurance Company	283	$25,564.15	51	$83,402.54	**334**	**$108,966.69**	included above
Provident American Life and Health Ins.	354	$35,696.40	59	$100,268.54	**413**	**$135,964.94**	included above
Provident Indemnity Life Ins. Co.	4	$766.09	3	$1,757.65	**7**	**$2,523.74**	included above
Conseco Medical Insurance Company	2,196	$420,954.91	472	$650,035.12	**2,668**	**$1,070,990.03**	$250,000.00
Guardian Life Insurance Company	1,217	$382,071.47	150	$688,107.85	**1,367**	**$1,070,179.32**	$325,000.00
Metropolitan Life Insurance Company	67	$8,424.32	201	$710,385.35	**268**	**$718,809.67**	$575,000.00
New England Life Insurance Company	149	$13,574.35	260	$513,861.60	**409**	**$527,435.95**	included above
Pacific Life and Annuity Company	3,928	$1,148,101.00	286	$2,091,478.00	**4,214**	**$3,239,579.00**	$250,000.00
Principal Life Insurance Company	12	$2,336.93	387	$1,078,979.23	**399**	**$1,081,316.16**	$250,000.00
Protective Life Insurance Company	240	$14,365.63	45	$13,414.56	**285**	**$27,780.19**	$125,000.00
Trustmark Insurance Company	512	$122,831.36	121	$666,872.51	**633**	**$789,703.87**	$300,000.00
TOTAL FOR APRIL 1 CONSENT ORDERS	**10,327**	**$2,409,251.71**	**2,273**	**$7,068,286.67**	**12,600**	**$9,477,538.38**	**$2,775,000.00**

Texas Department of Insurance -
Provider Ombudsman Project - Restitution Paid

As of 11/4/2002

Carrier April 29 Consent Orders	Number of Physicians	Restitution Paid	Number of Providers	Restitution Paid	Total Number of Entities Paid	Total Restitution Paid	Administrative Penalties
American Heritage Life Insurance Company	46	$11,403.16	31	$158,702.90	**77**	**$170,106.06**	$200,000.00
Avemco Insurance Company	105	$15,920.76	59	$103,651.32	**164**	**$119,572.08**	$220,000.00
Continental Assurance Company					**0**	**$0.00**	$75,000.00
Fortis Benefits Insurance Company	8	$196.26	22	$101,651.61	**30**	**$101,847.87**	$450,000.00
John Alden Life Insurance Company	10	$3,281.87	12	$30,307.35	**22**	**$33,589.22**	included above
Fortis Insurance Company	16	$2,807.92	33	$79,620.47	**49**	**$82,428.39**	included above
Golden Rule Insurance Company	2	$347.21	10	$51,630.75	**12**	**$51,977.96**	$60,000.00
Methodist Health Insurance Company - includes Combined Insurance Company of America	1,502	$301,559.22	150	$894,912.84	**1,652**	**$1,196,472.06**	$200,000.00
Methodist Care, Inc.	1,901	$545,200.49	458	$7,064,066.75	**2,359**	**$7,609,267.24**	included above
Oxford Life Insurance Company	40	$3,383.55	64	$47,326.81	**104**	**$50,710.36**	$125,000.00
World Insurance Company	21	$1,707.17	42	$171,195.13	**63**	**$172,902.30**	$400,000.00
TOTAL FOR APRIL 29 CONSENT ORDERS	**3,651**	**$885,807.61**	**881**	**$8,703,065.93**	**4,532**	**$9,588,873.54**	**$1,730,000.00**

Texas Department of Insurance -
Provider Ombudsman Project - Restitution Paid

As of 11/4/2002

Carrier	Number of Physicians	Restitution Paid	Number of Providers	Restitution Paid	Total Number of Entities Paid	Total Restitution Paid	Administrative Penalties
TOTAL FOR ALL GROUP 1 COMPANIES	11,558	$4,602,192.35	5,688	$21,709,328.30	17,246	$26,311,520.65	$10,400,000.00
TOTAL FOR APRIL 1 CONSENT ORDERS	10,327	$2,409,102.71	2,273	$7,068,286.67	12,600	$9,477,389.38	$2,775,000.00
TOTAL FOR APRIL 29 CONSENT ORDERS	3,611	$882,424.06	817	$8,655,739.12	4,428	$9,588,873.54	$1,730,000.00
GRAND TOTAL FOR CONSENT ORDERS	**25,496**	**$7,893,719.12**	**8,778**	**$37,433,354.09**	**34,274**	**$45,377,783.57**	**$14,905,000.00**
TOTAL RESTITUTION PLUS PENALTIES PAID BY COMPANIES							**$60,282,783.57**

APPENDIX B.6.

Texas Department of Insurance Survey Regarding HIPAA Administrative Simplification Requirements and Electronic Claims Submission

TDI Survey Regarding HIPAA Administrative Simplification Requirements and Electronic Claims Submission

Background

The Texas Department of Insurance surveyed a representative sample of the Texas licensed accident and health (A&H) insurers and HMOs subject to the HIPAA Administrative Simplification requirements to request information on their plans and activities related to compliance with the standardized transaction requirements and information on the submission/payment of electronic claims.

TDI surveyed a total of 44 basic-service HMOs throughout the state. A total of 27 HMOs representing 67 percent of Texas' fully insured HMO enrollment returned usable surveys.

A separate survey was sent to 46 indemnity insurers that write both traditional indemnity plans and offer coverage under plans commonly referred to as Insurer Preferred Provider Plans (Insurer PPOs). TDI received responses from 26 of the surveyed insurers representing 40 percent of Texas' total accident and health insurance premiums written in calendar year 2000.

TDI contacted the Texas Medical Association, which agreed to send an electronic copy of a brief survey form to member physicians across the state to obtain information regarding their use of electronic claims payments or plans for implementing HIPAA standard transactions requirements.

Highlights of the survey results:

For the month of September 2001

HMO DATA (25 HMOs Reporting)	**Contracted Providers**	**Non-Contract Providers**
Total dollar amount of claims paid	$186,905,071	$28,171,943
Total number of claims received	1,683,227	223,842
Total number of claims received electronically	1,102,175	99,120
Total dollar amount of claims paid electronically	$48,129,279	$2,106,258
INSURER DATA (19 Insurers Reporting)	**Contracted Providers**	**Non-Contract Providers**
Total dollar amount of claims paid	$59,155,550	$19,728,767
Total number of claims received	589,565	134,741
Total number of claims received electronically	450,772	48,467
Total dollar amount of claims paid electronically	$26,041,947	$4,688,351

- Most insurers and HMOs do not require contracted providers to submit claims electronically.
  - Of the 26 surveyed insurers, only three (12%) require electronic claims; 22 (85%) do not have a requirement, and one insurer did not answer.
  - Of the 27 HMOs responding, 24, (89%) reported that they do not require electronic submissions from their contracted providers. Only two HMOs currently require contracted providers to submit claims electronically; one of these charges providers if they submit paper claims.

- Ninety percent (221) of the responding physicians (248) reported they submit claims electronically. Only 27 responded that they do not.

- Regarding the total number of claims submitted electronically, 242 physicians responded and 52 (21%) indicated that they file no more than 50 percent of claims electronically, and 190 (79%) reported that they file between 51 and 100 percent of claims electronically.

- Overall, the surveyed physicians report that an average of 73 percent of all claims are filed electronically.

Reason electronic submission is not used	# of Physicians	% of Physicians
Carrier does not accept electronic filings	172	68%
Carrier routinely requires hard copy attachments	75	30%
Fees for filing electronically are excessive	12	5%
We do not have the appropriate hardware required by the carrier	7	3%
We do not have the appropriate software required by the carrier	16	7%
We have concerns about the confidentiality of certain information	1	0%
The carriers' requirements for electronic filing are too complicated	17	7%
Previous efforts to file electronically with the carriers have not been successful	78	31%

APPENDIX B.7.

Texas Insurance Population Characteristics

EXHIBIT A

Texas Insurance Population Characteristics
Calendar Year 2000 Estimates

Prepared by Texas Department of Insurance

Total Texas Population	**20,851,820** Source: U.S. Census Bureau
Uninsured Citizens	**4,486,050** Source: U.S. Census Bureau
Texas Insured Population	**16,365,770**
Medicaid Enrollees	**1,810,000** Source: HHSC Quarterly Caseload Report: Medicaid Monthly Average Enrollment
Medicare Enrollees	**2,223,175** Source: Centers for Medicaid and Medicare (CMS)
CHIP Enrollees as of December 2000	**183,550** Source: Texas Health and Human Services Commission, Research Department
HMO Commercial Fully-Insured Members (Excludes Medicare/Medicaid/CHIP Mbrs)	**2,986,580** Source: TDI HMO Financial Report – 2000
Fully-Insured Indemnity Insurance (Includes Group and Individual Plans)	**4,080,886** Source: TDI 2000 Group Health Insurance Survey and U.S. Census Bureau
Self-Insured Employer Groups (Includes HMO and Indemnity Plans)	**5,081,579** Source: No source for self-insured data; estimate calculated based on known data from sources above

EXHIBIT B

Fully Insured Health Plan Enrollees Subject to Texas Prompt Payment Requirements - Private (Non-Government) Plans

Type of Health Plan	Number of Enrollees	Percentage of Individuals Insured Under Private (non-government) Plan
HMO – private	2,986,580	25%
PPO – Group Plans	2,359,526	19%
PPO – Individual Plans	1,339,200	11%
Total:	**6,685,306**	**55%**

In addition, it should be noted that contracts covering children enrolled in HMOs under the Texas Children's Health Insurance Program (CHIP) are also subject to the prompt payment requirements. As of December 2000, a total of 146,295 children (80% of the CHIP population) were enrolled in 12 different HMOs across Texas.

Self-Funded Health Plan Enrollees Not Subject to Texas Prompt Payment Requirements - Private (Non-Government) Health Plans Only

Type of Health Plan	Number of Enrollees	Percentage of Individuals Insured under Private (non-government) Plans
HMO	632,931	5%
Indemnity/PPO/Other Group Plans	4,448,648	37%
Total:	**5,081,579**	**42%**

APPENDIX C.1.
State Medical Liability Laws

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

STATE MEDICAL LIABILITY LAWS TABLE

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Alabama	§6.5.482 (1975, 1993) 2 years from date of injury or 6 months from reasonable discovery; no suit may be brought 4 years after date of injury; minors under 4 by age 8 if statute would have otherwise expired by that time	§6.5.544 (1987) $400,000 limit on non-economic damages, including punitive damages; §6.5.547 $1 million limit on total damages (court decision upheld cap only in wrongful death actions); §6-11-21 $250,000 cap on punitive damages except for wrongful death and suits alleging patterns of intentional wrongful conduct, actual malice or defamation[2]	§6.5.545 (1987) Discretionary offset; allows the jury to be informed if medical bills and/or lost wages have been paid by a third party	§6.5.543 (1987) Mandatory periodic payment of future damages in medical injury cases in excess of $150,000		§6.5.548(1997) Expert witness must be certified in same specialty as defendant and must have practiced within previous year		Alabama Supreme Court upheld constitutionality of statute of limitations in *Barlow v. Humana*, (1986); *Tucker v. Nichols* (1983); *Reese v. Fite Memorial Hospital*, (1981); non-economic damages portion of damage awards limitations ruled unconstitutional in *Moore v. Infirmary Assoc.* (1991); cap on total damages, excluding wrongful death, overturned in *Ray v. Anesthesia Assoc.*(1995); punitive damages cap ruled unconstitutional in *Henderson v. Alabama Power Co.* (1993); non-medical malpractice statute similar to collateral source rule struck down in *American Legion Post No. 57 v. Leahey* (1996)

[1] Expert witness rules commonly are established by case history. Summary chart includes only rules established by statute.
[2] Underline indicates statutes overturned by decisions of court (see *Case History* for specific citation) or was repealed by act of the legislature.

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Alaska	§09.10.070 (1962) 2 years from discovery of injury; tolled by disability	§09.17.010 (1997) For injuries after Aug. 7, 1997, non-economic damages cap greater of $400,000 or plaintiff's life expectancy, in years, multiplied by $8,000; for severe injury, the greater of $1 million and life expectancy in years times $25,000; §9.17.020 (1997) punitive damages cap greater of $500,000 or 3 times compensatory damages, whichever is greater, unless malicious action, then greater of $7 million or 4 times compensatory damages; 50% of punitive damages to state fund	§09.55.548 (1992) Mandatory offset of collateral sources, except federal program benefits requiring subrogation and life insurance	§09.55.548 (1976) Discretionary periodic payment of future damages for medical treatment, care or custody, loss of future earnings, or loss of bodily function	§09.55.536 (1976) Mandatory submission of claims to pretrial screening panel, unless court waives this requirement or parties agree to arbitrate; results of screening admissible at later trial	§09.20.185 (1997) Expert witnesses must be licensed and trained in the defendant's discipline and certified by a board recognized by the state		Alaska Supreme Court upheld constitutionality of pretrial screening panels in *Keyes v. Humana Hospital Alaska, Inc.*, (1988)
Arizona	§12.502, 542 (1971, 1984) 2 years from injury or death; foreign object or intentional fraud: 1 year from discovery; minor or unsound mind: statute begins upon removal		§12.565 (1976, 1984) Discretionary offset; evidence of collateral sources of payment for economic damages admissible at trial	§12.582 May elect for periodic payments made pursuant to court rule; claim for future damages is effective unless objecting party shows trial or arbitration should not be conducted			§12.568 (1976) Upon request by a party, the court will review the reasonableness for each party's attorney fees	Arizona Supreme Court upheld constitutionality of collateral source rule and mandatory pretrial screening panel requirement in *Eastin v. Broomfield* (1977); periodic payments statute ruled unconstitutional in *Smith v. Myers* (1994)
Arkansas	§16.114.203 (1979, 1991) 2 years from the date of injury; foreign objects: 1 year from discovery; minors: before age 9, until age 11; plaintiff must bring suit within 1 year from date of removal of disability			§16.114.208 (1979) Discretionary periodic payment of damages over $100,000; upon death of claimant, court may deduct future pain and suffering and care expenses		§16.114.207 (1979) Testimony by experts whose compensation depends upon outcome of suit prohibited		

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
California	Civ. Proc. §340.5 (1975) 3 years after injury or 1 year after discovery, whichever is first; in no even more than 3 years after injury, unless caused by fraud, concealment, or a foreign object; minor under age 6: 3 years or before age 8, whichever is longer; tolled for foreign body cases until reasonable discovery	Civ. §3333.2 (1975) $250,000 limit for non-economic damages	Civ. §3333.1 (1975) Discretionary offset; evidence of collateral sources may be introduced at trial	Civ. Proc. §667.7 (1975) Mandatory periodic payment of future damages award exceeding $50,000, upon request of party; payments to continue after death of plaintiff to parties to whom judgement creditor owed a duty of support			Bus. & Prof. §6146 (1975, 1987) Sliding scale fees may not exceed 40% of the $50,000, 1/3 of the next $50,000, 25% of the next $500,000, and 15% of damages exceeding $600,000	California Supreme Court upheld constitutionality of damage awards limits and collateral source rules in *Fein v. Permanente Medical Group* (1985); periodic payment of damage awards upheld in *American Bank and Trust Co. v. Community Hospital of Los Gates . Saratoga, Inc* (1984); attorney fees statute upheld in *Roa v. Lodi Medical Group, Inc* (1985); additional attorneys' fees provisions rejected by voters in 1996
Colorado	§13.80.102(5) (1988) 2 years from date of accrual; in no event more than 3 years from act; foreign objects: 2 years from discovery; minors under age 6 must bring claim before age 8	§13.21.302 (1988) $1million limit for damages against a hospital or physician; non-economic damages limited to $250,000; court may increase limit in certain situations; §13.21.203 (1989) permissible recovery for wrongful death limited to $250,000; §13.64.302.5(5) (1990) no punitive damages against a physician for adverse outcome of prescription, medically prescribed (1991) or experimental drugs (1991) where FDA protocol was followed; §13-21-102 (1990) punitive damages may not exceed actual damage award; court may increase punitive damages to 3 times in certain situations	§§13.21.111. 6 (1986) Mandatory offset for sources not contracted by and paid for by the claimant	§13.64.203 (1988) Mandatory periodic payment of future damage awards exceeding $150,000	§13.22.402; §13.22.311, 401-409 (1988) Mandatory screening for claims of $50,000 or less by "arbitration panel"; findings of panel not admissible at trial; court may require mediation of medical injury claims	§13.64.401 Expert witness must be licensed physician and substantially familiar with standard of care on date of injury; §13.20.602 (1988) claimant must file certificate of review which states that an expert was consulted and is competent to testify		Colorado Supreme Court upheld constitutionality of non-economic damage awards cap in *Scholz v. Metropolitan and Pathologists*

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Connecticut	§52.584 (1969) 2 years from discovery; no more than 3 years after act; §52.555 (1991) wrongful death: 2 years from death; no more than 5 years from disputed act or omission		§52.225a (1985) Mandatory offset; court reduces award by collateral sources of payment received by plaintiff, but credits plaintiff with any premiums paid	§52.225d (1987) Discretionary periodic payment of all damages in excess of $200,000; the parties have 60 days to reach payment terms for damages over $200,000; if no agreement is reached, a lump sum is awarded	§§38a-56, 19f (1977) Voluntary pretrial screening; unanimous findings of panel members admissible at trial	§52.184c(d) (1986) Expert witness must be licensed physician practicing for 5 years before date of injury	§52.251c (1986) Sliding scale fees may not exceed: third of first $300,00; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million	
Delaware	§18.6856 (1976) 2 years from injury; 3 years from discovery if latent injury; minor: age 6 or same as adult	§18.6855 (1976) Punitive damages may be awarded only on finding of malicious intent to injure or will or wanton misconduct	§18.6862 (1976) Discretionary offset; evidence of "public collateral sources of payment" may be introduced (evidence of life insurance or private collateral sources of compensation benefits excluded)	§18.6864 (1976) Discretionary periodic payment of future damages in medical injury actions only; compensation for future pain and suffering and future expenses deducted from balance of payments on death of plaintiff	§18.6801-6814 (1976) submission to review panel on demand; negative opinion admissible as prima facie evidence at any subsequent trial; expert witness testimony may be required for panel	§18.6853-6854 (1976) Required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; experts knowledge of similar locality in order to testify	§18.6865 (1976) Sliding scale fees may not exceed: 35% of first $100,000; 25% of next $100,000; and 10% of damages exceeding $200,000	
District of Columbia	§12.301-2 (1995) 3 years from reasonable discovery; wrongful death: 1 year from death							

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Florida	§95.11 (1972, 1980) 2 years from injury or discovery, no more than 4 years from injury; minors: age 8; if fraud, concealment of injury or intentional misrepresentation prevented discovery within 4 year period, 2 year limit from discovery, not to exceed 7 years after the act	§768.73 (1997) Punitive damages in excess of 3 times economic damages or $500,000 presumed excessive; §766.207, 209 (1988) where parties agree to binding arbitration, (1) net economic damages for wage loss including to 80% of wage loss and earning capacity; (2) non-economic damages limited to maximum $250,000 calculated for capacity to enjoy life; where the plaintiff refuses to arbitrate, non-economic damages may not exceed $350,000 plus net economic damages including past and future medical expenses and 805 of wage loss and loss of earning capacity; no limits where defendant refuses to arbitrate	§768.76 (1986) Mandatory offset by court, except for those collateral sources for which there are subrogation rights; §§766.207, 209 (1988) rule extends to binding arbitration cases	§768.78 (1986) Mandatory periodic payment of future damage award exceeding $250,000, at the request of a party; defendant may elect to pay lump sum for future economic losses and expenses reduced to present value; §766.207(7)(c) (1988) damages for future economic losses awarded by arbitration payable on periodic basis under 766.202(8)	§766.106-107 (1985) Court may require submission of claim to an arbitrary panel; result not admissible in a later trial	§766.102(c) (1988) Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed	Atty. Conduct Reg. 4-1.5(f)(40(b) Separate sliding scales for cases settling before filing an answer or appointing an arbitrator, cases settling before or after going to trial, and cases in which liability is admitted and only damages contested; 5 % extra for cases appealed	Voluntary binding arbitration caps found unconstitutional in *Univ. of Miami School of Medicine v. Echarte*; 1975 statute, without the subrogation exception, upheld in *Pinillos v. Cedars of Lebanon Hospital Corp.*(1981) and *Smith v. Department of Insurance* (Fla. 1987); earlier pretrial screening panel provision found unconstitutional in *Aldana v. Holub* (1980)
Georgia	§9.3.71-73, 9.63 (1992) 2 years from injury or death; in no event longer than 5 years from act or death; foreign object: 1 year from discovery; minors: age 7 and, and in no event later than age 10; agreement by parties to arbitrated tolls statute	§51.12.5.1 (1992) $250,000 cap on punitive damages, unless demonstrated intent to harm	§51.12.1 (1987) Collateral sources evidence admissible to jury		§9.9.61-63 (1997) Voluntary arbitration subject to court review; binding if prior agreement to make it so	§9.11.9.1 (1998) Complaint must generally contain an affidavit of an expert stating that the facts justify a claim of negligence		Georgia Supreme Court upheld as constitutional statute of repose in *Craven v. Lowndes County Hospital Authority* (1993); collateral source rule found unconstitutional in *Georgia Power Co. v. Falagan, et al* (1991); *Dentor v. Con-Way Southern Express, Inc* (1991)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Hawaii	§657.7.3, 671.18 (1973, 1986) 2 years from discovery, not to exceed 6 years from act; minors: age 10 or within 6 years, whichever is longer; arbitration tolls statute until 60 days after the panel's decision is delivered but for no more than 18 months	§663.8.5, 8.7 (1986) $375,000 cap for pain and suffering damages; excludes mental anguish, disfigurement, loss of enjoyment of life, and loss of consortium			§601-20 (1986) Mandatory nonbonding arbitration for all cases involving $150,000 or less; §671.11-20 (1976) mandatory submission of medical injury claim to medical claim conciliation panel; results not admissible at trail		§607.15.5 (1986) Attorney fees must be approved by the court	
Idaho	§5.219 (1971) 2 years from injury; foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later	§6.1603 (1987) $400,000 cap on non-economic damages in any tort action, unless personal injury cause by "willful or reckless misconduct" or felony; cap adjusted annually according to the state's adjustment of the average annual wage; §6.1606 (1990) removed 1992 Sunset	§6.1606 (1990) Mandatory offset of collateral sources except for federal benefits, life insurance and subrogation rights	§6.1602 (1987) Discretionary periodic payment of future damage awards exceeding $100,000, excluding cases involving intentional tort, gross negligence, or extreme deviation from standards unless agreed to by claimant	§6.1001-1011 (1976) mandatory submission of claim to hearing panel; results not admissible at trail	§6.1012 (1990); Claimant must prove negligence by direct expert testimony; §6.1013 (1976) Expert witness must have knowledge of community standards		Idaho Supreme Court upheld constitutionality of statute of limitations in *Homes v. IWASA* (1983); earlier damage awards limit applying only to medical liability overturned in *Jones v. State Board of Medicine* (1976) *cert denied* (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Illinois	§735.5/13.212 (1992) 2 years from discovery but not more than 4 years from act; statute tolled for disability (where plaintiff is insane, mentally ill or imprisoned); minors: 8 years after act but not after age 22; §740.180/2 (1995) wrongful death: 2 years from death, if statute of limitation on personal injury still valid at time of death	§735.5/2.1115.1 (1997) $500,000 cap on non-economic damages; §735.5/1115 (1985) punitive damages not recoverable in medical malpractice cases	§735.5/2.1205 (1992) Claimant may apply within 30 days of judgment for 50% reduction of collateral payments for lost wages or disability benefits; 100% of medical benefits (with exceptions), but not more than 50% of total award	§735.5/2.1705-6 (1985) Voluntary or discretionary periodic payment of future damages awards over $250,000		§735.5-8 Plaintiff required to provide affidavit stating that competent expert has been consulted	§110.2.1114 (1985) Sliding scale fees may not exceed third of first $150,000; 25% of next $850,000 and 20% of damages exceeding $1 million; §735.5/2.1114 (1992) attorney may apply to the court for additional compensation under certain circumstances	Illinois Supreme Court upheld constitutionality of statute of limitations in *Anderson v. Wagner* (1979), *reversing Woodward v. Burnham City Hospital* (1987); non-economic damage award cap struck down in *Best v. Tayor Machine Works* (1997); similar 1975 statute overturned in *Wright v. Central Du Page Hospital Association* (1976); pretrial screening panel provision struck down and periodic payment of damage awards upheld in *Bernier v. Burris* (1986)
Indiana	§34-18-7-1 (1998) 2 years from act, omission, or neglect; minors: under age 6 until age 8; applies regardless of minority or other disability	§34-18-18-1 (1998) For acts prior to 1990, $100,00 cap from a single provider and $500,000 cap from all providers and Patient Compensation Fund (PCF); as of 1990, $750,000 cap for all providers and PCF; as of July 1999, $250,000 limit for each provider and a $1,250,000 for all providers and PCF; only 1 recovery per single injury; no damage caps in cases not brought against qualified providers	§34.44.1.2 (1998) Collateral sources except life insurance, insurance payments made directly to plaintiff, plaintiff's family or state/federal benefits paid before trail admissible at trail	§34.18.15.1 (1985) Discretionary periodic payment	§34.18.8.4-6 (1975) mandatory submission of claim, unless parties agree otherwise, of claims more than $15,000; panel determination is admissible at any later trail	§34.18.10.23 Medical review panel's testimony may qualify as expert testimony to establish prima facie	§16.9(5).5.1 (1975) Plaintiff's attorney fees may not exceed 15% of any award that is made from PCF (covers portion of an award that exceeds $100,000)	Indiana Supreme Court upheld constitutionality of statute of limitation, but established an exception where medical condition prevented discovery in *Martin v. Richey* 1999); original 1975 pretrial screening panel, limits on damage awards, and statute of limitation provisions upheld as constitutional in *Johnson v. St. Vincent Hospital* (1980); *St. Anthony Medical v. Smith* (1992); *Bova v. J.H. Roig, M.D* (1992)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Iowa	§614.1(9) (1997) 2 years from reasonable discovery but not more than 6 years from injury unless foreign object; minors under age 8: until age 10 or same as adults, whichever is later; mentally ill: extends to 1 year from removal of disability		§147.136 (1975) Mandatory offset of collateral sources	§668.3 (1987) Discretionary court-ordered periodic payment of future damages	§679A.1 (1981) Written arbitration agreement valid and irrevocable	§147.139 Qualifications of the expert must relate directly to problem at issue	§147.138 (1975) Court may review fees in any personal injury or wrongful death action against specified health care providers or hospitals	Eight Circuit upheld constitutionality of original 1945 statute of limitation in *Fitz v. Dolyak* (1983)
Kansas	§60.513.7(c) (1965) 2 years from act or reasonable discovery by not more than 4 years after injury; incompetent: 1 year from removal, but no more than 8 years from act	§60-19a02 (1988) $250,000 cap on non-economic damages recoverable by each party from all defendants; §60.3702 (1994) punitive damages limited to lesser of defendant's highest gross income for prior 5 years or $5 million; if profitability of misconduct exceeds cap, court may award 1.5 times profit instead; judge determines punitive damage; punitive damages unavailable in wrongful death cases	§60.3801-3807 (1992) Collateral sources admitted where plaintiff claims $150,000 or more in damages		§65.4901 (1976) Voluntary submission to medical screening panel upon request of party; §60.3501-3509 (1987) decisions admissible at any subsequent trial	§60.3412 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice		Kansas Supreme Court upheld constitutionality of statute of limitations in *Stephens v. Snyder Clinic Association* (1981); noneconomic damages cap ruled constitutional in *Samsel v. Wheeler Transport Services, Inc.* (1990); collateral source rule ruled unconstitutional in *Thompson v. KFB Insurance Company* (1993), Ks. Sup. Ct; earlier discretionary offset (1985, 1988) that applied only to medical liability actions struck down in *Farley v. Engleken (1987)*; 1965 cap on damage awards and periodic payment provision found unconstitutional in *Kansas Malpractice Victims v. Bell* (1988)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Kentucky	§413.140 (1974) 1 year from act or reasonable discovery, but not more than 5 years after act; minor and unsound mind: statute runs when disability lifted		§411.188.3 (1988) Discretionary offset of collateral sources except life insurance		§417.050 (1984) Written arbitration agreements enforceable and irrevocable			Kentucky Supreme Court ruled unconstitutional 5 year statute of limitation in *McCollum v. Sisters of Charity of Nazareth Health Corp.*(1990); collateral source rule overturned in *O'Bryan v. Hedgespeth* (1995)
Louisiana	§9.5628 (1975, 1987) 1 year from act or date of discovery, but no later than 3 years from date of injury; applies regardless of minority or disability; Civ. Code §2315.2 wrongful death: 1 year from death	$100,000 liability limit for qualified health care providers; punitive damages not recoverable, except in certain situations				§40.122.47 Medical review panel's report considered expert testimony		Appellate Court upheld the constitutionality of statute of limitation in *Valentine v. Thomas* (1983); Louisiana Supreme Court upheld the constitutionality of limits on damage awards in *Williams v. Kushner, slip. Op.* (1989), *Butler v. Flint Goodrich Hospital of Dillard University,* (1992); 1976 pretrial screening panel provision upheld in *Everett v. Goldman* (1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Maine	§24.2902 (1977) 3 years from cause of action; 6 years after accrual for minors or within 3 years of minority, whichever is first; foreign objects: accrue from reasonable discovery; incompetence: accrue upon lifting of disability	§18A.2.804 (1999, 1990) For wrongful death cases, non-economic damages limited to $150,000 and punitive damages limited to $75,000	§24.2906 (1990) Mandatory offset of collateral sources that have not exercised subrogation rights within 10 days after a verdict for the plaintiff	§24.2951 (1985) Mandatory periodic payments of future economic damages exceeding $250,000 at the request of a party	§24.2851-59 (1990, 1986-1989) Mandatory submission of medical injury claims to a "pre-litigation screening and mediation panel" except where all parties have agreed to bypass; any findings unanimous and unfavorable to the claimant as to both negligence and causation are admissible at any subsequent trial; for claims after January 1, 1991, panel's discovery is deemed court discovery at any subsequent trial		§24.2961 (1985-1987) Sliding scale fees may not exceed: third of first $100,000; 25% of next $200,000 and 20% of damages that exceed$200,000; for purpose of rule, future damages are to be reduced to lump-sum value	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Maryland	Cts. & Jud. Proc. §5.109 (1975) 5 years from act or 3 years from discovery, whichever is earlier; minors: statute begins at age 11; excepts reproductive system damage or foreign object injury; Cts. & Jud. Proc. §3.904 (1995) wrongful death: must be filed with 3 years of death	Cts. & Jud. Proc. §11.108 (1986, 1994) In any action for damages for personal injury accruing after October 1, 1994, $500,000 cap on non-economic damages; $620,000 cap in 2002 due to $15,000 increase every October 1 beginning in 1994; separate cap for each "direct victim"; wrongful death cases may not exceed 150% of cap		Cts. & Jud. Proc. §11.109 (1986) Discretionary periodic payment of future economic damages	Cts. & Jud. §3.2A.03-06 (1995) Discretionary submission of claims to a "health claims arbitration panel"; panel's decision on fault is "presumed to be correct" and its award is admissible as evidence at any subsequent trail; rejecting party liable to other for costs if verdict less favorable than findings	§3.2A.04 (1997) Within 90 days of filing, claimant must file certificate of expert consultation	Cts. & Jud. Proc. §3.2A.07 (1976) Court or pretrial screening panel will review disputed fees in medical injury actions	Damage award cap on non-economic damages ruled constitutional in *Murphy v. Edmonds*, 325 (1992)
Massachusetts	§§231.60D; 260.4, 7 (1986) 3 years from date of injury, but not more than 7 years from injury unless foreign object; minors: before age 6 until age 9; tolled for disability	§231,60H (1986) $500,000 cap for non-economic damages unless jury determines that there is "a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances"; if the total amount of general damages from a single occurrence for all plaintiffs exceeds $500,000, then the amount of such damages recoverable by each plaintiff will be reduced to a percentage of $500,000 proportionate to that plaintiff's share of the total amount	§231.60G (1986) Mandatory offset determined by the court		§231.608 (1975) Mandatory submission or medical injury claims to a "medical malpractice tribunal"; decision admissible at any subsequent trial; if tribunal finds against claimant, claimant must post $6,000 (or greater) bond for defendants costs if unsuccessful		§231.601 (1986) Sliding scale fees may not exceed: 40% of first $150,000, 33.33% of next $150,000, 30% of next $200,000 and 25% of damages that exceed $500,000; further limits if claimants recovery insufficient to pay medical expenses	Massachusetts Supreme Judicial Court upheld the constitutionality of pretrial screening panel requirement in *Paro v. Longwood Hospital* (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Michigan	600.5838a, 5851(1846-1986) 2 years from injury or 6 months from reasonable discoverability, whichever is later, not to exceed 6 years; 6 years tolled for fraud or reproductive systems; disabled plaintiff: 1 year after injury except in cases of reproductive injury; foreign object: 6 months; minors under age 8: 6 years from date of occurrence or age 10, whichever is later (if action brought after 10th birthday, must be within the 6 year limit)	§600.1483 (1986) After April 1, 1994, $280,000 cap on noneconomic damages, $500,000 cap for non-economic damages applies to certain other circumstance; caps adjusted annually for inflation; in 2002, caps are $349,700 and $624,500, respectively	§600.6303 (1986) Mandatory offset of collateral sources, except life insurance, admissible after a verdict for plaintiff	§600.5056 (1975) third of a medical malpractice arbitration award, unless parties stipulate awards in excess of $50,000, to be paid lump sum; §600.6307 (1986) mandatory periodic payment of future economic damages excluding future medical, other health care costs and collateral source benefits; future non-economic damages reduced to gross percent cash value	§600.4903,15, 17, 21 (1987) Mandatory review by medication panel; party rejecting panel's evaluation must pay opposing party's actual cost unless verdict more favorable than panel; §600.2912g (1975) parties may enter into binding arbitration if total damages claimed are less than $75,000	§600.2912 Expert must be a licensed health professional, practice in a similar specialty, be board certified (if required on specialty), during the year preceding action had clinical or academic experience in specialty; certificate of consultation must be filed	Mich. Court Rules 8.121(b) (1981) Maximum contingency fee for a personal injury action is third of the amount recovered	
Minnesota	§541.07 (1935, 1982) 2 years from injury or termination of treatment; tolled for insanity; infant's claim must be asserted within 7 years from injury or 1 year after age of majority		§548.36 (1986) Mandatory offset of collateral sources by court if defendant brings in evidence of payments made to plaintiff	§549.25 (1988) Discretionary periodic payment of future damages in excess of $100,000		§145.682 (1989) Claimant must file an affidavit stating that an expert has been consulted		Eighth Circuit has upheld the constitutionality of the statute of limitation in *Jewson v. Mayo Clinic* (1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Mississippi	§15.1.36 (1976) 2 years from act or reasonable discovery, within 7 years after the act; mentally incompetent plaintiffs: 2 years after disability ceases; minors under 6: 2 years after age 6 or death, whichever is first; tolled for insanity	HB2 3rd Extraordinary Session (2002) effective January 1, 2003, $500 thousand cap on non-economic damages; increases to $750 thousand on July 1, 2011 and to $1 million on July 1, 2017; caps are excluded in disfigurement cases or at the judge's discretion; §11-11-3(2) (2002) cases must be brought in the in which the alleged act or omission occurred				§11.1.61 (1990) Expert witness must be licensed physician		
Missouri	§516.105 (1976) 2 years from act; foreign object: 2 years from discovery; in no event longer than 10 years from act or 10 years from minor's 20th birthday, whichever is later; minor under 8: until age 20	§538.210 (1986) Cap on non-economic damages adjusted annually for inflation; set at $547,000 in 2002		§538.220 (1986) Mandatory periodic payment of future damages over $100,000 at the request of party		§538.225 Affidavit of expert consultation must be filed within 90 of filing of filing action		Supreme Court of Missouri upheld constitutionality of statute of limitation in *Ross v. Kansas City Gen. Hosp. & Med. Ct.* (1980); statute of limitation from minors 12 and older ruled unconstitutional in *Strahler v. St. Luke's Hospital* (1986); limit on damage awards upheld in *Adams v. Childrens Mercy Hospital* (1991); pretrial screening panel provision overturned in *State ex rel. Cardinal Glennin Memorial Hospital v. Geartner* (1979)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Montana	§27.2.205 (1971) 3 years from injury or discovery; in no event more than 5 years from act; tolled against a potential plaintiff where there has been a failure of disclosure of the act; minors under age 4: 3 years of age 8 or death, whichever occurs first	§25.9.411 (1995) court to impose a $250,000 limit any jury award for non-economic damages, for causes of action arising as of Oct. 1, 1995	§27.1.308 (1987) Mandatory offset of collateral sources by judge for awards greater than $50,000, in bodily injury and death cases	§25.9.4.3 (1995) Mandatory periodic payment at the request of party for awards in excess of $50,000, as of Oct. 1, 1995; in case of death, payments property of estate	§27.6.701 (1977) Mandatory review by Medical Legal Panel for actions not subject to valid arbitration agreement; panel report neither binding nor admissible at trial			Montana Supreme Court upheld the constitutionality of the pretrial screening panel statute in *Linder v. Smith* (1981)
Nebraska	§§25.222; 44.2828 (1976, 1996) 2 years from act or 1 year from reasonable discovery, but no more than 10 years after date of act; §25.213 under 21 or mentally disabled: statute runs from removal; §30.810 wrongful death: 2 years from death	§44.2825 (1976, 1986) $1 million limit on recoveries against health care providers qualifying for state-sponsored excess insurance; fundamental rule of Nebraska law prohibits punitive, vindictive, or exemplary damages	§44.2819 (1976) Non-refundable medical reimbursement insurance benefits credited against judgement, in certain actions		§44.2840-1 (1976) Mandatory review of medical injury claims except where plaintiff affirmatively waives his right to panel hearing; the panel report is admissible in any subsequent trial		§44.976 Court review for reasonableness of attorney fees in cases against health care providers	Nebraska Supreme Court upheld the constitutionality of the limit on damage awards, collateral source rule and pretrial screening panel requirement in *Prendergast v. Nelson* (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Nevada	§41A.097 (2002, 1989, 1985) 3 years from injury or 2 years from reasonable discovery, whichever is first; tolled for concealment; minors: statute runs until age 10 for brain damage or birth defects; if sterility alleged, statute runs 2 years after discovery; tolled for insanity or minors ward of state	§42.005 (1996) $300,000 or 3 times compensatory damages cap on punitive damages, only awarded for fraud, oppression, or malice; §41A (2002) $350,000 cap on non-economic damages with exception for cases of gross malpractice (effective October 1, 2002); limits damages for hospitals and doctors to $50,000 when treating trauma patients	§42.020 Damages against health care providers reduced by amount of any prior payment by health care provider to the claimant; mandatory offset	§42.020 (2002, 1985) Claimant may elect to receive award for future damages in a lump sum reduced to present value, if approved by the court, or as an annuity; or by other means if the defendant posts an adequate bond or other security to ensure full payment	§41A.003-069 (2002) Abolished the mandatory submission of claims to pretrial screening panel; decision and findings were admissible at subsequent trial; unfavorable ruling made claimant responsible for defendant's court cost, if lost at trial	§41A.800 (2002) District court must dismiss cases filed without an affidavit to support allegations submitted by a medical expert who practices or has practiced in an area similar to the practice related to the alleged malpractice	§7.085 (2002, 1995) Court shall require attorneys to personally pay for the cost of expenses that result from their unreasonable conduct in civil litigation	
New Hampshire	§507.C:4 2 year limit specific to medical malpractice found unconstitutional; §§508:4,8 (1986) 3 years from injury or reasonable discovery; infant or incompetents: 2 years from removal of disability	§507.C:7 (1977) $250,000 cap on non-economic damages; §556:13 $50,000 cap on wrongful death damages and restricted to immediate or dependent family members; after 1998, wrongful death cap raised to $150,000 and restricted to surviving spouse; §507:16 punitive damages prohibited	§507.C:7(I) (1977) Abolishes collateral source rule in medical malpractice cases	§524:6.a (1997) Periodic payment awarded at court discretion		§507.E.2 (1997) Claimants must provide expert testimony to support their claims	§508:4.e (1986) Fees for actions resulting in settlement or judgement of $200,000 or more shall be subject to court approval	New Hampshire Supreme Court struck down as unconstitutional the limit on non-economic damage awards, mandatory offset of collateral sources, and earlier provisions for discretionary award of periodic payment of future damages and attorney fees in *Carson v. Maurer* (1980); $875,000 limit on non-economic damages found unconstitutional in *Brannigan v. Usitalo* (1991)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
New Jersey	§2A:14.2, 14.23 (1987) 2 years from accrual of claim or discovery; under 21 or insane: runs upon removal; wrongful death: 2 years from death, 6 months after the death is not computed as part of the time period	§2A:15.5.14(b) (1997) punitive damages cap of $350,000 or 5 times compensatory damages, whichever is greater	§2A:15.97 (1987) Mandatory offset of collateral sources, excluding workers' compensation or life insurance, admissible at trail and deductible from any verdict for plaintiff		§4:21A.1-8 (1985) Voluntary arbitration of medical claims by written agreement, if claim under $20,000	§2A.53A.27 Affidavit of consultation of expert must be filed within 60 days of filing action	Court Rules §1:2107 (1976) Sliding scale fees may not exceed third of first $500,000, 30% of second $500,000, 25% of third $500,000 and 20% of fourth $500,000; 25% cap for a minor or an incompetent plaintiff	New Jersey Supreme Court upheld the constitutionality of a 1978 pretrial screening panel statute in *Perna v. Pirozzi* (1983)
New Mexico	§41.5.13, 22 (1976) 3 years from injury; minors under 6: until age 9 to file suit; applies to all persons regardless of minority or disability; the statute is tolled upon submission to hearing panel and shall not run until 30 days after panel final decision	§41.5.6-7 (1976) $600,000 ($500,000 for acts prior to April 1995) cap to all damages, excluding punitive damages and medical care and related costs; health care providers not liable for any amount over $100,000; future medical expenses not be awarded as monetary damages		§41.5.7 (1976) Mandatory periodic payment of damages for future medical care up to $200,000, after which patient's compensation fund must pay	§41.5.14-20 (1976) Mandatory submission of medical injury claims to a hearing panel; panel report is not admissible at any subsequent trial			

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
New York	CVP §214.a (1975) 2 1/2 years from injury or from last treatment where there is continuous treatment for condition giving rise to claim; foreign object: 1 year from discovery; incompetence tolls statute for maximum 10 years		Civ. Prac. §4545 (1981) Mandatory offset of collateral sources made by the court	Civ. Prac. §5031-5039 (1985) Mandatory periodic payment of future damages in excess of $250,000; parties may agree to lump sum payment; pain and suffering damages paid within a period no longer than 10 years	CPLR §3045 (1991) Defendant may concede liability if plaintiff agrees to arbitrate; if plaintiff refuses, defendant's concession of liability cannot be used for any other purpose; Public Health §4406.2 HMOs can put arbitration clauses in contracts, but not as a condition of joining	§3012.A Certificate of consultation of expert must be filed within 90 days of filing complaint	Jud. §474a (1985) Sliding scale fees may not exceed 30% of first $250,000, 25% of second $250,000, 20% of next $500,000, 15% of next $250,000 and 10% over $1.25 million	New York's highest court upheld the constitutionality of a pretrial screening panel statute in *Treyball v. Clark* (1985)
North Carolina	§1.15 (1979) 3 years from act or 1 year from reasonable discovery, but not more than 4 years after injury; foreign object: 1 year from discovery, but not more than 10 years from last act; wrongful death: 2 years from death	§1D.25 (1995) Punitive damages cap of $250,000 or 3 times compensatory damages, whichever is greater			§7A.38.1 (1997) Mandatory mediation	§90.21.12 (1990) Expert must testify to community standard of care; §8C.1 Rule 702 expert must be licensed		North Carolina Court of Appeals upheld the constitutionality of the statute of limitations in *Roberts v. Durham County Hospital Corp.* (N.C. App. 1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
North Dakota	§§28.01.18, 25 (1975) 2 years from act or reasonable discovery, but not more than 6 years after act, unless concealed by fraudulent conduct of defendant; disability, except minority, tolls statute for 5 years, in no case after 1 year from removal of disability or 6 years total; minors: 12 years	§32.42.02 (1995) $500,000 cap on non-economic damages; §32.03.2.08 economic damage awards in excess of $250,000 subject to court review for reasonableness	§32.03.2.06 (1987) Discretionary offset of collateral sources, excluding life insurance, death or retirement benefits or any insurance purchased by recovering party	§32.03.2.09 (1987) Discretionary periodic payment of future economic damages for continuing institutional or custodial care for a period of more than two years; adequacy of payments subject to continuing court review	§32.42.03 (1996) Attorneys must disclose alternative dispute resolutions option; good faith effort to resolve dispute required	§28.01.46 A claimant is required to obtain supportive expert opinion within 3 months of filing complaint		A $300,000 limit on medical liability awards and an earlier discretionary offset in cases involving $100,000 or more were struck down as unconstitutional in *Arneson v. Olson* (N.D. 1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Ohio	§2305.11 B(1) (1990) 1 year after reasonable discovery; if plaintiff gives written notice before the 1 year expires, suit may be brought within 180 days of the notice; persons with legal disability must bring suit within 4 years after occurrence; for actions accruing as of Jan. 27, 1997, 6 year statute of repose; minor, unsound mind, or imprisoned: tolled until disability removed; wrongful death: 2 years from death	§2323.54 (1997) as of Jan. 27, 1997, non-economic cap of $250,000 or 3 times economic damages up to $500,000, whichever is greater; for more serious loss, $1 million or $35,000 times remaining life expectancy; §2315.21 (1997) punitive damages cap or $100,000 or 3 times compensatory damages, except for defendants that employ more than 25 persons, for whom cap is $250,000 or 3 times compensatory damages; prohibits punitive damages if defendant already paid amount of cap of punitive damages in another case	§23 (1975) Evidence of collateral sources in medical actions, except for insurance benefits paid for by plaintiff or employer (but including workers' compensation), admissible at trail	§2323.57 (1987) Mandatory periodic payment of future damages over $200,000 at request of party	§2711.21 (1975, 1987) Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties; decision is not admissible at any subsequent trial; prior to 1987 amendment, submission was mandatory and results were admissible	§2743.43 (1975) Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching; §2305.01.1 claimant must file certificate of consultation with expert		Ohio Supreme Court ruled unconstitutional a comprehensive tort reform package passed in 1997 that included noneconomic damage caps in *Ohio Academy of Trial Lawyers v. Sheward* (1999); a $200,000 limit on general damages struck down in *Morris v. Savoy* (1991); a $250,000 limit on non-economic damages overturned in *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the 8th District twice upheld the collateral source rule in *Morris, et al. v. Savoy* (1991) and *Charles William May v. Tandy Corp., et al* (1993) and *Gladon v. Greater Cleveland Regional Transit Authority* (1994); the Court of Appeals of Ohio (11th District) struck down collateral source rule in *Schenk v. The Cleveland Electric Illuminating Company* (1994); Ohio Supreme Court upheld the 1975 pretrial screening panel statute in *Beatty v. Akron City Hospital* (1981)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Oklahoma	§§76.18 (1987) 2 years from reasonable discovery; after 3 years from act, recovery limited to past and future actual medical and surgical expenses; §12.96 (1988) minors under 12: 7 years; minors over 12: 1 year after attaining majority but in no event less than 2 years from injury; incompetents: 7 years from injury unless adjudged incompetent, then 1 year after such adjudication, but in no event less than 2 years from injury	§23.9.1 (1998) $100,000 cap on punitive damages for reckless disregard; punitive damages cap of $500,000, 2 times compensatory damages, or benefit derived by defendant from his conduct for intentional and malicious acts (waived in certain circumstances); discretionary waiver of damages by court if defendant already paid punitive damages for same action	Discretionary offset of collateral sources				§5.7 (1953) Maximum percentage: fee may not exceed 50% of net judgement	Oklahoma Supreme Court upheld 2.year statute of limitations as constitutional in *McCarroll v. Doctors General Hospital* (1983); 3 year statute of repose on all damages other than past and future medical and surgical expenses ruled unconstitutional in *Wofford v. Davis* (Okla. 1988); earlier limit on damage awards struck down in *Reynolds v. Porter* (1988)
Oregon	§§12.110;160 (1988) 2 years from reasonable discovery; but not more than 5 years from act; fraud: 2 years from reasonable discovery; minors or insane: 5 years from accrual or 1 year after disability ceases; wrongful death: 3 years from death or reasonable discovery	§18.540, 560 (1987) $500,000 cap on non-economic damages (overturned except with regard to wrongful death); §18.550 (1989) no punitive damages awarded against licensed physician unless malice is shown; 60% of punitive damages paid to Criminal Injuries Compensation Account	§18.580 (1987) Discretionary offset after judgement of collateral sources by court, except benefits plaintiff must repay, life insurance, retirement, disability, pension plans or social security				§18.540 Attorneys fees from punitive damages may not exceed half the claimant's 40%	Oregon Supreme Court ruled non-economic damages cap unconstitutional, except in wrongful death suits, in *Lakin v. Senco Products, Inc* (1999)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Pennsylvania	§42.5524 (1975) 2 years from injury or reasonable discovery; §42.5533 minor: 2 years after age of majority	§40.1301.812.A(g) (1997) Effective Jan. 25, 1997, punitive damages cap of $100,000 or 2 times compensatory damages; members of Medical Professional Liability Catastrophe Loss Fund, in effect, subject to limited liability			§40.1301.825A (1975) Mandatory "conciliation hearing", which may be a settlement conference or mediation as the parties prefer	§1301.821.A Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position		Pennsylvania Supreme Court found a statute providing for a mandatory offset of collateral sources in medical liability actions unconstitutional by the in *Mattes v. Thompson* (1980); earlier mandatory pretrial screening panel struck down in *Mattes v. Thompson* (1980); panels may exist as long as participation is voluntary and the outcome is not binding; attorney fee limits struck down in *Heller v. Frankston* (1984)
Rhode Island	§§9.1.14.1; 10.7.2 (1976, 1988) 3 years from injury, death or reasonable discovery; minors and incompetents: 3 years from removal of disability	§9.1.8 (1997) Punitive damages not recoverable against executor or administrator of an estate; §9.19.41 (1997) $100,000 minimum recovery in any wrongful death action	§9.19.34.1 (1986) Mandatory offset by court in medical liability actions, if evidence is admitted	§9.21.12-13 (1986) Mandatory conference on periodic payment where judgment exceeds $150,000		§9.19.41 (1997) expert must have training/ education to qualify as an expert		Pretrial screening panels were found unconstitutional in *Boucher v. Sayeed* (1983)
South Carolina	§15.35.45, 15.3.40 (1977-1988) 3 years from injury or reasonable discovery, but not more than 6 years after act; foreign object: 2 years from discovery; minors: tolled, but no more than 7 years from act or 1 year from majority; tolled for disability, up to 5 years or 1 year after disability ceases							

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
South Dakota	§15.2.14.1, 221 (1984) 2 years from injury; tolled for fraud or foreign object until end of treatment; tolled for minority for 3 years or until age 8 if under age 6; metal illness: tolls statute up to 5 years; 1 year from removal; wrongful death: 3 years from death	§21.3.11 (1997, 1985) $500,000 cap on non-economic damages	§21.3.12 (1977) Discretionary offset in medical liability cases, except benefits that have a right if subrogation or were paid for by plaintiff	§21.3A.1-12 (1986-1988) Mandatory periodic payment of future damages in excess of $200,000 or past and future damages of $500,000, whichever is less; discretionary at the request of a party	§21.25B.1 (1976) Parties may agree to arbitrate for past and future services; revocable as to future services			The South Dakota Supreme Court rejected the discovery rule in *Alberts v. Giebink* (1980); law reducing statute of limitation for minors ruled unconstitutional in *Lyons v. Lederle Laboratories* (1989); $1 million cap on total damages ruled unconstitutional, reviving prior $500,000 cap on noneconomic damages, in *Knowles v. U.S.* (1996)
Tennessee	§29.26.116 (1975) 1 year from discovery, but no more than 3 years from act unless foreign object; foreign object: 1 year from discovery; under 18 or unsound mind: 1 year from removal		§29.26.119 (1975) Mandatory offset except for assets purchased by plaintiff or private insurance		§29.5.101 All causes of action may be submitted to the decision of arbitrators except wher 1 of the parties is an infant or a person of unsound mind	§29.26.115(b) (1975) Expert witness must be licensed in Tennessee or contiguous state and practice for one year preceding date of injury	§29.26.120 (1975) Plaintiff's attorney fees in a medical injury suit shall not exceed third of all damages awarded	Tennessee Supreme Court upheld the constitutionality of statute of limitation in *Harrison v. Schrader* (1982)
Texas	Civ. §4590i.10.01 (1977) 2 years from occurrence (discovery); minors under 12: until age 14; otherwise applies to all regardless of minority or disability	Civ. §4509.11.02-04 (1977) approximately $1.3 million cap on wrongful death damages, adjusted annually for inflation; Civ. Prac. & Rem. §41.008 (1995) punitive damages cap as of Sept. 1, 1995 of 2 times economic damages, plus non-economic damages (not to exceed $750,000), or $200,000, whichever is greater, with certain exclusions				§14.01 Expert must have experience relating to complaint; Tex. Rev. Civ. Stat. Ann. 4590I, §13.01 plaintiff must post file on expert w/in 90 days of filing		The Texas Supreme Court struck down limit on damage awards as unconstitutional in *Lucas v. United States* (1988); limit subsequently found constitutional only in wrongful death cases in *Rose v. Doctors Hosp.* (1990)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Utah	§78.14.14 (1985) 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	§78.14.7.1 (1986) $250,000 cap on non-economic damages	§78.14.4.5 (1985) Mandatory offset by court except for benefits where subrogation rights exist	§78.14.9(5) (1986) Mandatory periodic payment of future damages that exceed $100,000, exclusive of attorneys' fees and costs	§78.14.8-16 (1985) Decision of pre-litigation panel may be considered binding arbitration upon written agreement of parties; mandatory submission of claims to panel; panel recommendations not admissible at subsequent trial		§78.14.7(5) (1985) Contingency fee shall not exceed third of award	Utah Supreme Court ruled unconstitutional the minority provision of the statute of limitation in *Lee v. Dr. Lynn Craufin*; *Griffith v. Dr. J. Dallas Van Wagoner* (1993); this reversed an earlier decision in *Allen v. International Health Care, Inc.* (1981)
Vermont	§12.521, 551 (1977) 3 years from injury or 2 years from reasonable discovery, but no more than 7 years from act, excluding concealment and foreign objects; foreign object: 2 years from discovery; tolled until removal of disability				§12.7002 (1995) Voluntary submission to pretrial arbitration panel; findings subject to appeal unless parties agree to binding arbitration			

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Virginia	§8.01.229, 243 (1959, 1987) 2 years from injury, but not more than 10 years from act; foreign object or fraud: 1 year from reasonable discovery; infants: 5 years from date of accrual of cause of action; for claims accruing on or after July 1, 1987, minors under 8: age 10; age 8 or older: 2 years after last treatment unless; minors who were 10 or older on or before July 1, 1987: 2 years from that date to bring an action	§8.01.581.15 (1976-1983) $1.5 million cap on recovery damages for bodily injury or death, shall increase on July 1, 2000 by $50,000 and every July 1 after that until 2007 and 2008 when the final increases will be $75,000 per year; cap applies for each injury, regardless of number of theories or defendants; §8.01.38.1 (1992) $350,000 cap on punitive damages		§8.01.424 Periodic payment of awards permitted, if reviewed by court and secured by bond or insurance	§8.01.581.2, 8 (1997) Review by pretrial panel by request; findings non-binding; testimony of panel members, except chair, admissible; §8.01.581.12 (1997) parties permitted to agree in advance of treatment to binding arbitration, with period of patient withdraw	§8.01.581.20 (1992) Claims must be supported by expert testimony; physicians must have had an active clinical practice in the field about which he will testify within year of incident		Virginia Supreme Court upheld constitutionality of a prior $750,000 cap on damage awards in *Etheridge v. Medical Center Hospitals* (1989); pretrial screening panel statute upheld as constitutionality in *Speet v. Bauaj* (1989)
Washington	§4.16.350 (1971, 1988) 3 years from injury or 1 year from discovery, whichever is later, but no more than 8 years after act; fraud, concealment or minority toll statute; foreign object: 1 year from discovery; wrongful death: 3 years from death	§4.56.250 (1986) Noneconomic damages in person injury suit may not exceed an amount determined by multiplying 0.43 by the average annual wage in state and by the life expectancy of the person incurring noneconomic damages; a plaintiff's life expectancy shall not be less than 15 years for the purpose of determining maximum noneconomic damages	§7.70.080 (1976) Information on collateral sources may be introduced except for insurance purchased by plaintiff or employer	§4.56.260 (1986) Mandatory periodic payments in personal injury actions of future economic damages of $100,000 or more			§7.70.070 (1976) In any medical injury the court shall determine the reasonablen ess of each party's attorney fees	Washington Appellate Court upheld constitutionality of statute of limitation on constitutional in *Duffy v. King Chiro. Practice Clinic* (1977); limit on damage awards struck down in *Sofie v. Fibreboard Corporation* (1989)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
West Virginia	§55.7B.4 (1986) 2 years from injury or reasonable discovery, whichever occurs last; in no event longer than 10 years after injury; minors under 10: 2 years from injury or by age 12, whichever provides a longer period; statute tolled for any period during which fraud or concealment prevents discovery	§55.78.9 (1986) $1 million cap on non-economic damages; court must instruct jury				§55.75.7 (1986) Expert witness must be licensed physician and engaged in the same or substantially similar medical field as defendant		West Virginia Supreme Court upheld constitutionality of limit on damage awards in *Robinson v. Chaleston Area Medical Center* (1991)
Wisconsin	§893.55, 56 (1979) 3 years from injury or 1 year from discovery, but not more than 5 years from act; foreign object: 1 year from discovery or 3 years from act, whichever is later; minors: by age 10 or standard provision, whichever is later	§893.55(4)(d) (1995) For acts as of May 25, 1995, $350,000 cap adjusted annually for inflation for non-economic damages, excluding wrongful death cases, which are limited to $500,000 for a child and $350,000 for an adult	§893.55(7) Effective May 25, 1995, collateral source information is admissible at trial	§655.015 (1986, 1995) For settlement or judgement for act occurring on or after May 25, 1995 in excess of $100,000, award paid into interest baring fund, from which periodic payments are made	§655.42, 442-5 (1985, 1989) Voluntary submission of medical injury claims to mediation panel; findings of panel inadmissible at subsequent court action		§655.013 (1986) Sliding scale may not exceed: third of first $1 million or 25% or first $1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding $1 million	The Wisconsin Supreme Court upheld the constitutionality of earlier statute of limitation in *Rod v. Farrell* (1980); earlier cap on non-economic damages ruled unconstitutional in *Jelenik v. The Saint Paul Fire and Casualty Insurance Company* (1994); periodic payment awards upheld in *State ex re. Strykowski v. Wilkie* (1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules[1]	Attorneys' Fees	Case History
Wyoming	§1.3.107, 1.38.102 (1977) 2 years from injury or reasonable discovery; minors: until age 8 or within 2 years, whichever is later; legal disability:1 year from removal; wrongful death: 2 years from death	Limits on damage awards prohibited by state constitution					Ct. Rules, Contingent Fee R. 5 (1997) Where recover is $1 million or less: third if claim settled prior 60 days after filing, or 40% if settled after 60 days or judgement; 30% over $1 million	Wyoming Supreme Court struck down the 1986 pretrial screening panel statute requiring mandatory submission of all medical injury claims to a "medical review panel" in *Hoem v. Wyoming* (1988)

Sources: National Conference of State Legislatures (October 16, 2002)
McCullough, Campbell and Lane, *Summary of United State Medical Malpractice Law*, available on the Web at http://www.mcandl.com/states.html
American Tort Reform Association (ATRA)

For more information, please contact:
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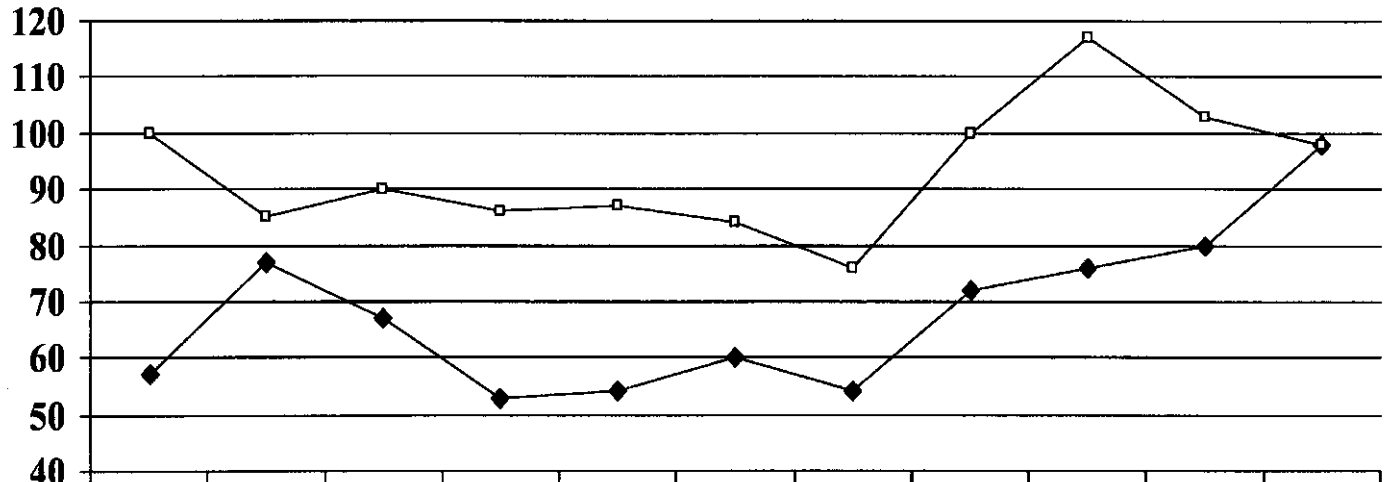
APPENDIX C.2.
Loss Ratios for the Country and Texas

The Current Market: Loss Trends cont.

Loss Ratios for the Country and Texas

Losses Incurred by Premiums Earned

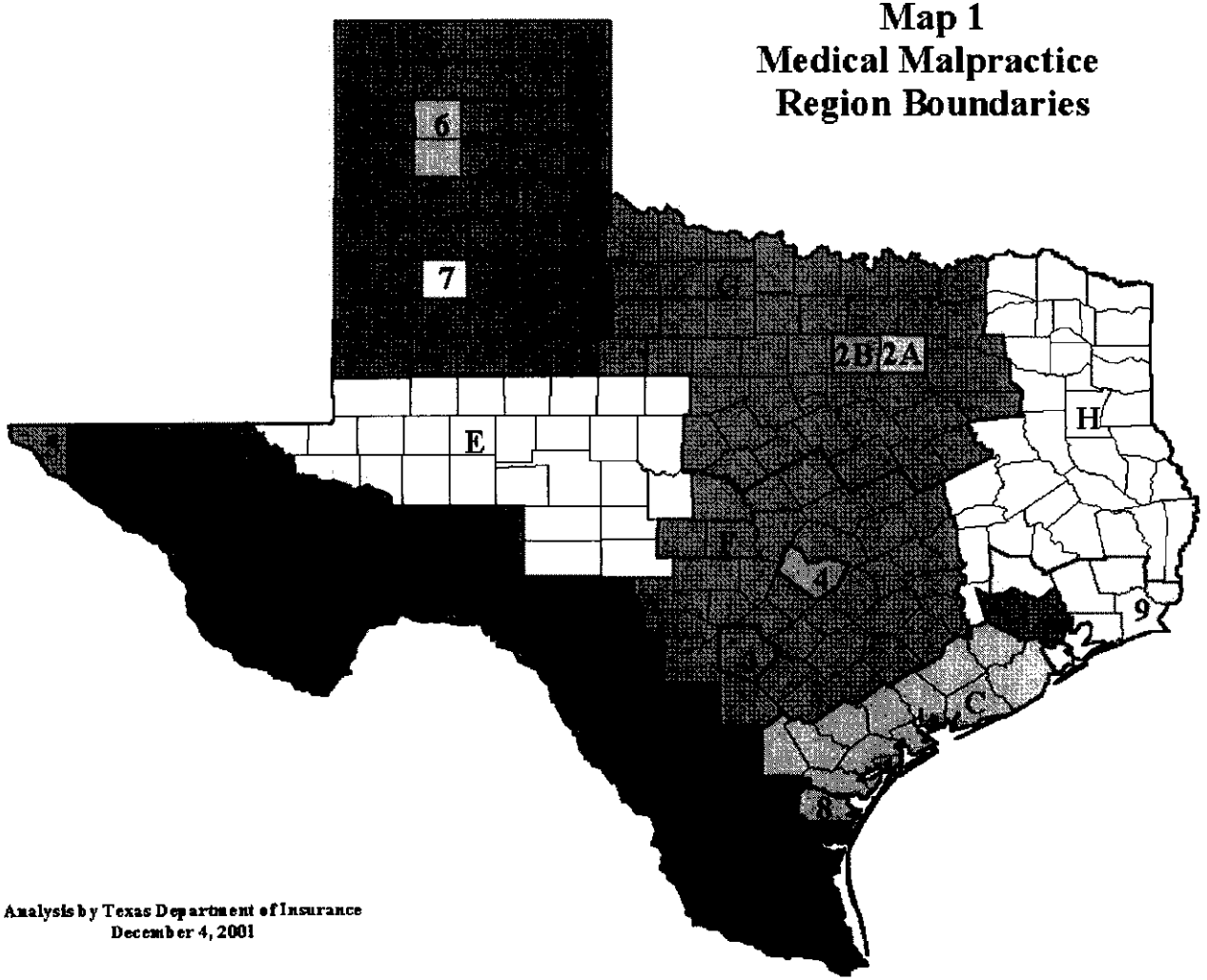


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Country	57	77	67	53	54	60	54	72	76	80	98
Texas	100	85	90	86	87	84	76	100	117	103	98

APPENDIX C.3.

Map 1 & Table A3: Medical Malpractice Region Boundaries
Exhibit A: Projected Unlimited Cost Per Insured Physician
Exhibit B: Projected Number of Reported Claims Per 100 Insured Physicians
Exhibit C: Projected Unlimited Cost Per Reported Claim

Map 1
Medical Malpractice
Region Boundaries



Analysis by Texas Department of Insurance
December 4, 2001

Table A3
MEDICAL MALPRACTICE REGION BOUNDARIES

Territory	Counties		
1	Harris		
2A	Dallas		
2B	Tarrant		
3	Bexar		
4	Travis		
5	El Paso		
6	Randall, Potter		
7	Lubbock		
8	Nueces		
9	Galveston	Liberty	Orange
	Chambers	Hardin	Montgomery
	Jefferson		
A	Brewster	Jeff Davis	Real
	Crockett	Kinney	Reeves
	Culberson	LaSalle	Terrell
	Dimmit	Maverick	Uvalde
	Edwards	McMullen	Val Verde
	Frio	Pecos	Zavala
	Hudspeth	Presidio	
B	Brooks	Jim Hogg	Starr
	Cameron	Jim Wells	Webb
	Duval	Kenedy	Willacy
	Hidalgo	Kleberg	Zapata
C	Aransas	Goliad	Refugio
	Bee	Jackson	San Patricio
	Brazoria	Live Oak	Victoria
	Calhoun	Matagorda	Wharton
	Fort Bend		

Territory	Counties		
D	Armstrong	Fisher	Lamb
	Bailey	Floyd	Lipscomb
	Borden	Gaines	Lynn
	Briscoe	Garza	Moore
	Carson	Gray	Motley
	Castro	Hale	Ochiltree
	Childress	Hall	Oldham
	Cochran	Hansford	Parmer
	Collingsworth	Hartley	Scurry
	Cottle	Hemphill	Sherman
	Crosby	Hockley	Stonewall
	Dallam	Hutchinson	Swisher
	Dawson	Roberts	Terry
	Deaf Smith	Kent	Wheeler
	Dickens	King	Yoakum
	Donley		
E	Andrews	Kimble	Runnels
	Callahan	Loving	Schleicher
	Coke	Martin	Serling
	Coleman	McCulloch	Sutton
	Concho	Menard	Taylor
	Crane	Midland	Tom Green
	Ector	Mitchell	Upton
	Glasscock	Nolan	Ward
	Howard	Reagan	Winkler
	Irion		

Table A3 (continued)
MEDICAL MALPRACTICE REGION BOUNDARIES

Territory	Counties		
F	Atascosa	Comal	Lampasas
	Austin	Coryell	Lavaca
	Bandera	Falls	Lee
	Bastrop	Fayette	Llano
	Bell	Gillespie	Medina
	Blanco	Gonzales	Milam
	Brazos	Guadalupe	Robertson
	Burleson	Hays	San Saba
	Burnet	Karnes	Washington
	Caldwell	Kendall	Williamson
	Colorado	Kerr	Wilson
G	Archer	Grayson	Mills
	Baylor	Hamilton	Montague
	Bosque	Hardeman	Navarro
	Brown	Haskell	Palo Pinto
	Clay	Henderson	Parker
	Collin	Hill	Rockwall
	Comache	Hood	Shackelford
	Cooke	Hunt	Somervell
	Denton	Jack	Stephens
	Eastland	Johnson	Throckmorton
	Ellis	Jones	Van Zandt
	Erath	Kaufman	Wichita
	Fannin	Knox	Wilbarger
	Foard	Limestone	Wise
	Freestone	McLennan	Young

Territory	Counties		
H	Anderson	Houston	Rusk
	Angelina	Jasper	Sabine
	Bowie	Lamar	San Augustine
	Camp	Leon	San Jacinto
	Cass	Madison	Shelby
	Cherokee	Marion	Smith
	Delta	Morris	Trinity
	Franklin	Nacogdoches	Tyler
	Gregg	Newton	Upshur
	Grimes	Panola	Walker
	Harrison	Polk	Waller
	Hopkins	Red River	Wood

EXHIBIT A

TEXAS PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE
Projected Average Indemnity And Defense Cost Per Insured Physician
Including All Mass Tort Except Phen-Fen
Claims Made Policies Only

[TOTAL AVERAGE COST PER PHYSICIAN]

Region	Year Coverage Was Provided (Report Year)					Total	Avg # Docs	Statewide Relativity	Average Trend
	1997	1998	1999	2000	2001				
1	14,042	17,291	18,220	21,200	21,251	18,820	2,758	1.205	10.9%
2A	7,944	10,078	10,323	11,049	14,328	10,989	2,504	0.704	13.6%
2B	10,377	11,985	11,315	18,624	17,628	14,442	1,188	0.925	16.2%
3	7,257	8,218	11,902	13,709	17,076	11,905	1,435	0.762	24.9%
4	6,317	19,937	12,620	14,188	22,756	15,752	1,126	1.009	24.9%
5	17,938	15,720	19,285	21,065	14,024	17,806	321	1.140	-2.0%
6	6,178	7,418	24,873	14,033	3,188	11,348	317	0.727	-6.6%
7	13,221	8,433	12,575	13,816	10,737	11,940	402	0.764	0.8%
8	11,216	16,991	32,107	19,170	16,722	19,943	437	1.277	9.6%
9	23,371	38,531	25,506	25,511	36,794	30,270	528	1.938	5.1%
A	25,654	16,331	23,613	20,847	20,999	21,428	79	1.372	-1.6%
B	16,201	18,124	19,547	20,411	19,543	18,872	627	1.208	5.1%
C	9,542	20,717	18,159	11,986	14,090	15,033	440	0.962	2.4%
D	8,509	15,869	11,757	11,097	11,320	11,676	170	0.748	2.2%
E	9,584	12,698	7,979	11,801	21,755	13,137	555	0.841	17.0%
F	9,079	8,875	7,612	8,518	14,587	10,000	765	0.640	9.5%
G	19,408	18,085	18,113	19,324	18,373	18,788	1,421	1.203	-0.4%
H	8,594	15,654	15,458	24,231	16,780	16,621	956	1.064	19.4%
Total	11,582	14,745	15,157	16,736	18,144	15,619	16,028	1.000	10.8%

Notes:

1. Due to the long settlement time for medical malpractice, the values for 2001 are subject to a good deal of uncertainty.
2. Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (or low) risk specialties and therefore have a higher (or lower) loss costs.
3. Some regions lack statistical credibility.
4. Regional data may also be affected by different average policy limits. Average costs would be understated in regions with lower than average policy limits and overstated in regions with higher than average policy limits.

EXHIBIT 6

TEXAS PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE
Projected Number of Reported Claims Per 100 Insured Physicians
Including All Mass Tort Except Phen-Fen
Claims Made Policies Only

[REPORTED CLAIM FREQUENCY]

Region	Year Coverage Was Provided (Report Year)					Total	Avg. Docs Per Year	Statewide Relativity	Average Trend
	1997	1998	1999	2000	2001				
1	28.36	26.33	26.46	26.26	27.69	27.01	2,758	1.139	-0.5%
2A	14.12	16.21	13.58	16.41	18.55	15.87	2,504	0.670	5.7%
2B	19.16	19.95	23.32	22.49	22.50	21.65	1,188	0.913	4.5%
3	17.13	20.17	18.73	17.63	18.75	18.49	1,435	0.780	0.5%
4	16.03	19.30	15.77	20.67	22.76	19.23	1,126	0.811	8.0%
5	22.42	27.86	22.64	22.58	20.97	23.25	321	0.981	-3.4%
6	15.25	11.01	14.96	16.08	8.67	13.15	317	0.554	-7.2%
7	18.77	21.02	17.89	25.87	19.31	20.81	402	0.878	2.7%
8	27.61	38.61	29.27	34.10	28.46	31.32	437	1.321	-0.6%
9	30.08	28.58	31.68	35.68	49.01	35.41	528	1.494	12.7%
A	30.57	21.40	26.42	40.79	22.31	28.19	79	1.189	0.2%
B	34.64	30.82	135.81	128.68	35.44	73.71	627	3.109	15.9%
C	24.43	31.40	27.16	25.19	23.55	26.13	440	1.102	-2.9%
D	17.91	14.87	16.25	13.71	24.22	17.33	170	0.731	5.4%
E	19.57	13.59	12.14	11.14	12.23	13.32	555	0.562	-10.8%
F	15.32	16.21	17.36	13.87	18.71	16.37	765	0.690	2.5%
G	20.55	22.53	24.16	26.03	26.79	24.44	1,421	1.031	7.0%
H	19.33	20.06	22.19	26.19	25.17	22.92	956	0.967	8.3%
Total	20.91	21.65	25.20	26.17	23.78	23.71	16,028	1.000	4.6%

Notes:

1. Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (or low) risk specialties and therefore have a higher (or lower) claim frequencies.
2. Some regions may lack statistical credibility.

EXHIBIT C

TEXAS PHYSICIANS AND SURGEONS MEDICAL MALPRACTICE
Projected Average Indemnity And Defense Cost Per Reported Claim
Including All Mass Tort Except Phen-Fen
Claims Made Policies Only

[REPORTED SEVERITY]

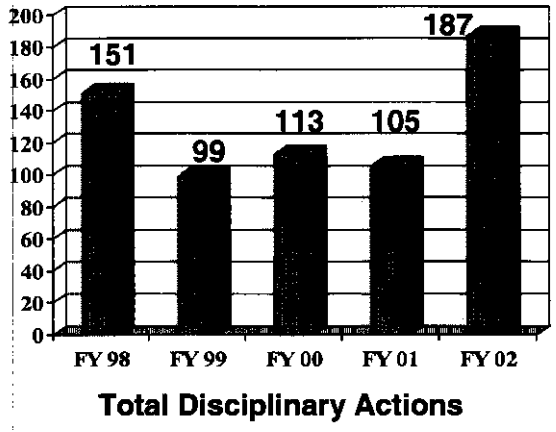
Region	Year Coverage Was Provided (Report Year)					Total	Avg. Docs Per Year	Statewide Relativity	Average Trend
	1997	1998	1999	2000	2001				
1	49,507	65,661	68,860	80,715	76,752	69,674	2,758	1.058	11.4%
2A	56,278	62,157	76,033	67,329	77,245	69,221	2,504	1.051	7.4%
2B	54,172	60,080	48,510	82,816	78,356	66,688	1,188	1.012	11.2%
3	42,372	40,740	63,556	77,772	91,060	64,394	1,435	0.978	24.3%
4	39,405	103,313	80,029	68,636	99,992	81,939	1,126	1.244	15.6%
5	80,006	56,420	85,175	93,284	66,879	76,571	321	1.162	1.5%
6	40,512	67,391	166,279	87,252	36,761	86,340	317	1.311	0.6%
7	70,445	40,119	70,296	53,397	55,599	57,362	402	0.871	-1.9%
8	40,628	44,009	109,702	56,223	58,753	63,670	437	0.967	10.3%
9	77,697	134,817	80,512	71,489	75,070	85,465	528	1.297	-6.8%
A	83,922	76,322	89,364	51,114	94,125	76,000	79	1.154	-1.7%
B	46,767	58,800	14,393	15,862	55,149	25,600	627	0.389	-9.3%
C	39,058	65,970	66,861	47,590	59,822	57,526	440	0.873	5.4%
D	47,517	106,719	72,372	80,940	46,740	67,354	170	1.023	-3.0%
E	48,984	93,452	65,707	105,931	177,810	98,615	555	1.497	31.0%
F	59,261	54,760	43,843	61,409	77,966	61,096	765	0.928	6.9%
G	94,434	80,269	74,958	74,236	68,582	76,855	1,421	1.167	-6.9%
H	44,468	78,018	69,667	92,535	66,662	72,526	956	1.101	10.3%
Total	55,393	68,107	60,158	63,954	76,286	65,871	16,028	1.000	5.9%

Notes:

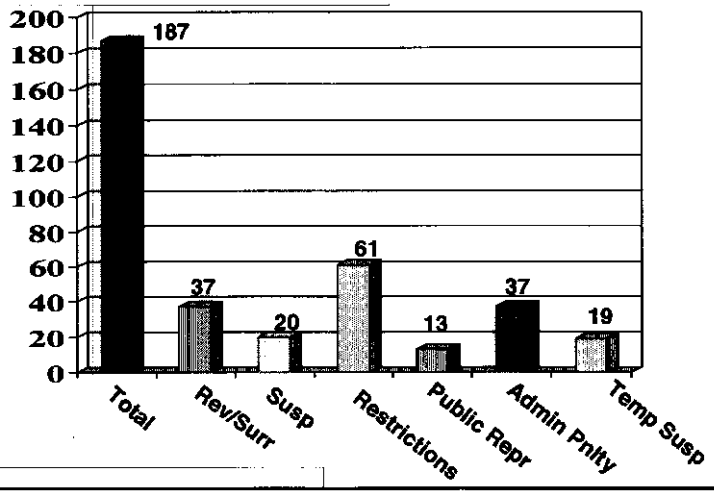
1. Due to the long settlement time for medical malpractice, the values for 2001 are subject to a good deal of uncertainty.
2. Regional data may be distorted by differing distributions of insured specialties by region. For example, Region X may have a larger proportion of high (or low) risk specialties and therefore have a higher (or lower) claim severities.
3. Some regions lack statistical credibility.
4. Regional data may also be affected by different average policy limits. Average costs would be understated in regions with lower than average policy limits and overstated in regions with higher than average policy limits.

APPENDIX C.4.
State Board of Medical Examiners
Regulatory Improvements

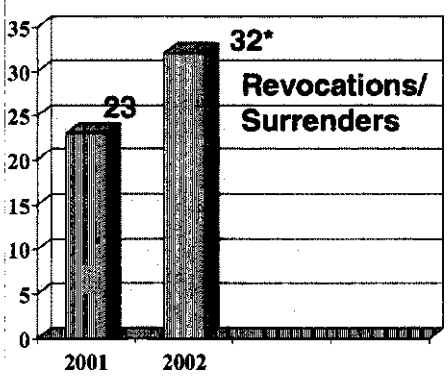
Disciplinary Accomplishments FY 1998-2002



Disciplinary Detail FY 2002

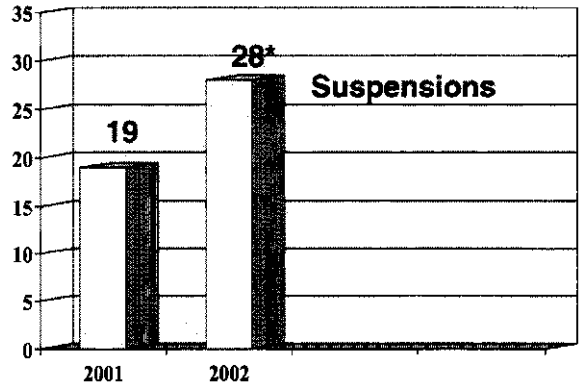


Calendar year comparison 2001-02*



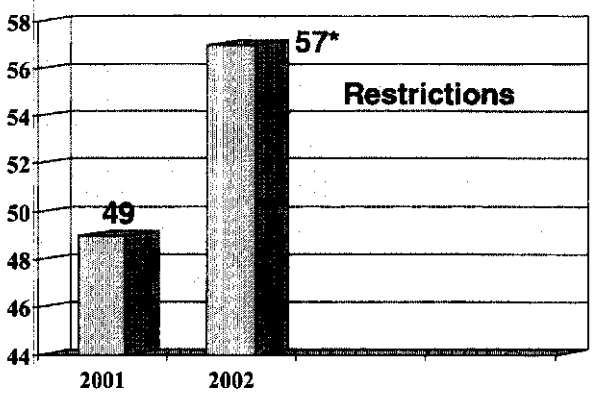
* Based on calendar years; 2002 figures are projected based on totals through October 2002.

Calendar year comparison 2001-02*



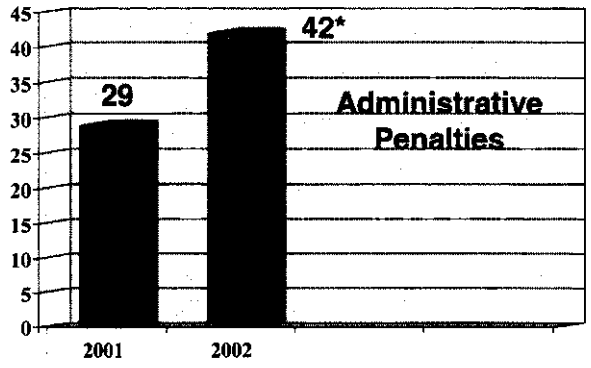
* Based on calendar years; 2002 figures are projected based on totals through October 2002.

Calendar year comparison 2001-02*



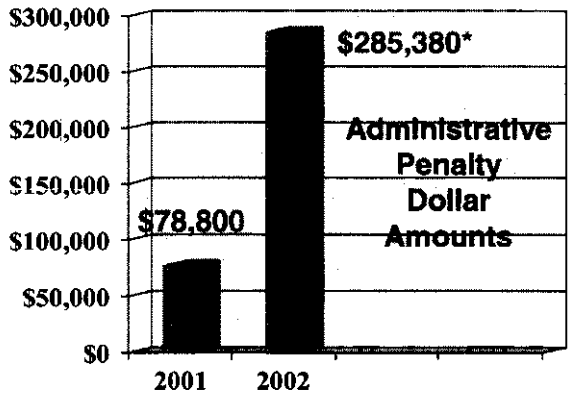
* Based on calendar years; 2002 figures are projected based on totals through October 2002.

Calendar year comparison 2001-02*



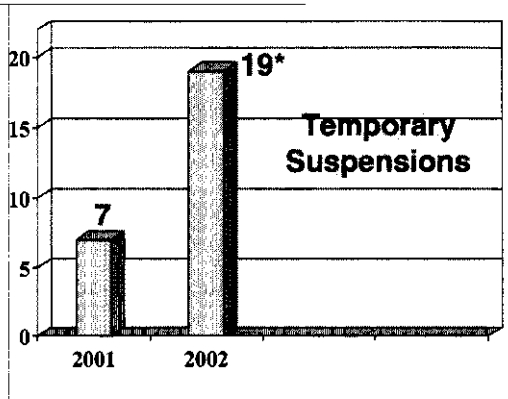
* Based on calendar years; 2002 figures are projected based on totals through October 2002.

Calendar year comparison 2001-02*



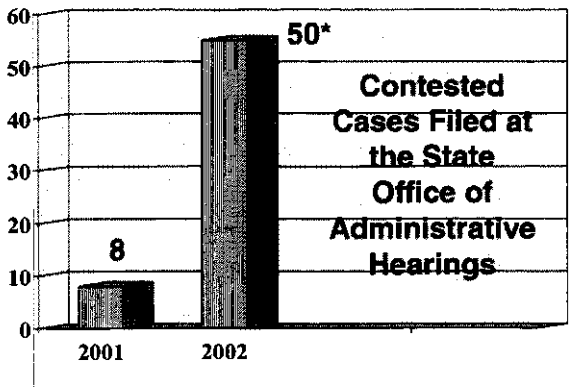
* Based on calendar years; 2002 figures are projected based on totals through October 2002.

Calendar year comparison 2001-02*



* Based on calendar years; 2002 figures are projected based on totals through September 2002.

Calendar year comparison 2001-02*



* Based on calendar years; 2002 figures are projected based on totals through October 2002.

APPENDIX C.5.
Chronological History of Medical Malpractice Actions in Texas

Chronological History of Medical Malpractice Actions in Texas

August 29, 1977: Texas Medical Liability and Insurance Improvement Act, codified as Article 4590i of the Texas Civil Statutes, becomes effective. The article:

- Requires any health care liability claim to be filed within two years from the occurrence of the injury or from the date the medical or health care treatment is completed. Minors under the age of 12 years have until their 14th birthday in which to file, or have filed on their behalf, the claim. (Section 10.01)

- Caps recovery on a civil health care liability claim against a physician or health care provider at $500,000. This does not apply to damages awarded to cover the cost of past, present, or future necessary medical, hospital, and custodial care. (Subchapter K, Section 11.02)

- Provides that if the cap in Section 11.02 is invalidated, the civil liability of a physician or health care provider for all past and future noneconomic losses recoverable by an injured person or the person's estate is capped at $150,000, including past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement, and any other non-pecuniary damage. (Subchapter K, Section 11:03)

- Provides that the caps in Sections 11.02 or 11.03 shall be adjusted for increases or decreases in the consumer price index. (Subchapter K, Section 11.04)

January 30, 1985: In *Neagle v. Nelson*, 658 S.W.2d 11 (Tex. 1985), the Texas Supreme Court rules that the two-year statute of limitations in Section 10.01 violated the "open courts" provision of the Texas Constitution (Article I, Section 13) to the extent the statute barred a plaintiff from bringing a medical malpractice claim before the injured party had a reasonable opportunity to discover the injury.

May, 11, 1988: In *Lucas v. United States*, 757 S.W.2d 687, 691 (Tex. 1988), the Texas Supreme Court rules that the limitations on damages set out in Section 11.02 violated the "open courts" provision of the Texas Constitution.

September 1, 1989: House Bill 18, enacted by the 71st Legislature, becomes effective. This bill adds Subchapter N, Section 14.01, to Article 4590i, which sets out the qualifications for an expert witness in a health care liability claim.

September 1, 1993: Section 3 of Senate Bill 1409, enacted by the 73rd Legislature, becomes effective, adding Subchapter M Sections 13.01 and 13.02, to Article 4590i. This subchapter requires a plaintiff in a medical malpractice suit to file an affidavit that the plaintiff has obtained an expert opinion that the acts or omissions of a physician or health care provider were negligent and the proximate cause of harm to the plaintiff.

September 1, 1995: Senate Bill 25, enacted by the 74th Legislature, becomes effective. The bill amends Section 41.008 of the Civil Practice and Remedies Code to limit exemplary damages that may be awarded against a defendant to the greater of: two times the amount of economic damages, plus noneconomic damages found by the jury, not to exceed $750,000; or $200,000.

September 1, 1995: House Bill 971, enacted by the 74th Legislature, becomes effective. The bill:

- Amends Section 13.01 to require that a plaintiff in a medical malpractice suit file a $5,000 bond or place that amount in escrow, for each defendant physician or health provider. In lieu of such bond or escrow, the plaintiff may file an expert report setting out the manner in which the care provided by a physician or health care provider failed to meet accepted standards and caused the harm claimed.

- Amends Section 14.01 to set out what a court must consider in determining whether an expert witness is qualified.

- Adds Subchapter P to Article 4590i, which concerns the determination of prejudgment interest in medical malpractice suits.

August 24, 2000: In *Horizon/CMS Healthcare Corporation v. Auld*, 985 S.W.2d 216 (Tex. 2000), the Texas Supreme Court makes the following rulings:

- The cap on damages in Section 11.02 does not include punitive damages, which serve the purposes of deterring and punishing willful or wrongful conduct.

- The cap on compensatory damages in Section 11.02 is only unconstitutional as it applies to claims brought under common-law claim, such as for personal injuries resulting from medical negligence. However, this cap does apply to causes of action that are not derived from the common law, but are created by legislative enactment, such wrongful death and survival claims.

- The statutory cap on punitive damages in Section 41.008 of the Texas Civil Practice and Remedies Code applies to punitive damages awarded in a health care liability claim.

June 27, 2002: In *Columbia Hospital Corporation of Houston v. Moore*, 45 Tex. Sup. J. 957 (Tex. 2002), the Texas Supreme Court rules that any prejudgment interest awarded under Subchapter P of Article 4590i is subject to the cap on compensatory damages contained in Subchapter K.