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 for CS/SB 560 & CS/SB 2080

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

SUBJECT: Medical Malpractice Insurance

DATE: April 11, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.	Greenbaum	Roberts	JU	Favorable/CS
3.				
4.				
5.				
6.				

I. Summary:

This CS:

- Provides for a statement of legislative intent;
- Allows a group of 10 or more health care providers to form a commercial self-insurance fund;
- Requires insurers to provide 90-days notice of a policy cancellation and a 60-day notice of a rate increase;
- Establishes medical malpractice rate filings standards to be administered by the Office of Insurance Regulation;
- Provides rulemaking authority to the Department of Financial Service to require additional information in its analysis of professional liability cases;
- Requires the Office of Insurance Regulation to provide health care providers with a comparison of rates;
- Requires the Office of Insurance Regulation to prepare a report on closed claims information and medical malpractice insurer financial information;
- Provides for a rollback of medical malpractice insurance rates to levels in effect January 1, 2001 and provide a mechanism to review proposed deviations from the rollback rate;
- Provides a trigger for the implementation of the Florida Medical Malpractice Insurance Fund;
- Creates the Florida Medical Malpractice Insurance Fund, a primary medical malpractice insurance carrier;
- Provides for public hearings on proposed medical malpractice insurance rates;
- Provides that insurers are to make rate filings that reflect the impact of the provisions of this bill;
- Mandates the reporting of claim information to Office of Insurance Regulation that is reported to National Practitioner Data Bank;

- Requires the Office of Program Policy Analysis and Government Accountability to study the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and report to the Legislature by January 1, 2004;
- Authorizes healthcare facilities to apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents. Insurers must file with the Department of Financial Services a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program and these facilities must receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law;
- Creates the Health Care Professional Liability Insurance Facility to provide an alternative source of excess medical malpractice insurance;
- Prohibits excessive profits by medical malpractice insurers and provides a mechanism for refunding excessive profits;
- Provides for the application of common law principles of good faith to bad-faith actions of insurers arising out of medical malpractice claims and limits bad faith actions against medical malpractice insurers when the insurer tender its policy limits and meets reasonable conditions of settlement during the presuit investigation period;
- Provides that as a requirement of licensure healthcare facilities must install a computerized prescription system that uses software that prevents prescription errors;
- Provides for severability of provisions of this PCS; and
- Provides an effective date contingent upon the passage of other legislation addressing medical malpractice issues.

This PCS substantially amends s. 624.462; ss. 627.062, .0645, .4147, .912, & .357; ss. 627.357, and 766.106 of the Florida Statutes. This PCS creates ss. 627.41491, .41492, .41493, .41495, .3575, .9121, and .0662 of the Florida Statutes. This CS creates eight undesignated sections of law.

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 two-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; Commercial Self-Insurance Funds

Background - 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).

But, 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 has 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. Insurers must generally maintain a surplus (net worth) of $4 million or 10 percent of liabilities, whichever is greater (s. 624.408, F.S.). In contrast, a commercial self-insurance fund is not subject to surplus requirements, other than a "$1" surplus requirement that the ratio of net assets to net liabilities of at least 1 to 1, and other requirements, as described below. The Department of Insurance has experienced problems with funds that attempt to collect assessments from their members and the litigation that can ensue.

With regard to rates for coverage, the absence of a profit factor (usually about 5 percent of premium) and, possibly, lower expenses, could result in lower rates as compared to authorized insurers. But, there is no particular reason why the claims experience and investment income of a self-insurance fund would be different than for an authorized insurer, so the portion of the rate that covers expected claims (discounted for expected investment income) should be approximately the same as amounts charged by an authorized insurer, subject to the actual claims experience of the insurer or fund.

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. Authorized insurers are more likely to have available surplus to compensate for inadequate premiums. In the event of insolvency, an authorized insurer's claims are covered by the Florida Insurance Guaranty Association. 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.).

Former medical malpractice self-insurance funds - Section 627.357, F.S., which previously authorized the formation of a medical malpractice risk management trust fund, required approval from the Department of Insurance, subject to the following requirements: (1) employment of a professional consultant for loss prevention and claims management coordination under a risk management program; (2) being subject to "regulation and investigation by the department" and "subject to rules of the department and to part IX of chapter 626, relating to trade practices and frauds"; (3) being allowed to ("may") purchase excess insurance, as necessary, and to purchase such risk management services as may be required; and (4) "to engage in prudent investment of trust funds and other activities reasonably relating to the payment of claims and to providing medical malpractice self-insurance, to the extent otherwise consistent with this section and law generally applicable to medical malpractice insurers." Such funds were authorized to insure hospital parent corporations, hospital subsidiary corporations, and committees against claims

[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.

arising out of the rendering of, or failure to render, medical care or services. The department adopted rules pursuant to this section, providing more specific requirements (ch. 4-187 F.A.C.). This statute prohibits the formation of a self-insurance fund after October 1, 1992.

Current commercial self-insurance funds - Commercial self-insurance funds may be authorized by the Office of Insurance Regulation, pursuant to ss. 624.460-624.488, F.S. Such 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 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. 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.)

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 recommendations relating to medical malpractice insurance are included in the final report of the Task Force.

> *Recommendation 4.* The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the November 2002 report, Fostering Rapid Advances in Healthcare, by the Institute of Medicine (IOM) at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.
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> *Recommendation 5.* If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.
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> *Recommendation 9.* The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.
> *Recommendation 47.* The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.
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> *Recommendation 48.* The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insured, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.
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> *Recommendation 49.* The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.
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> *Recommendation 50.* The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Reporting of Professional Liability Closed Claims

Certain insurers providing professional liability insurance to health care practitioners, and certain physicians and dentists licensed in Florida, are required to report liability claims, once they are closed, to various governmental agencies under state and federal law.

Section 627.912, F.S., requires each medical malpractice self-insurer and each insurer or joint underwriting association providing professional liability insurance to specified health care practitioners and facilities, health maintenance organizations, and members of the Florida Bar to

report to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

- A final judgment in any amount; or
- A settlement in any amount.

The Department of Insurance has applied the closed claim reporting requirements to those insurers over which they have regulatory control, i.e. authorized insurers that have a Certificate of Authority from the Department of Insurance to write insurance in Florida. To the extent that health care providers are obtaining medical malpractice insurance through risk retention groups, surplus lines insurers, or offshore insurers, their closed claims are not being reported under s. 627.912, F.S. Also, claims attributable to health care practitioners who are not insured are not reported to the Department of Insurance.

Under s. 456.049, F.S., Florida-licensed physicians and dentists must report to the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and the claim resulted in:

- A final judgment in any amount;
- A settlement in any amount; or
- A final disposition not resulting in payment on behalf of the licensee.

The Health Care Quality Improvement Act of 1986 requires reporting of medical malpractice payments, sanctions taken by Boards of Medical Examiners, and professional review actions taken by health care entities to the National Practitioner Data Bank. Under 42 U.S.C. section 11131, each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report information respecting the payment and circumstances thereof. The information to be reported includes:

- The name of any physician or licensed health care practitioner for whose benefit the payment is made;
- The amount of the payment;
- The name (if known) of any hospital with which the physician or practitioner is affiliated or associated;
- A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
- Such other information as the Secretary of the U.S. Department of Health and Human Services determines is required for appropriate interpretation of the information reported.

Good Faith Dealings Between an Insurer and Its Insured

Insurance policies which impose an obligation on the insurer to defend and indemnify its insured against liability obligate the insurer to a duty of good faith in the handling of the defense of or settlement of claims against the insured.[2] If the insurer breaches its good faith duty, it may be liable for the amount of the judgment rendered against the insured which exceeds the limits of coverage under the insurance policy or contract with the insured. Florida law provides civil remedies by statute and at common law[3] for aggrieved litigants damaged by an insurer's failure to handle the defense of or settle a claim of the insured. At common law as early as 1938, Florida courts have allowed third party bad faith actions. Even though the tort of bad faith occurred between the insurer and its insured, Florida courts have permitted the injured third party to bring a bad faith action directly against the first party insurer because the injured third-party, as the beneficiary to the bad faith claim, is the real party in interest.[4]

In 1962, the Legislature enacted section 624.155, F.S., which provides civil remedies to any person who has been damaged by an insurer who has not attempted to settle and pay a claim for policy benefits in good faith. Section 624.155(7), F.S., provides that the civil remedy in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or the statutory remedy, but shall not be entitled to a judgment under both remedies. In addition, the section has been interpreted to allow a litigant to choose between his common law and statutory remedies for bad faith. Under s. 624.155(4), F.S., punitive damages are recoverable for the acts of the insurer which give rise to violation in such frequency as to indicate a general business practice and the acts: are willful, wanton, and malicious; in reckless disregard for the rights of any insured; or in reckless disregard for the rights of the beneficiary under a life insurance contract.

Insurance Rate Standards

All property and casualty insurers authorized to do business in the state are required to file rates for approval with the Department of Insurance either 90 days before the proposed effective date ("file and use") or 30 days after the rate filing is implemented ("use and file").[5] Under the file and use option, the department may finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing. These notices are "agency action" for purposes of the Administrative Procedure Act, and give the insurer the right to choose an administrative hearing or binding arbitration. Prior to approving or disapproving a rate filing, the department may request additional supporting information for the filing from the insurer, but such a request does not toll the 90-day review period. If the department fails to issue a notice of intent to approve or disapprove within the 90-day review period, the filing is deemed approved.

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[2] See *Boston Old Colony Insurance Company v. Guitierrez*, 386 So.2d 459 (Fla. 1985).

[3] See *Thompson v. Commercial Union Insurance Co. of New York*, 250 So.2d 259 (Fla. 1971) the Florida Supreme Court declared that an insured or injured plaintiffs have the right to sue and recover damages against the insurer for an excess of the policy limits, based on the alleged fraud or bad faith of the insurer in the conduct or handling of the defense of the insured's suit.

[4] See *Auto Mutual Indemnity Co. v. Shaw*, 134 Fla. 815, 184 So. 852 (1938) and *State Farm Mutual Automobile Ins. Co. v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).

[5] See s. 627.062, F.S.

Under the "use and file" option, an insurance company may be ordered by the department to refund a portion of the rate to the policyholder in the form of a credit or refund if it is found to be excessive.

The department may disapprove a rate filing if it determines such rates to be "excessive, inadequate, or unfairly discriminatory." These terms are defined in the Florida Statutes in the following manner:[6]

(a) Rates are "excessive" if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.[7]

(b) Rates are "inadequate" if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Also, rates are deemed "inadequate" as to premium charged to a risk if discounts or credits are allowed which exceeded a reasonable reflection of expense savings and expected loss experience from the risk.

(c) Rates are "unfairly discriminatory" as to a risk if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[8]

In making its rating decision, the department must consider, in accordance with generally accepted and reasonable actuarial techniques, thirteen factors which affect the insurer's rate filing which include: past and prospective loss experience, expenses, market competition for the risk insured, investment income, the reasonableness of the judgment reflected in the rate filing, dividends, the adequacy of loss reserves, cost of reinsurance, trend factors, catastrophe hazards, profits, medical services (if applicable), and other relevant factors which impact upon the frequency or severity of claims or upon expenses.

Medical Malpractice Self-Insurance Funds

Section 627.357, F.S., once authorized the establishment of medical malpractice self-insurance funds. In 1992, the statute was amended to provide that no such funds could be formed after October 1, 1992. Currently there are only two funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. The Department of Insurance is directed

[6] S. 627.062, F.S.
[7] Rates are also *excessive* if, among other things, the rate structure established by a stock company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.
[8] A rating plan, including discounts, credits, or surcharges, shall be deemed *unfairly discriminatory* if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program.

to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund maintain sufficient reserve to cover contingent liabilities in the event of dissolution.

The funding of a Medical Malpractice Risk Management Trust Fund is provided by premiums paid by members. Additionally, each member has a contingent assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. The Department of Insurance must review and approve all expense factors related to rates before a new rate can be implemented. For the Department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The Governor's Select Task Force on Healthcare Professional Liability Insurance found that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than go without insurance, quit practicing medicine, or reduce services provided. Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

Florida Birth-Related Neurological Injury Compensation Association

The Tort and Insurance Reform Act of 1986 created the Academic Task Force for Review of the Insurance and Tort Systems. A major concern of the Task Force was the increasing unavailability of obstetric services to the women of Florida. The significant increase in malpractice insurance premiums caused many physicians to cease the practice of obstetrics, creating a shortage of professionals to provide care for expectant mothers. To combat this health care delivery crisis, the Task Force recommended that the Legislature implement a no-fault plan of compensation for catastrophic birth-related neurological injuries.

In response to the recommendations, the Legislature enacted the Florida Birth-Related Neurological Injury Compensation (NICA) Act in 1988 (ss. 766.301-766.316, F.S.). NICA provides compensation, regardless of fault, for specific birth-related neurological injuries. Participating hospitals and physicians are immune from liability under medical malpractice for claims covered by NICA. A birth-related neurological injury is defined to mean:

> [I]njury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

The Florida Supreme Court has ruled that in order for an infant to qualify under the above definition, the infant must be both mentally and physically impaired, not just one or the other.[9] If the administrative law judge finds that the statutory criteria are satisfied, then the infant, as well

[9] Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So.2d 1349, (1997).

as the infant's parents or legal guardians, are entitled to the award of specifically defined, but limited, financial benefits without regard to fault. Section 766.31, F.S.

In the fourteen years NICA has been in place, 161 cases have been accepted and there are presently 87 current open cases. Reports reflect an average of $3 million dollars per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of the child, and the premise that as the child ages, care becomes more expensive.

The Governor's Select Task Force on Healthcare Professional Liability Insurance heard testimony about the high premium costs for medical malpractice coverage for obstetricians and the effects that high premium costs are having on these physicians and hospitals. The Task Force suggested that modifications to the eligibility requirements for NICA, such as changing the birth weights and changing the requirement that the infant be "mentally *and* physically" impaired to "mentally *or* physically" impaired might encourage greater participation. The broadening of the definition of eligible claimants may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services. However, any changes that open the program up to more claims would have to be evaluated for the level of financial assessments that would be required on hospitals and physicians.

III. Effect of Proposed Changes:

Section 1. Provides a statement of legislative intent.

Section 2. Amends s. 624.462, F.S., to allow 10 or more health care providers to form a commercial self-insurance fund under ss. 624.460-624.488. The definition of health care provider that is cited in s. 627.351(4)(h), F.S., includes a hospital, physician, osteopath, chiropractor, naturopath, nurse, midwife, clinical laboratory, physician assistant, physical therapist, physical therapist assistant, health maintenance organization, ambulatory surgical center, blood bank, plasma center, industrial clinic, renal dialysis facility, and other medical facilities meeting certain criteria, as well as professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

The bill, in effect, allows 10 or more health care providers to form a commercial self-insurance fund, where today such a fund for medical malpractice could be formed only if it is formed by 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. Otherwise, all of the current requirements for such a fund, as described in Present Situation, would continue to apply.

Section 3. Amends s. 627.062, F.S., relating to rate filings for property, casualty, and surety insurance, including medical malpractice insurance. The bill provides that an insurer that makes a medical malpractice rate filing, would not be permitted to require arbitration of the rate filing after the rate has been disapproved by the Office of Insurance Regulation. More specifically, an insurer is currently allowed to require arbitration after "any action with respect to a rate filing that constitutes agency action," which would no longer be allowed for an insurer that makes a medical malpractice rate filing. Therefore, if the office disapproved a medical malpractice rate

filing, the insurer would only have the options available under the Administrative Procedures Act to request a formal or informal hearing.

The bill also creates additional requirements for rate filings of medical malpractice insurers:

- the insurer cannot include in the base rate nor used to justify a rate or rate change:
  - a portion of a judgment or settlement paid as a result of bad faith actions of the insurer;
  - a portion of a judgment in which punitive damages were awarded against the insurer; or
  - taxable costs or attorneys fees which relate to the assessing of damages against the insurer for bad faith actions;
- a mechanism to determine whether a rate is excessive, inadequate, or discriminatory; and
- a mechanism to apply a discount or surcharge to the rate applied to a policy based on the health care provider's loss experience.

Section 4. Amends s. 627.0645, F.S., to except medical malpractice insurers from the requirement to make an annual base filing to the Office of Insurance Regulation and reporting of deviations from such base rate filings.

Section 5. Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts, to require the insurer or self-insurer to notify the insured no less than 90 days, rather than 60 days, prior to the effective data of cancellation or nonrenewal of a policy or contract. In addition, the insurer or self-insurer must provide 60-days notice prior to the effective date of a rate increase. Currently, under s. 627.4133, F.S., all property and casualty insurers, which includes medical malpractice insurers, must provide at least 45-days written notice of the renewal premium.

The bill requires medical malpractice insurers to apply a discount or surcharge on a health care provider's premium based on the provider's loss experience, including state disciplinary action. The insurer may establish an alternative method of considering the provider's loss experience. The insurer must include a schedule of all discounts and surcharges or a description of alternative methods in all filings with the Office of Insurance Regulation and must also provide them to policyholders or prospective policyholders. Medical malpractice insurers may not use any rate or charge any premium unless the director of the Office of Insurance Regulation has approved such schedule or alternative method.

The bill deletes a prohibition against medical malpractice insurers requiring the insured to be a member in good standing of a duly recognized state or local professional society of health care providers which maintains a medical review committee. The bill also deletes a prohibition against a professional society expelling or suspending a member solely because he or she participates in a health maintenance organization.

The changes to s. 627.4147, F.S., are made to apply to all policies issued or renewed after October 1, 2003.

Section 6. Amends s. 627.912, F.S., relating to reporting of professional liability claims and actions by insurers, to increase the upper limit of the fine for violations of the reporting requirements by an insurer, from $1,000 per case to $10,000 per case. Authorizes the Office of

Insurance Regulation to adopt by rule additional information requirements for its analysis and evaluation of reported professional liability cases.

Section 7. Creates s. 627.41491, F.S., to require the Office of Insurance Regulation to provide health care providers with a comparison of the rate in effect for each medical malpractice insurer and self-insurer and the Florida Medical Malpractice Joint Underwriting Association (FMMJUA). The comparison chart is to be made available to the public through the Internet and other commonly used means of distribution no later than July 1 of each year.

Section 8. Creates s. 627.41492, F.S., to require the Office of Insurance Regulation to prepare annually a report which analyzes closed claim information and medical malpractice insurer quarterly financial reports.

Section 9. Creates s. 627.41493, F.S., to require medical malpractice insurance rate rollbacks. For any coverage for medical malpractice insurance subject to ch. 627, F.S., that is issued or renewed on or after July 1, 2003, every insurer must reduce its charges to levels that were in effect on January 1, 2001. According to the Office of Insurance Regulation, this equates to about a 60 percent rate rollback compared to rates that are currently in effect.

For policies issued or renewed on or after July 1, 2003, and July 1, 2004, rates and premiums that have been reduced as prescribed above may only be increased if the director of the Office of Insurance Regulation finds, after a hearing, that an insurer or self-insurer or the FMMJUA is unable to earn a fair rate of return. Beginning July 1, 2003, insurance rates for medical malpractice must be approved by the director of the Office of Insurance Regulation prior to being used. Each separate affiliate of an insurer is subject to this section.

Section 10. Creates an undesignated section of law to provide a trigger to effect the operation of the Florida Medical Malpractice Insurance Fund. Provides that if the director of the Office of Insurance Regulation determines that the rates of medical malpractice insurers have been reduced to the January 1, 2001, level but have not remained at that level for the year beginning July 1, 2003, and, that the medical malpractice insurers have proposed increases that are greater than 15 percent in each of the next two years beginning July 1, 2004 then the Florida Medical Malpractice Insurance Fund shall become effective.

Section 11. Creates the Florida Medical Malpractice Insurance Fund (fund). This fund is to be a primary medical malpractice insurance carrier. Provides for findings and purpose; definitions; limits of coverage; factors to be addressed in the setting of premium rates by the fund, including that there should be no factor for profits and that the anticipated future investment income of the fund should be based on an average of the actual income of the fund for the prior seven years; provides for tax exemption from state corporate income and premium taxes and for the fund to seek federal tax-exempt status; provides for an initial capitalization of $100 million derived from a loan from the Florida Birth-Related Neurological Injury Compensation (NICA) Fund; provides for oversight by the Financial Services Commission; provides for termination of the fund on January 1, 2013 and for the reversion of remaining assets back to the state's General Revenue Fund.

Section 12. Provides that all medical and osteopathic physicians obtain and maintain professional liability coverage in an amount not less than $250,000 per claim and $500,000 in the aggregate from an entity authorized to underwrite such coverage.

Section 13. Creates s. 627.41495, F.S., to require consumer participation in rate review. Medical malpractice insurers, self-insurers, or risk retention groups, upon the filing of a proposed rate change, must give notice to the public and to its insureds. The rate filing must be available for public inspection. If the insureds request a hearing within 30 days after the mailing of the notification of the proposed rate changes, the director of the Office of Insurance Regulation must hold a hearing within 30 days after such request. Any consumer may participate in the hearing. The Office of Insurance Regulation is authorized to adopt rules governing participation by consumers.

Section 14. Creates an undesignated section of law to provide that medical malpractice insurers are to submit rate filings effective January 1, 2004, which reduces rates by a presumed factor that reflects the impact of the changes provided for in this bill. The Office of Insurance Regulation is to review the rate filings using generally accepted actuarial techniques and standards. Insurers are to also file along with that rate filing an alternative rate with supporting evidence when such insurer contends that the rate required under this section is excessive, inadequate, or unfairly discriminatory.

Section 15. Amends s. 456.049, F.S., to provide that the Department of Health must provide to the Office of Insurance Regulation information collected under the section regarding claims or actions for damages based on professional negligence.

Section 16. Amends s. 627.357, F.S., to eliminate a prohibition against creating medical malpractice self-insurance funds after October 1, 1992. An application to form a medical malpractice self-insurance fund must be filed with the Office of Insurance Regulation. The Office of Insurance Regulation must ensure that medical malpractice self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Office of Insurance Regulation is granted rulemaking authority to implement its responsibilities over medical malpractice self-insurance trust funds.

Section 17. Creates s. 627.9121, F.S., to require each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim and that is required to report information to the National Practitioner Data Bank under 42 U.S.C. section 11131 to also report the same information to the Office of Insurance Regulation. The Office of Insurance Regulation must include such information in the data that it compiles under s. 627.912, F.S. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with the requirements imposed by law.

Section 18. Creates an undesignated section of law, to require the Office of Program Policy Analysis and Government Accountability to complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and to submit a report to the Legislature by January 1, 2004, recommending whether

or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under s. 766.302, F.S., should be modified.

Section 19. Creates an undesignated section of law, to authorize a licensed hospital, ambulatory surgical center, or mobile surgical facility to apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents, which result in the reduction of serious events at the facility. The Department of Financial Services must develop criteria for certification. Insurers must file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program. A health care facility must receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law. The department must consider, in reviewing filings, whether, and the extent to which a certified program is otherwise covered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 20. 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 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 will 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 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. 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 $50 million.

Section 21. Any policy issued under s. 627.3575, F.S., (section 20, above) 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.

It is not clear how the impact of this provision is given effect as other provisions of the bill require professional liability coverage or impact the underwriting of professional liability coverage.

Section 22. Creates s. 627.0662, F.S., to prohibit excessive profits for medical malpractice insurers and to provide a mechanism for reviewing the gains and losses of insurance companies to determine if any insurance company has realized excessive profits. Provides for refunds to policyholders on a pro rata basis in the event it is determined the insurance company has realized excessive profits.

Section 23. Amends s. 766.106, F.S., to provide that common law principles of good faith and not statutory principles of good apply in regard to bad-faith actions arising out of medical malpractice claims. This would preclude the assessing of punitive damages against an insurer in actions arising out of medical malpractice.

This section also precludes a bad-faith action against an insurer for failure to timely pay its policy limits where an insurer has tendered an offer at its policy limits and meets reasonable

conditions of settlement prior to the conclusion of the pre-suit period or an extension thereof, as provided by subsection (4), and for a 120 day period thereafter, or during a 60-day period after the filing of an amended complaint alleging new facts previously unknown to the insurer.

Section 24. Creates an undesignated section of law that mandates that each facility licensed under ch. 395, F.S., must install a computerized prescription system linked to software designed to prevent prescribing errors. This is to be a licensure requirement for facilities and further, healthcare practitioners with hospital privileges in that facility must use such system when ordering or prescribing medications in that facility.

Section 25. Provides that the provisions of the bill are severable.

Section 26. Provides that except as otherwise provided within the bill, the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Each entity that is required under federal law to report information to the National Practitioner Data Bank must, pursuant to section 6 of the bill, also report the same information to the Florida Office of Insurance Regulation, and will incur costs to do so.

There is no apparent actuarial justification for the requirement for a rate rollback of medical malpractice rates to 20 percent below January 1, 2001 levels, which the Office of Insurance Regulation estimates equates to about a 60 percent rollback from rates currently in effect. If insurers continue writing medical malpractice insurance, they are likely to experience financial losses. More likely, by requiring rate rollbacks, rate hearings, and 90 days notice of rate increases, the eight remaining medical malpractice

insurers that are currently issuing coverage in Florida, may elect to terminate or restrict the offering of such coverage. Other insurers may be unwilling to enter the Florida insurance market under such restrictions.

The bill would allow the insurer to increase rates beginning July 1, 2003, until July 1, 2004, if the director of the Office of Insurance Regulation finds, after a hearing that the insurer is unable to earn a fair rate of return. It is not clear how much time may elapse between the effective date of the rollback (the date on or after July 1, 2003, when a policy is issued or renewed) and the date of the possibly increased rate (the effective date of a policy on or after July 1, 2003, and before July 1, 2004, for which the office approves an increased rate). Given the 90-day notice and public hearing requirements, there would appear to be some period where the rolled back rates must be in effect, for which the insurer may simply refuse to issue or renew coverage until a higher rate has been approved.

Also, the change in law regarding the uses of national rate and form filings could also discourage insurers from writing insurance in Florida.

To the extent that medical malpractice insurers are willing to offer coverage in Florida, health care providers would enjoy a significant decrease in their rates for coverage, and would be provided greater protections against rate increases. It is not clear how the creation of a what is in effect a not-for-profit primary medical malpractice insurance carrier by the state would impact on the willingness of private, for-profit insurers to participate in the Florida medical malpractice insurance market.

The bill allows the formation of a commercial self-insurance fund by 10 or more health care providers. The current law provides a fair degree of solvency standards for such funds, but member assessments remain the ultimate solvency requirement, rather than a surplus requirement. With regard to rates for coverage, the absence of a profit factor (usually about 5 percent of premium) and, possibly, lower expenses, could result in lower rates as compared to authorized insurers. But, the portion of the rate that covers expected claims (discounted for expected investment income) should be approximately the same as amounts charged by an authorized insurer, subject to the actual claims experience of the insurer or fund. If rates turn out to be inadequate and a deficit exists, member insureds of a self-insurance fund must be assessed.

C. Government Sector Impact:

The Department of Health may incur costs to report closed claims data to the Office of Insurance Regulation.

The Office of Insurance Regulation will incur costs to: modify its review of rates to exclude judgments for bad-faith and punitive damages from an insurer's rate base; review applications to form a medical malpractice self-insurance fund; modify information that it collects regarding closed claims; and handle increased numbers of closed claims being reported. There will also be costs associated with regulating medical malpractice self-insurance funds.

The Department of Financial Services will incur costs to certify health care facilities' programs to reduce adverse incidents and to review rate filings to ensure that facilities receive a discount for the effects of certified programs.

The Office of Program Policy Analysis and Government Accountability will incur costs to complete the study of eligibility requirements for a birth to be covered by the Florida Birth-Related Neurological Injury Compensation Association

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.