Market Study – Approaches to Increase the Availability of Medical Malpractice Insurance for Community-Based Healthcare Providers in Washington State Carceral Settings:

Related to Community-Based Healthcare Providers, Qualified Under the Medicaid 1115 Waiver, Providing Transitional Services to Individuals in the Last 90 Days of their Incarceration Per the MTP 2.0 Initiative

Prepared for the Washington State Office of the Insurance Commissioner

Prepared by Davies Actuarial, Audit & Consulting, Inc.
with support from Alvarez & Marsal Financial Services Industry Group, LLC

November 27, 2024

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The Honorable Mike Kreidler
Insurance Commissioner, Washington State
302 Sid Snyder Ave. SW
Olympia WA 98504-0258

Re: Market Study Regarding Approaches to Increase Availability of Medical Malpractice Insurance for Community-Based Healthcare Providers, Qualified under the 1115 Medicaid Waiver, Delivering Transition of Care Services to Individuals During the Last 90 Days of Incarceration in Washington State per the MTP 2.0 Initiative

Dear Commissioner Kreidler:

Please find attached the above-referenced study.

We appreciate the opportunity to work with you and the Washington State Office of the Insurance Commissioner ("OIC") and to assist the Washington State Legislature ("Legislature"). Please do not hesitate to contact us with any comments or questions.

Sincerely,

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Executive Summary

On June 30, 2023, the Centers for Medicare & Medicaid Services ("CMS") approved Washington State's request to extend and amend its Section 1115 waiver. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to approve pilot projects that promote the objectives of the Medicaid program and that demonstrate policy approaches that better serve Medicaid populations.[1] The Washington Health Care Authority ("HCA") has named the associated initiative "Medicaid Transformation Project 2.0" or "MTP 2.0."[2]

Under MTP 2.0, Medicaid funds can be used to reimburse Community Healthcare Providers ("CHPs") for transitional services they provide to incarcerated individuals during their last 90 days of incarceration. CMS and the US Department of Health and Human Services Health Resources & Services Administration ("HRSA") refer to these individuals as "justice-involved individuals reentering the community" or "JI-R individuals."

Based on interviews and other research,[3] medical and correctional leaders strongly support this initiative. In their opinion, when incarcerated individuals have an established relationship with CHPs prior to release, they are more likely to continue their treatment when re-entering their communities. This may strongly reduce overdoses and other negative behaviors upon release, more effectively encourage compliance with prescribed medical or Medications for Opioid Use Disorder ("MOUD") programs, reduce recidivism, and create substantial societal, safety, and even financial benefits.

Additionally, in Executive Order 24-03, "Building Safe and Strong Communities Through Successful Reentry," dated September 16, 2024, Washington Governor Jay Inslee ordered the HCA to "increase supports under the Medicaid 1115 waiver reentry provisions by assisting with pre-release eligibility assessments and enrollment planning to access Medicaid-covered services and behavioral health care. The agency shall offer medication-assisted treatment for opioid use disorder ('MOUD') and alcohol use disorder up to 90 days prior to reentry." Additionally, the Order requires the HCA to "seek funding to support collaboration among state agencies to ensure the secure and effective exchange of patient health data in carceral facilities with community providers."[4]

Medical malpractice insurance, also called medical professional liability insurance, provides a method to protect both the harmed individual and the healthcare system in the event of an error or omission by a healthcare practitioner during their work. In the event of a claim against a practitioner, the insurance will:

- Compensate the injured party if the damages were a result of the practitioner's act or omission and;

[1] See https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

[2] https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/what-were-working

[3] Report to US Congress – Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, January 2023, p. 19.

[4] State of Washington Executive Order 24-03, dated September 16, 2024.

- Provide financial protection for the practitioner that enables him or her to practice the art of medicine.

As will be described further in this report, medical malpractice insurance is required of healthcare providers in many carceral settings. CHPs are encountering challenges in obtaining such insurance related to work performed in carceral settings, which has become an obstacle in the execution of Washington's MTP 2.0 initiative.

Accordingly, in the 2024 supplemental operating budget (ESSB 5950), the Washington State Legislature ("Legislature") requested the Washington state Office of Insurance Commissioner ("OIC") to study "how to increase the availability of health care malpractice liability coverage or other liability protection options for community-based health care providers who deliver transition of care services to incarcerated individuals."[5] The language of the law is as follows:

> The commissioner [should] study approaches to increasing the availability of health care medical liability coverage or other liability protection options for community-based health care providers delivering transition of care services to incarcerated individuals. . . . The study must include:
> (i) A review of the state's commitments to facilitating safe transitions of care for incarcerated individuals through medicaid coverage of health services under the 2023 medicaid transformation waiver;
> (ii) An analysis of the barriers to accessing liability coverage for community-based health care providers on the private market;
> (iii) An actuarial analysis of the potential risk to be incurred by providing health care malpractice liability coverage for transition of care services to individuals who are incarcerated and near release; and
> (iv) Policy options and recommendations, if any, for consideration by the Legislature regarding provision of or increasing the availability of health care malpractice liability coverage or other liability protection options for community-based health care providers delivering these services.

The OIC retained the Authors to conduct this study; each of the items mentioned in the bill is addressed in this report.

The Authors' Approach

To study the issue, the Authors conducted many interviews with market participants to understand the issues, challenges, and potential policy options. This included, but was not limited to, learning about the MTP 2.0 initiative, researching the benefits of CHP involvement in carceral settings, and researching the current diverse structures for providing healthcare services in a variety of carceral settings. They also issued, via the OIC, a voluntary survey to jails regarding their current structure for the provision of healthcare services. The Authors also gathered publicly available data regarding the medical malpractice environment in Washington State and nationally, as well as information specific to carceral settings.

[5] https://www.insurance.wa.gov/2024-legislative-summary

Conditions and Limitations

The policy options recommended for consideration are based on the Authors' research. Although the Authors have attempted to identify potential consequences of each policy option, it is not possible to identify every consequence. Furthermore, the Washington Legislature may choose to execute some option in a manner not contemplated by this study. The outcome of any option or combination of options cannot be guaranteed.

As discussed in this report, sufficient data to project the expected costs of various policy proposals was unavailable. (A sufficient quantity of data is necessary to produce credible actuarial projections). While some estimates and benchmarks are presented in this study for context, they should not be considered actuarial projections, and future values may differ significantly from these estimates and benchmarks.

Our review was limited to the scope as defined by the Washington Legislature and the OIC; namely, it addresses the availability of medical malpractice insurance for CHPs providing transitional services, as defined by MTP 2.0, in carceral settings for the last 90 days of incarceration of JI-R individuals. There are other potential services that CHPs may be able to provide in carceral settings.

This report should be read and distributed in its entirety, as opposed to parts thereof.

Carceral Settings

Carceral settings encompass both prisons and jails.

There are 11 state prisons in Washington, all administered by the Department of Corrections ("DOC"). Incarcerated individuals are placed in a state prison if they have committed a felony, and their term of incarceration is a year and a day or more.

Individuals who have committed a misdemeanor or who have committed a felony with a term of incarceration of a year or less are placed in jails. Additionally, incarcerated individuals stay in jails during pre-trial detention and while awaiting sentencing. Jails are administered by counties, cities, and tribes.

There are 36 county jails, 18 city or tribal jails, and two multi-jurisdictional jails, each administered by the local government. In 2023, the average daily population ("ADP") in Washington jails ranged from as few as one or two inmates to more than a thousand. [6]

There are instances in which an incarcerated individual under Washington State DOC jurisdiction may be temporarily placed in a jail. In those situations, Washington State DOC remains the entity responsible for the healthcare of the incarcerated individual.

The Eighth Amendment of the United States Constitution states that "excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." In Estelle v. Gamble, 429 U.S. 97 (1976), the United States Supreme Court held that deliberate indifference to a prisoner's medical needs meets the definition of "cruel and unusual punishment" and is therefore a violation of the Eighth Amendment.

[6] Washington Association of Sheriffs & Police Chiefs 2023 Annual Jail Statistics https://www.waspc.org/assets/2023%20Jail%20Statistics%20Website.xlsx

Potential Advantages of Involving CHPs in Transitional Care

Recent research indicates that the engagement of community healthcare providers in carceral settings may lead to improved outcomes upon release. The existing relationship with a provider in the individual's community leads to greater compliance with MOUD programs and overall follow-up with healthcare providers.

In its January 2023 Report to Congress entitled, "Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group,"[7] the US Department of Health and Human Services ("HHS"), Office of the Assistant Secretary for Planning and Evaluation, found:

1. "Professionals who work with justice-involved individuals often note that they frequently are hesitant to engage with the health care system, possibly reflecting a mistrust rooted in poor care experiences before, during, and after incarceration. Additionally, and not unrelatedly, many providers report a lack of cultural competence in working with formerly incarcerated patients. Culturally competent clinics, programs, and models of care can help build trust between patients and providers and support greater engagement in health care." (p. 19)

2. "A recent analysis found recidivism rates dropped from 46 percent to 21.8 percent for participants who had been on parole for 2 years at one program site [which helped individuals access health care and social services in the community]." (p. 19)

Several interviewees, representing both medical and correctional leadership, strongly believed that the provision of services by community healthcare providers in carceral settings would reduce drug addiction and overdoses upon release, reduce recidivism, improve the JI-R individuals' prospects at meaningful return to society, and benefit society at large.

The ability to transition health records from jail and prison health providers and work with inmates prior to release may allow CHPs to offer more effective services once that person is outside the carceral setting.

Additionally, when a person is released from custody, they often do not know how to access healthcare services, and any treatment of health issues can cease, leading to adverse outcomes and emergency room visits. If an individual abruptly ceases their MOUD program, overdoses and death are probable.

In the voluntary survey issued to jails shown in Appendix F, respondents were asked whether they would be in favor of CHPs providing medical services in their jail. Sixty percent were in favor and 25% were unsure ("no" responses totaled 15%).

[7] Report to US Congress – Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, January 2023.

Based on publicly available data from the Washington Association of Sheriffs & Police Chiefs ("WASPC"),[8] the average daily bed rate for jails in Washington in 2023 was $123 and the average length of stay was 17 days. In amounts only related to these two metrics, and without consideration of the impact on individuals and societies of a successful release vs addiction and/or recidivism, the average cost of just one additional jail stay is $2,091. Based on the HHS study described above as well as input from medical and carceral professionals, the engagement of CHPs in transitional carceral care could materially reduce repeat jail stays.

During interviews, the Authors heard some desire from medical and carceral professionals, as well as from CHPs, for CHP providers to play a much greater role in providing medical services in jails. However, under the MTP 2.0 Reentry Initiative, CHPs would provide only a restricted set of services and only in the 90 days before release.[9] Consistent with the scope provided by the OIC and the Legislature, this study focuses only on those transitional services.

[8] https://www.waspc.org/crime-statistics-reports

[9] https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting

Regulation of Medical Malpractice Insurance in Carceral Settings

As will be described in further detail later in this report (see "Healthcare Mechanisms, Medical Liability Exposures, and Insurance/Self-Insurance – Prisons and Jails" section), during the course of interviews and research, the Authors did not identify providers of insurance in the carceral setting that are directly regulated by the OIC:

1. State prisons are self-insured through the State of Washington Self-Insurance Liability account. The Self-Insurance Liability account is maintained by the Washington Office of Risk Management, an office of the Washington Department of Enterprise Services ("DES"). This office is not regulated by the OIC.
2. County, city and tribal jails interact with a variety of insurance or self-insurance mechanisms:
    a. The jails are frequently self-insured or insured through risk pools. None of these entities are regulated by the OIC.
    b. Many jails require third-party medical providers to present evidence of their own medical malpractice insurance.
3. Regarding insurance companies that provide medical malpractice insurance to third-party providers in carceral settings, many may not be admitted insurance companies. As noted in Appendix D – Insurance Regulation Overview, non-admitted insurance companies do not have their policy forms and rate filings reviewed by the OIC. (As explained further in Appendix A – Additional Information on Washington Jail Liability, that these third-party providers are frequently retaining all or almost all of the risk. It is important to note that a typical insurance market does not appear to exist for medical malpractice coverage in carceral settings).

Review of Washington State's Commitment to Facilitating Safe Transitions of Care for Incarcerated Individuals Through Medicaid Coverage of Health Services Under the 2023 Medicaid Transformation Waiver

In this section, the Authors will explain the referenced Medicaid Transformation Waiver and the potential impact of the waiver on the provision of transitional services provided by CHPs in carceral settings.

Section 1115 Medicaid Waiver and Medicaid Transformation Project ("MTP") 2.0

The Washington State Health Care Authority ("HCA") administers Apple Health, Washington's Medicaid program in partnership with the Centers for Medicare & Medicaid Services ("CMS"), a federal agency within the United States Department of Health and Human Services. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental or pilot programs intended to give states flexibility in meeting the objectives of the Medicaid Program. Section 1115 proposals are reviewed and approved for five years by CMS, with a possible extension for up to another five years. [10]

The Medicaid Transformation Project ("MTP") is Washington's Section 1115 Medicaid demonstration project, originally approved in 2018. In 2023, CMS extended the project for another five years. The extension is called "MTP 2.0," and includes multiple projects and initiatives, including the "Reentry Initiative." As of this report, similar reentry projects have been approved under Section 1115 for 11 states, including Washington. [11]

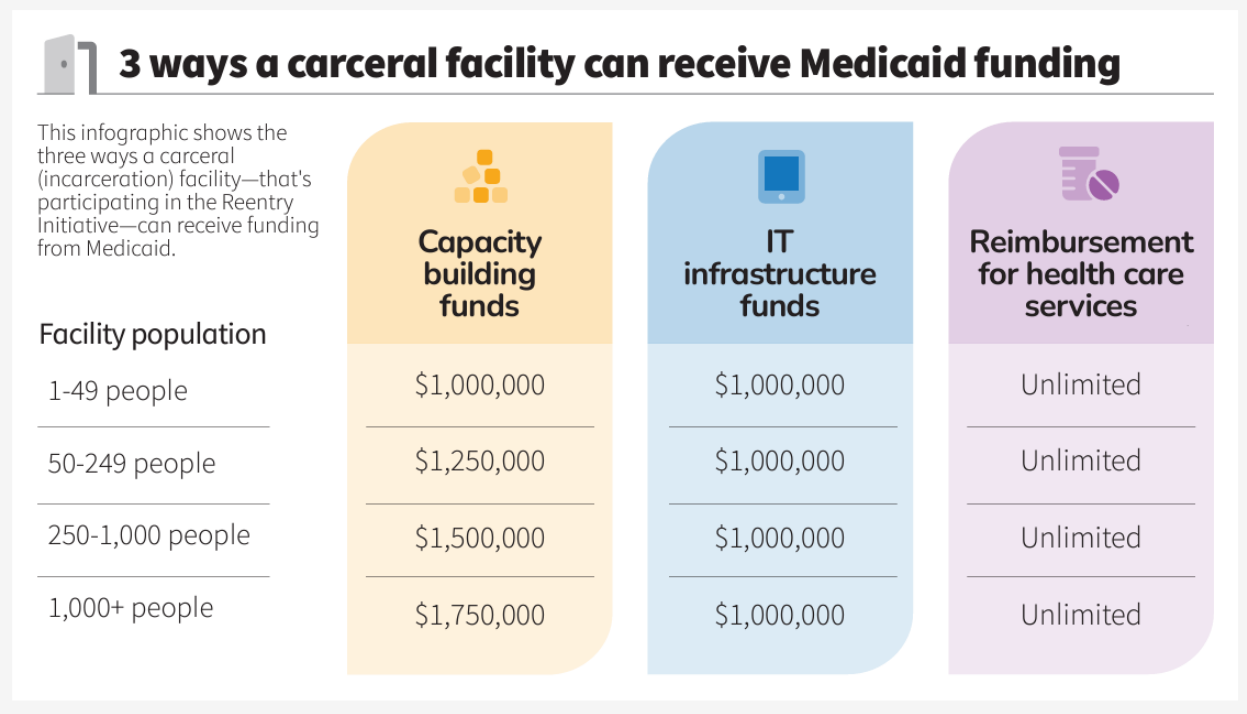
The goal of the Reentry Initiative is to provide pre-release services for people leaving incarceration. Historically, Medicaid coverage had been terminated for incarcerated individuals and people leaving jail or prison were required to reapply for Apple Health coverage. Beginning in 2016, HCA was allowed to suspend rather than terminate coverage. Washington House Bill 1348, passed in 2021, delays that suspension for 29 days and allows for application for coverage while incarcerated. Washington Senate Bill 5304, also passed in 2021, allows HCA to seek federal funds to provide pre-release services to a JI-R individual leaving jail or prison and to maximize care coordination during a person's transition into the community. [12]

Under the Reentry Initiative, HCA will fund certain healthcare services provided to Apple Health-eligible adults and youth in carceral settings up to 90 days prior to release. Note that the funding consists of three different types: eligibility for capacity building funds, eligibility for IT infrastructure funds, and *Medicaid*

[10] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[11] https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity/index.html
[12] https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting#:~:text=Additional%20information,-Background%20on%20reentry&text=Senate%20Bill%20(SB)%206430%20passed,an%20incarcerated%20person's%20Medicaid%20coverage.

reimbursement for healthcare services. Reimbursement to the carceral facility of healthcare services is available for services from any CHP, regardless of whether they are federally qualified healthcare centers (FQHCs), described below.

The following infographic was provided by HCA:



The services covered under the Reentry Initiative include the following, and the first three are required of participating programs:

- Case Management
- Medications for alcohol and opioid use disorder
- 30-day supply of medications and medical supplies at release
- Medications during the pre-release period
- Lab and radiology
- Services by community health workers with lived experience
- Physical and behavioral clinical consultations[13]

The initial group of carceral facilities participating in the project are scheduled to launch in July 2025. To provide the covered services, these facilities seek CHPs able and willing to participate.

In an April 17, 2023 bulletin to State Medicaid Directors, CMS provided guidance for designing demonstration projects under Section 1115 of the Social Security Act to improve care transitions for individuals soon to be exiting carceral settings and who are otherwise eligible for Medicaid. The bulletin states, "While states' applications may propose to make certain carceral health care services that are currently paid exclusively with state and/or local dollars eligible for FFP [federal financial participation], the

[13] https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting

Reentry Section 1115 Demonstration opportunity is not intended to shift current carceral health costs to the Medicaid program. . . . Accordingly, CMS does not expect to approve state proposals to receive federal Medicaid matching funds through the Reentry Section 1115 Demonstration Opportunity for any existing carceral health care services that are currently funded with state and/or local dollars unless states agree to reinvest the total amount of new federal matching funds received for such services under the demonstration into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including those who are soon-to-be-released) or were recently released from incarceration, or for health-related social services that may help divert individuals from criminal justice involvement."[14]

Medicaid reimbursement will clearly provide expense relief to carceral settings that offer CHP-provided transitional services. Based on the language in the bulletin above as well as the newness of this program, it is unclear whether there will be any reduction in *current* operational expenses for the various carceral institutions. However, as noted in an earlier section, any benefit in decreased recidivism produces material financial and social benefits to the State.

The Authors' understanding is that the implementation of MTP 2.0, as well as continued national research about the benefits of CHPs providing transitional services in carceral settings,[15] provided momentum to address the lack of availability of medical malpractice insurance for CHPs in carceral settings.

[14] Centers for Medicare and Medicaid Services, SMD #23-003, dated April 17, 2023.
[15] Report to US Congress – Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, January 2023, p. 19.

Analysis of the Barriers to Accessing Liability Coverage in Carceral Settings for CHPs in the Private Insurance Market

The barriers to CHPs accessing medical professional liability coverage in the private insurance market for services provided in carceral settings are not specific to CHPs; rather, it is difficult for many healthcare providers to obtain this coverage for work in carceral settings. (Note that, based on the Authors' interviews and research, CHPs do have liability insurance for work performed in other settings such as their offices, mobile units, etc).

This section discusses several factors that lead to liability insurance availability challenges in carceral settings generally. These factors also create availability challenges for CHPs in carceral settings. Further information on overarching challenges in carceral settings, how those challenges restrict the pool of potential healthcare providers, and some related options for legislative consideration, are discussed in Appendix A – Additional Information on Washington Jail Liability.

Eighth Amendment Rights and Related Suits

As noted above in the "Carceral Settings" section, based on the Eighth Amendment of the United States Constitution and its interpretation by the United States Supreme Court in Estelle v. Gamble, 429 U.S. 97 (1976), deliberate indifference to a prisoner's medical needs is a violation of the Eighth Amendment. 42 U.S. Code § 1983 allows for any person who is deprived of rights granted in the U.S. Constitution by someone acting under state law to bring a claim against that party ("Section 1983 claim"). Therefore, jails and prisons must provide adequate healthcare to incarcerated individuals, and if that care is not provided an incarcerated individual may make a claim alleging violation of civil rights.

Beyond the right to healthcare granted by the U.S. Constitution, incarcerated individuals are also able to file lawsuits alleging medical malpractice. In practice, incarcerated individuals claiming injury from improper medical treatment will frequently claim that both medical malpractice and a civil rights violation occurred and will name all related parties on the notice of claim.

For this reason, many self-insured carceral entities reference "jail liability" or "prison liability" without distinguishing between the Eighth Amendment and medical malpractice aspects of the suit. Based on interviews with insurance, risk management, and carceral professionals, it appears difficult to untangle these two types of liability in many claims or suits. This creates uncertainty on both sides – carceral settings can likely not separate themselves from errors or omissions from third-party medical providers caring for incarcerated individuals, and medical providers and their insurers may be named in what is essentially an Eighth Amendment suit.

Healthcare Mechanisms, Medical Liability Exposures, and Insurance/Self-Insurance – Prisons and Jails

There are key differences between prisons and jails that affect the medical malpractice exposure in these settings. Additionally, there are differences in the ways in which medical malpractice exposures are insured or self-insured. Key differences are listed below:

1. **Length of Stay** –
   - **Jails –** Individuals incarcerated in a jail setting seldom remain for over a year. Many inmates in a jail are kept for only a few days, and the average length of stay in most jails is less than 30 days.[16]

   - **Prisons –** By definition, almost all individuals incarcerated within the state prison system have lengths of stay over a year, with many staying for many years.

2. **Knowledge Regarding Medical History of Incarcerated Individuals** –
   - **Jails** - Jails must handle medical intake of unknown individuals. Notwithstanding the state's ongoing efforts to address behavior health issues and interventions to divert some instances from ending in the carceral setting, it is not uncommon for an individual to enter the jail system under the influence of drugs, with untreated mental health problems, or with another undiagnosed medical condition. Arrestees are often victims of violence themselves and may have untreated injuries. There is therefore a burden on jails to handle medical issues upon intake despite little knowledge of an individual's medical condition.

   - **Prisons** - The prison population typically enters either from a jail or from another prison. Generally, more is known about a prison inmate's medical history compared to a jail inmate.

3. **Provision of Healthcare and Liability Insurance** –
   - **Jails** – The diversity of healthcare systems between jails is notable. In some jails, healthcare may be provided by contracted third party providers who visit and/or staff the jails regularly. Based on a survey of local jail leadership conducted for this study, 12 of the 20 respondents stated that non-emergency medical services are provided primarily on-site by third party providers. Another five respondents stated that services are provided on-site by a combination of city/county employees and third parties. Overall, 85% of jails participating in the survey indicated that third parties are used on-site in some fashion.

     In other instances, particularly in rural areas or when a procedure cannot be performed in the jail, jails may transport incarcerated individuals to local doctors or facilities. In these cases, security officers must accompany the incarcerated individual. Two out of 20 survey respondents indicated that medical services are provided primarily off-site.

[16] Washington Association of Sheriffs & Police Chiefs 2023 Annual Jail Statistics https://www.waspc.org/assets/2023%20Jail%20Statistics%20Website.xlsx

In still other instances, a healthcare provider may visit the jail on a regular schedule, although it is frequently not daily, and emergencies are sent to a local emergency room.

In many cases, third-party providers are required by the county or municipality to demonstrate that they have their own medical malpractice insurance.

In all instances, counties, cities, and tribes must be prepared to defend their own Eighth Amendment liability, in addition to any potentially uninsured/under-insured medical malpractice liability. Some counties or cities insure through a risk pool, and others self-insure.

There is no central repository of insurance data regarding jail exposures and claims.

- **Prisons** - Based on interviews, the Authors understand that healthcare at state prisons is undertaken by a combination of state employees and, depending on the location of the prison, community providers who are under contract. Certain types of procedures, such as radiation therapy or major surgery, must be provided off-site. In situations in which community providers or facilities are used, the DOC uses a standard insurance and indemnification agreement. The DOC self-insures the prison and medical malpractice liability of its employees and insures and indemnifies third-party contractors through the State of Washington Self-Insurance Liability account. As mentioned earlier, the Self-Insurance Liability account is maintained by the Washington Office of Risk Management, an office of DES. DES has accumulated the relevant historical insurance-type data for its prison exposures and claims.

4. **Types of Medical Malpractice Claims that Typically Arise** –
   - **Jails –** Based on interviews, the Authors understand that many medical malpractice or jail liability claims arise due to overdoses, especially with opioid drugs such as fentanyl, immediately before or upon arrival. Immediately before arrest, an individual who possesses illegal drugs on their person may choose to ingest the drugs so that they cannot be charged with possession. They may then deny any drug use. In some instances, the overdose cannot be immediately detected, even by medical professionals, and the incarcerated individual may suffer many medical consequences, possibly including death. A plaintiff may contend that the jail and/or medical provider should have detected the overdose and failed in their responsibility to do so.

     Some jails have additional problems with fentanyl being provided to individuals already in jail. Estimates of the number of entrants with exposure to fentanyl are as high as 80% in some jails.

     Some jails begin the drug detoxification ("detox") process immediately upon intake. This process can lead to adverse medical conditions such as dehydration and related complications. Additionally, during the detox process, there is the potential for other types of health problems to be mistaken for drug withdrawal symptoms, particularly when there is another undiagnosed condition.

     Other types of medical/jail liability claims include:

- Suicides after an incarcerated individual has been given a very long sentence, and before they are transferred to a prison. Although this suit would likely be primarily considered an Eighth Amendment type claim, plaintiffs may also contend that mental health medication was not handled appropriately.
- Individuals with mental health issues who are arrested for a misdemeanor often deny guilt and may be detained for a longer period of time before trial. They may refuse medications and eventually cause harm to themselves or others.

- **Prisons** – Based on interviews, the Authors understand that medical malpractice/Eighth Amendment liability cases in prisons generally arise from longer coordination of care issues or incidents of alleged missed diagnosis. This is consistent with the longer stay of individuals in prisons. The types of claims that were disclosed included:
  - Failure to diagnose cancer
  - Delayed cancer care
  - Failure in diabetes management
  - Failure in sepsis management
  - Co-morbidity issues
  - Hybrid claims where an individual is injured through in-prison violence and then is dissatisfied with the subsequent medical care.

Further information about healthcare in prisons and jails, as well as current challenges in obtaining medical malpractice insurance overall and the impact this has on healthcare provision, can be found in Appendix A.

Insurer Concerns in Carceral Settings

The Authors discussed the possibility of offering medical malpractice insurance to CHPs providing services in carceral settings with several insurance professionals, including underwriters, brokers and third-party administrators experienced in carceral exposures. They listed a variety of concerns, including:

1. Entanglement of "pure" medical malpractice claims with Eighth Amendment/civil rights complaints

   Insurance professionals stated that, in their experience, many carceral medical malpractice claims are tied to civil rights claims. This has several potential impacts:
   - Time to close a claim – one professional stated that the average amount of time to close and investigate a carceral incident that proves to be without merit is over 200 days. The average time to close any claim is over 500 days, and the average time to close a suit is over 700 days. These average durations are substantially longer than for medical malpractice incidents, claims, and suits in other markets.
   - Attorneys' fees – the duration and complexity of investigation lead to heavier-than-usual attorneys' fees in carceral medical malpractice claims. As described in "Appendix C - Insurance Market Overview," attorneys' fees are a strong proportion of total cost in medical malpractice insurance generally, even more so in carceral claims. The 2024 Medical Malpractice Annual Report by the WA OIC shows the average defense costs for local or

state correctional facilities were approximately $240,000 per claim, in contrast to a statewide average of approximately $89,000.[17]

- Number of claims – Anyone who has been in jail or prison has the right to file a civil rights claim, and those may be associated with medical malpractice claims. They do not require a lawyer to file the claim, and the documentation may not be as comprehensive as it would be if an attorney had filed. All claims must be investigated.
- In some cases, the facility may not coordinate the defense of the claim proactively with the medical malpractice insurer.

2. Existing Medical Complications and Lack of Continuity of Care of Many Incarcerated Individuals

   Many incarcerated individuals may have long-term health issues that have been unaddressed. There may be mental health or substance abuse issues. The provider treating the individual in the carceral setting may not have sufficient background on all the other health issues and then may be named in a claim related to long-duration illnesses.

   Related to this, there may be insufficient or poor documentation of medical history or previous medical treatments, which puts the providers at further risk in a liability claim.

3. Location

   - The location itself may present security and other risks. Healthcare providers may not be able to provide the same standard of care if they feel threatened or at risk.
   - The facility may not have the same standardized equipment as would typically be found in a medical facility.
   - Care provided via telemedicine includes additional risks, such as HIPAA compliance, patient selection process, patient supervision, and potential miscommunication.

4. Reinsurance

   Several insurance professionals that were interviewed, including underwriters, third party claims administrators, and reinsurance brokers, expressed that reinsurers would not provide coverage for insurers for any medical professional liability insurance provided to practitioners in carceral settings.

   As described further below in "Appendix C – Insurance Market Overview", the vast majority of Property & Casualty ("P&C") insurers rely on reinsurance.

5. Insurance company financial ratings

   The underwriting of carceral setting liability could impact an insurer's financial rating by rating agencies such as AM Best, unless it has a very large amount of capital and surplus to offset the risk. Insurers rely heavily on ratings from agencies that assess the financial strength and resilience of the company. A strong rating is often a precondition for writing business.

[17] 2024 Medical Malpractice Annual Report, Washington Office of the Insurance Commissioner, October 2024.

In summary, private insurers are reluctant to provide medical malpractice insurance to most healthcare providers in carceral settings, not only CHPs. As explained further in Appendix A – Additional Information on Washington Jail Liability, many large third-party healthcare providers in jails are effectively self-insuring; other providers cannot present the liability insurance frequently mandated by the jail healthcare request for proposals ("RFPs"). In contrast, state prisons frequently employ their own healthcare providers, and state prisons and their employees are covered as part of a self-insurance pool through DES.

Additional medical malpractice considerations that may impact private insurers' decisions are discussed in Appendix C – Insurance Market Overview.

Actuarial Analysis

In the course of their work, the Authors learned that a repository of sufficient insurance-type exposure and claim data that would be necessary to make a credible actuarial projection for this report was unavailable for review.

In their proposal for this work, the Authors noted that if credible data was unavailable, an actuarial analysis would not be able to be performed.

A number of metrics about overall prison and jail data are presented in Appendix B – Claims Metrics – Prisons vs Jails, based on a small amount of data provided by DES and one risk pool, and based on a summary of a small number of data points in the WA OIC 2024 Medical Malpractice Annual Report. However, the Authors note the following caveats:

1. The datasets were not substantial enough to be credible.
2. Only claim data was provided; exposure data was not provided.
3. The information is based on closed claims only.
4. The DES and risk pool data reflect prison and jail liability, which could include (or could be restricted to) Eighth Amendment liability. It does not completely align with the medical malpractice liability in the scope of this study.
5. This (non-credible) data relates to all types of medical jail and prison liability claims. It does not relate to the subset of claims related to transitional care, and there was no way, based on the nature of the data, to decide definitively if a particular claim was related to transitional care or not. Because this transitional care initiative is fairly new, not only in Washington but nationally, there was no benchmark ratio to apply to any overall information to project a liability for the liabilities within this scope.

One policy option listed below includes gathering enhanced data for future studies. Although some confidential data is gathered for the WA OIC Medical Malpractice Annual Report, the information in its current form would not be sufficient for the scope of this project, as will be described further in the policy option section below, even if it were released to the Authors.

Federal Tort Claims Act ("FTCA")

Prior to any discussion of policy options, a presentation of the interaction between FTCA and Federally Qualified Health Centers ("FQHCs") is necessary.

FQHCs are federally funded nonprofit health centers or clinics that provide services to underserved populations. FQHCs receive Medicaid reimbursement for eligible patients, other federal funding for non-eligible patients, and malpractice coverage under the Federal Tort Claims Act ("FTCA"). Under the FTCA, someone alleging property damage or injury may seek compensation from the United States for actions committed by federal employees or others operating under authority of the federal government ("covered individuals.") Covered individuals have protection under the FTCA only for covered activities. For FQHCs, the covered activities are those approved within each covered individual's scope of employment and within the scope of the approved Federal Section 330 grant project of the health center.[18] FQHCs scopes of project generally do not currently include prisons and jails as approved locations.

In April 2024, the U.S. Department of Health and Human Services Health Resources and Services Administration issued a draft Policy Information Notice ("HRSA PIN") proposing program policy guidance for FQHCs to clarify when they may provide health services to incarcerated individuals expected to be released within 90 days.[19] The HRSA PIN identifies a set of services that a health center may provide and the conditions under which the services may be provided. The HRSA PIN confirms that a health center's scope of project determines eligibility for FTCA coverage. To the extent that changes outlined in the HRSA PIN for services to incarcerated individuals in prisons and jails are added to the FQHC's scope of project, FTCA coverage would apply assuming other FTCA criteria were met.

Notably, the provisions in the HRSA PIN would not allow transitions provided outside the 90-day window to be part of a FQHC's scope of project, and an FQHC would not be able to be the primary healthcare provider in the jail or prison. Also, the health center may not assume the jail or prison's obligation to provide health care. To date, the HRSA PIN changes have not been implemented. However, approval of the HRSA PIN provisions should allow for FQHC's to receive FTCA coverage when operating under MTP 2.0s Reentry Initiative.

Note that FTCA coverage may not be sufficient to meet the insurance requirements of some counties or municipalities, as not all claims that a plaintiff might assert are federal torts. Counties or municipalities may anticipate a situation in which a case is dismissed under the FTCA, but the plaintiff still sues the county or municipality for the actions of the CHP, alleging that the county or municipality did not abide by its Eighth Amendment duties when it engaged the CHP, or in its oversight of the CHP.

During interviews, the Authors learned that one CHP does intermittent work in its mobile unit which it brings into a juvenile carceral setting. The unit is currently within the approved "scope of project" and thus services within the unit are covered by FTCA. Notwithstanding this coverage, the relevant county still requires the CHP to provide evidence of additional insurance coverage, which the CHP was able to obtain in a

[18] HRSA Federal Tort Claims Act Health Center Policy Manual

[19] HRSA is a U.S. federal agency that provides federal award funding to health centers under section 220 of the Public Health Service (PHS) Act 42 U.S.C. § 254b.

"wraparound" provision to its insurance policy. Based on interviews with industry personnel, although certain insurers currently offer this liability coverage in Washington State, it is only available based on a very small number of carceral visits per year. The insurer would not offer this coverage were a CHP to be engaged on a regular basis to provide JI-R individuals with transitional care.

Policy Options

The first policy option listed below, which suggests the collection of more detailed data related to medical malpractice exposures in carceral settings, may be a precursor to the successful implementation of other options. This data collection is likely necessary to conduct the robust actuarial analysis that other options may be dependent upon.

Policy Option #1: Support the future development of liability insurance mechanisms for CHPs providing transitional services in carceral settings by **supplementing future data that is collected for the WA OIC confidential Annual Medical Liability Study**. (Note that this option could assist in any future carceral medical liability studies, including ones broader than this scope provides).

Rationale:

As noted elsewhere in this report, the insurance mechanisms related to insurance and self-insurance for jail medical liability are disparate. There is no central repository of insurance type data, including exposures and other key claim information. Actuarial projections cannot be performed without key data elements.

In 2006, the Washington State Legislature mandated in RCW 48.140.020:

For claims closed after January 1, 2008:

(a) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report each medical malpractice closed claim to the commissioner.

(b) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

The OIC uses this data to create a public annual Medical Malpractice report. The underlying collected data is confidential.

The 2024 Annual Medical Malpractice Report ("2024 Report") notes that attorneys' compliance with section (b) of the law stated above has been low, and that the OIC does not have enforcement mechanisms to improve compliance. [20]

During the Authors' review of the 2024 Report, it was noted that one summarized set of information was provided for "local or state correctional facility."

The Authors consulted with personnel at the OIC and learned more about the claim-specific information that is required in the data reporting. Based on that discussion, the Authors determined that the currently available data would not be sufficient to project costs related to the scope of this study.

The Legislature may wish to consider enhancing the required reporting so that meaningful future studies could be performed. The development of the modified data requirements should be performed in close coordination with DES and risk pools that self-insure this liability as well as insurers and experts in carceral

[20] 2024 Medical Malpractice Annual Report, Washington Office of the Insurance Commissioner, October 2024.

healthcare. However, the Authors would anticipate that *minimum* additional data that would be required would include:

Exposures:

- Annual submission of exposure data by each insurer or self-insurer of jails or prisons.
- Annual reporting on relevant policy deductibles and limits
- Annual report of services provided by facility and specialty
- If premium is charged, annual premium reporting.
- Identification of facility

Losses:

- In the event that an insurer or self-insurer has no closed claims to report in a given year, they must submit an empty loss report to instill confidence that no submission has been overlooked.
- Identification of facility for each claim reported.
- Identification of specialties/medical services involved/named on the claim (perhaps a drop-down list could be developed in consultation with the relevant parties)
- The developers of the revised reporting requirements would need to determine a method of reporting for self-insureds such that the claims reported represent the best estimate of only the medical malpractice portion of the claim, not any civil liability/Eighth Amendment claim amount.

Challenges:

1. The constitutional requirement to provide healthcare in a carceral setting (per the Eighth Amendment) and medical malpractice liability issues are intertwined in carceral settings because plaintiffs often sue under both legal theories simultaneously for the same underlying incident. This makes the data difficult to analyze, but imperfect data is better than having no data.
2. The data would remain confidential for use by the WA OIC and/or the Legislature. For this reason, this policy option, as it currently stands, would not on its own enhance availability or comfort in the private market to provide this insurance; it would only enable the WA OIC and/or the Legislature to perform or engage an actuarial study in the future. Should the goal of this repository be to encourage private market involvement in these exposures, the OIC may wish to enhance its annual medical malpractice report to include more specific reporting regarding carceral setting claims that does not undermine the confidentiality of the data.
3. Some discussion with interested parties may be necessary about the preferred parties to report the data in order to accumulate the most comprehensive data set:
    a. Insurers and self-insurance mechanisms (such as pools) may be the best equipped to provide insurance-type data; however, the OIC's authority over risk retention groups (RRGs) and non-admitted carriers is limited (see Appendix D – Insurance Regulation Overview). It may be difficult for the OIC to ensure compliance from these entities.
    b. Carceral settings that are invested in this project may be motivated to provide information and the Legislature can require the provision of this information; however, as non-insurance-entities, it may be difficult for them to provide the insurance-type information requested.
    c. In the event that information is gathered from multiple parties, the repository will need to include sufficient data to identify records from multiple parties on the same claim (for instance, a third-party medical vendor, municipality, insurance company, etc).

4. Note that this policy-option would only impact reporting of claims in the future. Data may need to be accumulated for several years before it could create a foundation for actuarial projections.

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Policy Option #2: Increase availability of insurance by creating **a new risk pool or other insurance mechanism that provides medical liability insurance for transitional services and then reinsures to the Lloyd's market**. The state could subsidize the cost of insurance if the risk pool charges less than actuarially justified premiums for the coverage. For this initiative, a program manager could design and price the program in partnership with Lloyd's. Note that Lloyd's of London is a group of insurance syndicates that reinsure challenging and/or unusual exposures. [21]

Rationale: Establishing a risk pool that specializes in this market will resolve the insurance availability problem. Designing the program in partnership with a program manager that has sufficient data and underwriting experience in carceral settings to price the risk, and strong relationships with the Lloyd's market, will accelerate the implementation of this solution. (As noted elsewhere in this report, credible public data is not currently available regarding this exposure; however, program managers who have historically placed insurance business for large third-parties and/or for states or municipalities may have access to such data, in combination with Lloyd's). Reinsuring losses above a certain claim value will reduce the volatility of the risk pool.

The risk pool could alternatively insure the entirety of the risk and forego reinsurance to the Lloyd's market. This would increase volatility in the risk pool and would also eliminate access to the expertise in the Lloyd's market.

Note that industry professionals found it unlikely that Lloyd's would be willing to reinsure limits greater than $1 million per claim/$3 million annual aggregate, which are the most typical limits in the medical malpractice industry.

Risks and Strategies to Mitigate Them:

Risks	Potential Mitigants
1. The risk pool will not have sufficient data to accurately price the risk	Work with a program manager that specializes in medical malpractice insurance in carceral settings to design the overall program. The program manager, perhaps in combination with Lloyd's may have sufficient data on medical liability claims in carceral settings to price the risk.
2. Reinsurers may not want to participate	Recruit a management team or program manager that has strong relationships with specialty reinsurers, including the Lloyd's market, that have experience in this sector.
3. The risk pool may not manage claims effectively or efficiently	Recruit an experienced claim management team or outsource claim management to a TPA, [22] with oversight from the risk pool.

[21] See https://www.lloyds.com/

[22] A third-party administrator ("TPA") is a company that administers claims for other entities.

Limitations:

1. Jails, counties, or municipalities may require the CHPs to provide evidence of insurance coverage with a limit much higher than $1 million per claim. The Authors' discussions with market participants and review of carceral healthcare Requests for Proposal ("RFPs") indicate that some counties require insurance coverage limits of $5 million per claim/$10 million aggregate.

   Because of this consideration, additional policy options may need to be undertaken such that counties and municipalities become comfortable with the risk and may lower the required limits. These are described further below and may include:

   - Changing the standard of negligence for CHPs providing transitional services in carceral settings
   - Creating a data repository to track liability claims in carceral settings

   Alternatively, the risk pool could choose to insure CHPs at the required county or municipality limits, over and above the layer insured by Lloyd's. This would create greater volatility and risk for the risk pool.

2. Lloyd's may have underwriting criteria regarding the CHPs it will accept, as well as criteria regarding the carceral facilities or services provided. In this case, the coverage may not be open to all CHPs nor may it provide the exact type of coverage anticipated.

   For instance, as described further above, a subset of CHPs are federally qualified healthcare centers ("FQHCs"). Should the HRSA PIN become an established rule, Lloyd's (or potentially the risk pools) could theoretically limit their coverage to "gap" or "wraparound" coverage for FQHCs which have received approval to add transitional services to their scope of project, thus reducing the potential liability.

Dependencies:

There are many details beyond the scope of this review which would need to be studied before this policy option could be implemented. This includes the terms and costs of coverage provided by the risk pool and the reinsurer(s), and any coverage eligibility requirements. If the Legislature wishes to explore this recommendation further, the Authors recommend further study of these issues.

The state will need to provide the initial capitalization for the risk pool. The amount of capital needed would depend on the expected claims and operating costs of the risk pool, the insurance coverage provided, the expected number of participants in the pool, and the terms of the reinsurance program.

In addition, if the premium rates charged by the risk pool are lower than necessary to pay claims and operating expenses and sustain its capital, then the state will need to provide the risk pool with a source of ongoing funds to cover its operating losses.

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Policy Option #3: Establish a **joint underwriting association ("JUA")** or other residual market mechanism to provide medical liability insurance for CHPs providing transitional services in carceral settings.

A JUA is a nonprofit risk pooling association to provide certain insurance coverage, potentially to certain specified groups, when there are availability issues with that coverage.[23] Other residual market mechanisms are also available.

In a typical JUA or other residual market mechanism, the insureds are charged premiums and issued policies by the JUA; however, those premiums may not be actuarially sound because of affordability considerations. Voluntary admitted insurance companies and RRGs are typically required to fund a portion of the shortfall through assessments based on market share; the government may fund any remaining shortfall.[24] Additionally, at least one JUA (the South Carolina JUA, which is part of the South Carolina Medical Malpractice Association), requires producers and brokers to collect a policy surcharge for medical malpractice policies written on a nonadmitted basis; these surcharges are remitted to the JUA.[25]

It may be possible for a potential JUA to reinsure a portion of its risk with the Lloyd's market, similar to what is described under Policy Option #2. In this scenario, the risk of assessments due to excessive losses would be reduced. However, the cost of reinsurance would have to be passed on to insureds or funded through assessments or by the government.

Precedent:
The Washington State Midwifery and Birthing Center Joint Underwriting Association ("Midwifery JUA") was established in 1994.[26, 27] As noted in RCW 48.87.010, the Midwifery JUA was created because, "midwives practicing outside hospital settings are unable to obtain medical malpractice coverage at any price in the state at this time." That historical situation for midwives seems somewhat analogous to the current situations of CHPs who seek to provide transitional services in carceral settings.

RCW 48.87.040 notes that "the association shall be comprised of all insurers possessing a certificate of authority to write and engaged in medical malpractice insurance within this state and general casualty companies. Every insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact business in this state." As such, the Authors understand that assessments made by the Midwifery JUA, if any, would be based on the market share of all authorized medical malpractice and general casualty companies.

The inclusion of general casualty companies as members is an important consideration in potentially developing a JUA for CHPs providing transitional services in carceral settings. If the members were limited to only medical malpractice admitted insurance companies and RRGs, one domestic Washington insurance company would bear more than 50% of any assessment (see "Medical Malpractice Market – Washington State" section of Appendix C), which could discourage its appetite to provide voluntary medical malpractice

[23] https://www.irmi.com/term/insurance-definitions/joint-underwriting-association
[24] "A Survey of Residual Market Plan Assessment and Recoupment Mechanisms", Milliman, Nov 2023.
[25] See https://law.justia.com/codes/south-carolina/title-38/chapter-79/section-38-79-220/ paragraph (4).
[26] https://www.washingtonjua.com/About.htm
[27] https://app.leg.wa.gov/RCW/default.aspx?cite=48.87

insurance in Washington. Should this occur, the overall medical malpractice market in Washington could be severely disrupted, causing further-ranging availability concerns.

This policy consideration is only put forth regarding the limited scope discussed in this report, CHPs providing transitional services in carceral settings. The Authors do **not** currently suggest a JUA to provide coverage for medical malpractice insurance generally in carceral settings. It is possible that the initiation of such a JUA may cause substantial exit from the Washington voluntary medical malpractice and casualty insurance market.

Risks:
It is reasonable to assume that the potential liability for the very limited scope of transitional services is smaller than overall medical malpractice exposure in carceral settings. However, in the absence of historical data, this assumption cannot be validated. It is possible that CHPs providing transitional services could be named in a claim with a large ultimate payment, and this claim could either arise for the CHPs direct provision of services or from a claim naming multiple practitioners (for instance, in a case of missed diagnosis). If the members of the voluntary market are required to pay substantial assessments related to this potential JUA, it may impact their appetite to do business in Washington.

It is possible that premiums that are adequate to cover the insured risk will be considered unaffordable. In this case, this policy option would make coverage available but not necessarily affordable without funding through assessments or another source such as government subsidization.

If the number of CHPs providing transitional services in carceral settings that purchase insurance from the JUA is small, there will be increased volatility in underwriting results because a small group is inherently less stable than a large group, especially if there is a risk of large claim values.

Dependencies:
The JUA would need to be created. Rates, underwriting guidelines, and capital and surplus would need to be established.

Based on the lack of adequate data related to transitional services, the Authors are unable to provide an estimate of funding for this option and/or an estimate of the rates that should be charged. A future study would need to be engaged. As noted above, Policy Option #1 may need to be implemented for some time before an actuary might be able to conduct a rate study that produces credible results with any certainty. The Legislature may choose to create a JUA more quickly, in which case the risk of inadequate or excessive premiums is greater. (Note that the distinction of transitional services provided by a specific set of providers, as defined by MTP 2.0, appears to be a relatively new phenomenon both in Washington and nationally. This may lengthen the time necessary to accumulate adequate data for an actuarial rate study).

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Policy Option #4: Increase availability of insurance by **extending the state tort claims act ("STCA") to CHPs** that meet certain criteria established by the state,[28] including certification by a state agency. The CHPs would then be deemed employees of the state only when providing transitional services.

Rationale: As described further in the "Insurer Concerns in Carceral Settings" section of this report, commercial insurers are reluctant to provide medical malpractice coverage in carceral settings.

STCA provides that actions against state officers, employees, volunteers and foster parents must be defended and indemnified by the state of Washington. Extending the act to cover certified CHPs in their provision of transitional services in carceral settings would offer the same level of defense and indemnification to CHPs that state government employees currently receive.

There is a precedent for such an extension in Washington. In 1989, the Legislature extended the STCA to cover foster parents. [29] The Legislature wrote: "The legislature finds and declares that foster parents are a valuable resource providing an important service to the citizens of Washington. The legislature further recognizes that the current insurance crisis has adversely affected some foster family homes in several ways: (1) In some locales, foster parents are unable to obtain liability insurance coverage over and above homeowner's or tenant's coverage for actions filed against them by the foster child or the child's parents or legal guardian. In addition, the monthly payment made to foster family homes is not sufficient to cover the cost of obtaining this extended coverage and there is no mechanism in place by which foster parents can recapture this cost; (2) foster parents' personal resources are at risk. Therefore, the legislature is providing relief to address these problems."

Limitations:
This policy option alone would not reduce the ultimate cost of claims. Rather, it would shift the burden of claim payments from the CHPs to the state. RCW 4.92.090 states, "the state of Washington… shall be liable for damages arising out of its tortious conduct to the same extent as if it were a private person or corporation."

Claims arising under the State Tort Claims Act are paid from a liability account that is financed through annual premiums assessed by DES to state agencies based on sound actuarial principles. Under this existing framework, the Legislature would need to assign medical liability claims for transitional services to a state agency – for example, to the Department of Social and Human Services ("DSHS"), HCA, or the Department of Corrections ("DOC") – and increase that agency's budget in order to pay the annual premiums. Alternatively, or in addition, the Legislature could create a legal mechanism by which that state agency could recoup all or a portion of the cost from counties or municipalities served by the CHPs.

It would be important to clearly define the state's obligation to CHPs is limited to defense and payment of liability claims. The language would have to clarify that CHPs are not deemed employees for the sake of state benefits, workers' compensation coverage, and other items.

Considerations by Setting:

[28] See RCW 4.92.060 (https://app.leg.wa.gov/RCW/default.aspx?cite=4.92.060)
[29] See https://leg.wa.gov/CodeReviser/documents/sessionlaw/1989c403.pdf?cite=1989%20c%20403%20s%201

1. **State Prisons** – This policy option would be very similar to the existing coverage by the STCA of many DOC employees and would allow CHPs to practice in prisons. There is already an arrangement between the DOC and DES, wherein DES assesses premiums to the DOC based on biannual estimates of medical malpractice and jail liability costs borne by the state.

2. **County and City Jails** – This policy option would create a new relationship between the state and the counties and cities regarding this exposure. This would enable CHPs to provide transitional services in the county and city jails. However, it comes with several challenges:

    a. It would be difficult for the DES-engaged actuaries to estimate the initial premiums because jail liability is quite different from state prison liability and the state does not currently have complete statewide data on medical malpractice claims in the jail setting. Additionally, as noted earlier, it would be difficult to project liabilities for transitional services based on the data available.

    b. The state and counties and cities would need to determine whether the state and its attorneys are responsible for investigation and defense of the claim, or whether the county or city should continue to engage counsel to defend the claim. If the state is responsible under STCA, it may prefer to use its own attorneys and then potentially charge back some or all of that expense to the counties or cities.

    c. Counties and cities may not have sufficient budgets to pay the entire premium cost, assuming the state decides to invoice them. In this case, the state may choose to subsidize a portion of the cost, but it would need to allocate sufficient funding to do so.

    d. If the state denies STCA treatment for a particular claim, the liability for that claim would stay with the CHP or the county or city jail, who would need insurance for this possibility.

3. **Tribal Jails** – It is unclear whether the STCA can be applied to transitional services providers in tribal jails due to the tribes' sovereign status. This question is beyond the scope of the Authors' expertise and would need to be separately investigated by the Legislature. If STCA can be applied in this setting, the considerations that apply to county and city jails would also apply to tribal jails.

    In addition, some municipalities that do not have a jail have contracts that allow them to transport individuals to tribal jails for incarceration in exchange for a fee. The Legislature will need to determine whether transitional services for non-tribal individuals held in tribal jails can be covered by the STCA.

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Policy Option #5: Reduce cost by **implementing different negligence standards for transitional services provided by CHPs** in some circumstances, so that they can only be held liable if they display gross negligence or bad faith.

Rationale: This recommendation envisions a situation in which certain qualified CHPs can be sued only for

gross negligence or bad faith, as long as they have (i) become certified by the state and (ii) demonstrate compliance with state-determined protocols for the provision of transitional services. Because "gross negligence" is a higher bar to prove in court, this policy option would discourage the filing of spurious claims, reduce claim frequency, reduce overall losses, and reduce legal costs borne by CHPs and their insurers.

Dependency: Developing statewide standards for the provision of healthcare in carceral settings is a pre-requisite to the state certification process.

Limitations: This policy option would not reduce the risk of large verdicts in cases that involve grossly negligent acts and omissions or wanton misconduct. Additionally, this option does not immediately provide insurance for CHPs in carceral settings; it merely lays the groundwork for the risk to be perceived as potentially more insurable by the private insurance market. There is no guarantee that the private market will perceive it as such, even if such legislation is enacted.

Risks: The U.S. Supreme Court has interpreted the Eighth Amendment of the U.S. Constitution, which prohibits cruel and unusual punishment, to include the right to adequate medical care in carceral settings. Implementing a different negligence standard for transitional services by CHPs does not change this right and may simply shift the medical liability risk from the CHP to the jail or prison. Additionally, a different negligence standard may create a situation in which an injured party cannot recoup compensation.

Precedent: In 1982, the U.S. Supreme Court held that federal government officials are entitled to qualified immunity, which provides immunity from being sued rather than a mere defense to liability. In essence, federal government officials could no longer be sued unless they violated "clearly established" rights.[30] Since then, this judicial doctrine has been applied by many states to shield public service employees, such as police, paramedics and fire fighters, from lawsuits.

The Washington legislature has enacted different standards of negligence historically in specific cases. For example:

- RCW 36.28A.080 – enacted in 2023 – states that, "units of local government and their employees. . . are immune from civil liability for damages arising out of the creation and use of the statewide first responder building mapping information system, unless it is shown that an employee acted with gross negligence or bad faith."

- Chapter 370, Laws of 2024 amended RCW 71.24.907 to provide liability protections to responders to behavioral health crises in the course of their employment and delivered under the clinical supervision of a mental health professional or approved medical program director, such that the responders can only be held liable for their actions or omissions in the event of gross negligence or wanton or willful misconduct.[31]

[30] Source: https://supreme.justia.com/cases/federal/us/457/800/

[31] https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/2088.SL.pdf#page=1

- RCW 76.04.183 creates a prescribed burn manager program for those who practice prescribed burning in the state. For certified burn managers, "no civil or criminal liability may be imposed by any court. . . for any direct or proximate adverse impacts resulting from a prescribed fire conducted under the provisions of this chapter except upon proof of gross negligence or wanton or willful misconduct."[32]

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Policy Option #6: Combine policy options to integrate benefits of several options.

As an example, the Legislature may consider the combination of the following options:

1. Initiate Policy Option #1 (enhanced data collection) to begin gathering sufficient data about medical malpractice claims in carceral settings as they relate to transitional services.
2. An agency of the state creates certification requirements for CHP best practices in providing transitional care in carceral settings (part of Policy Option #4). These requirements would be developed by a team of stakeholders with expertise in correctional settings, medicine, and law. The goal of these certification requirements would be to improve healthcare and ultimately reduce claims.
3. If desired, different negligence standards could be put in place for certified CHPs (Policy Option #5), further reducing potential liability.
4. Some funding/insurance mechanism could be made available for certified CHPs, which may include:
    a. A risk pool, JUA, or other residual market mechanism (Policy Options #2 or 3) OR
    b. STCA (Policy Option #4)

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Potential Sources of Funding

Several of the potential policy options described above will require funding to implement. While the Authors make no specific recommendations as to how any of the policy options should be funded, some considerations for the Legislature are identified.

While some of the money to implement these policy options could be funded through the insurance industry, such policy options would have to be carefully coordinated with the OIC to make sure all implications are understood. By way of example:

- If any funding is achieved via an increase in premium taxes, other states will impose a 'retaliatory premium tax' on Washington domestic[33] insurers that are doing business in their state.

[32] RCW 76.04.183: Prescribed burn manager certification program—Rule-making authority. (wa.gov)

[33] A U.S. insurer can be licensed to do business in many states but must be "domiciled" in one state, whose insurance regulator has primary regulatory oversight over the insurer. An insurer domiciled in Washington is also referred to as a Washington "domestic" insurer. An insurer domiciled in a different U.S. state is referred to by Washington as a "foreign" insurer. An insurer domiciled in a foreign country is referred to as an "alien" insurer.

- Existing premium taxes could instead be earmarked or reallocated to fund some portion of these policy options. However, it is important to note that without any increase in funding otherwise, this would necessarily require diverting funds away from any other current or planned uses.

- Money could be collected via special surcharges or fees on insurance companies. However, surcharges or fees will likely be passed on to policyholders through premium rate increases.

- Funding could be diverted from general funds or could be raised from other taxes or fees.

Appendix A –Additional Information on Washington Jail Liability

The body of this report is restricted to discussing the scope as presented by the Legislature. During their research and analysis, the Authors learned additional information about the medical malpractice environment in Washington carceral settings. To understand the Washington State medical malpractice availability issues for CHPs providing transitional services in carceral settings, there are key underlying issues which must be presented. al In the event that this research is useful to legislators in the context of broader policy discussions, it is presented in this Appendix:

Concerns Expressed by Risk Managers and Survey Respondents Regarding Jail Liability

As noted above, many healthcare providers in jails are required by the county or municipality to demonstrate that they have their own medical malpractice insurance. The Authors understand that this requirement has narrowed the pool of the respondents to Jail Healthcare RFPs.

Two different interviewees commented that five to ten years ago, they each had many respondents to their third-party jail healthcare RFPs, and recently they each only had one respondent. This was attributed to the increasing challenges these providers have experienced in obtaining medical malpractice insurance in carceral settings. Both interviewees expressed concern that it is difficult to choose the most qualified medical provider when only one provider will respond because of challenges in obtaining medical malpractice insurance.

Twelve of 20 respondents to the survey reported difficulty obtaining providers for medical care. Only one of these 12 stated that availability/affordability of medical malpractice insurance was not a contributing factor. One respondent stated:

> "Our previous provider had to go out of business due to the cost of insurance. When last we published an RFP for medical, we received zero bids. I had to contact our current medical provider and request a bid. The cost of liability insurance for medical in the jail greatly reduces the amount of providers willing to do it."

Another survey respondent stated, "Our providers have been dropped from coverage when taking jail contracts or pay significantly higher prices for a few hours a week than for their total private practice office."

One administrator of jail liability claims for a number of counties submitted publicly available articles about the potential bankruptcy of a key third-party healthcare provider, and stated that the jails she oversees will have no healthcare option if that provider goes bankrupt because of the very limited pool of respondents to RFPs.

Based on statements from a variety of interviewees, it appears that large third-party carceral healthcare providers effectively self-insure their risk by providing an insurance carrier sufficient collateral on a large

deductible policy such that the insurance carrier does not absorb any true risk. Alternatively, the insurance company may write the business and then cede that business to a captive insurance company owned by the healthcare provider. Carceral medical malpractice insurance is otherwise either unavailable or unaffordable for many potential third-party practitioners. Thus, the set of providers who can respond to carceral healthcare RFPs is very small.

The overall healthcare system in Washington State jails appears to be materially impacted by the challenges in obtaining affordable medical malpractice insurance.

In all instances, counties, cities, and tribes must be prepared to defend their own Eighth Amendment liability, in addition to any potentially uninsured/under-insured medical malpractice liability. Some counties or cities insure through a risk pool, and others self-insure. At least one risk pool no longer covers jail liability claims because of the substantial potential liability. Risk pool administrators are also worried that their excess insurance will at some point disallow jail claims. Some cities have closed their jails in part because of the large associated potential liabilities.

There has been recent large claim activity in jail liability. Some claims that have been recently brought, but have not yet concluded, include a $20 million wrongful death lawsuit related to a jail in Klickitat County[34] and a $25 million lawsuit related to a wrongful death at a jail in Seattle[35] among others.

Potential Policy Considerations Related to Jail Liability

As noted above, the state prison system has an established system for self-insuring its liabilities. In contrast, many interviewees representing county and municipal jails expressed material concern regarding the ongoing ability of these entities to a) cover any potential liabilities and to b) engage qualified healthcare professionals when medical malpractice insurance is unavailable to many of them in the carceral setting.

These interviewees submitted the following options for consideration by the Legislature:

1. Reduce cost by replacing joint and several liability for medical malpractice claims with proportional liability based on each party's relative culpability.

   Interviewees cited joint and several liability as a material risk to the provision of liability insurance in Washington carceral settings. Under RCW 4.22.070, joint and several liability would generally apply in a situation where an incarcerated individual claims negligent medical care. "Joint and several liability" means that each one of the liable parties is independently liable for the full extent of injuries stemming from the tort act. [36] It also means that if one defendant cannot pay its portion of the jury award, the other defendants may be required to do so. When plaintiffs sue for medical

[34] https://www.opb.org/article/2024/04/02/southwest-washington-county-jail-to-close-following-lawsuit-inmate-safety-concerns/
[35] https://www.seattletimes.com/seattle-news/family-of-man-who-died-in-seattle-jail-sues-county-for-millions/
[36] https://www.law.cornell.edu/wex/joint_and_several_liability

liability damages in a carceral setting, they typically sue all the parties who could possibly have any culpability – including the prison or jail and the healthcare provider.

Recent history shows that jury awards can be considerable in these cases. In one recent case in Spokane, Washington following the death of a jail inmate who died from unrelated causes while going through heroin withdrawal, the jury awarded $2.75 million of compensatory damages allocated 10% to the county and 90% to the medical provider, and ordered the medical provider to pay another $24 million in punitive damages. [37]

Because of joint and several liability, in a situation where a jail healthcare provider has inadequate insurance coverage, the local government may be forced to pay large claim amounts even when found only marginally responsible. In other words, if the medical provider had not been insured, the county could have paid 100% of the $2.75 million compensatory award, even though the jury determined that it was only 10% responsible.

(In the situation cited above, the medical provider had the insurance to pay the 90% of the compensatory damages, and the county was not responsible for the punitive damages.)

The financial concerns about joint and several liability extend both directions. Counties and cities are concerned about absorbing damages based on the negligence of the healthcare provider, and medical malpractice insurers have concerns that they will bear liability for civil liberty violations by the county or city.

2. Reduce cost by creating regional jails managed and funded by the state.

   Several interviewees familiar with rural jails indicated that small rural counties may not have the financial ability to provide the healthcare required and insure liability risks. The creation of large regional jails, run and funded by the state, for individuals convicted of misdemeanors or serving time of a year or less, could provide the expertise, central location, and critical mass needed to improve healthcare and healthcare standards and reduce damages. This would in turn lead to lower medical malpractice costs and potential greater insurance availability in the long run.

   In addition to the necessary funding for this initiative, there are logistical issues that would need to be addressed. A rural area may have only one or two police officers on duty at a time; asking one of those to leave their post to transport an arrestee to a regional jail is impractical. Individuals in custody may need to reside in the rural jail for a short time until shuttle transportation (which could perhaps be provided by the state) is available. Virtual meetings may need to be put in place for court arraignments; alternatively, the incarcerated individual may need to remain in the rural jail until arraignment, and later be transported to a regional jail.

3. Reduce cost by state subsidization of initiatives to mitigate medical risks to incarcerated individuals and improve medical services.

[37] https://www.spokesman.com/stories/2022/jul/20/jury-awards-27-million-to-the-estate-of-woman-who-/

Interviewees cited examples of actions to improve the overall healthcare experience in jails and reduce the likelihood and cost of medical malpractice claims. However, many of them require investments that jails may be unable to fund.

A number of options are presented below based on interviews with medical and carceral professionals, with the caveat that the Authors are not experts in these risk management approaches.

Potential Action	**Rationale**
Develop statewide **healthcare staffing ratio guidelines and provide increased funding to jails to meet those guidelines**.	The quality of health services may be limited if the ratio of healthcare professionals to incarcerated individuals is too low. By way of example, there are typically minimum staffing requirements in nursing homes to ensure safe and quality care. [38] That same operation in a jail setting may be more logistically challenging because of the nature of the population, and the need for corrections officers to guard the medical provider. (Note: Corrections officer ratios may need to consider this additional component as well). Many interviewees noted that the "daily bed rate" paid by the state to jails is insufficient for their expenses.
Subsidize the cost of **medical devices and related services** that monitor Individuals' health and other risk factors, to reduce the risk or serious injury or death.	Large claims frequently stem from accidental deaths of inmates, especially in jails. These claims are often the result of drug overdoses, sometimes coupled with chronic medical conditions. The risk is particularly high within several days after an inmate's admittance to a jail, sometimes due to the ingestion of opioids immediately prior to arrest or due to the hiding of drugs in body cavities. In the event of an overdose, rapid medical intervention is critical. However, jails may not have the staff necessary to constantly monitor newly admitted inmates. Several interviewees commented that body scanners and drug dogs have been especially helpful in determining whether drugs have been hidden in body cavities, strongly reducing incidents of in-jail overdoses. (These interventions cannot detect ingested drugs). Another interviewee mentioned a durable wristwatch-like device that continuously transmits the wearer's vital signs to a remotely monitored central repository that is monitored remotely. The remote monitor immediately alerts local staff in the event of adverse vitals so that they can intervene quickly. Note this may result in liability to the jail if the staff fails to monitor or react quickly.

[38] Department of Health and Human Services 42 CFR Parts 438, 442, and 483. Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Appendix B - Claim Metrics - Prisons vs Jails

Upon request, the Authors were provided two sources of information regarding medical liability claims related to prisons and jails:

1. The Authors were provided publicly available information regarding Washington State DOC payouts related to closed prison medical claims.
2. The Authors were provided closed claim jail liability information for a risk pool that insures a number of Washington counties.

In both instances, defense costs were provided as a separate field, subject to the limitation described below, and were included in the estimates.

In both instances, the data was limited in the following ways:

1. Many carceral claims are based on a combination of charges related to medical care and other charges. The data provided was a set of closed claims in which medical care was a key identified cause of loss. There may be other claims which were not included in which healthcare was a part of the charge. Conversely, for the claims in the dataset, the payout information related to the total claim – some portion of the payout may be related to other areas of liability.
2. The information provided relied upon what was ultimately paid by the state or county. For the counties especially, in which third-party contractors may have been held responsible for much of the claim, the data may not have included totality of the payout. (In other words, if the county paid for its Eighth Amendment liability and a third-party medical provider paid for medical malpractice liability, the provided claim listing would only capture the former).
3. Only closed claim information was provided; information on open claims was not provided.
4. Defense actions to arrive at a settlement (rather than a suit) were sometimes handled by the Washington Office of Risk Management for prisons or risk pool employees for counties. Other defense activities were performed by external attorneys. Only the cost of the external attorneys was included.
5. **The Authors also note that neither data set provided a large enough set of information, in terms of number of claims, to form a basis for actuarially credible projections.**

The Authors' review focused on claims with payouts greater than $1,000, to eliminate nuisance claims.

Information was obtained on the prison average daily population from the Department of Corrections website,[39] and jail average daily population from the WASPC website[40] for the counties under review. There were years in which not all jails reported their average daily population to WASPC. For this reason, jail population may be incomplete, and the metrics below regarding jail frequency and loss cost may be somewhat inflated.

With those caveats in mind, the Authors note:

- The **frequency** (claims per hundred populated beds over a year) of jail liability claims of 0.276 was approximately twelve times the frequency of prison liability claims of 0.022. (The Authors note

[39] https://www.doc.wa.gov/information/data/analytics.htm
[40] Washington Association of Sheriffs & Police Chiefs 2023 Annual Jail Statistics https://www.waspc.org/assets/2023%20Jail%20Statistics%20Website.xlsx

again that the 0.276 figure may be somewhat inflated based on incomplete information on average daily population in some jails).

- The **average severity** (average cost per claim) of prison claims of almost $1 million was approximately 3 times that of jail claims of approximately $325,000. This includes one large prison claim of approximately $10 million. When that one outlier claim is eliminated, the average severity of prison claims drops to approximately $540,000, or about 165% of the jail severity.
- The **loss cost** (average payment per populated bed per year) of jails, at almost $900, was four times as high as the loss cost of prisons, at approximately $215. (Again, jail loss cost may be somewhat inflated based on incomplete population metrics).

The Authors again emphasize that these metrics are not based on a large enough set of data to be actuarially credible and should not be used for projections; they are provided for informational purposes only.

Although the available data was not statistically credible and should not be used for projection purposes, it could preliminarily indicate that the frequency of claims in jails is higher than that in prisons and that the average medical liability cost per bed in jails is higher than that of prisons.

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Appendix C - Insurance Market Overview

Medical Malpractice Market – United States

The profitability of an insurance company is determined by its operating income, which reflects both underwriting income and investment income.

Underwriting income is equal to earned premiums[41] minus incurred losses[42] and loss adjustment[43] and other underwriting expenses[44]. In other words, it is a record of whether the premiums charged were adequate to cover the associated losses and expenses.

Three key ratios are associated with underwriting income:

- Loss and Loss Adjustment Expense (LAE) Ratio – this is the sum of incurred loss plus expenses associated with adjusting claims **divided by** earned premium
- Expense Ratio – this is other underwriting expenses **divided by** premium
- Combined Ratio – this ratio is the **sum** of the loss & LAE ratio **AND** the expense ratio

A combined ratio of 100% would be the breakeven point for underwriting profit or loss. At a combined ratio of 100%, underwriting losses and expenses are exactly equal to premium. The insurance company has charged premium exactly equal to the losses and expenses which it incurred.

Investment income reflects the gains that insurance companies realize from investing assets in securities that have sufficient liquidity to meet payment demands, and sufficient stability in the aggregate to be acceptable to regulators. Investment income is an important consideration for lines of business in which claims may take quite a while to be paid. In these lines, combined ratios over 100% may still result in positive income for an insurance company. (An insurance company, like any company, needs to make sufficient profit for its investors, shareholders, or mutual members to continue investing in it).

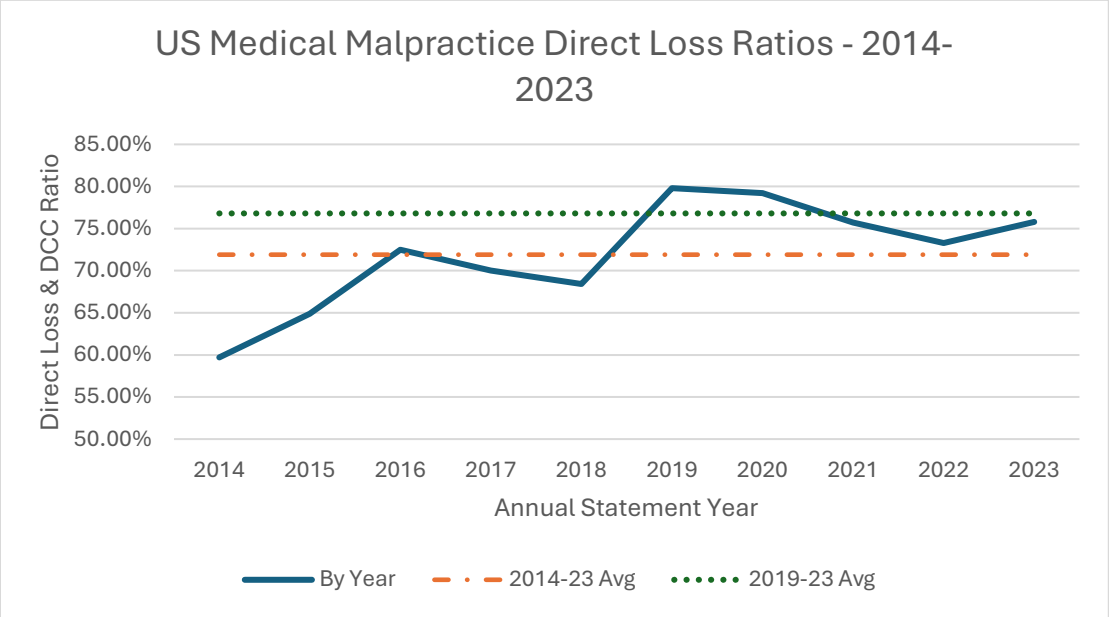
When surveying the performance of an insurance company or an insurance line of business over time, it is helpful to review loss and LAE ratios and/or combined ratios. Note that because of certain readily available state metrics from insurance companies' annual financial statements, loss and defense and cost containment (DCC) ratios may sometimes be used instead of loss and LAE ratios. DCC is a subset of LAE.

According to the October 2023 edition of the Medical Liability Monitor,[45] calendar year 2022 was the ninth consecutive year in which the medical malpractice insurance industry experienced underwriting losses.

[41] Premium is the amount of money charged for an insurance policy. Earned premium is the portion of the premium related to the portion of the policy that has elapsed during a certain time period.
[42] Incurred loss refers to the indemnity amounts paid for claims and changes in loss reserves during a certain time period.
[43] Loss adjustment expenses refer to the cost of investigating, defense of, and adjusting a loss.
[44] Other underwriting expenses refer to the other expenses (excluding loss adjustment expenses) necessary to issue and maintain policies and to run the insurance company.
[45] Medical Liability Monitor, October 2023, Annual Rate Survey Issue.

Investment returns offset the underwriting losses in order to produce an operating profit; however, medical malpractice return on equity is weaker than in many other industry lines of business.

The following graph shows aggregate US direct loss and DCC ratios for the medical malpractice line over time, as well as averages for the 2014 – 2023 and 2019 – 2023 periods.[46] "Direct" loss and DCC refers to the loss and DCC on policies covered by the insurance companies without regard to cessions to reinsurers.[47]



For context, in many lines of business and for many insurers, a breakeven loss and DCC ratio may be in the general area of 65%. Without regard to the specific breakeven loss and DCC ratios for medical malpractice insurance, these ratios are clearly higher in the 2019 – 2023 period than they were in the longer 2014 – 2023 period, indicating an upward trend.

Note that the 2020 – 2022 period is somewhat unusual because of the disruption caused in medical practices and in the court system by COVID-19. Many non-critical procedures were delayed in 2020 and early 2021, thereby also delaying potential claims. Additionally, many courts were not in session and then later backlogged because of mandatory shutdowns in 2020 extending into 2021. Thus, the filing and adjudication of medical malpractice claims and suits were delayed. Notwithstanding these considerations, the graph above indicates that loss ratios in the medical malpractice market have been generally increasing over time.

This national trend is largely attributed to both economic inflation and to changing trends in the way that society views damages. Economic inflation is when the cost of goods and services rise over time. Everything else being equal, courts and juries in 2020 will likely award the same claim a higher dollar amount than they

[46] Based on Annual Statement "Page 14" data gathered from S&P Global

[47] A "direct writer" refers to the insurance company that accepts the transfer of risk directly from a consumer, business, or other entity that is seeking coverage for a liability. This direct writer may then "cede" (or transfer) a portion of its premiums and losses to a reinsurer. A reinsurer acts as an insurer to the insurance company. A direct loss and DCC ratio is a metric to indicate the total ratio of loss and DCC to premium related to an insurance policy or group of insurance policies, without regard to how much was ceded to reinsurers.

would have in 2010, because a dollar is worth less in 2020 than it was worth in 2010. Loss ratios may increase if the insurers' estimates of future economic inflation are inadequate. Additionally, jury verdicts and settlements appear to have risen faster than economic inflation alone would explain; this may be due to trends in perception about how much injured parties should be compensated for particular injuries.

Given the increasing possibility of large verdicts, reinsurance is a necessity for many medical malpractice insurers. Recent increasing reinsurance rates will be discussed below.

Medical Malpractice Market – Washington State

The Authors used several resources to review the medical malpractice market in Washington State specifically:

The 2024 Medical Malpractice Annual Report (Claims closed Jan 2019 through Dec 2023) of the WA OIC, dated October 2024[48] provided valuable information about the state of the Washington medical malpractice market. Readers are directed to the OIC report in its entirety for further information. However, the Authors present several particularly relevant points here:

- In 2023, excess and surplus lines ("E&S") insurers and risk retention groups wrote approximately 55% of the medical malpractice insurance in Washington.
    - Authors' Note: These entities are not regulated by the WA OIC, and they typically write riskier business. Per RCW 48.15.040, to acquire a surplus lines policy, "the insurance must not be procurable, after diligent effort has been made to do so from among a majority of the insurers authorized to transact that kind of insurance in this state." Risk retention groups also typically focus on high-risk business. The heavy presence of surplus lines insurers and risk retention groups may indicate that Washington is considered a higher-risk venue for medical malpractice.
- Physicians Insurance, A Mutual Company, which is domiciled locally and is the admitted insurer writing the most medical malpractice coverage in Washington State, wrote approximately 33% of the total insurance business in 2023 and approximately 56% of the admitted and RRG business. Physicians Insurance has been a key participant in Washington state's medical professional liability market for decades. The rates and forms of admitted insurers are regulated by the OIC.
- Both average and median indemnity payments on closed claims have increased over the 2019 – 2023 period. The average indemnity payment rose from approximately $620,000 to approximately $900,500 and the median payment rose from $125,000 to $262,500 in that period. (Note that average indemnity payments show a dip in closure years 2020 and 2021; this may be related to COVID-19 and the difficulty in closing more challenging cases in those years because of court delays).
- Average and median defense costs per claim also increased in the 2019 – 2023 period. The average defense cost increased from approximately $75,000 to approximately $90,000 and the median defense cost increased from approximately $23,000 to approximately $35,000.

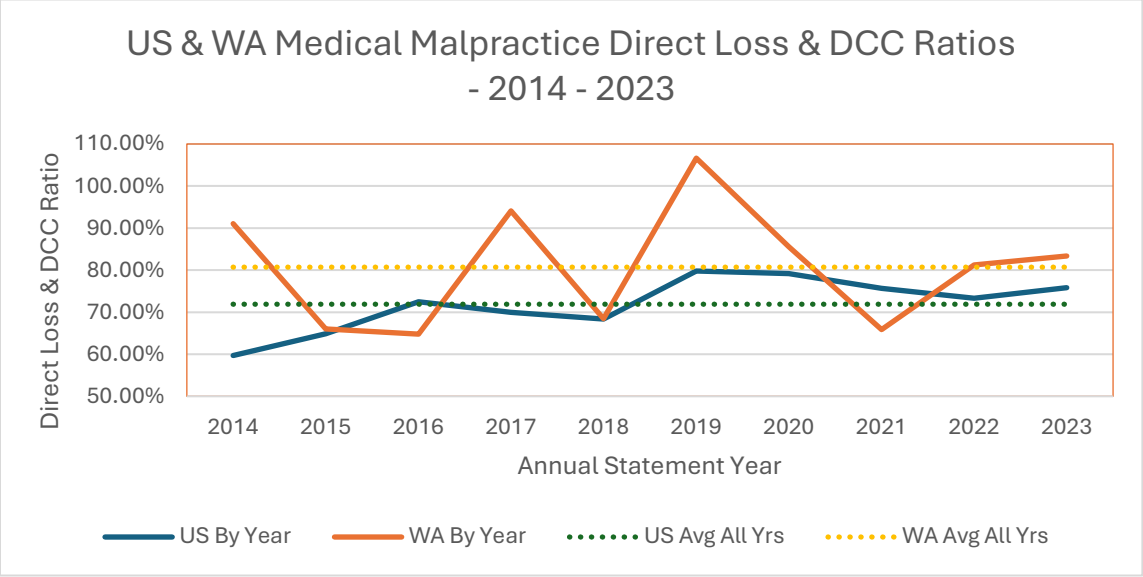
[48] 2024 Medical Malpractice Annual Report, Washington Office of the Insurance Commissioner, October 2024.

- For medical malpractice cases against local or state correctional facilities, the average paid indemnity over the five-year period of approximately $300,000 is lower than the statewide average of approximately $707,000. However, the average paid defense cost of approximately $240,000 is much higher than the statewide average of approximately $90,000.
- Both average paid indemnity and average defense costs per claim in the 2019-2023 period are highest in King and Pierce counties.
- Between 2014 and 2023, the report calculates an annual trend of:
    - 14.3% for average paid indemnity
    - 8.2% for average limited paid indemnity, in which individual claims were restricted to $1 million
    - 5.9% for average defense costs

  Note that the OIC report contains several caveats about the use of these trends based on the nature of the data reviewed.

In summary, as it relates to the Authors' scope, the OIC report indicates that much of the medical malpractice insurance written in Washington State is written by E&S insurers or by RRGs. Physicians Insurance is the largest admitted insurer in the Washington market. Insurers have experienced increased claims severity in recent years in both indemnity and defense costs.

The Authors reviewed **publicly available Annual Statement data**[49] to compare medical malpractice loss and DCC ratios over time in Washington State to countrywide loss ratios. A graph of this comparison is shown below:



The Washington State loss and DCC ratio shows greater volatility over time than the US ratio; this is to be expected when comparing a smaller dataset with a larger one. However, the average all-years Washington loss and DCC ratio is significantly higher than the all-years US ratio. This may indicate that the medical malpractice environment is more challenging than average.

[49] Based on Annual Statement "Page 14" data gathered from S&P Global

Finally, the Authors reviewed information from the **National Practitioners Data Bank** ("NPDB"), a medical malpractice data resource administered by HRSA. [50] This data bank contains records of closed medical malpractice claims by state and can be queried in a variety of ways.

The Authors performed two queries by state to rank Washington average medical malpractice severity, compared with other states. Both queries were performed in September 2024 and related to accident years 2018 – 2021:

- Our first query related to average indemnity severity for claims with a single payment. The Authors calculated the weighted average severity by state over the 2018 – 2021 accident year period. Washington, with a non-inflation-adjusted severity of approximately $480,000, ranked 16th in the nation. (In this scale, the state ranking 1 would have the highest average severity). The overall national average severity was approximately $343,000.

- Our second query related to average indemnity severity for claims with a single payment, where the case involved *death or major permanent disability*. Washington, with a non-inflation-adjusted severity of approximately $698,000, ranked 17th in the nation. The overall national average severity was approximately $516,000.

Based on NPDB data, Washington severity may be somewhat higher than average severity for medical malpractice claims.

Key Concepts in Insurance Availability

The price of insurance is based on the insurers' expected cost of the exposure. Under Washington State law, premiums charged for insurance are required to "not be excessive, inadequate or unfairly discriminatory." RCW 48.19.020.

Insurance pricing and availability are based both on historical claim sets and on perception and estimation of future trends, as described further in the "Insurance Ratemaking Principles" section.

The long-term methods for addressing insurance availability issues are to:

a. modify the exposure so that the expected losses are reduced (either because losses are less frequent, less severe, or both) or
b. modify the legal or other environments, or the coverage provided, such that the expected losses in the insurance layer are reduced (either because losses covered under the insurance policy are less frequent, less severe, or both) or
c. decrease insurer expenses (such as reinsurance) or
d. create alternate forms (reducing or limiting coverage) or more expensive pricing such that insurers are incented to enter the market or
e. any combination of the above

[50] See https://www.npdb.hrsa.gov/

Alternatively, if the commercial market is unable to provide insurance that is affordable and consistent with the Legislature's objectives for a market, the Legislature may choose to create a program to itself insure the risk.

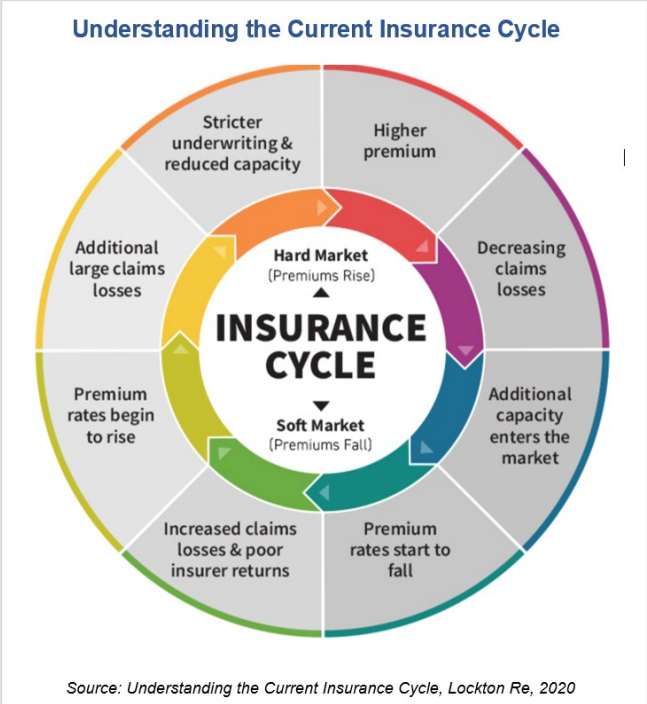
Overall Property and Casualty ("P&C") Market

Here, the Authors provide further context regarding overall P&C market conditions which have led to premium rate increases and some availability challenges over the past several years.

The U.S. Property & Casualty Market is Cyclical, and Has Been In a Hard Market Since 2019

The P&C industry is both highly competitive and notably cyclic, involving periods of "soft" market conditions when insurance is readily available and premium rates are stable, and "hard" markets when coverage is more difficult to find, and rates increase.

Understanding the Current Insurance Cycle: Global insurance broker Lockton Re provided this helpful graphic illustrating the phases of the insurance cycle.



Source: Understanding the Current Insurance Cycle, Lockton Re, 2020

Since 2019, the P&C industry in the U.S. has been in a sustained hard market. While there are some signs of improvement, hard market conditions persisted into 2024, forcing higher rates and continued restrictions in availability as insurers look to de-risk.

In 2019, analysts from the National Association of Insurance Commissioners ("NAIC") identified the shift from a 12 year-long soft market that was just beginning to change: "[s]oft market conditions are characterized by flat or declining rates, relaxed underwriting standards, abundant capacity and increased competition among insurers. Although soft market conditions have existed in the U.S. property and casualty insurance industry since 2007, the market is beginning to show signs of firming in most lines. This comes as the industry reported record catastrophe losses in 2017 and above average catastrophe losses in 2018."[51]

According to industry data compiled by the NAIC, in 2023 the industry experienced total underwriting losses of $18.4 billion. This compares to a reported $27.4 billion in losses in 2022. [52]

[51] *Source: U.S. Property & Casualty and Title Insurance Industries - 2019 Full Year Results, NAIC.*
[52] *Source: U.S. Property & Casualty and Title Insurance Industries - 2023 Full Year Results, NAIC.*

In March of this year, AM Best attributed downgrades of 55 U.S. P&C insurers in 2023, compared to 30 in 2022, to "higher reinsurance costs, worsening economic and social inflation and rising loss costs in 2023. Many struggled to navigate the uncertain economic environment and reported deteriorating results."[53]

Volatility in the Reinsurance Market Has Made the Problem Worse

The reinsurance markets provide a critical level of financial stability to insurers across all lines of business. Insurers utilize reinsurance to spread the risk of their direct business to a reinsurer, and frequently the use of reinsurance is a necessary expense for a direct writer[54]. The reinsurance market also provides additional capacity to the direct markets, given regulatory capital and other constraints that limit the amount of risk that a direct writer can place on their balance sheet.

Since 2019, the global reinsurance market has also experienced significant market strain. They have experienced the same spikes in loss costs as direct writers and seen payouts increase due to weather related events over this period. Reinsurers raised rates which forced direct writers to take on more risk than they would like, causing them to increase their own rates.

[53] US Property/Casualty Downgrades Outpace Upgrades in 2023, Best's Special Report (2024).
[54] A "direct writer" refers to the insurance company that accepts the transfer of risk directly from a consumer, business, or other entity that is seeking coverage for a liability. A reinsurer, in contrast, typically has no contractual relationship with the consumer, business, or other entity seeking coverage for a liability. A reinsurer, instead, enters into a contract with an insurer that is looking to transfer on some or all of a risk it has assumed.

Appendix D - Insurance Regulation Overview

Some of the companies participating in the Washington State medical malpractice insurance market are regulated by the OIC, and others are not.

Market participants include admitted insurers, excess and surplus lines ("E&S") insurers, risk retention groups ("RRGs"), risk pools, and reinsurance companies.

- **Admitted insurers**: Insurers range from small insurers that cover one line of business in a single state to national or international companies covering many lines of business. Admitted insurers are required to file rates and policy forms with the states in which they do business. For instance, admitted insurers writing medical malpractice insurance in Washington State must file their manuals, rate, and forms with the WA OIC. Note that insurers of commercial lines, such as medical malpractice, frequently use schedule credits and debits, experience rating, and other mechanisms to modify the filed base rates, depending on the historical loss experience of the insured as well as other underwriting criteria.

- **Non-admitted or Excess & Surplus (E&S) insurers**: E&S insurers provide insurance coverage for "specialty" risks that admitted insurers will not cover. The OIC does not have direct regulatory authority over E&S insurers' policy forms or premium rates, as (unlike admitted insurers) they are not required to maintain rate manuals or standard forms nor submit publicly available rate & form filings with the state.

- **Risk Retention Groups (RRGs)**: RRGs are liability insurance companies owned by their members. They are formed under the Federal Liability Risk Retention Act of 1986. An RRG is domiciled in one state but then can write directly in other states in which they are registered without obtaining a license. RRGs that are domiciled in states other than Washington do not need to file their rates with the OIC, although they can write business in Washington. These non-Washington domiciled RRGs are not directly regulated by the OIC.

- **Risk Pools:** Some counties and cities pool their self-insured risks through risk pools. These risk pools are regulated for solvency by DES, but their premiums and rates are not regulated.

- **Reinsurers**: As noted above, an insurance company will typically purchase reinsurance such that its potential losses are limited such that it does not risk insolvency. Because reinsurance agreements are commercial contracts between sophisticated parties, the OIC does not have regulatory authority over their terms or rates.

Appendix E - Insurance Industry Primer

Insurance Concepts and Terminology

The concepts and definitions described in this section are important to understand when considering potential solutions to the current challenges in the availability of medical malpractice insurance for CHP's providing transitional services in carceral settings.

Definitions of Policy Terms: A policyholder pays the insurer a "**premium**" to accept the risk. The insurance policy specifies the amount of the premium, the types of risks that are covered, the time period during which incidents (or "events") are covered, the maximum amount that the insurer will pay under the policy (called the "**policy limit**" or "total insured value"), and various other terms. If the policyholder suffers financial harm from an event that is covered by the insurance policy, the policyholder can file a **claim** against the insurance company. Covered claims that result in payments by the insurer are referred to simply as **losses** (or "covered losses") or claims. If the insurance policy has a **deductible**, the insurer deducts the amount of the deductible from the amount that it pays. If damages from the covered event are less than the deductible, then the insurer does not pay anything.

Transfer of Covered Risks: An insurance policy transfers risk from the policyholder (or "insured") to the insurer. In this context, "risk" refers to the possibility of financial harm due to an unforeseen incident, such as an accident or error. **Liability risk** is the risk of being held financially responsible for harming another person or their property.

Medical Professional Liability Insurance: Medical professional liability insurance, or medical malpractice insurance, is a type of liability insurance that compensates claimants for errors or omissions committed by a licensed healthcare provider in the course of their professional work.[55] It also pays for legal costs necessary in the investigation and defense of the claim. Medical professional liability coverage is typically subject to both per claim and aggregate limits. This type of insurance is typically required of medical providers.

Insurable Risk: Not all risks are considered insurable. Basic insurance principles require that for a risk to be insurable, it should (i) be measurable; (ii) be accidental and uncertain, rather than controlled by the insured party; (iii) be one of a pool of similar risks that is large enough to allow reasonably accurate predictions of future losses; (iv) have a cause and time of loss that is definite and easily identifiable; (v) be non-catastrophic, in the sense that it is not so widespread that it threatens the insurer's ability to pay claims; and (vi) have affordable premiums, in the sense that they are reasonable compared to the potential payout.[56]

Indemnity: The insured should be restored (or "indemnified") to the same financial position as they were in before the loss, subject to limits, deductibles, and other coverage limitations, but not better. This principle

[55] See https://www.irmi.com/term/insurance-definitions/medical-malpractice-insurance
[56] See *Principles of Risk Management and Insurance (13th ed.)*, Rejda, G. E., & McNamara, M. J. (2017)

eliminates the policyholder's incentive to profit from a claim and ensures that the policyholder and insurer have a common interest in avoiding a loss event.

Utmost Good Faith: Both parties must disclose all material facts that could affect the insurance policy. If either party fails to uphold this principle, the contract may be voided. One example of this could be the policyholder's failure to disclose during the application process any past losses that would be relevant to the insurance coverage.

Risk Management Strategies: There are five primary strategies for managing risk.

1. Risk Avoidance eliminates the risk by avoiding the activity which gives rise to the risk. For example, avoiding skydiving eliminates the possibility of injury from a skydiving accident.

2. Risk Reduction (also referred to as risk mitigation) entails taking action to reduce the likelihood of the risk event occurring, and/or the size of the loss if the event does occur. For example, medical providers may have protocols about how to interact with the patient if an incident happens during the course of care.

3. Risk Transfer involves shifting the risk to someone else – for example, by purchasing an insurance policy that shifts the risk of the loss to the insurer.

4. Risk Spreading is the process of pooling together risks from multiple sources. For example, insurance companies write policies for many different entities, often across different lines of business and geographic areas.

5. Risk Retention is the acceptance of the risk, including its financial costs in the event of a loss. For example, a county which is unable to find commercial insurance may retain and self-fund its liability exposure.

Calculating Insurance Premiums

The premium amount charged by the insurer is developed as the sum of all the insurer's estimated costs from the insurance policy, plus a profit margin. The primary elements of those costs are further described below.

Insurance is one of the few products whose price must be set before its cost is known.

Covered Losses: The largest component of cost is typically the **estimated covered losses**. The insurer estimates covered losses by analyzing past data on similar risks. It uses that data to estimate the probability that a covered event will occur and the amount of its covered losses if the event occurs. To estimate the risk of events that are very unlikely to occur but will be very costly if they do occur – such as hurricanes or earthquakes – the insurer typically supplements its historical data with estimates from "catastrophe models" developed by specialized analytical firms.

The losses used in premium calculations are not entirely dependent on the actual covered losses on a particular policy. For example, the use of a large pool of similar risks is necessary to estimate losses on a property for which the insurer has no direct experience. Typically, any one policy will not have sufficient volume to be the sole basis for a loss projection. By grouping together similar risks, an insurance company can review more data to create more stable projections.

Note that many insurance company rate plans, particularly in commercial lines, do incorporate individual policy loss experience via experience rating. For example, an individual policy has loss experience (either frequency or severity of claims) higher than anticipated in the overall rate plan, the insurance company will likely issue a surcharge on the policy to account for this.

Operating Expenses: The insurer includes estimates of **all the operating expenses it will incur** to issue and manage the policy – such as commissions paid to insurance brokers, its employees' salaries, fees paid to independent insurance adjusters and law firms, etc.

Net Cost of Reinsurance: Insurance purchased by one insurer from another insurer (called the "reinsurer") is called reinsurance. The insurer (also referred to as the "cedent") transfers (or "cedes") a portion of its risk to the reinsurer. The reinsurer "assumes" the risk in exchange for the insurer's payment of a "reinsurance premium". The reinsurer also pays a "ceding commission" to reimburse the cedent for a portion of its costs to sell the policy, such as commissions and marketing costs. The reinsurance premium, minus the ceding commission, minus the portion of covered losses that the reinsurer is expected to pay, is the "net cost of reinsurance". This is a necessary cost borne by most insurers and should be factored into the insurer's rate calculations. *Insurers purchase reinsurance to limit their losses in order to manage the risk of a large event*. In the case of medical malpractice insurance, this typically takes the form of ceding losses per claim above a certain amount. For instance, the insurer may write a policy with $5 million per claim limits, but may wish to only retain the first $1 million of each claim and cede claim amounts above $1 million to the reinsurer.

Cost of Capital: An insurer should also consider its cost of capital when setting rates. This is calculated as the rate of return an investor requires in order to invest in the business (instead of investing in a different business), multiplied by the amount of the investment required – for which minimum regulatory capital (see below) is a reasonable estimate.

Direct investment by an owner into an insurance company is referred to as "capital," and net profits that have accumulated over time are referred to as "surplus". **Capital and surplus** together are the equivalent of owners' equity in the business. Capital and surplus can also be thought of as a "cushion" to protect policyholders if the insurer's reserves – which it sets aside to pay future claims – are inadequate.

Accordingly, regulators require insurers to hold a minimum amount of capital and surplus ("**regulatory capital**") that reflects the amount of uncertainty in the insurer's business. An insurer that invests in risky assets and is exposed to highly volatile liabilities will require more regulatory capital than one that invests only in U.S. Treasuries and covers stable, well understood risks. Therefore, the insurer's concentration by line of business, asset investment strategy, catastrophe exposure and reinsurance program all impact its regulatory capital requirement.

Profit Margin: To the elements of cost described above, an insurer adds a target profit margin. Mutual insurers may also include a "profit" margin if necessary to build up their capital and surplus to enable growth and fulfil their mission, or to better protect their policyholders going forward.

Insurance Ratemaking Principles

According to the Casualty Actuarial Society, insurance premium rates should be based on actuarial estimates of all future costs of providing the insurance for each property individually.[57] The Casualty Actuarial Society has established four ratemaking principles:

1. A rate is an estimate of the expected value of future costs.

2. A rate provides for all costs associated with the transfer of risk.

3. A rate provides for the costs associated with an individual risk transfer.

4. A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

When estimating future costs, insurers must consider historical trends as well as costs related to reinsurance – which is necessary for most insurers.

- **Trends:** When using past losses as a proxy for expected future losses, consideration should be given to past and prospective changes in claim costs, claim frequencies, exposures, expenses and premiums. For example, historical data for medical malpractice claims should be adjusted to reflect economic inflation and changes in jury awards.

- **Reinsurance:** Consideration should be given to the effect of reinsurance arrangements. Insurers must demonstrate to insurance regulators and ratings agencies their ability to remain solvent even in the event of very large jury awards; for this reason, reinsurance is typically a necessity.

[57] *Source: Statement of Principles Regarding Property and Casualty Insurance Ratemaking.* https://www.casact.org/sites/default/files/2021-05/Statement-Of-Principles-Ratemaking.pdf

Appendix F – Jail Survey

The following questions were sent to jails across Washington. Responses were received from twenty different city and county jails.

Question	Possible Response
Respondent profile	
1. Respondent's first name	free-form input
2. Respondent's last name	free-form input
3. Respondent's title	free-form input
4. Respondent's organization name	free-form input
5. Respondent's email address	free-form input
6. Respondent's phone number	+1 (###) ###-####
7. Organization type	county jail, city jail, tribal jail, holding cells, other
8. If organization type is "Other", please specify:	free-form input
9. Organization's inmate capacity	number
10. Approximately average inmate population or organization	number
Provision of Medical Services:	
11. Does your county or city have a program to provide non-emergency medical services to incarcerated individuals?	yes, no, don't know
a. Wellness checks	yes, no, don't know
b. Routing testing	yes, no, don't know
c. Acute care	yes, no, don't know
d. Chronic disease management	yes, no, don't know
e. Other (please specify)	yes, no, don't know
i. If you responded "yes" to "Other", please specify:	free-form input
12. Who administers non-emergency medical services?	
a. Primarily (or only) city / county employees	yes, no, don't know
b. Primarily (or only) employees of third parties	yes, no, don't know
c. A combination of city / county employees and third parties	yes, no, don't know
13. At which location are medical services provided to incarcerated individuals?	on-site, off-site, depends
14. Have you experienced any difficulties obtaining providers for medical care?	yes, no, don't know
15. Has availability or affordability of medical professional liability insurance presented a challenge in obtaining providers?	yes, no, don't know
a. If yes, please elaborate.	free-from input
16. Are there additional medical services that you are aware of that your facilities' inmates want or need?	free-from input

Question	Possible Response
17. Are there any risk mitigation tools, that if improved/implemented/eliminated, could reduce the likelihood of medical related incidents or improve the outcome of jail liability related to medical care and/or medical professional liability claims?	free-from input
Community Healthcare Providers:	
18. Are you aware of the proposal to allow federally qualified community healthcare providers (FQHC's) to provide medical care to incarcerated individuals within 90 days of release?	yes, no
19. Would you be in favor of community healthcare providers (CHCs) providing medical services in your facilities?	yes, no, don't know
20. If so, would you prefer that they supplement your existing providers or replace them for all services within the 90-day window?	supplement, replace, don't know
a. If you view CHC's as potentially supplementary to your current providers, what types of services would the CHC's provide?	free-form input
Medical Liability Insurance:	
21. If medical services are provided by city / county employees, what insurance company or risk pool provides medical liability insurance coverage?	free-form input (or can select "don't know")
22. If medical services are provided by third parties…	
a. Are they indemnified for medical liability claims?	yes, no, don't know
i. If yes, by whom?	free-form input
b. If yes, is there a limit to the amount of the indemnification:	
i. Per occurrence	yes, no, don't know
ii. In the aggregate	yes, no, don't know
23. Do you have any suggestions on the ways to increase the availability and affordability of medical professional liability insurance to providers working in jails?	yes, no
a. If yes, please elaborate.	free-from input