HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 881 CS Community Behavioral Health Agencies
SPONSOR(S): Cannon and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2486 and SB 182

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	19 Y, 0 N, w/CS	Cooper	Cooper
2) Civil Justice Committee	4 Y, 0 N	Kruse	Billmeier
3) Health Care Appropriations Committee	12 Y, 0 N, w/CS	Ekholm	Massengale
4) Commerce Council	9 Y, 0 N, w/CS	Cooper	Bohannon
5)			

SUMMARY ANALYSIS

House Bill 881 CS provides that, notwithstanding any other provision of law, mental health or substance abuse providers that are members in good standing of a nonprofit statewide association, which has been in existence for at least 10 years and comprises at least 50 community-based mental health and substance abuse agencies that are primarily publicly funded and located in this state, may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under worker's compensation. This authorization is predicated upon the fund: 1) having annual normal premiums in excess of $5 million; 2) maintaining a continuing program of excess insurance coverage and reserve evaluation to protect the fund's financial stability; 3) submitting to the Office of Insurance Regulation annual audited financial statements; and 4) having a governing body comprised entirely of provider officials. For a fund's first five years of its existence the fund must comply with the same regulatory requirements of all other commercial or group self-insurance funds.

The bill also exempts the self-insurance fund from the solvency, reserve and financial reporting requirements pertaining to workers compensation group self-insurance funds, as well as from the premium tax and participation in the Florida Self-Insurance Fund Guaranty Association after five years of a fund's formation. The bill provides that no self-insurance fund created under the bill shall be deemed to be or considered to be an insurer for any purpose under chapter 631, Florida Statutes.

The bill limits liability in tort actions based on services for crisis stabilization. The bill requires that net economic damages be limited to $1 million per liability claim, including but not limited to past and future medical expenses, wage loss, and loss of earning capacity. Additionally any non-economic damages specified against the entities specified by this bill are limited to $200,000 per claim. The bill allows for any claim to be settled up to the policy limits without action by the Legislature.

The bill specifies that the immunities enjoyed by a provider under the provisions of this act extend to an employee of the provider when the employee is acting in furtherance of the provider's responsibilities under its contract with the department. However, these immunities are not applicable to a provider or employee who acts in a culpably negligent manner or with willful and wanton disregard or unprovoked physical aggression when such acts result in injury or death.

The bill's provisions exempting self-insurance funds after 5 years from the premium tax and relating to possible claims bills will have an undetermined fiscal impact on the state.

The effective date of the bill is July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill exempts certain providers of mental health and substance abuse services from the statutory requirements of forming self-insurance funds.

Ensure lower taxes—The bill exempts specifically authorized self-insurance funds from the premium tax. Making providers agents of the state may impact the state's financial resources.

Safeguard individual liberty—The bill reduces regulatory oversight over programs to compensate injured employees (workers compensation) and patients (tort). The bill limits the amount of damages an injured plaintiff may recover.

Promote personal responsibility—The bill will place more responsibility for ensuring financial accountability and solvency on the providers who participate in the self-insurance fund authorized by this bill. The bill also limits the liability of a provider who injures a patient. Recovery for amounts above the limits specified in the bill, if approved by the Legislature in a claims bill, will originate from the state budget.

Empower families—To the extent that providers reduce their costs for liability insurance and from legal immunity, the offering of services, with the attendant emotional and financial benefits, may increase for families. To the extent that injured patients are not able to recover fully for their injuries then more families may be dependent on Medicaid or other governmental assistance programs.

B. EFFECT OF PROPOSED CHANGES:

Current Law Regarding Self-Insurance Funds

Sections 624.460-624.488, Florida Statutes, are known as the "Commercial Self-Insurance Fund Act." Self-insurance fund means both commercial insurance funds organized under section 624.462, Florida Statutes, and group self-insurance funds organized under section 624.4621, Florida Statutes.

Pursuant to section 624.462, Florida Statutes, a not-for-profit trade association, industry association, or professional association of employers or professionals that has been organized for purposes other than that of obtaining or providing insurance may form a commercial self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any commercial property or casualty risk or surety insurance.

An entity that forms a self-insurance fund under current law must obtain and maintain a certificate of authority. Among the initial and continuing regulatory requirements necessary for a certificate of authority are measures relating to plans of risk management, certain financial statements of members, excess insurance, surplus and reserve requirements, assurances of actuarial soundness and assessment procedures. Under current law a commercial self-insurance fund is also subject to the premium tax, form and rate approval, and regulatory oversight regarding rehabilitation, liquidation, reorganization and conservation, and is required to participate in the Florida Group Self-Insurers Guaranty Association.

Pursuant to section 624.4621, Florida Statutes, two or more employers are allowed to pool their workers' compensation liabilities and form a self-insurance fund for workers' compensation purposes. If employers elect to become a self-insurance fund for workers' compensation purposes, the fund must comply with administrative rules adopted by the Financial Services Commission relating to reserve requirements, organization and operation. The rules relating to reserve requirements are designed to insure the self-insurance fund can maintain financial solvency. Current law also requires workers' compensation self-

insurance funds to carry reinsurance, unless the fund is comprised of state or local government employers.[1] Current law establishes restrictions on dividend or premium refunds made by a workers' compensation self-insurance fund.[2] Workers' compensation self-insurance funds are subject to the insurance premium tax, but at a reduced rate. The rate is reduced from 1.75 percent of the gross receipt of insurance premiums to 1.6 percent.[3] Workers' compensation self-insurance funds are subject to license taxes and premium receipt taxes.[4] Current law also requires workers' compensation self-insurance funds to participate in the Florida Self-Insurance Fund Guaranty Association (Association).[5] The purpose of the Association is to pay workers' compensation claims of self-insurance funds that may become insolvent.[6] In addition to complying with the administrative rules for workers' compensation self-insurance established by the Financial Services Commission, a workers' compensation self-insurance fund must comply with administrative rules adopted by the Department of Financial Services (DFS) relating to the filing of reports by workers' compensation self-insurance funds.[7]

The Commercial Self-Insurance Fund Act also contains a provision that makes more than 228 sections of the Florida Insurance Code applicable to the self-insurance funds.[8] Among those many provisions are laws relating to civil remedy and civil liability; accounting, assets and liabilities investments, administration of deposits, insurance field representatives and operations; unfair methods of competition and unfair or deceptive acts or practices; powers of department and office; cease and desist procedures and penalties; policyholders bill of rights claims administration; payment of settlements; attorney's fees; insurance rates and contracts; motor vehicle and casualty contracts; professional liability claims and actions; reports by insurers and health care providers; and, as previously indicated, provisions relating to insurer insolvency; rehabilitation and liquidation; and the Florida Self-Insurance Fund Guaranty Association.

Florida Council for Community Mental Health and the Florida Council for Behavioral Healthcare

The Florida Council for Community Mental Health (Council), a 501(c)(3) corporation, and its sister organization, the Florida Council for Behavioral Healthcare – a 501(c)(6) corporation established for political action purposes, are statewide associations of 70 community-based mental health and substance abuse agencies. The Council was formed in 1958 as an association of mental health clinic directors. Its role broadened in the 1960s and 1970s, as the focus of treatment shifted from state hospitals to communities. The membership expanded to include a number of agencies that specialize in substance abuse services and children's services. [9]

The Council is the sole community mental health provider association and the largest behavioral health association representing local mental health interests in Florida. Council members serve predominately low-income individuals and families and the majority of the adults and children receiving publicly-funded mental health and substance abuse services in Florida. Most clients served by member agencies are adults with serious and persistent mental illness, children with severe emotional disturbance, adults with long-term addictions, and children who are drug users or at risk of abusing drugs. Member agencies provide a range of services, including emergency services, residential treatment, crisis stabilization, outpatient services and rehabilitation and support services.

Member agencies provide behavioral health care for Medicaid, Medicare, Department of Children and Family Services' clients, and commercially-insured populations. According to the Council, they serve as the state's public behavioral health safety net.

---

[1] s. 624.4621(4), F.S. (2004).
[2] s. 624.4621(5), F.S. (2004).
[3] s. 624.4621(7), F.S. (2004); s. 624.509(1), F.S. (2004).
[4] s. 624.509(2), F.S. (2004).
[5] s. 624.4621(9), F.S. (2004).
[6] s. 440.385(3)(a), F.S. (2004).
[7] s. 440.38(2)(b), F.S. (2004); *See* Chapter 4L-5, F.A.C. for the administrative rules relating to workers' compensation self-insurance funds.
[8] s. 624.488, F.S. (2004)
[9] Email from Bob Sharpe, President and CEO of FCCMH, March 9, 2005 on file with the Insurance Committee.

Access to Insurance

According to the Council, availability of property, liability, automobile and workers' compensation insurance is limited for its members and members of its sister organization, the Florida Council for Behavioral Healthcare (FCBH). The Council maintains that its 70 member treatment organizations are a critical part of the state's safety net, providing publicly-funded mental health and substance abuse services to Floridians who cannot afford the cost of their care. They report that they have difficulty obtaining insurance coverage that recognizes the type of services they provide and the risks to which they are exposed.[10]

Proponents suggest that a group program or self-insurance pool, specifically designed for the homogeneous group that comprises the Councils' membership, will enhance the availability of insurance for its members. The following types of insurance would be included in a pool:

Property Insurance—Florida presents unique problems in obtaining property insurance due to coastal wind and flooding exposure.

Automobile Insurance—Some insurance programs for behavioral health care agencies do not include automobile coverage, requiring members to obtain separate automobile insurance.

General Liability and Professional Liability—There are only four insurance companies that write liability policies for mental health and substance abuse agencies. Because of the size of market, underwriting is very stringent. One loss can result in the escalation of premiums and the imposition of unattractive "Claims Made" and "Retro Date" restrictions.

Workers' Compensation—Florida is not considered an attractive state to write workers' compensation policies. This has led to the lack of carriers willing to consider coverage for behavioral health agencies. An adverse loss history can lead to surcharges and higher premiums.

According to the Council, 30 to 50 members are expected to participate in the self-insurance fund.[11]

The Council states that "along with other health care providers in Florida, mental health and substance abuse providers have seen rapid and sizable increases in their liability insurance premiums. This is especially true for agencies that operate inpatient emergency behavioral health care facilities such as crisis stabilization units. The average cost of liability insurance for a community mental provider was $238,847 in FY 2002–2003. The average cost in FY 2003-2004 was $355,715, an increase of 49%. But, for some providers, *the increase in premiums was 150% or more*."

As part of their proposal, the Council cites statutory precedent for creating group self-insurance programs. County governments and local municipalities are authorized to establish self-insurance programs so they can reduce costs and obtain less costly insurance through their pooled purchasing power and the ability to spread risk over multiple entities. Also, the Florida Independent Colleges and Universities Risk Management Association (FICURMA) was authorized by the Florida Legislature through section 624.4623, Florida Statutes, to establish a self-insurance fund. This group of private, non-governmental organizations has established a mechanism for members to obtain lower cost insurance and experience predictable future premium costs.

The language of House Bill 881 CS is modeled after the existing statutory authorization for local governments and private colleges and universities and, in fact, is mostly identical. However, section 624.4623, Florida Statutes, relating to the formation of self-insurance funds by independent colleges and universities contains a provision that is not included in House Bill 881 CS. Pursuant to section 624.4623, Florida Statutes, only those educational institutions accredited by the Commission on Colleges of the Southern Association of Colleges and Schools or accredited schools chartered by the State of Florida are eligible for the exemptions.

[10] FCBH proposal "Community Mental Health and Substance Abuse Provider Self-Insurance Fund" on file with the Insurance Committee.
[11] Id.

According to a representative of the Florida Independent Colleges and Universities Risk Management Association, the prerequisite for accreditation requires that their members submit to the rigorous programmatic and financial review of this federally-sanctioned accrediting agency. This outside review ensures that their pooled members are financially stable and have the appropriate resources to conduct their operations. The federal government relies on this accreditation status for participation in all federally-sponsored programs such as student financial aid, research contracts and other types of grants. Also, the colleges and universities rely on this accreditation status to be the primary test of an institution's financial strength.[12]

Among the financial and resource requirements necessary for good standing and membership are the following statements from the accrediting standards manual:

3.10 Financial and Physical Resources

1) The institution's recent financial history demonstrates financial stability.

2) The institution provides financial statements and related documents, including multiple measures for determining financial health as requested by the Commission, which accurately and appropriately represent the total operation of the institution.

3) The institution audits financial aid programs as required by federal and state regulations.

4) The institution exercises appropriate control over all its financial and physical resources.

5) The institution maintains financial control over externally funded or sponsored research and programs.

6) The institution takes reasonable steps to provide a healthy, safe, and secure environment for all members of the campus community.

7) The institution operates and maintains physical facilities, both on and off campus, that are adequate to serve the needs of the institution's educational programs, support services, and other mission-related activities.

Regulatory Issues

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, that is, an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida. Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers.

In House Bill 881 as originally filed, OIR was initially concerned that the authorization to create this self-insurance fund effectively removes any and all solvency and rate regulation oversight that is exercised by OIR to protect Florida's insurance consumers. According to OIR, the lack of regulatory oversight coupled with the significant risk this newly created self-insurance fund would assume would have led to the formation of an inadequate financial framework to pay claims. They also opined that the inability to pay claims meant that injured employees otherwise eligible for workers compensation benefits may not have had medical and lost wage expense paid; that damaged property may have gone unrepaired; and that fund participants could have

[12] Email from Ben Donatelli, Collaborative Ventures, Independent Colleges and Universities of Florida, March 19, 2005, on file with the Insurance Committee.

been drawn into costly litigation to personally defend against a liability claim.[13] In the Insurance Committee the bill was amended to add subsection (3) to section 626.4624, Florida Statutes, which provides a transition time of 5 years for a self-insurance fund to comply with the same regulatory requirements of other commercial and group self-insurance funds, as well as to provide certain financial information to OIR.

Regarding the bill's creation of section 624.4624(2), Florida Statutes, if the self-insurance fund fails to comply with the provisions of the entire section, the fund defaults to regulation under section 624.4621, Florida Statutes—regulation pertaining to group self-insurance funds writing only workers compensation insurance coverage. OIR notes that the new section is silent with respect to a default regulation for the property/casualty and surety coverage being issued by the funds. In any type of forensic handling of a self-insurance fund in default, OIR opines that it could be difficult to determine the proper allocation of reserves that should have been associated with the multiple lines of coverage provided by the fund.

Proposed Changes Regarding Self-insurance Funds

This bill provides that, notwithstanding any other provision of law, mental health or substance abuse providers which are members of the Florida Council for Community Mental Health or the Florida Council for Behavioral Healthcare may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under worker's compensation. This authorization is predicated upon the fund: 1) having annual normal premiums in excess of $5 million; 2) maintaining a continuing program of excess insurance coverage and reserve evaluation to protect the fund's financial stability; 3) submitting to the Office of Insurance Regulation annual audited financial statements; and, 4) having a governing body comprised entirely of provider officials. For a fund's first five years of its existence the fund must comply with the same regulatory requirements of all other commercial or group self-insurance funds.

After five years, the bill exempts self-insurance funds composed of two or more nonprofit community mental health and substance abuse providers from the provisions in current law applicable to workers' compensation self-insurance funds relating to reserve requirements, reinsurance requirements, restrictions on dividend or premium refunds, and mandatory participation in the Florida Self-Insurance Fund Guaranty Association. The bill exempts these self-insurance funds from the premium tax, license tax, and premium receipt tax. The bill also exempts these self-insurance funds from the rules promulgated by DFS relating to reports workers' compensation self-insurance funds must file with DFS.

The bill revokes the exemptions from the statutory requirements relating to reserve requirements, reinsurance requirements, restrictions on dividend or premium refunds, mandatory participation in the Florida Self-Insurance Fund Guaranty Association, and taxes if the community mental health and substance abuse provider self-insurance fund does not have annual normal premiums in excess of $5 million, does not maintain a continuing program of excess insurance coverage and reserve evaluation, and does not annually submit an audited fiscal year end financial statement to the Office of Insurance Regulation.

The bill provides that no self-insurance fund created under the bill shall be deemed to be or considered to be an insurer for any purpose under chapter 631, Florida Statutes.

Background on Provision of Mental Health Services and Treatment and Prevention of Substance Abuse

The Department of Children and Families (DCF) contracts with community-based substance abuse and mental health treatment providers to deliver services on behalf of the state to individuals who have a mental health or substance abuse disorder. These agencies deliver a wide range of services to local communities, from prevention and outpatient therapy to critical crisis intervention and detoxification services.

[13] Concerns expressed are contained in OIR's bill analysis on HB 881, on file with the Insurance Committee.

As of Fiscal Year 2004-2005, the department maintains contracts with 249 community mental health provider agencies and 159 substance abuse provider agencies. Of 249 mental health agencies, 55 provide mental health crisis services. Of the159 contracted substance abuse provider agencies, 32 provide substance abuse detoxification services. In the first half of fiscal year 2004-05, these agencies provided mental health crisis intervention or detox services to 35,216 individuals.[14]

Current DCF contract language clearly specifies that a provider is an independent contractor not an agent. The specific relevant section reads:

> To act in the capacity of an independent contractor and not as an officer, employee of the State of Florida, except where the provider is a state agency. Neither the provider nor its agents, employees, subcontractors or assignees shall represent to others that it has the authority to bind the department unless specifically authorized in writing to do so . . . To take such actions as may be necessary to ensure that each subcontractor of the provider will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the State of Florida.[15]

Under Florida law, receiving facilities are required to examine and provide treatment to everyone— regardless of their diagnosis or their ability to pay. According to the Council, approximately 98 percent of persons served by these facilities are low income, uninsured individuals or Medicaid eligible. Virtually all funding for receiving facilities comes from local, state and federal government sources.

According to the Council, the cost of medical malpractice liability insurance is limiting the ability of publicly supported community mental health and substance abuse agencies to provide critical treatment and intervention services that are depended upon by law enforcement, local communities and state agencies. The Council states that medical malpractice insurance rates for community mental health and substance abuse agencies have increased 105 percent over the past three years—approximately 35 percent per year. In some cases, 5 percent or more of a facility's operating budget is used to pay for liability insurance— resources that could otherwise be used for treatment.

The average cost of liability insurance for a community behavioral health provider was $238,847 in FY 2002–2003. The average yearly cost in FY 2003-2004 was $355,715—an increase of 49 percent. As an example of the impact on treatment capacity, a community mental health provider could have provided an additional 1,457 bed days of crisis stabilization care in lieu of paying for liability insurance during FY 2003-2004. The following chart provided by the Council shows examples of the escalation of liability insurance premiums (which includes medical malpractice, officers and directors insurance and other liability insurance) for a sample of behavioral health care providers.

Facility	FY 2002-03 Premiums	FY 2003-04 Premiums	% Increase
ACT Corporation, Daytona Beach	$391,000	$425,000	8.7%
Lakeview Center, Pensacola	$555,301	$793,063	42.8%
Personal Enrichment thru Mental Health Svcs., Pinellas Park	$72,315	$225,662	212.1%
Mental Health Care, Tampa	$184,288	$489,007	165.3%
Meridian Behavioral Health, Gainesville	$91,426	$113,076	23.7%
Apalachee Center, Tallahassee	$95,630	$247,239	158.5%
Bayview Center, North Miami	$74,000	$94,000	27.0%
Circles of Care, Melbourne	$463,972	$512,060	10.4%
Citrus Health Network, Hialeah	$221,691	$302,331	36.4%

[14] Department of Children and Families bill analysis on HB 881, on file with the Insurance Committee.
[15] Id.

Report by the Department of Children and Family Services on the Experience of Public Receiving Facilities in Securing and Maintaining Medical Malpractice Insurance

The 2004 Florida Legislature mandated that the Department of Children and Families develop a report that reviewed the experience of public receiving facilities as defined in section 394.455, Florida Statutes, in securing and maintaining medical malpractice insurance. The review was to include the current cost of insurance and the rate of increase or decrease in these costs over the past three years and the experience of these facilities with lawsuits and associated awards. The department was directed to investigate whether these facilities were experiencing problems with malpractice insurance and the impact such problems have on service delivery. Recommendations regarding this issue were also required to be included in the report. The department delivered the report to the Governor and the Senate and House Appropriations committees by December 31, 2004. The following is an excerpt from the DCF report.[16]

Public receiving facilities, as defined in section 394.455, Florida Statutes, include crisis stabilization units, children's crisis stabilization units, and hospital inpatient units that have a contract with the Department. These facilities receive state funds to provide short-term intensive acute mental health services to voluntary and involuntary persons.

METHODOLOGY USED TO ESTIMATE MEDICAL MALPRACTICE COST

Providers were asked to provide the annual cost of the public receiving facility's medical malpractice insurance.[17] Only one agency of the 26 reporting agencies provided this information.

If the annual cost of the medical malpractice insurance for the public receiving facility was not available, the provider provided budgetary information to serve as an approximation of insurance cost attributable to the public receiving facility.

Based on survey findings, the percentage of public receiving facility budget compared to total agency budget as of FY 2004 - 2005 is 14.59%. This percentage has remained consistent over the past four years.

It was determined that the median total insurance cost increased 72.5% over the four years, from $104,249 in FY 2001 - 2002 to $179,845 in FY 2004 - 2005. The median total insurance cost peaked at a high of $223,457 in FY 2003 - 2004.

Using the 14.59% approximation above, the median cost of insurance attributable to the public receiving facilities increased from $15,210 in FY 2001 - 2002 to $26,239 in FY 2004 - 2005. The median insurance cost attributable to public receiving facilities peaked at a high of $32,602 in FY 2003 - 2004.

This cost may be an underestimate, given that public mental health receiving facilities serve children and adults who are experiencing acute symptoms of emotional disturbances and mental illnesses. These services are provided in a licensed inpatient setting staffed by medical personnel.

It could not be determined what percent of the total public receiving facility insurance cost was specifically related to medical malpractice insurance costs since most agencies were unable to specify this cost.

FINDINGS

The findings include overall insurance costs, litigation, and system impact as follows:

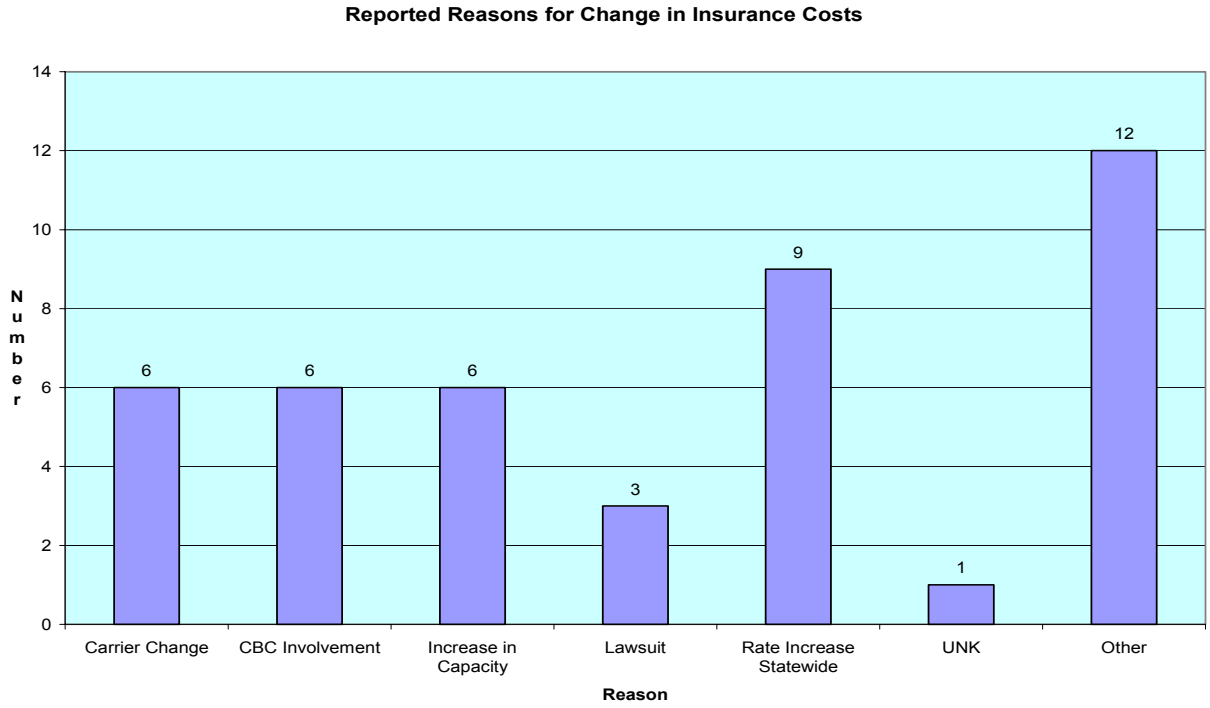
---

[16] Florida DCF report: The Experience of Public Receiving Facilities in Securing and Maintaining Medical Malpractice Insurance, December 31, 2004, on file with the Insurance Committee.

[17] Medical malpractice, as defined by DCF in this report, "means injudicious treatment of a patient, professionally and in respect to the particular diagnosis, resulting in injury, unnecessary suffering, or death to the patient and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rule or principles, neglect or a malicious or criminal intent."

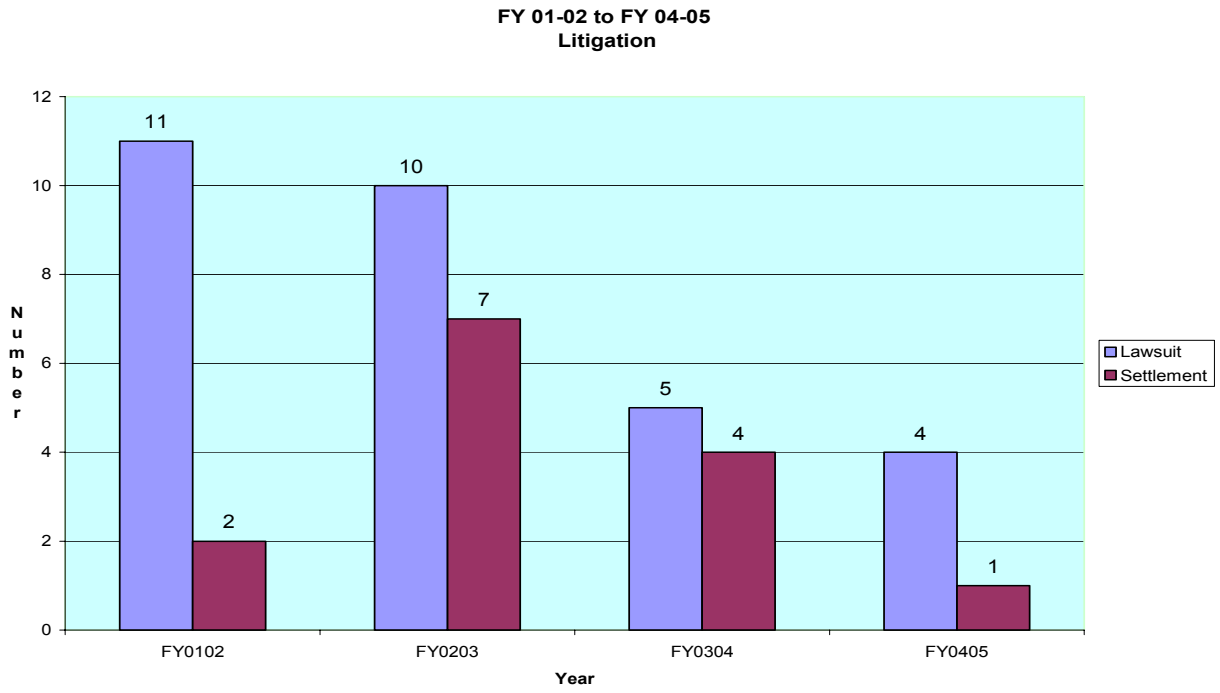
Overall Agency Insurance Costs

- Most reporting providers did not have cost data specific to medical malpractice costs, they reported total insurance cost.
- The median total insurance cost rose 72.5% during the four years, from a low of $104,249 in FY 2001 - 2002 to $179,845 in FY 2004 - 2005. The median total insurance cost peaked to a high of $223,457 in FY 2003 - 2004.
- The median cost of insurance for public receiving facilities rose by 72.5% during the past four years, from $15,210 in FY 2001 - 2002 to $26,239 in FY 2004 - 2005. The median insurance cost for public receiving facilities peaked to a high of $32,602 in FY 2003 - 2004. These costs were estimated based on the percentage of the public receiving facility budget to overall agency budget, and may be an underestimate of insurance costs related to public receiving facilities.
- The average cost of insurance for reporting providers is $236,821 for this fiscal year. This represents a 67.59% increase from an average cost of $141,309 in FY 2002 - 2002.
- The predominant factor associated with change in insurance costs for all providers was rate increases by insurance carriers. The reported reasons for change in insurance costs are displayed below.



Litigation

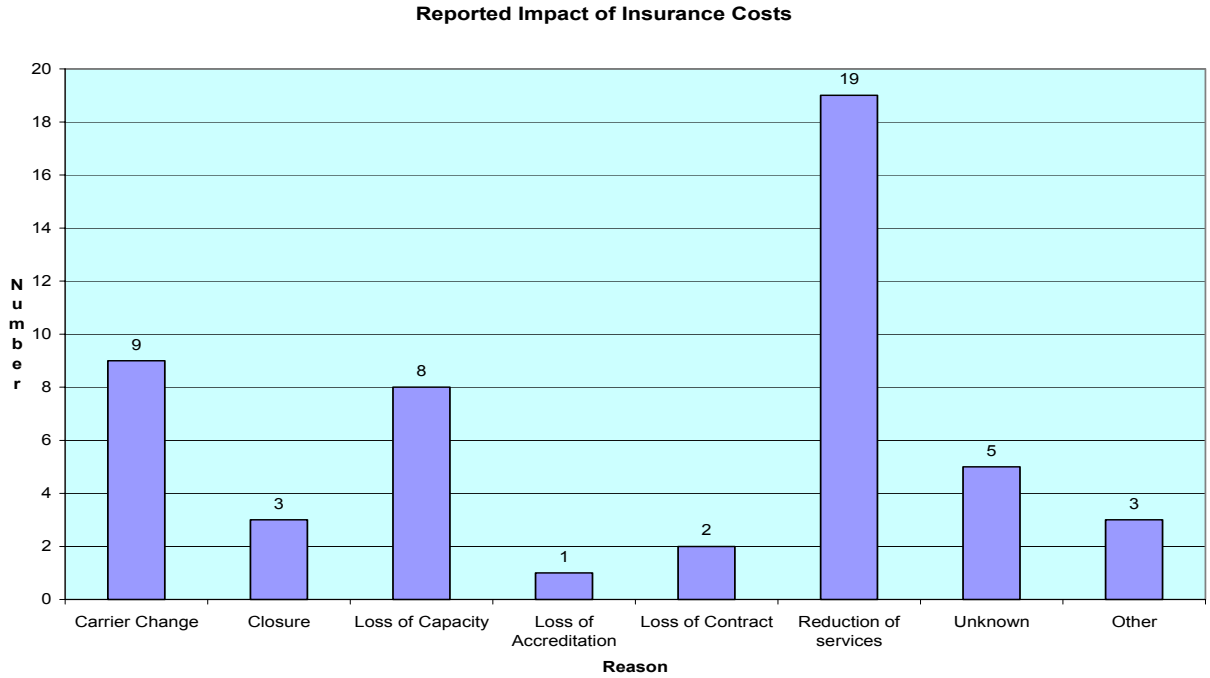
- The reporting agencies provided information about their lawsuits and settlement agreement activity.
- The number of lawsuits has declined from 11 in FY 2001 - 2002 to four in FY 2004 - 2005. The number of settlement agreements generally declined over the same time frame, from a peak of seven settlement agreements in FY 2002 - 2003 to a current low of one settlement agreement in FY 2004 - 2005.



- Rate increases by insurance carriers may have followed litigation activity which increased an average of 15 open cases in FY 2002 - 2002 and FY 2002 - 2003 compared to an average of six open cases during FY 2003 - 2004 and FY 2004 - 2005.

System Impact

- Nineteen of the responses indicated a potential for reductions in agency-wide services as a result of increased insurance costs. Eight of the responses indicated potential loss of agency-wide capacity in addition to the reduction in services. Reported impact of insurance costs:



- The reporting agency's acute care budgets have increased by 23.01% from $2,564,742 in FY 2001 - 2002 to $3,155,014 in FY 2004 - 2005.

- In FY 2001-2002 the state contracted for 254,294 units (696.7 beds) in public receiving facilities. In contrast, during FY 04-05 the state has contracts for 210,198 units (575.9 beds) in public receiving facilities. This represents a decline of 17.3%. However, the survey responses did not provide sufficient information to attribute these decreases solely to the increased cost of medical malpractice insurance.

RECOMMENDATION

The Department will continue to study this issue to establish more definitive trends in the cost of medical malpractice insurance, the prevalence of lawsuits and awards, and the associated impact on service delivery at public receiving facilities.

Behavioral Provider Liability

The bill creates s. 394.90085, F.S., to provide that certain facilities or programs [a detoxification program defined in s. 397.311(18) (b), F.S, an addictions receiving facility defined in s. 397.311 (18) (a), F.S., or a designated public receiving facility defined in s. 394.455 (26), F.S.] shall have liability limits in tort actions based on services for crisis stabilization. The bill requires that net economic damages be limited to $1 million per liability claim, including but not limited to past and future medical expenses, wage loss, and loss of earning capacity. The bill also specifies that damages be offset by any collateral source payment that is paid in accordance with s. 768.76, F.S. Additionally any non-economic damages specified against the entities specified by this bill are limited to $200,000 per claim. The bill allows for any claim to be settled up to the policy limits without action by the Legislature. However, claims for any amount exceeding limits specified by this bill may be brought to the Legislature in accordance with s. 768.28, F.S. The provider or its insurer must assume any costs for defending action brought under this section.

The bill specifies that the immunities enjoyed by a provider under the provisions of this act extend to an employee of the provider when the employee is acting in furtherance of the provider's responsibilities under its contract with the department. However, these immunities are not applicable to a provider or employee who acts in a culpably negligent manner or with willful and wanton disregard or unprovoked physical aggression when such acts result in injury or death.

The bill specifies that a person who provides contractual services to the Department of Children and Family Services is not an employee or agent of the state for the purposes of ch. 440, F.S., Worker's Compensation. The provider is required, as a part of its contract, to obtain and maintain general liability coverage in the amount of $1 million per claim and $3 million per incident.

This bill additionally specifies that the conditional limitations on damages specified by this act shall be increased at the rate of five percent each year, to be prorated from its effective date to the date at which damages subject to such limitations are awarded by final judgment or settlement.

It is reported that the implementation of this legislation will likely result in lowered insurance premiums for those substance abuse and mental health providers that are specified by this bill.

C. SECTION DIRECTORY:

Section 1. Creates s. 624.4624, F. S., relating to nonprofit community mental health and substance abuse providers' self-insurance fund.

Section 2. Provides that no self-insurance fund created under the bill is an insurer for any purpose under chapter 631, Florida Statutes.

Section 3. Amends s. 768.28, F. S., relating to behavioral provider liability; limits net economic damage to $1 million and non-economic damages to $200,000 per incident.

Section 4. Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Section 1 of the bill exempts providers who form a self-insurance fund from paying the premium tax on their insurance policies which will result in an indeterminate decrease in revenues to the state. This decrease should only occur after the self-insurance fund has been in existence for five years.

2. Expenditures:

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that providers reduce their costs for liability insurance and from legal immunity, the offering of services, with the attendant emotional and financial benefits, may increase for families. To the extent that injured patients are not able to recover fully for their injuries then more families may be dependent on Medicaid or other governmental assistance programs.

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to take an action requiring the expenditure of funds; does not reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

This bill does not delegate rule-making authority to any administrative authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Other Comments

The Office of Insurance Regulation provided the following comments regarding the bill when the bill did not contain the five-year transition period where the funds would have to comply with full panoply of regulatory requirements. However, their comments are still relevant to the fund's operation after the first five years of existence:

Technical Review—The construction of newly created section 624.4624, Florida Statutes:

The newly created self-insurance fund (SIF), as drafted in this legislation, was not drafted to expand the definition of "commercial" self-insurance fund (otherwise defined at section 624.462, Florida Statutes). Thus, the provisions of sections 624.460–624.488, Florida Statutes, ("Commercial Self Insurance Funds") would not apply to this newly created SIF.

And, the newly created SIF is, at subsection (2) of this bill, exempt from section 624.4621, Florida Statutes, for purposes of definition and regulation as group self-insurance fund formed to provide workers compensation coverage.

Thus, by construction of the statute, the newly created SIF appears regulated only by the specific provisions within its newly created statute, section 624.4624, Florida Statutes. That construction:

- Exempts the fund from any form of solvency requirement;
- Does not provide the OIR with authority to protect member participants against inadequate rates and premium collection;
- Is constructed to exempt the fund from requirements otherwise applicable to self-insurance funds—either those formed to provide self-insurance for workers compensation insurance or those formed for sharing property and casualty and surety risk; and,
- Creates an ambiguity related to Guaranty Fund Protection, that is,
  - For risks associated with property/casualty and surety, it is not clear if the newly created SIF would qualify for FIGA protection, because at s. 624.462(5) a commercial self-insurance fund is required to participate in FIGA. This newly created SIF is not bound by the provisions of section 624.462, Florida Statutes;
  - For risks associated with workers compensation, section 631.905(5), Florida Statutes,[18] the FIGA workers compensation account may cover this SIF, because the definition of covered entities specifically excludes only local government SIFs organized under section 624.4622, Florida Statutes, (group self-insurance funds formed specifically for providing workers compensation benefits);

With respect to the occurrence of a deficit, a significant difference between the SIFs already permitted in statute and that proposed in this bill is that local government SIFs created at section 624.4622, Florida Statutes, could generate additional revenues with the exercise of local government taxing authority. Independent educational SIFs created at section 624.4623, Florida Statutes, could raise revenues through additional tuition and fees. In contrast, nonprofit community mental health and substance abuse providers have no associated source of additional revenue generation.

[18] 631.904 Definitions.--As used in this part, the term:
(5) "Insurer" means an insurance carrier or self-insurance fund authorized to insure under chapter 440. For purposes of this act, "insurer" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, or an individual self-insurer as defined in s. 440.385.
Continuation of footnote 20: (6) "Self-insurance fund" means a group self-insurance fund authorized under s. 624.4621, a commercial self-insurance fund writing workers' compensation insurance authorized under s. 624.462, or an assessable mutual insurer authorized under s. 628.6011. For purposes of this act, "self-insurance fund" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, or an individual self-insurer as defined in s. 440.385.

Subsection (1)—In describing the risk being assumed by the newly created SIF the term "securing the payment of benefits under chapter 440" may mean the SIF intends to provide workers compensation coverage to its participants.

However, at subsection (2) the legislation specifically exempts the newly created SIF from the requirements that apply to group self-insurance funds at section 624.4621, Florida Statutes, designed for SIFs that provide workers compensation insurance to member participants.

Subsection (1)(a)—requires the fund to have "annual normal premiums in excess of $5 million" The self-contained nature of the newly created statute implies there would be no oversight of policy form or rate approval. Member participants would not benefit from the protections of form and rate approval that assure rates are not excessive, inadequate, or non-discriminatory and that contracts issued by the fund provide reasonable benefits for the risks being assumed by the fund.

Subsection (1)(b)—Requires the fund, as determined by a qualified actuary, to maintain a program of excess insurance coverage. The actuary is also to provide a reserve evaluation – but not an actuarial opinion -- in light of the need to protect the financial stability of the fund. Subsection (1)(b) does not require rate development by a qualified actuary and does not require the fund to maintain reserves sufficient to meet the cost of risks associated with the coverage the fund will provide.

Limiting Liability and Constitutional Access to Courts

This bill limits the liability of a behavioral provider eligible under newly created section 394.9085, F.S. This bill places a cap on the amount of damages that a plaintiff may recover. Net economic damages will be limited to $1 million per claim and non-economic damages to $200,000 per claim.

If the damage award limitation is challenged, the courts will likely consider the precedent in the following cases briefly mentioned below.

According to "access to courts provision" of Article 1, Section 21, of the Florida Constitution, the Legislature is limited in what it may do to limit economic and non-economic damage awards. According to Florida case law, the Legislature may not cap non-economic damages unless it satisfies the test created by the Court in Kluger. Smith v Department of Insurance, 507 So. 2d 1080, 1087-88 (Fla. 1987); *see* Kluger v White, 281 So. 2d 1 (Fla. 1973) (In Kluger, a statute that eliminated a cause of action that pre-dated the 1968 Florida Constitution was held unconstitutional for violating the "access to courts provision" of the Florida Constitution. In Kluger, the Court created a test for the Legislature that was modified in Smith and applied to tort reform legislation passed in 1986 that limited non-economic damages).

In order to satisfy the Kluger test, the Legislature must provide a reasonable alternative remedy or commensurate benefit; or show an overpowering public necessity for the abolishment of the right to recover unlimited damages and show that no alternative method of meeting the public necessity was available to the Legislature. Smith v Department of Insurance, 507 So. 2d 1080 (Fla. 1987).

In Smith, the Court held that the Legislature did not satisfy the Kluger test. Smith at 1089. However, the Legislature was held to have satisfied the Kluger test in a case that litigated 1988 legislation that limited non-economic damages in medical malpractice cases. University of Miami v Echarte, 618 So. 2d 189, 193 (Fla. 1993).

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 24, 2005 the Insurance Committee considered and adopted three amendments to the bill. As originally filed the bill required providers to be members in good standing with the Florida Council for Community Mental Health and The Florida Council for Behavioral Healthcare in order to qualify for the bill's self insurance fund provisions. An amendment was adopted to delete that specific reference and replace it with a more general classification. The second amendment provided a transition time for the formation of self-insurance funds; allowing regulatory oversight and requiring financial reporting. The final amendment restricted application of agency status to only those providers who treat publicly funded patients. This staff analysis addresses the bill with these three amendments incorporated.

On April 11, 2005, the Health Care Appropriations committee adopted two amendments to HB 881 CS.

- The first amendment specifies that no self-insurance fund created under this bill shall be deemed or considered to be an insurer for any purpose under chapter 631, Florida Statutes.

- The second amendment specifies that any person or entity designated as an agent of the state in this bill shall reimburse the state for the actual costs of defending any claim and for any amounts paid by the state in payment of a settlement or judgment arising out of the claim up to the liability limits set forth in the bill. Penalties are specified if a person fails to reimburse the state as required in the bill.

On April 21, 2005, the Commerce Council adopted one amendment to HB 881 CS. The amendment removed the provision of this bill related to sovereign immunity and replaced it with a $1 million cap on net economic damages and a $200,000 cap on non-economic damages per claim.

This analysis reflects these amendments.