SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1154

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Peaden

SUBJECT: Health Care Professional Liability Insurance

DATE: April 3, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.	Deffenbaugh	Deffenbaugh	BI	Favorable
3.			JU	
4.			AP	
5.				
6.				

I. Summary:

This bill creates the Health Care Professional Liability Insurance Facility, a not-for-profit facility intended to provide medical physicians, osteopathic physicians, and physician assistants who have coverage for smaller claims with an affordable source of insurance (excess liability insurance coverage) for larger claims. The facility will allow policyholders to choose from professional liability insurance policies with deductibles of $100,000, $200,000, and $250,000; and excess coverage limits of $250,000 per claim and $750,000 annual aggregate; $1 million per claim and $3 million annual aggregate; or $2 million and $4 million annual aggregate. The facility must begin providing excess coverage no later than January 1, 2004.

All health care professionals licensed under ch. 458 or ch. 459, F.S., must purchase coverage provided by the facility as a condition of licensure. In order to qualify for coverage, the insured will be required to maintain at all times an escrow account, under the provisions of s. 625.52, F.S., a letter of credit, established under the provisions of ch. 675, F.S., or professional liability insurance coverage equal to the selected deductible amount.

The facility must charge actuarially indicated premiums and is subject to regulation by the Office of Insurance Regulation in the same manner as other insurers. The facility must operate under a plan of operation approved by the Office of Insurance Regulation. The bill does not provide for any assessments against its member insureds (or anyone else) for funding any deficit that might occur. In order to provide start-up funds for the facility, the board of governors may incur debt or enter into agreements for lines of credit up to an amount that may not exceed $10 million. The sole source of funds for repayment of any is future premium revenues of the facility.

The facility will operate under a board of governors consisting of the Secretary of Health, who will serve as board chair; three members appointed by the Governor; and three members appointed by the Chief Financial Officer.

This bill creates s. 627.3575, F.S.

II. Present Situation:

Availability and Affordability of Medical Malpractice Insurance

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in many areas of the country, including Florida.

After almost a decade of essentially flat prices, medical malpractice insurance premiums began rising in 2000. According to the Department of Insurance, rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported 12/31/01) ranged from a minimum of 33.5 percent to a maximum of 149.9 percent from 1/1/01 through 1/1/03. There was a 73 percent average rate increase, weighted for market share. Rate increases for the top three insurers ranged from 74.3 percent to 81.3 percent for the 2-year period.

In October 2002, the Department of Insurance surveyed 18 insurers (top 15 malpractice writers in Florida and three other insurers known to be writing coverage) to determine the status of insurers departing the state and the status of insurers writing new business. Of the 18 insurers, five medical malpractice insurers had decided to no longer write any new or renewal business in Florida. Four additional insurers were not accepting any new business from physicians. Nine remaining insurers were still accepting new business in October 2002. As of February 28, 2003, the largest medical malpractice insurer in the state, which had not been writing new business in October 2002, decided to resume writing new business.

While there is general agreement that medical malpractice insurance premiums have risen sharply and that physicians are having a more difficult time obtaining medical malpractice insurance coverage, there appears to be little agreement on the causes of these problems. Insurers and doctors blame “predatory” trial attorneys, “frivolous” law suits, and “out of control” juries for the spike in insurance premiums. Consumer groups accuse insurance companies of “price gouging” and cite “exorbitant” rates of medical errors. Plaintiffs’ attorneys also point to medical errors, and to “predatory” pricing practices and bad business decisions of insurers during the 1990s.

There is also disagreement about possible solutions to these problems. Insurers and physicians demand tort reform, changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims’ access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Whatever the causes and solutions, the effects of the rising cost of medical malpractice insurance and the reduction in the availability of such coverage are being felt in Florida's health care system. There have been numerous reports of doctors discontinuing doing risky procedures, retiring prematurely, practicing without insurance, and leaving litigious areas of the state in an effort to deal with the price of liability coverage. In some cases, the decision of high risk specialists to reduce or eliminate their services has led to further reductions in services by hospitals. Some hospitals are discontinuing services such as maternity services and trauma services because of the high cost of malpractice coverage for the specialists needed to provide these services.

Medical Malpractice Self-Insurance Funds (s. 627.357, F.S.)

Florida law previously allowed health care providers to form medical malpractice self-insurance funds (referred to as a "medical malpractice risk management trust fund"), pursuant to s. 627.357, F.S. However, the law was amended in 1992 to prohibit the formation of any new funds under this section after October 1, 1992. Five relatively small, specialized funds are still operating (one of which is in "run-off" by assessing its members and not issuing new coverage). The law required approval from the Department of Insurance, with minimal statutory requirements, such as employment of a professional consultant for loss prevention and claims management, the requirement to engage in prudent investment of trust funds, and to be subject to the statutes regulating trade practices and fraud. The law provided rulemaking and regulatory authority to the department for more specific requirements. (ch. 4-187 F.A.C.)

Commercial Self-Insurance Funds (ss. 624.460-624.488, F.S.)

The current law allows for the formation of commercial self-insurance funds pursuant to ss. 624.460-624.488, F.S., as approved by the Department of Insurance, now, the Office of Insurance Regulation, or "office"[1] These funds may be formed for property and casualty insurance, including medical malpractice, but in practice have been limited to providing workers' compensation coverage. No such funds have been formed to provide medical malpractice insurance. Certain restrictions on who may establish such funds, as well as more stringent requirements than applied to the former medical malpractice self-insurance funds, may be inhibiting factors. Also, it is reported that the department (and now the office) have generally cautioned prospective organizers of such funds, due to a self-insurance fund's reliance on assessments against member insureds as the fallback solvency requirement, as compared to the surplus that must be maintained by authorized insurers. The Department of Insurance has experienced problems with funds that attempt to collect assessments from their members and the litigation that can ensue.

Commercial self-insurance funds may be formed only by: (1) a not-for -profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated in Florida, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year; (2) a medical malpractice self-insurance trust fund organized

[1] Legislation in 2002 (ch. 2002-404, L.O.F.), effective January 7, 2003, transferred the Department of Insurance to the Department of Financial Services and to the Financial Services Commission and its Office of Insurance Regulation. Conforming changes to the statutes have not yet been enacted, which are addressed in CS/CS/SB 1712.

pursuant to s. 627.357 and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance pursuant to this section; or (3) a not-for-profit group comprised of no less than 10 condominium associations meeting certain requirements.

A commercial self-insurance fund must be operated by a board of trustees. If formed pursuant to (1), above, the board of trustees must be responsible for appointing independent certified public accountants, legal counsel, actuaries, and investment advisers as needed; approving payment of dividends to members; and contracting with an administrator authorized under s. 626.88 to administer the affairs of the fund. For all commercial self-insurance funds, a majority of the trustees or directors must be owners, partners, officers, directors, or employees of one or more members of the fund. Requirements also include: (1) an indemnity agreement binding each fund member to individual, several, and proportionate liability; (2) a plan of risk management which has established measures to minimize the frequency and severity of losses; (3) proof of competent and trustworthy persons to administer or service the fund; (4) an aggregate net worth of all members of at least $500,000; (5) a combined ratio of current assets to current liabilities of more than 1 to 1; (6) a deposit of cash or securities, or a surety bond, of $100,000; (7) specific and aggregate excess insurance with limits and retention levels satisfactory to the department (office); (8) a fidelity bond or insurance providing coverage of at least 10 percent of the funds handled annually by the fund; (9) a plan of operation designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles, and a statement by an actuary to that effect; and (10) such additional information as the department may reasonably require. After certification, additional requirements are imposed related to restrictions on premiums that may be written, annual reports, dividends, assessments, and approval of forms and rates. Rates may not be excessive, inadequate, or unfairly discriminatory and must be filed with the department (now, office) for approval. But, the standard for excessiveness is limited to a determination of whether the expense factors are not justified or are not reasonable for the benefits and services provided. A fund has the burden of proving that a rate filed is adequate if, during the first 5 years of issuing policies, the fund files a rate that is below the rate for loss and loss adjustment expenses for the same type and classification of insurance that has been filed by the Insurance Services Office and approved by the department (office). (ss. 625.460-624.482, F.S.)

If rates turn out to be inadequate and a deficit exists, member insureds of a self-insurance fund are assessed, in proportion to their premium, to fund the deficit. There is no guaranty fund coverage for medical malpractice claims of a commercial self-insurance fund (but guaranty fund coverage is provided for workers' compensation claims of a self-insurance fund, pursuant to part V of ch. 631, F.S.).

Florida Patient's Compensation Fund (s. 766.105, F.S.)

The Florida Patient's Compensation Fund (or "PCF") , established in s. 766.105, F.S., was created by the Legislature in 1975 to provide affordable medical malpractice insurance for Florida's physicians and hospitals, during a time of severe availability problems, as well as affordability problems. The fund provided coverage from 1975 to 1983, until funding problems required the Legislature to terminate coverage. The PCF is still in operation for the purpose of administering past claims.

The PCF provided excess coverage over a large deductible, revised over the years, last set as ranging from $150,000 to $250,000. Physicians and other individual health care providers were required to have other insurance or financial responsibility to cover the deductible. One option was to obtain coverage for the deductible from the Florida Medical Malpractice Joint Underwriting Association, which is still operational (as described below). The limits of PCF coverage for physicians were up to $2 million per claim with a $4 million annual aggregate, and hospitals could obtain coverage of $2.5 million per claim with no annual aggregate. Physicians were allowed, but not required, to obtain coverage from the PCF, but hospitals were required to participate in the fund unless they obtained other professional liability coverage providing limits of coverage specified in the law, or met other financial responsibility requirements. This law continues to effectively require that hospitals maintain a minimum level of professional liability insurance as a condition of not participating in the fund.

The law required actuarially sound premiums ("fees"), but provided that if the premiums collected for a given year were not sufficient to satisfy the claims, the insured members were subject to assessment for the amount of the deficit, similar to a self-insurance fund. For most years, the law limited the assessments against physicians and other individual health care providers to 100percent of the amount of their annual premium. However, hospitals were subject to unlimited assessments as required to fund the deficit. Ultimately, millions of dollars of assessments were levied against hospitals, leading to a legal challenge as to the constitutionality of the law. The law was upheld by the Florida Supreme Court, and the assessments were collected to fund all claims. In 1983, the law was amended to prohibit the PCF from issuing coverage in any year in which it did not obtain a minimum level of premiums, based on applications for coverage. The law continues to provide that an annual determination must be made by the PCF as to whether the minimum level of premiums will be collected (s. 766.105(3)(h), F.S.).Claims continue to be administered by the PCF, but any money left in the fund after all claims have been resolved are to be returned on a prorated basis to the physicians and facilities that contributed to the fund.

Florida Medical Malpractice Joint Underwriting Association (s. 627.351(4), F.S.)

The Florida Medical Malpractice Joint Underwriting Association (FMMJUA) provides medical malpractice insurance to health care providers, as defined, who are otherwise unable to obtain coverage in the voluntary market, per s. 627.351(4), F.S. Coverage is limited to $250,000 per claim/$750,000 annual aggregate, except for hospitals which may obtain up to $1.5 million per claim, $5 million annual aggregate. The FMMJUA has not generally been a major writer of coverage for physicians, but its physician policyholders have increased significantly over the last 2 years. The law requires the FMMJUA to file rates for approval with the department (now, Office of Insurance Regulation), and requires that rates be adequate to pay claims and expenses, but does not provide any specific requirement for rates to be above the market. However, the FMMJUA reports that its rates have always been maintained at about 40 percent above the private market, but it provides refunds to its members if the funds are actuarially determined to be not needed. If a deficit occurs, after using available surplus, the law requires the FMMJUA to assess its member insureds up to one-third of their premiums, and any excess amount of the deficit is assessed against casualty insurers writing specified lines of insurance. To date, the FMMJUA has never made an assessment.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had ten meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into thirteen volumes that accompany the main report.

The following findings and recommendations relating to alternative professional liability insurance products are included in the final report of the Task Force. The Task Force found that "…the healthcare community has an option to address medical malpractice self-insurance programs. Further, the Task Force finds that the Department of Insurance does not have sufficient rule making authority to provide protection to the health care professionals and the victims of medical malpractice utilizing or making claims against self-insurance funds."

The Task Force made three recommendations regarding alternative insurance products:

> *Recommendation 1.* The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.
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> *Recommendation 2.* The Legislature should encourage the creation of self-insurance options for healthcare providers.
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> *Recommendation 3.* The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to insure they remain solvent and provide the insurance coverage purchased by participants.

Chapters 458 and 459, Florida Statutes

Chapter 458, Florida Statutes, is the medical practice act, which governs the practice of allopathic medicine within the state. This chapter establishes requirements for licensure of medical physicians and physician assistants. Section 458.320, F.S., establishes financial responsibility requirements for medical physicians for the payment of claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services. This section also permits a physician to go without insurance if the physician agrees to pay a judgment creditor the lesser amount of the judgment or $100,000 ($250,000 if the physician maintains hospital privileges) and notifies his patients.

Chapter 459, Florida Statutes, is the osteopathic medical practice act, which governs the practice of osteopathic medicine within the state. This chapter establishes requirements for licensure of osteopathic physicians and physician assistants. Section 459.0085, F.S., establishes financial responsibility requirements for osteopathic physicians for the payment of claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services. This section also permits a physician to go without insurance if the physician agrees to pay a judgment creditor the lesser amount of the judgment or $100,000 ($250,000 if the physician maintains hospital privileges) and notifies his patients.

III. Effect of Proposed Changes:

The bill creates s. 627.3575, F.S., creating the Health Care Professional Liability Insurance Facility. The not-for-profit facility is intended to provide health care professionals, who are licensed under ch. 458 and ch. 459, F.S., and who have coverage for smaller claims, with an affordable source of insurance for larger claims. The facility is self-funding, is not a state agency and does not create any state liability. The facility will have the powers necessary to operate as an excess insurer, including the power to sue and be sued; hire employees, consultants, attorneys, and other professionals; contract with service providers; maintain offices appropriate to the conduct of its business; and take other actions as necessary in the fulfillment of its responsibilities.

The facility will allow policyholders to choose from professional liability insurance policies with deductibles of $100,000, $200,000, and $250,000; excess coverage limits of $250,000 per claim and $750,000 annual aggregate; $1 million per claim and $3 million annual aggregate; or $2 million and $4 million annual aggregate.

All health care professionals licensed under ch. 458 or ch. 459, F.S., (medical physicians, osteopathic physicians, and physician assistants) must purchase coverage provided by the facility as a condition of licensure. In order to qualify for coverage, the insured will be required to maintain at all times an escrow account, under the provisions of s. 625.52, F.S., or a letter of credit, established under the provisions of ch. 675, F.S., or professional liability insurance coverage equal to the selected deductible amount. The professional liability insurance coverage may be obtained from an authorized insurer, a surplus lines insurer, a risk retention group, the Medical Malpractice Joint Underwriting Association, or a medical malpractice self-insurance fund.

The facility must charge actuarially indicated premiums for the coverage provided and must retain the services of consulting actuaries to prepare its rate filings. The rate filings must have no more than three rating categories by specialty and must apply a discount or surcharge based on the provider's loss experience. The facility will not pay dividends to policyholders. If the consulting actuaries determine that the premiums collected are more than enough to pay future claims, the excess funds may be distributed to the participants. If the facility is dissolved, any amounts not required as a reserve for outstanding claims must be transferred to the policyholders of record as of the last day of operation. The bill does not provide for assessments against its member insureds (or anyone else) for funding a deficit that might occur. In order to provide start-up funds for the facility, the board of governors may incur debt or enter into agreements for lines

of credit up to an amount that may not exceed $10 million. The sole source of funds for repayment of any is future premium revenues of the facility.

The facility will operate under a board of governors consisting of the Secretary of Health, who will serve as board chair; three members appointed by the Governor; and three members appointed by the Chief Financial Officer. Members will serve at the pleasure of the official who appointed them, and any vacancy will be filled in the same manner as the original appointment. Board members will not be eligible for compensation but may be reimbursed for per diem and travel expenses.

The facility will operate under a plan of operation that must be submitted to the Office of Insurance Regulation for approval. At any time the board of governors may adopt amendments to the plan and submit the amendments to the Office of Insurance Regulation for approval. The facility will be subject to regulation by the Office of Insurance Regulation as to rates and policy forms in the same manner as a private sector insurance company. The Office of Insurance Regulation may adopt rules to implement the provisions of the bill. The facility is not subject to part II of ch. 631, F.S., which establishes the Florida Insurance Guaranty Association and requires insurers to be members.

The facility must begin providing excess coverage no later than January 1, 2004. The Governor and the Chief Financial Officer must make their appointments to the board of governors no later than July 1, 2003. Prior to the appointment of the board, the Secretary of Health, as chair, may perform ministerial acts on behalf of the board. The Office of Insurance Regulation must provide support services to the facility until the facility has hired its own permanent staff.

Any policy issued under this act will take effect January 1, 2004, except that a health care provider holding a liability insurance policy that commenced in 2003 and did not terminate until after January 1, 2004, would be required to purchase coverage under this act upon the termination date of that policy.

The bill will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physicians and physician assistants licensed under ch. 458 or ch. 459, F.S., would be required to have coverage for the amount of the deductible and would be required to purchase excess coverage from the Health Care Professional Liability Insurance Facility. Private insurers currently providing excess coverage would lose this business.

The bill does not provide a "deep pocket" source of funding in the event that premiums prove to be inadequate and a deficit occurs. But, the bill provides that the board of governors may incur debt or enter into agreements for lines of credit to obtain start-up fund of up to $10 million. The sole source of funds for repayment of any is future premium revenues of the facility.

C. Government Sector Impact:

The Office of Insurance Regulation would incur the cost of providing support staff to the facility before it has hired its own staff as well as the cost of overseeing the operation of the facility.

The Department of Health will incur costs for ensuring physician compliance with the requirements of the bill as part of licensure and licensure renewal and the cost of the Secretary's performing ministerial acts on behalf of the board before the board is appointed.

VI. Technical Deficiencies:

On page 3, line 11, the words "per claim" should be inserted after "$2 million."

VII. Related Issues:

This bill appears to eliminate the option for a physician to go without insurance.

The bill includes physician assistants in the requirement to maintain minimum financial responsibility and purchase excess coverage through the Health Care Professional Liability Insurance Facility. It is not clear that these requirements should apply to physician assistants.

VIII. Amendments:

None.