1983

Session Law 83-206

Florida Senate & House of Representatives

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### LEGISLATIVE SUPPLEMENT "B" - SESSION LAW ABSTRACT

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### Committee Records

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### Other Documentation

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A bill to be entitled
An act relating to medical malpractice
insurance; amending s. 627.351(4), Florida
Statutes, 1982 Supplement; requiring the
Florida Medical Malpractice Joint Underwriting
Association to make certain levels of coverage
available to physicians, osteopaths, hospitals,
and ambulatory surgical centers; increasing
potential assessments against members;
providing immunity from suit to certain persons
relating to actions taken in performance of
duties; providing for departmental approval of
rates; deleting obsolete language; amending s.
768.54(2) and (3), Florida Statutes, 1982
Supplement; permitting the Florida Patient's
Compensation Fund to reject certain risks;
changing liability limits of the fund;
increasing financial responsibility limits for
hospitals not participating in the fund;
increasing the fund entry level, providing for
reimbursement of board members; providing
immunity from liability for certain actions of
board members and others; granting certain
powers to the fund; requiring approval of fund
membership fees and assessments by the
Insurance Commissioner; providing that fund
members must pay protested assessment prior to
filing suit; removing limitations on deficit
assessments to fund members; prohibiting
execution against the fund due to insufficient
assets; providing for stay of execution absent
premiums for the lines of insurance defined in s. 624.605(1)(b), (k), and (q), including premiums for such coverage issued under package policies.

(f) The plan shall provide for one or more insurers able and willing to provide policy service through licensed resident agents and claims service on behalf of all other insurers participating in the plan. In the event no insurer is able and willing to provide such services, the Joint Underwriting Association is authorized to perform any and all such services.

(g) All books, records, documents, or audits relating to the Joint Underwriting Association or its operation shall be open to public inspection, except that a claim file in the possession of the Joint Underwriting Association shall not be available for review during the processing of that claim.

(h) As used in this subsection:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopaths licensed under chapter 459; podiatrists licensed under chapter 461; dentists licensed under chapter 466; chiropractors licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under chapter 464; clinical laboratories licensed under chapter 483; physicians' assistants certified under chapter 458; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part II of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or

2.42 other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine shall not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part II of chapter 641, ambulatory surgical center licensed under chapter 395, or other medical facility as defined in subparagraph 2.

(i) The manager of the plan or his assistant is the agent for service of process for the plan.

Section 2. Subsections (2) and (3) of section 768.54, Florida Statutes, 1982 Supplement, are amended to read:

(2) COVERAGE LIABILITY.--

(a) All hospitals, unless exempted under this paragraph or paragraph (c), shall, and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to

CODING Words in struck through type are deletions from existing law, words underlined are additions
subsection (3). Any hospital operated by an agency of the state shall be exempt from the provisions of this section and shall not be required to participate in the fund. The fund may establish reasonable criteria for selecting any health care provider, other than hospitals, having adverse claims experience.

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage
shall be liable to the extent of its coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by
the fund independently for each fiscal year, such fiscal year to run from July 1 to June 30. The fund may also provide coverages for portions of each fiscal year. The limits maximum-limit of such coverage afforded by liability-of the fund for each health care provider other than a hospital shall not exceed total limits for both entry level and fund coverage of $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, or $3 million-per-claim, $5 million-per-claim, $8 million-per-claim, or $10 million-per-claim as selected elected by the health care provider. In the case of coverage for a hospital, the limit of coverage afforded by the fund shall not exceed total limits for both entry level and fund coverage of $5 million per claim with no annual aggregate. The health care provider who makes such election is responsible for the payment of liable-for any amount of a claim in excess of the elected limit. The fund shall not be responsible for payment of punitive damages awarded for actual or direct negligence of the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods:

1. A bond in the applicable amount set forth in paragraph (f) per claim and times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total bond amount for all years equal to reserved loss and expense amounts for known cases plus times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required. The bond shall be purchased from a licensed surety company;

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total escrow account for all years equal to reserved loss and expense amounts for known cases plus times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required; the bond shall be

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) per claim from
private insurers or the Joint Underwriting Association established under s. 627.351(4); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or the failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $5 million per claim with a $10 million annual aggregate, $10,000 per-claim for each hospital-bed-in such-hospital, not-to-exceed-a $250,000 annual-aggregate.

2. Establish an escrow account in an amount equivalent to $5 million per claim with a $10 million annual aggregate, $10,000 per-claim for each hospital-bed-in such-hospital, not-to-exceed-a $250,000 annual-aggregate, to the satisfaction of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in the amount of $5 million per claim with a $10 million annual aggregate equivalent to $10,000 per-claim for each hospital-bed-in such-hospital from a private insurer, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

However, no hospital shall be required to obtain such coverage in an amount exceeding a $25,000,000 annual-aggregate.

(d) Any health care provider who does not participate in the fund or participates in the fund and who and does not meet the provisions of paragraph (b) shall not be covered by the fund be-subject-to-liability-under-law without-regard-to-the-provisions-of-this-section.

2. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and shall remain in compliance, with the provisions of this section. The department shall review the documentation and then deliver the documentation to the board of governors. At least 60 days prior to the time a license will be issued or renewed, the department shall request from the board of governors a certification that each hospital is in compliance with the provisions of this section. The board of governors shall not be liable under the law for any erroneous certification. The department shall not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the department.

c) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopaths, podiatrists, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, physician,s assistants licensed under chapter 458, osteopaths licensed under chapter 459,
dentists licensed under chapter 466, and podiatrists licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to hospital physicians, interns, employed physician residents, physicians in a resident training program, and other physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

(f) Each health care provider shall be responsible for paying the amount of each settlement or judgment for each claim up to the fund entry level selected amount it selects. The selected entry level shall be not less than of each claim up to the following amounts:

1st As of July 1, 1982—$100,000 per claim or
$500,000 per occurrence.

2nd As of July 1, 1983—$150,000 per claim or
$750,000 per occurrence.

3rd As of July 1, 1984—$200,000 per claim or
$1,000,000 per occurrence.

4th As of July 1, 1985—$250,000 per claim or
$1,250,000 per occurrence.

5th As of July 1, 1986—$300,000 per claim or
$1,500,000 per occurrence.

6th As of July 1, 1987—$350,000 per claim or
$1,750,000 per occurrence.

7th As of July 1, 1988—$400,000 per claim or
$2,000,000 per occurrence.

8th As of July 1, 1989—$450,000 per claim or
$2,250,000 per occurrence.

As of July 1, 1989, the minimum entry level amount shall be indexed to the medical component of the Consumer Price Index and shall be adjusted by the fund each year thereafter accordingly.

(3) PATIENT'S COMPENSATION FUND.—
(a) The fund.—There is created a "Florida Patient's Compensation Fund" for the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members' activities for those health care providers set forth in subparagraphs (1) (b), 5., 6., and 7. which is in excess of the fund entry level selected limits as set forth in paragraph (2) (b). The fund shall be responsible only for payment of claims against health care providers who are in compliance with the provisions of paragraph (2) (b), of reasonable and necessary expenses incurred in the payment of claims, and of fund administrative expenses.

(b) Fund administration and operation.—The fund shall operate subject to the supervision and approval of a board of governors consisting of a representative of the insurance industry appointed by the Insurance Commissioner, an attorney appointed by the Florida Bar, a representative of physicians appointed by the Florida Medical Association, a representative of physicians' insurance appointed by the Insurance Commissioner, a representative of physicians' self-insurance appointed by the Insurance Commissioner, a representative of physicians' self-insurance appointed by the Insurance Commissioner, two representatives of hospitals appointed by the Florida Hospital Association, a representative of hospital insurance appointed by the Insurance Commissioner, a representative of hospital self-insurance appointed by the Insurance Commissioner, a representative of the osteopathic physicians' or podiatrists' insurance or self-insurance appointed by the Insurance Commissioner, and a representative of the general public appointed by the Insurance Commissioner. The board of
MINUTES

FMMJUA BOARD OF GOVERNORS SPECIAL CALL MEETING

TALLAHASSEE, FLORIDA

MARCH 3, 1983

Chairman George Cross called the meeting to order at 9:30 AM at the La Quinta Inn. The Manager advised that a quorum was present.

MEMBERS PRESENT:

George R. Cross, Chairman
James P. Jensen, Vice Chairman
Bill Bell (alternate)
Richard E. DeChene
Frank Klopp (alternate)
Charles A. McCallister
John Thrasher (alternate)

OTHERS PRESENT:

Bruce Culpepper
William D. Rubin
Allan Katz
Jack Herzog
Jerome Vogel
Alfred K. Chandler
Jim Brainard
Harry Landrum
Jim Massie
Patrick J. McNally
Prentiss Mitchell
Vince Rio
E. Allen Shiver
Nadine Bragg
Joanne W. Brown

REPRESENTING:

Crum & Forester - AIA
Liberty Mutual - AAI
Florida Hospital Association
CNA - Unaffiliated
State Farm - Unaffiliated
Florida Farm Bureau - NAII
Florida Medical Association

General Counsel
Insurance Department
Swann & Haddock (representing Insurance Department)
Insurance Department
Insurance Department
FAIA
AIA
AAI
NAII
NAII
State Farm
FMMJUA
FMMJUA
FMMJUA

Mr. Cross then asked the Manager to review the circumstances involving the business of the meeting.

Mr. Shiver asked the Board to refer to the Report of the Insurance Commissioner to the Florida Legislature on Medical Malpractice Insurance. He first read from the report that the future solvency of the Florida Patient's Compensation Fund is the most significant problem facing the state in the area of medical malpractice insurance and that it is of paramount importance that the Legislature act this session either to assure the financial integrity of the PCF or to dissolve it altogether.
March 7, 1983

TO:               Board of Governors
FROM:       Joanne W. Brown, Administrative Assistant
SUBJECT: Minutes - Board of Governors Meeting
            March 3, 1983

Enclosed are the Minutes for the above captioned meeting. If you have any additions or corrections, please advise of same.

Please notice on page three of the Minutes, the notice of another Special Call Meeting of the Board to be held on March 18, 1983. This meeting will be held in Tampa at the Tampa Marriott Hotel on West Shore Boulevard in the Terrace Room, beginning at 9:30 AM.

We are holding rooms at the hotel for the night of March 17th, however we must release them on March 11. Please let us know if you need a room and if you plan to attend this meeting.

/\b

MEMBERS: George R. Cross, Chairman
          James P. Jensen, Vice Chairman
          Robert J. Brennan, M.D.
          Richard E. DeChene
          Charles A. McCallister
          Miles A. McGrane, III
          Robert E. Morrow
          Kenneth W. Whisenand

CC: Allan Katz
    Jack Herzog
    Jerome Vogel
    Jim Brainard
    Harry Landrum
    Jim Massie
    Patrick J. McNally
    Prentiss Mitchell
    Vince Rio

CC: The Honorable Bill Gunter
    William D. Rubin
    Alfred K. Chandler
    Bruce Culpepper
    Hartford Insurance - 2
    U.S.F.&G
    St. Paul - 2
    Harold Eliason
    House Commerce Committee
    AIA - John P. Friedman
    FADIC - Hugh E. Ray
    FAIA - Robert Ross
    PIA - David H. Watkins, Joe Fuller
    FMA - W. Harold Parham, D.H.A
    AAI - Debra K. Wilcox
    John W. Odem
    Dan Holloway
    Florida Hospital Trust Fund
    ISO - Joe Jensen
    PCM - Joe Blanton

Enclosure
assure availability of coverage if the PCF goes under.

Bruce Culpepper, General Counsel for the FMMJUA, asked how this proposal would fit in the FMMJUA Plan of Operation procedure for increasing coverage. Jack Herzog explained that the plan provides for amendments by the Board with the approval of the Commissioner.

After further discussion, Jim Jensen moved that the Board be given more time to make a decision on the Commissioner's recommendation. This was seconded by Frank Klopp, and approved unanimously.

It was then agreed that the Board would hold another special call meeting on March 18, 1983, in Tampa to make a final decision. Harry Landrum requested that a reminder of the time and place of the meeting be sent to all those present.

Being no further business, the meeting was adjourned.

EAS/ib'

March 7, 1983
With this background he then reviewed the Commissioner's recommendations for changes in the PCF, the FMMJUA, and other insurance system items. Mr. Shiver explained how he thought these changes would affect the market place and the political implications involved. This seemed important in the light of the fact that the changes proposed for the FMMJUA can be made without legislative action. It was his opinion that the changes required of the FMMJUA should be made without statutory change if at all possible, to lessen the chances of additional changes in the FMMJUA law being made which would more adversely affect the FMMJUA operations and results. In closing, he recommended that the Board favorably act on the request that the FMMJUA file for approval of the changes recommended by the Insurance Commissioner to the Florida Legislature.

The Chairman then asked for comments from the Department of Insurance representatives.

Assistant Commissioner of Insurance Bill Rubin agreed with the previous remarks of the General Manager. He added that the problem was a complex economic situation involving doctors and lawyers, as well as insurers. Also speaking for the Department of Insurance, Attorney Allan Katz said that the Commissioner is prepared to approve rates adequate to deal with the problems. He stated that the FMMJUA rates would have to be higher for excess coverage than those of the PCF, and that most of those seeking malpractice coverage would surely go to other markets because of the cost differential.

The Chairman then called for comments from other Board members.

Mr. Bill Bell and Mr. Charlie McCallister asked questions of the Insurance Department representatives for clarification on certain aspects of the law and on the recommendations of the Commissioner. To one question, Mr. Rubin responded that the present request does not include the filing of hospital forms modified to include coverage for anesthesiologists.

Following this discussion, the Chairman recognized the various trade group representatives for their statements.

Harry Landrum, speaking for the AIA, and Pat McNally for NAIU, both felt that the Commissioner's proposals would not cure the medical malpractice problems. Mr. Landrum also stated that the action requested would not stop the thrust of the South Florida physicians and others from the efforts to change the laws and to secure some kind of subsidy for the cost of malpractice insurance.

Jim Massie, speaking for the AAI, and Vince Rio for State Farm, brought up questions on the constitutionality of the Insurance Department's proposals and the current FMMJUA statute. In response to the trade group representatives, Allan Katz stated that availability of coverage is not a problem now, but that no one wants this type of problem in the future. Also, if the Commissioner feels a threat to the constitutionality of the law, he will seek changes in the Legislature which would open up other issues, which no one wants to do. The purpose of the Department's request is merely to
March 9, 1983

Bruce Culpepper, Esquire
318 North Calhoun
Tallahassee, Florida 32301

Dear Bruce:

It is my hope, that the FMMJUA Board will act favorably on the Department's recommendations that the FMMJUA increase the limits of coverage it offers and offer excess coverage.

The Board members should be made aware that the purpose behind the Department's recommendations is to assure the availability of an adequate market of last resort. I feel that the FMMJUA should be maintained as a "last resort" market.

Due to structural differences in the FMMJUA and in the FPCF, as well as the different markets served by these entities, I cannot foresee that the FMMJUA will at any time be directly competitive with the FPCF. As long as the FPCF remains viable, I believe it will be a principal provider of excess coverage. However, rates should be self-sustaining and not subsidized. For past years, the FMMJUA has a track record of adequate rates. I contemplate that this record will continue in the future for the new coverages provided.

It is my intention that fully supportable actuarially sound rates filed by the FMMJUA will receive Department approval. I encourage the FMMJUA Board to voluntarily make available increased limits and excess coverage.

Sincerely,

Bill Gunter
State Treasurer and
Insurance Commissioner

BG: lm
cc: Allen Shiver
The FMMJUA should offer limits of up to $1 million per claim and $3 million annual aggregate and $2 million per claim and $4 million annual aggregate for any physician wishing to purchase malpractice insurance from it. Lesser amounts may also be offered.

In addition, physicians should be permitted to buy first dollar coverage from the FMMJUA to the upper limits.

These changes would prevent the occurrence of an availability crisis in the event the PCF is unable or unwilling to continue providing coverage.
March 17, 1983

TO: Board of Governors

FROM: E. Allen Shiver, General Manager

Re: Agenda
Board of Governors Meeting
March 18, 1983

1. Approval of Minutes of Prior Meetings
   Previously distributed
   February 3, 1983
   March 3, 1983

2. Request of Department of Insurance
   See report of Insurance Commissioner, page 25 "FMMJUA"

EAS/nb

MEMBERS: George R. Cross, Chairman
         James P. Jensen, Vice Chairman
         Robert J. Brennan, M.D.
         Richard E. DeChene
         Charles A. McCallister
         Miles A. McGrane, III
         Robert E. Morrow
         Kenneth W. Whisenand

CC: Alfred K. Chandler
     Bruce Culpepper
Chairman George Cross called the meeting to order at 9:40 AM at the Tampa Marriott Hotel. The Manager advised that a quorum was present.

MEMBERS PRESENT:

George R. Cross, Chairman
James P. Jensen, Vice Chairman
Dr. Robert J. Brennan
William E. Foley (alternate)
Frank Klopp (alternate)
Charles A. McCallister
Miles A. McGrane, III

OTHERS PRESENT:

Bruce Culpepper
Preston Cowie
Alfred K. Chandler
Robert J. Atkins
Cathy Sims
Jim Massie
K. B. Meurlott
Patrick J. McNally
Vince Rio
Elsie Trask
E. Allen Shiver
Joanne W. Brown

Mr. Cross then called for the business of the meeting.

MINUTES OF PRIOR MEETINGS

There being no corrections or additions requested, approval was voted of the Minutes of the Board of Governors' meeting of February 3, 1983, and the Minutes of the Board of Governors' meeting of March 3, 1983, as distributed.

BUSINESS OF THE SPECIAL CALL MEETING

Lengthy discussions and many comments were considered with the following brief commentary noting the principle points.

The Chairman called on Preston Cowie to report on the discussions between members of the industry and representatives of the Florida Insurance Department concerning the approval of the recommendations of the Insurance Commissioner by the FMMJUA Board of Governors.
March 2', 1983

TO:         Board of Governors
FROM:      Joanne W. Brown, Administrative Assistant
SUBJECT: Minutes - Board of Governors' Special Call Meeting
          March 18, 1983 in Tampa

Enclosed are the Minutes for the above captioned meeting. If you have any additions or corrections, please advise of same.

/b

MEMBERS: George R. Cross, Chairman
          James P. Jensen, Vice Chairman
          Robert J. Brennan, M.D.
          Richard E. DeChene
          Charles A. McCallister
          Miles A. McGrane, III
          Robert E. Morrow
          Kenneth W. Whisenand
          CC: Preston Cowie
          Allan Katz
          Jerome Vogel
          Jack Herzog
          Jim Brainard
          Joe Fuller
          Harry Landrum
          Jim Massie
          Patrick J. McNally
          Prentiss Mitchell
          K. B. Meurlott
          Vince Rio
          Cathy Sims
          Robert L. Atkins
          Elsie Trask

CC: The Honorable Bill Gunter
    William D. Rubin
    Alfred K. Chandler
    Bruce Culpepper
    Hartford Insurance - 2
    U.S.F.&G.
    St. Paul - 2
    Harold Eliason
    House Commerce Committee
    AIA - John P. Friedman
    FADIC - Hugh E. Ray
    FAIA - Robert Ross
    PTA - David H. Watkins
    FMA - W. Harold Parham, D.H.A.
    AAI - Debra K. Wilcox
    John W. Odem
    Dan Holloway
    Florida Hospital Trust Fund
    ISO - Joe Jensen
    PCM - Joe Blanton
said that since the last Board meeting, it was indicated that the Commissioner would seek change in the statute and that he would like some guidelines as to the changes being sought. Preston Cowie responded that the changes sought of the Legislature would be minimal.

Vince Rio again questioned the constitutionality of the statute, governing the FMMJUA. It was General Counsel's opinion that discretion in this matter is given to the Commissioner in his police power for the general welfare or in the public interest and that the statute is constitutional. Counsel stated a statute is presumed constitutional until proven otherwise. Therefore at this time, the statute must be treated as constitutional.

Mr. Rio then suggested that a possible solution concerning the immunity of the Board of Governors on voting approval of the recommendations, might be that it be made contingent on ratification by the membership of the association.

Mr. Culpepper said he thought the industry might want to modify the provision that would allow some of the profits of the FMMJUA to be retained because it could possibly affect the tax status and require payment of substantial taxes. The General Manager said that after consultation with the tax adviser, he had no concern with the use of reinsurance in the pure sense, but he does fear using monies from one year's policyholders for the benefit of another year's policyholders unless IRS first gave a favorable ruling to the association. Jim Massie said the Department did not commit to that provision and he did not mean to give that impression. Dr. Brennan questioned the use of money retroactively unless that statute was changed.

Vince Rio then explained his understanding of the statutory authority and components involved in ratemaking. The Chairman said he was very reluctant to be specific about this, and in the past, the actuarial consultants had taken care of this even though there are differences of opinion among actuaries.

Preston Cowie reported that Allan Katz had phoned and that he had spoken with the Commissioner who stated that he had no problem with the conditions as discussed, if the Board gave a yes vote to his recommendations.

Dr. Brennan said the proposed motion was nebulous. The Chairman then attempted to clarify the motion by explaining that the Board would be voting to voluntarily raise the limits of the FMMJUA, in return for certain conditions to be supported by the Commissioner.

Following a short recess, the Chairman called the meeting back to order. The General Manager announced that it had been requested that the individual votes of the Board members be recorded. The Chairman called for the vote on the motion approving the recommendations of the Commissioner for the FMMJUA. The motion passed by a count of 4 Yeas and 3 Nays, and was recorded as follows:

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Charlie McCallister requested that the Minutes reflect that his vote was cast on behalf of the NAIJ.

There being no further business, the meeting was adjourned.
Mr. Cowie explained the conditions presented to the Commissioner as follows:

1. Some mechanism for reinsurance in case of deficit assessment against the member companies.
2. Make available excess claims-made coverage.
3. Support repeal of the deficit assessment coverage.
4. Immunity for the Board of Governors and member companies of the FMMJUA.
5. Having the FMMJUA statute or Plan of Operation, provide for actuarially sound rates.
6. Resist any efforts to make the FMMJUA a "Deep Pocket" for the FPCF.

Other discussions, as pointed out by Jim Massie, included concern for maintaining the one-third assessment feature in the statute and the possibility of retention of funds of profitable years for the use of unprofitable years. These and others were either included in those presented by Mr. Cowie or not pressed to a conclusion.

In order to bring the matter up for further discussion, the Chairman requested that a motion be made. Miles McGrane moved that the Commissioner's recommendations for the FMMJUA be approved, subject to the acceptance of the six commitments by the Commissioner. This was seconded by Jim Jensen, and opened the motion to discussion. Charlie McCallister asked for an explanation of the motion. The Chairman stated that the Commissioner's recommendations for the FMMJUA would be approved by the Board subject to his agreement to the proposals of the industry.

Vince Rio raised the question of possible anti-trust violation by the Board for discussing rates or ratemaking on business that the FMMJUA is not presently authorized to write. Counsel advised that these discussions of the statutes and Plan of Operation of the FMMJUA were appropriate.

Bruce Culpepper, General Counsel, responded that the FMMJUA is confined to using only actuarially sound rates. He added that he was uncomfortable with the list of "commitments" necessary before the Board would approve the recommendations of the Commissioner since the Commissioner may not have any control over them because they require acts by the Legislature. Pat McNally said that the Department had agreed to seek these commitments from the Legislature.

The Chairman asked if all the agreements had to be accepted by the Department before approval of the recommendations be given? Charlie McCallister said that even if the Board could not reach an agreement, the Commissioner had the authority by Rule to make the recommendations and the industry would get none of the caveats proposed, but the Commissioner is offering some conditions for the Board's support. Miles McGrane added that if the Board acts in good faith, then the Commissioner would support it. Also, that the South Florida physicians are going after relief in the Legislature, and the Board will need all the help it can get from the Department.

The Chairman wanted to clarify the motion further, by stating that before a final vote would be made, the Commissioner or his office, would confirm by phone their acceptance of commitments made to the industry. Vince Rio
ing use of the word "fair"; deleting designation of Florida State Fair; providing for an advisory council; providing for use of buildings; providing that the Florida State Fair Authority is an instrumentality of the state; providing for beverage licenses; repealing a 6 of chapter 81-81, Laws of Florida, and s. 6 of chapter 81-297, Laws of Florida, which provide for review and repeal of the Florida State Fair Authority and the Agricultural and Livestock Fair Council, respectively; providing for legislative review; providing an effective date.

—was read the second time by title.

The Committee on Agriculture recommended the following amendments which were moved by Senator Kirkpatrick and adopted:

Amendment 1—On page 24, lines 14-19, strike all of subsection (4)

Amendment 2—In title, on page 1, line 21, strike "restricting use of the word 'fair';"

On motion by Senator Kirkpatrick, by two-thirds vote HB 408 as amended was read the third time by title, passed and certified to the House. The vote on passage was:

**Yeas—39**

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**Nays—None**

On motion by Senator Margolis, the rules were waived and the Senate reverted to:

**MESSAGES FROM THE HOUSE OF REPRESENTATIVES**

**The Honorable Curtis Peterson, President**

I am directed to inform the Senate that the House of Representatives has passed as amended CS for HB 758 and requests the concurrence of the Senate.

—Allen Monroe, Clerk

By the Committee on Tourism & Economic Development and Representative Simon—

CS for HB 758—A bill to be entitled An act relating to commercial development; creating s. 288.062, Florida Statutes; directing the Department of Education in consultation with the Department of Commerce to develop a comprehensive plan to promote better relations between certain organizations in the state and foreign nations; requiring completion of the plan by January 1, 1994; providing for the required elements of the plan; providing for a statewide conference; providing applicability; providing an appropriation; providing an effective date.

—was read the first time by title and referred to the Committee on Commerce

**SPECIAL ORDER, continued**

On motions by Senator Margolis, by two-thirds vote CS for HB 758, a companion measure, was withdrawn from the Committee on Commerce.

On motion by Senator Margolis, the rules were waived and CS for HB 758 was substituted for SB 684. On motions by Senator Margolis, by two-thirds vote CS for HB 758 was read the second time by title and by two-thirds vote the third time by title, passed and certified to the House. The vote on passage was:

**Yeas—39**

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**Nays—None**

SB 684 was laid on the table.

On motions by Senator Barron, the rules were waived and by two-thirds vote HB 1251 was withdrawn from the Committee on Judiciary-Civil, HB 591 was withdrawn from the Committee on Commerce and House Bills 1071 and 1003 were withdrawn from the Committee on Natural Resources and Conservation and placed on the local calendar.

On motion by Senator Barron, the rules were waived and by two-thirds vote SB 1142 was placed on the revised special order calendar.

On motions by Senator Barron, the rules were waived and by two-thirds vote CS for SB 512 was withdrawn from the Committee on Finance, Taxation and Claims and by two-thirds vote placed on the revised special order calendar.

On motion by Senator Johnson, the rules were waived and by two-thirds vote SB 688 was withdrawn from the Committee on Appropriations.

On motions by Senator D. Childers, the rules were waived and by two-thirds vote HB 1109 was withdrawn from the Committee on Health and Rehabilitative Services and Appropriations.

On motion by Senator D. Childers, the rules were waived and—

**HB 1109**—A bill to be entitled An act relating to cancer control and research; amending s. 381.712(4)(a), Florida Statutes, 1982 Supplement, expanding the membership of the Florida Cancer Control and Research Advisory Board; amending s. 381.3812(4), Florida Statute, 1982 Supplement; eliminating the proportional utilization requirement with respect to funds for the statewide cancer registry program; requiring reimbursement of reasonable costs to reporting hospitals; providing an effective date.

—a companion measure, was substituted for CS for SB 777 and read the second time by title. On motion by Senator D. Childers, by two-thirds vote HB 1109 was read the third time by title, passed and certified to the House. The vote on passage was:

**Yeas—38**

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**Nays—None**

CS for SB 777 was laid on the table.

On motion by Senator Thomas, the rules were waived and by two-thirds vote HB 1302 was withdrawn from the Committee on Commerce.

On motion by Senator Thomas—

**HB 1302**—A bill to be entitled An act relating to medical malpractice insurance, amending s. 627.351(4), Florida Statutes, 1982 Supplement; requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, podiatrists, hospitals, and ambulatory surgical centers; increasing potential assessments against members; providing immunity from suit to certain persons relating to actions taken in performance of duties; providing for departmental approval of rates; deleting obsolete language; amending s. 768.542(2) and (3), Florida Statutes, 1982 Supplement, permitting the Florida Patient’s Compensation Fund to reject certain risks; changing liability limits of the fund, increasing financial responsibility
Journal of the Senate
State of Florida

FIFTEENTH REGULAR SESSION
UNDER THE CONSTITUTION AS REVISED IN 1968
APRIL 5 THROUGH JUNE 13, 1983
2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total escrow account for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required;

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from private insurers or the Joint Underwriting Association established under s. 627.351(7); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2,500,000 annual aggregate.

2. Establish an escrow account in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each hospital bed in such hospital from a private insurer, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. However, no hospital shall be required to obtain such coverage in an amount exceeding a $2,500,000 annual aggregate.

(d) Any health care provider who does not participate in the fund or participates in the fund and who and does not meet the provisions of paragraph (b), shall not be covered by the fund subject to liability under law without regard to the provisions of this section.

2. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and shall remain in compliance, with the provisions of this section. The department shall review the documentation and then deliver the documentation to the board of governors. At least 60 days prior to the time a license will be issued or renewed, the department shall request from the board of governors a certification that each hospital is in compliance with the provisions of this section. The board of governors shall not be liable under the law for any erroneous certification. The department shall not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the department.

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, workers, committee members (including physicians, osteopaths, podiatrists, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, physician’s assistants licensed under chapter 458, osteopaths licensed under chapter 459, dentists licensed under chapter 466, and podiatrists licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physician residents physicians in a resident training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

(f) Each health care provider shall be responsible for paying the amount of each settlement or judgment for each claim up to the fund entry level initial amount it selects. The selected entry level shall not be less than of the following amounts:

1. As of July 1, 1986: $200,000 per claim or $500,000 per occurrence.
2. As of July 1, 1987: $250,000 per claim or $500,000 per occurrence.

As of July 1, 1989 the minimum entry level amount shall be indexed to the medical component of the consumer price index and shall be adjusted by the fund each year thereafter accordingly.

3. TREATMENT OF COMPENSATION FILLED.
June 2, 1983 JOURNAL OF THE SENATE 765

limits for hospitals not participating in the fund; increasing the fund entry level, providing for reimbursement of board members, providing immunity from liability for certain actions of board members and others, granting certain powers to the fund; requiring approval of fund membership fees and assessments by the Insurance Commissioner, providing that fund members must pay protested assessment prior to filing suit, limiting on-defect assessments to fund members; prohibiting execution against the fund due to insufficient assets, providing for stay of execution absent posting of supersedeas bond, providing for a stay of execution against fund members, providing for termination of coverage by the fund under certain conditions and for cessation of coverage by the fund, providing effective dates

—was read the second time by title

Senator Thomas moved the following amendment

Amendment 1—On page 2, line 9, strike everything after the enacting clause and insert

Section 1 Subsection (4) of section 627.351, Florida Statutes, 1982 Supplement, is amended to read

627.351 Insurance risk apportionment plans—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT—

(a) The department shall, after consultation with insurers as set forth in paragraph (b), adopt a joint underwriting plan as set forth in paragraph (d)

(b) Entities licensed to issue casualty insurance as defined in a 624.6051(b), (k), and (q) and self-insurers authorized to issue medical malpractice insurance under a 627.357 shall participate in the plan and shall be members of the Joint Underwriting Association

(c) The Joint Underwriting Association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the Joint Underwriting Association, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, and a hospital representative to be named by the Florida Hospital Association The board of governors shall choose, during the first meeting of the board after June 30 of each year, one of its members to serve as chairman of the board and another member to serve as vice chairman of the board There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, self-insurer, or its agents or employees, the Joint Underwriting Association or its agents or employees, the board of governors, or the department or its representatives for any action taken by them in the performance of their powers and duties under this subsection

(d) The plan shall provide coverage for claims arising out of the rendering of, or failure to render, medical care or services and, in the case of health care facilities, coverage for bodily injury or property damage to the person or property of any patient arising out of the insured’s activities, in appropriate policy forms for all health care providers as defined in paragraph (b) The plan shall include, but shall not be limited to

1. Classifications of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas To assure that plan rates are adequate to pay claims and expenses, the Joint Underwriting Association shall develop a means of obtaining loss and expense experience, and the plan shall file such experience, when available, with the department in sufficient detail to make a determination of rate adequacy Within 60 days after a rate filing, the department shall approve such rates or rate revisions as are fully supported by the filing In addition to provisions for claims and expenses, the rate-making formula may include a factor for projected claims trending and a margin for contingencies The use of trend factors shall not be found to be inappropriate

2. A rating plan which reasonably recognizes the prior claims experience of insureds

3. Provisions as to rates for:
   a. Insureds who are retired or semiretired
   b. The estates of deceased insureds
   c. Part-time professionals

4. Protection in an amount not to exceed $250,000 per claim, $750,000 annual aggregate for health care providers other than hospitals and non-hospital plans on an annual basis, not to exceed $2.5 million per claim, not to exceed $2.5 million annual aggregate Such coverage for non-hospital health care providers shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and total limits of $250,000 per claim, $750,000 annual aggregate to be determined by the Insurance Commissioner

5. Protection to members of the Florida Patient’s Compensation Fund established under s. 768.54, which will cover the full amount of any or all claims issued by the fund against a member for the 1982/83 fiscal year The premium continous premium for each fiscal year is $750,000, but is subject to adjustment at any time The premium established pursuant to this paragraph The rate charged for such protection shall not exceed one-third of the membership fee charged the member by the fund The protection shall only be available to fund members as defined in s. 768.541(1)(b), (2), (3), and (4). A request for such protection must be made in writing to an agent Such coverage shall be made available no later than the first day of the fiscal year being covered and shall be purchased, if at all, no later than the last day of such fiscal year This sub-paragraph shall stand repealed July 1, 1983

The Insurance Commissioner may, in his discretion, require that insureds participating in the Joint Underwriting Association offer excess coverage

Section 2. Subsections (2) and (3) of section 768.54, Florida Statutes, 1982 Supplement, are amended to read

768.54 Limitation of liability and Patient’s compensation fund—

(2) COVERAGE LIABILITY—

(a) All hospitals, unless exempted under this paragraph or paragraph (c), shall, and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to subsection (3) Any hospital operated by an agency of the state shall be exempt from the provisions of this section and shall not be required to participate in the fund

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage the extent of the coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater Coverage for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from July 1 to June 30 The fund may also provide coverage for portions of each fiscal year The limits maximum limit of such coverage afforded by liability of the fund for each health care provider other than a hospital shall not exceed total limits for both entry level and fund coverage of $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, $3 million per claim, $5 million per claim, $8 million per claim, or $10 million per claim, as selected elected by the health care provider In the case of coverage for a hospital, the limit of coverage afforded by the fund shall not exceed total limits for both entry level and fund coverage of $2.5 million per claim with no annual aggregate The health care provider who makes such election is responsible for the payment of liability for any amount of the claim in excess of the elected limit The fund shall not be responsible for payment of punitive damages awarded for actual or direct negligence of the health care provider member The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods

1. A bond in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses, however a total bond amount for all years equal to reserved loss and loss adjustment expenses for known claims, plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required The bond shall be purchased from a licensed surety company
1. Any person may file an action against a participating health care provider for damages covered under the fund, except that the person filing the claim shall not recover against the fund unless the fund was named as a defendant in the suit. The fund is not required to actively defend a claim until the fund is named therein. If, after the facts upon which the claim is based are reviewed, it appears that the claim will exceed the applicable amount set forth in paragraph (2)(f) or, if greater, the amount of the health care provider’s basic coverage, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the account for the appropriate year attorneys’ fees and expenses, including court costs incurred in defending the fund. In any claim, the attorney or law firm retained to defend the fund shall not be retained to defend the Joint Underwriting Association authorized by s. 627.351(4). The fund is authorized to negotiate with any claimants having a judgment exceeding the applicable amount set forth in paragraph (2)(f) to reach an agreement as to the manner in which that portion of the judgment exceeding such amount is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure, as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed which potentially affects the fund, with respect to such insurance or self-insurance contract. The insurer or self-insurer shall act in a fiduciary relationship toward the fund with respect to any claim affecting the fund. No settlement exceeding the applicable amount set forth in paragraph (2)(f), or any other amount which could require payment by the fund, shall be agreed to unless approved by the fund.

3. A person who has recovered a final judgment against the fund or against a health care provider who is covered by the fund may file a claim with the fund to recover that portion of such judgment which is in excess of the applicable amount set forth in paragraph (2)(f) or the amount of the health care provider’s basic coverage, if greater, as set forth in paragraph (2)(b). The amount of liability of the fund under a judgment, including court costs, reasonable attorney’s fees, and interest, shall be paid in a lump sum, except that any claims for future special damages, as set forth in s. 768.481(1)(a) and (b), shall be paid periodically as they are incurred by the claimant. If a claimant dies while receiving periodic payments, payment for future medical expenses shall cease, but payment for future wage loss, if any, shall continue at a rate of not more than $100,000 per year. The fund may pay a lump sum reflecting the present value of future wage loss in lieu of continuing the periodic payments.

4. Payment of settlements or judgments involving the fund shall be paid in the order received within 60 days after the date of settlement or judgment, unless appealed by the fund. If the account for a given year does not have enough money to pay all of the settlements or judgments, those claims received after the funds are exhausted shall be payable in the order in which they are received. However, no claimant shall have the right to execute against the fund to the extent that the judgment is for a claim covered in a membership year for which the fund has insufficient assets to pay the claim, as determined by membership fees for such year, investment income generated by such fees, and assessments collected from members of such year. When a fund year has insufficient assets to pay claims, the fund shall not be required to post a supersedeas bond in order to stay execution of a judgment pending appeal. The fund shall retain a reasonable sum of money for payment of administrative and claims expense which money shall not be subject to execution.

5. Except to the extent of the appropriate fund entry level amount selected, if a judgment is entered against the fund for a year in which there are insufficient assets to satisfy the claim, an automatic stay of execution and collection in favor of the fund member shall exist for that portion of the judgment which exceeds the selected entry level amount, and for which fund coverage exists. Such stay shall only be granted to those members who have fully complied with the requirements of fund membership, and shall be in effect until adequate assessments are collected by the fund to pay the claim. Upon competent proof that the portion of any claim covered by the fund is uncollectible from the fund, the member shall have the right to execute against the fund, and such execution may be initiated by the court, upon application of the plaintiff and hearing thereon.

6. If a health care provider participating in the fund has coverage in excess of the applicable amount set forth in paragraph (2)(f), such health care provider shall be liable for losses up to the amount of his coverage, and such health care provider shall receive an appropriate reduction of the fees and assessments for participation in the fund. Such reduction shall be granted only after that health care provider has proved to the satisfaction of the fund that such health care provider had such coverage during the period of membership of the fiscal year.

7. The manager of the fund or his assistant is the agent for service of process for the plan.

(h) The fund shall establish a risk management program by July 1, 1982, as a part of its administrative functions. All health care providers, as defined in subparagraphs (1)(b)1., 5., 6., and 7., participating in the plan shall comply with the provisions of the risk management program established by the fund. The risk management program shall include the following components:

1. The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients,

2. The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients;

3. The analysis of patient grievances which relate to patient care and the quality of medical services;

4. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of health care providers and health care facilities to report injuries and incidents; and

5. Auditing of participating health care providers to assure compliance with the provisions of the risk management program.

The fund shall establish a schedule of fee surcharges which it shall levy upon participating health care providers which are found to be in violation of the provisions of the risk management program. Such schedule shall be subject to approval by the department and shall provide an escalating scale of surcharges based upon frequency and severity of the incidents in violation of the risk management program. No health care provider shall be required to pay a surcharge if it has corrected all violations of the provisions of the risk management program and established an affirmative program to remain in compliance by the time its next fee or assessment is due.

(h) The fund shall determine, no later than 7 days prior to the beginning of each fiscal year, whether the total of the membership fees to be charged for the fiscal year to health care provider applicants other than hospitals exceeds $5 million and whether the total of the membership fees to be charged to hospital applicants exceeds $12.5 million. If the total of the membership fees to be charged to health care provider applicants other than hospitals does not exceed $5 million, the fund shall return the membership fees collected from such providers and shall, not later than the day prior to the beginning of the fiscal year, notify all such providers, advising them that coverage will not be available from the fund. Thereafter, the fund may not issue coverage to any health care provider, including any hospital, for that fiscal year. If the total of the membership fees to be charged to hospital applicants for the fiscal year does not exceed $12.5 million, the fund shall return the membership fees collected from the hospitals and shall, not later than the day prior to the beginning of the fiscal year, notify such hospitals that coverage of hospitals will not be available from the fund. Thereafter, the fund may not issue coverage to any hospital for that fiscal year. If the fund ceases to provide coverage to hospitals, hospitals shall continue to meet the financial responsibility requirements of subparagraphs (2)(c)1., 2., or 3. An application for fund membership for a particular fiscal year does not guarantee coverage for that year, and the fund is not liable for coverage of an applicant for any fiscal year in which the fund does not provide coverage in accordance with the provisions of this paragraph.

Section 3 This act shall take effect upon becoming law.

Senator Scott moved the following amendment to Amendment 1 which was adopted:

Amendment 1A—On page 4, line 28, after "agency" insert: , subdi-

vention, or instrumentality

Amendment 1 as amended was adopted

Senator Thomas moved the following amendment which was adopted:

Amendment 1A—On page 4, line 28, after "agency" insert: , subdi-

vention, or instrumentality
3. Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the fund is created.

4. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this section.

5. Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the fund and to perform other necessary or proper functions unless prohibited by law.

6. Take such legal action as may be necessary to avoid payment of improper claims.

7. Indemnify an employee, agent, member of the board of governors and any alternate, or any person acting on behalf of the fund in an official capacity, for expenses, including attorney's fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by him in connection with any action, suit, or proceeding, including any appeal thereof arising out of his capacity on acting on behalf of the fund, if he acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the fund and, with respect to any criminal action or proceeding, had reasonable cause to believe his conduct was lawful.

(d) Fees and assessments—Each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) for a given fiscal year shall pay the fees and any assessments established under this section relative to such fiscal year set for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. Those entering the fund after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. Actuarially sound membership fees payable annually, semiannually, or quarterly with appropriate service charges shall be established by the fund prior to July 1 of each fiscal year, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund; and

3. Risk factors for persons who are retired, semiretired, or part-time professionals.

Such fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Such fees shall be based on not more than three geographical areas, not necessarily contiguous, with five categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. The fund is authorized to adjust the fees of an individual member to reflect the claims experience of such member. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund, in cases in which a participant is a member of the fund for less than the total fiscal year, a member shall be subject to assessments for that year on a pro rata basis determined by the percentage of participation for the year. The fund shall submit to the Insurance Commissioner the classifications and membership fees to be charged, and the Insurance Commissioner shall review such fees and shall approve them if they comply with all the requirements of this section and fairly reflect the considerations provided for in this section. If the classifications or membership fees do not comply with this section, the Insurance Commissioner shall set classifications or membership fees which do comply and which give due recognition to all considerations provided for in this section. Fees, assessments, or refunds shall be set by the Insurance Commissioner after consultation with the board of governors of the fund. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the Joint Underwriting Association authorized by s. 627.351(4)(f) or its member insurers. If the fund determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected excess or insufficiency to the Insurance Commissioner and request the Insurance Commissioner to levy an assessment against or refund to all participants in the fund for that fiscal year, prorated, based on the number of days of participation during the year in question. The Insurance Commissioner shall approve the fund's request to refund to, or levy any assessment against, the participants, provided that the refund or assessment fairly reflects the separate risk of claims handling and reinsurance procedures and classifications upon which the membership fees were based. The assessment shall be in an amount sufficient to satisfy reserve requirements for known claims including expenses to satisfy the claims made against the account for a given fiscal year. In any proceeding to challenge the amount of the refund or assessment it is presumed that the amount of refund or assessment requested by the fund is correct, if the fund demonstrates that it has used reasonable claims handling and reinsurance procedures. Additional assessments may be certified and levied in accordance with this paragraph as necessary for any fiscal year. If a fund member objects to his assessment, he shall, as a condition precedent to bringing legal action contesting the assessment, pay the assessment, under protest, to the fund. If necessary to pay claims and related expenses, fees, and costs timely for a given fiscal year, the fund may borrow money needed for current operations from an account for another fiscal year until such time as sufficient funds have been obtained through the assessment process. Any such money, together with interest at the mean interest rate earned on the investment portfolio of the fund, shall be repaid from the next assessment for the given fiscal year. The Insurance Commissioner shall order such refund to, or levy such assessment against, such participants in amounts that fairly reflect the classifications prescribed above and are sufficient to obtain the money necessary to meet all claims for that fiscal year. In no case shall any assessment for a particular year against any health care provider, other than those health care providers defined in subparagraphs (ii)(b), (c), and (d), exceed an amount equal to the fees established by the fund for a prorated membership for participation in the fund for the fiscal year giving rise to such assessment. If any assessments are levied in accordance with this subsection as a result of claims in excess of $500,000 per occurrence, and such assessments are a result of the liability of certain individuals and entities specified in paragraph (2)(e), only hospitals shall be subject to such assessments. Prior to approving the fund's request to charge membership fees, issue refunds, or levy assessments, the Insurance Commissioner shall publish notice of the request in the Florida Administrative Weekly. Pursuant to chapter 120, all parties substantially affected may request appropriate proceedings. Petitions for such proceedings shall be filed with the Department of Insurance within 21 days after the date of publication of notice in the Florida Administrative Weekly.

(e)(d) Fund accounting and audit.—

1. Money 

Money shall be withdrawn from the fund only upon vouchers as authorized by the board of governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public, except that a claim file in possession of the fund, fund members, and their insurers shall not be available for review during processing of that claim. Any book, record, document, audit, or asset acquired by, prepared for, or paid for by the fund is subject to the authority of the board of governors, which shall be responsible therefor.

3. Persons authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse fund money shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the fund shall furnish, upon request, audited financial reports to any fund participant and to the Department of Insurance and the Joint Legislative Auditing Committee. The reports shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Money 

Money shall be invested in interest-bearing investments by the board of governors of the fund as administrator. However, in no case shall such money be invested in the stock of any insurer participating in the Joint Underwriting Association authorized by s. 627.351(4) in the parent company or company owning a controlling interest of such insurer. All income derived from such investments shall be credited to the fund.

6. Any health care provider participating in the fund may withdraw from such participation only at the end of a fiscal year, however, such health care provider shall remain subject to any assessment or any refund pertaining to any year in which such member participated in the fund.

(f)(e) Claims procedures —
Amendment 2—In title, on pages 1 and 2, strike everything before the enacting clause and insert: An act relating to professional malpractice, amending s. 627.35114, Florida Statutes, 1982 Supplement, requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, hospitals, and ambulatory surgical centers, deleting obsolete language, amending s. 768.54(2), (3), Florida Statutes, 1982 Supplement, increasing the fund entry level; requiring approval of fund membership fees and assessments by the Insurance Commissioner, removing limitations on default assessments to fund members, providing immunity for board members; providing certain powers to the fund, providing conditions for protesting assessments, providing for stay of execution against the fund, providing for minimum fee requirements for fund to offer coverage; providing effective dates

Further consideration of HB 1302 was deferred.

On motion by Senator Jenne, the Senate reconsidered the vote by which SB 1130 passed this day:

Pending further consideration of SB 1130 as amended, on motion by Senator Jenne, the rules were waived and by two-thirds vote HB 1239 was withdrawn from the Committee on Judiciary-Civil

On motion by Senator Jenne, the rules were waived and—

HB 1239—A bill to be entitled An act relating to liens, creating s. 713.79, Florida Statutes, providing that a lien for certain charges and fees of any publicly owned and operated airport attaches to any aircraft owned or operated by a person owning such charges and fees, providing a penalty; creating s. 713.792, Florida Statutes, providing for enforceability of certain liens with respect to aircraft, providing for required notice; providing for applicability, providing an effective date

—a companion measure, was substituted for SB 1130 and read the second time by title

Senator Jenne moved the following amendments which were adopted:

Amendment 1—On page 1, line 16, strike everything after the enacting clause and insert:

Section 1. Airport facilities, lien for landing and other fees—
(1) The governing body of any publicly owned and operated airport shall have a lien upon all aircraft landing upon any airport owned and operated by it for all charges for landing fees and other fees and charges for the use of the facilities of such airport by any such aircraft, when payment of such charges and fees is not made immediately after demand therefor to the operator or owner of the aircraft by a duly authorized employee of the airport. The lien for the full amount of the charges and fees due to the airport or governing body of any publicly owned and operated airport attaches to any aircraft owned or operated by the person owning such charges and fees. Such lien may be enforced as provided by law for the enforcement of warehousemen's liens in this state

(2) It is unlawful for any person to remove or attempt to remove any such aircraft from such airport after notice of the lien has been served upon the owner or operator thereof or after posting of such notice upon such aircraft. Any person who removes or attempts to remove any such aircraft from such airport after service or posting of the notice of lien as herein provided; and before payment of the amount due to the airport for landing fees and charges incurred by such aircraft, is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or a 775.083

Section 2. Subsection (1) of section 713.58, Florida Statutes, is amended to read:

713.58 Liens for labor, services, or material on personal property.

(1) Any person who furnishes labor, services, or material to any other person shall have a lien upon the personal property for which the labor, services, or material is furnished, if the latter upon which the labor or services is performed, or which is used in the business, occupation, or employment in which the labor, services, or material is furnished performed

Section 3. Section 713.792, Florida Statutes, is hereby repealed

Section 4. Section 125.021, Florida Statutes, is hereby repealed

Section 5. This act shall take effect October 1, 1983

Amendment 2—In title, on page 1, strike everything before the enacting clause and insert: A bill to be entitled An act relating to liens, providing for the imposition of a lien on certain aircraft landing on certain publicly owned and operated airports; prohibiting the removal of such aircraft after notice of lien has been served or posted, providing penalties, amending s. 713.58(1), Florida Statutes; providing for liens upon personal property for labor, services, or material, creating s. 713.792, Florida Statutes, providing for notice of liens for aircraft; repealing s. 125.021, Florida Statutes, relating to liens on aircraft landing at county airports, providing an effective date.

On motion by Senator Thomas, by two-thirds vote HB 1239 as amended was read the third time by title.

Further consideration of HB 1239 was deferred.

CORRECTION AND APPROVAL OF JOURNAL

The Journal of June 1 was corrected and approved.

On motion by Senator Barron, the Senate adjourned at 7:11 p.m. to reconvene at 9:30 a.m., Friday, June 3.
**Bill Action Record**  
**Commerce Committee**  
**House of Representatives**

SubCommittee on **Health Care & Life & Health Insurance**  
Meeting Time: 1:00-2:00 PM 4-26-83  
Place: 21 HOB  
Bill No. **PCB 83-44**  
Date received:  
Committee Action:  
Date Reported:  

Referred to Subcommittee on  

Subcommittee report:  
- **favorable**  
- **favorable with amendments**  
- **favorable with committee substitute**  
- **unfavorable**  

Other action:  

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TOTALS  

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**Committee Action:**
- Temporarily passed
- Reconsidered
- Favorable
- Favorable with ___ amendments
- Favorable with committee substitute
- Unfavorable

**Final vote:**

**TOTALS**
**Bill Action Record**

**Commerce Committee**

**Subcommittee on Health Care & Life & Health Insurance**

**Meeting Time**: 1:00-2:00 PM 4-26-83

**Place**: 21 HOB

**Bill No.**: PCB 83-44

**Date received**

**Date Reported**

**Referred to Subcommittee on**

**Subcommittee report:**

- Favorable
- Favorable with amendments
- Unfavorable

**Final vote on bill**

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**Committee Action:**

- Temporarily passed
- Reconsidered
- Favorable
- Favorable with amendments
- Favorable with committee substitute
- Unfavorable

**Other action:**

**Final vote #11**

**Totals**

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8-83
Representative [Signature]

HR PCB 83-44
SB [Signature]

offered the following amendment:

On page 3, line 7-8, strike all of said lines

and insert 4. Protection in an amount equal to the minimum entry levels specified in s. 768.54(2)(f) to be determined by the insurance commissioner.

adopted [Signature]

4-26-83
offered the following amendment:

On page 3, lines 26-31 and
(on page 4, line 1-12) strike all of said lines

and insert: The insurance commissioner may, in his discretion, require that
insurers participating in the joint underwriting association offer excess coverage:

adopted failed of adoption Withdrawn
4-26-83
A bill to be entitled

An act relating to medical malpractice insurance, amending s. 627.351(4), Florida Statutes, 1982 Supplement; requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, hospitals, and ambulatory surgical centers; increasing potential assessments against members, deleting obsolete language, amending s. 768.54(2), (3), Florida Statutes, 1982 Supplement; permitting the Florida Patient's Compensation Fund to reject certain risks, increasing financial responsibility limits for hospitals not participating in the fund, requiring anesthesiologists with staff privileges at participating hospitals or ambulatory surgical centers to be covered by the fund; increasing the fund entry level; requiring approval of fund membership fees and assessments by the Insurance Commissioner; removing limitations on deficit assessments to fund members; providing for termination of coverage by the fund under certain conditions and for cessation of coverage by the fund; providing effective dates

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 627.351, Florida Statutes, 1982 Supplement, is amended to read:

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subparagraph 2.; blood banks, plasma centers, industrial
clinics, and renal dialysis facilities; or professional
associations, partnerships, corporations, joint ventures, or
other associations for professional activity by health care
providers.

2. "Other medical facility" means a facility the
primary purpose of which is to provide human medical
diagnostic services or a facility providing nonsurgical human
medical treatment, to which facility the patient is admitted
and from which facility the patient is discharged within the
same working day, and which facility is not part of a
hospital. However, a facility existing for the primary
purpose of performing terminations of pregnancy or an office
maintained by a physician or dentist for the practice of
medicine shall not be construed to be an "other medical
facility."

3. "Health care facility" means any hospital licensed
under chapter 395, health maintenance organization
certificated under part II of chapter 641, ambulatory surgical
center licensed under chapter 395, or other medical facility
as defined in subparagraph 2

(1) The manager of the plan or his assistant is the
agent for service of process for the plan

Section 2 Subsections (2) and (3) of section 768.54,
Florida Statutes, 1982 Supplement, are amended to read

768.54 LIMITATION OF LIABILITY AND PATIENT'S
compensation fund.--

(2) COVERAGE LIABILITY.--

(a) All hospitals, unless exempted under this
paragraph or paragraph (c), shall, and all health care
providers other than hospitals may, pay the yearly fee and
assessments or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to subsection (3). Any hospital operated by an agency of the state shall be exempt from the provisions of this section and shall not be required to participate in the fund. The fund may establish reasonable criteria for rejecting health care providers, other than hospitals, having adverse claims experience.

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage shall be is able to the extent of the coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from July 1 to June 30. The fund may also provide coverages for portions of each fiscal year. The limits maximum limit of such coverage afforded by insolvency of the fund for each health care provider other than a hospital shall not exceed total limits for both entry level and fund coverage of be $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, $3 million per claim, $5 million per claim, $6 million per claim, $8 million per claim.

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or $10 million per claim, as selected elected by the health
care provider. In the case of coverage for a hospital, the
limit of coverage afforded by the fund shall not exceed total
limits for both entry level and fund coverage of $5 million
per claim with no annual aggregate. The health care provider
who makes such elected is responsible for the payment of
liable for any amount of a claim in excess of the elected
limit. The fund shall not be responsible for payment of
punitive damages awarded for actual or direct negligence of
the health care provider member. The health care provider
shall have the same responsibility for punitive damages it
would have if it were not a member of the fund. A health care
provider may have the necessary funds available for payment
when due or may provide underlying financial responsibility by
one of the following methods:

1. A bond in the applicable amount set forth in
paragraph (f) per claim and 3 times the applicable per-claim
limit in the aggregate per year, plus an additional amount
which is sufficient to meet claims defense and expenses;
however a total bond amount for all years equal to reserved
loss and expense amounts for known cases plus three times the
applicable amount set forth in paragraph (f) plus $45,000
shall be the maximum bond amount required. The bond shall be
purchased from a licensed surety company;

2. An adequate escrow account in the applicable amount
set forth in paragraph (f) per claim and 3 times the per-claim
limit in the aggregate per year, plus an additional amount
which is sufficient to meet claims defense and expenses;
however a total escrow account for all years equal to reserved
loss and expense amounts for known cases plus three times the

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applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required; Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from private insurers or the Joint Underwriting Association established under s. 627.351(7); or coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year (c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or the failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $5 million per claim with a $10 million annual aggregate for each hospital bed in such hospital; not to exceed a $2,500,000 annual aggregate.

2. Establish an escrow account in an amount equivalent to $5 million per claim with a $10 million annual aggregate $10,000 per claim for each hospital bed in such hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in the amount of $5 million per claim with a $10 million annual aggregate equivalent to $10,000 or more per claim for each bed.
PCB 83-44

1. In such hospital from a private insurer, from the Joint
2. Underwriting Association established under s. 627.351(4), or
3. through a plan of self-insurance as provided in s. 627.357.
4. However, no hospital shall be required to obtain such coverage
5. in an amount exceeding a $2,500,000 annual aggregate:
6. (d)1. Any health care provider who does not
7. participate in the fund, or participates in the fund and who
8. and does not meet the provisions of paragraph (b), shall not
9. be covered by the fund be subject to liability under law
10. without regard to the provisions of this section.
11. 2. Annually, the Department of Health and
12. Rehabilitative Services shall require documentation by each
13. hospital that such hospital is in compliance, and shall remain
14. in compliance, with the provisions of this section. The
15. department shall review the documentation and then deliver the
16. documentation to the board of governors. At least 60 days
17. prior to the time a license will be issued or renewed, the
18. department shall request from the board of governors a
19. certification that each hospital is in compliance with the
20. provisions of this section. The board of governors shall not
21. be liable under the law for any erroneous certification. The
22. department shall not issue or renew the license of any
23. hospital which has not been certified by the board of
24. governors. The license of any hospital that fails to remain
25. in compliance or fails to provide such documentation shall be
26. revoked or suspended by the department.
27. (e) The coverage afforded by the fund for a
28. participating hospital or ambulatory surgical center shall
29. apply to the officers, trustees, volunteer workers, trainees,
30. committee members (including physicians, osteopaths,
31. podiatrists, and dentists), and employees of the hospital or

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ambulatory surgical center, other than employed physicians
licensed under chapter 458, physician's assistants licensed
under chapter 458, osteopaths licensed under chapter 459,
dentists licensed under chapter 466, and podiatrists licensed
under chapter 461. However, the coverage afforded by the fund
for a participating hospital shall apply to house physicians,
interns, employed physicians in a resident training program,
or physicians performing purely administrative duties for the
participating hospitals other than the treatment of patients,
or anesthesiologists with staff privileges at the hospital or
ambulatory surgical center when acting within the scope of
such privileges. This coverage shall apply to the hospital or
ambulatory surgical center and those included in this
subsection as one health care provider.

(f) Each health care provider shall be responsible for:

paying the amount of each settlement or judgment for each
claim up to the fund entry level initial amount it selects.
The selected entry level shall be not less than of each claim
up to the following amounts:

1. As of July 1, 1982 - $400,000 per claim or $500,000
   per occurrence

2. As of July 1, 1983: $150,000 per claim or
   $500,000 per occurrence

3. As of July 1, 1986: $200,000 per claim or
   $500,000 per occurrence.

4. As of July 1, 1989: $250,000 per claim or
   $500,000 per occurrence.

As of July 1, 1989 the minimum entry level amount shall be
indexed to the medical component of the consumer price index.
and shall be adjusted by the fund each year thereafter accordingly.

(3) PATIENT'S COMPENSATION FUND --

(a) The fund.--There is created a "Florida Patient's Compensation Fund" for the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members' activities for those health care providers set forth in subparagraphs (1)(b)1., 5., 6., and 7 which is in excess of the fund entry level selected *as set forth in paragraph (2)(f) and less than the maximum limit selected elected under paragraph (2)(b) The fund shall be responsible *itable only for payment of claims against health care providers who are in compliance with the provisions of paragraph (2)(b), of reasonable and necessary expenses incurred in the payment of claims, and of fund administrative expenses.

(b) Fund administration and operation --The fund shall operate subject to the supervision and approval of a board of governors consisting of a representative of the insurance industry appointed by the Insurance Commissioner, an attorney appointed by The Florida Bar, a representative of physicians appointed by the Florida Medical Association, a representative of physicians' insurance appointed by the Insurance Commissioner, a representative of physicians' self-insurance appointed by the Insurance Commissioner, a representative of hospitals appointed by the Florida Hospital Association, a representative of hospital insurance appointed by the

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posting of supersedeas bond; providing for a
stay of execution against fund members;
providing for termination of coverage by the
fund under certain conditions and for cessation
of coverage by the fund; providing effective
dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 627.351, Florida
Statutes, 1982 Supplement, is amended to read:

627.351 Insurance risk apportionment plans.--
(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
(a) The department shall, after consultation with
insurers as set forth in paragraph (b), adopt a joint
underwriting plan as set forth in paragraph (d).
(b) Entities licensed to issue casualty insurance as
defined in s. 624.605(1)(b), (k), and (q) and self-insurers
authorized to issue medical malpractice insurance under s.
627.357 shall participate in the plan and shall be members of
the Joint Underwriting Association.
(c) The Joint Underwriting Association shall operate
subject to the supervision and approval of a board of
governors consisting of representatives of five of the
insurers participating in the Joint Underwriting Association,
an attorney to be named by The Florida Bar, a physician to be
named by the Florida Medical Association, and a hospital
representative to be named by the Florida Hospital
Association. The board of governors shall choose, during the
first meeting of the board after June 30 of each year, one of
its members to serve as chairman of the board and another

CODING: Words in struck through type are deletions from existing law; words underlined are additions.
A bill to be entitled
An act relating to medical malpractice insurance; amending s. 627.351(4), Florida Statutes, 1982 Supplement; requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, hospitals, and ambulatory surgical centers; increasing potential assessments against members; providing immunity from suit to certain persons relating to actions taken in performance of duties; providing for departmental approval of rates; deleting obsolete language; amending s. 768.54(2) and (3), Florida Statutes, 1982 Supplement; permitting the Florida Patient's Compensation Fund to reject certain risks; changing liability limits of the fund; increasing financial responsibility limits for hospitals not participating in the fund; increasing the fund entry level; providing for reimbursement of board members; providing immunity from liability for certain actions of board members and others; granting certain powers to the fund; requiring approval of fund membership fees and assessments by the Insurance Commissioner; providing that fund members must pay protested assessment prior to filing suit; removing limitations on deficit assessments to fund members; prohibiting execution against the fund due to insufficient assets; providing for stay of execution absent CODING: Words in caesura through type are deletions from existing law, words underlined are additions.
2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for:
   a. Insureds who are retired or semiretired.
   b. The estates of deceased insureds.
   c. Part-time professionals.

4. Protection in an amount to be determined by the Insurance Commissioner.


and-8.--A-request-for-this-protection-must-be-made-in writing-to-an-agent.--Such-coverage-shall-be-made-available-no later-than-the-first-day-of-the-fiscal-year-being-covered-and shall-be-purchased,--if-at-all,-no-later-than-the-last-day-of such-fiscal-year.--This-subparagraph-shall-stand-repealed-July 1, 1983.

The Insurance Commissioner may, in his discretion, require that insurers participating in the Joint Underwriting Association offer excess coverage. The plan shall make available coverage with limits of $1 million per claim, $3 million annual aggregate, and coverage with limits of $2 million per claim, $4 million annual aggregate, to physicians

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member to serve as vice chairman of the board. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or self-insurer, or its agents or employees, the Joint Underwriting Association or its agents or employees, members of the board of governors, or the department or its representatives, for any action taken by them in the performance of their powers and duties under this subsection.

(d) The plan shall provide coverage for claims arising out of the rendering of, or failure to render, medical care or services and, in the case of health care facilities, coverage for bodily injury or property damage to the person or property of any patient arising out of the insured's activities, in appropriate policy forms for all health care providers as defined in paragraph (h). The plan shall include, but shall not be limited to:

1. Classifications of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas. To assure that plan rates are adequate to pay claims and expenses, the Joint Underwriting Association shall develop a means of obtaining loss and expense experience; and the plan shall file such experience, when available, with the department in sufficient detail to make a determination of rate adequacy. Within 60 days after a rate filing, the department shall approve such rates or rate revisions as are fully supported by the filing. In addition to provisions for claims and expenses, the rate-making formula may include a factor for projected claims trending and a margin for contingencies. The use of trend factors shall not be found to be inappropriate.
licensed under chapter 458 and to osteopaths licensed under chapter 459. Such coverage shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and limits of $1 million per claim, $3 million annual aggregate, and limits of $2 million per claim, $4 million annual aggregate, and, in addition, various lesser levels of coverage may be made available. The plan shall make available coverage to hospitals of $5 million per claim, $10 million annual aggregate, and may make lesser levels of coverage available. Hospital or ambulatory surgical center coverage under the plan shall comply with the requirements of s. 627.4146.

(e) In the event an underwriting deficit exists for any policy year the plan is in effect, each policyholder shall pay to the association a premium contingency assessment not to exceed one-half one-third of the premium payment paid by such policyholder to the association for that policy year. The association shall pay no further claims on any policy for the policyholder who fails to pay the premium contingency assessment.

1. Any deficit sustained under the plan shall first be recovered through the premium contingency assessment.

2. If there is any remaining deficit under the plan after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct premiums of each such member written during the calendar year immediately preceding the end of the policy year for which there is a deficit assessment bears to the aggregate net direct premiums written in this state by all members of the association. The term "premiums" as used herein means

CODING: Words in italics through type are deletions from existing law; words underlined are additions.
This proposal on the FMMJUA ties into the proposal for the Patient's Compensation Fund in section 2. The PCF is a separate malpractice fund created by statute. The bill adds a "self-destruct" mechanism that will terminate the PCF unless it receives $5 million in premiums from individual health care providers. The PCF presently provides excess coverage up to $10 million per claim over a "deductible" of $100,000. As proposed, the maximum PCF limits would be reduced to $2 million per claim, $4 million annual aggregate, the same maximum limits proposed for the FMMJUA.

A primary difference between the PCF and the FMMJUA is the assessment method in the event of a deficit. Physicians may be assessed up to 200 percent of their annual premium in the PCF. Hospitals are subject to an unlimited assessment, but no hospitals remain in the PCF today. In the FMMJUA insureds may be assessed up to 33 1/3% of their premium. The bill increases this potential assessment to 50% of the annual premium. As presently provided, casualty insurance companies may be assessed for any additional deficit. (A one-time provision was added last session to allow PCF members to buy insurance from the FMMJUA to cover potential assessments in the PCF for 1982-83. This provision is repealed since it is no longer applicable.)

The bill provides additional rate approval standards for the FMMJUA. The FMMJUA is required to develop a means of obtaining loss and expense experience to be included in a rate filing with the department. Within 60 days of a rate filing, the department would be required to approve rates as are fully supported by the filing. The rate-making formula may include a factor for projected claims trending and a margin for contingencies.

The bill also provides immunity from liability to member insurers or employees of the FMMJUA or the department for any action taken in performance of their duties.

The Patient's Compensation Fund currently offers excess malpractice insurance to all health care providers, as defined. The bill makes the following changes for the PCF:

1. The PCF would be authorized to reject coverage for health care providers other than hospitals, having adverse claims experience.

2. The maximum limits would be reduced from $10 million per claim, to $2 million per claim with a $4 million annual aggregate. For hospitals the maximum coverage would be $5 million per claim with no (unlimited) annual aggregate.

3. Presently, hospitals are required to join the PCF unless they obtain coverage equal to $10,000 per claim for each bed, not to exceed $2.5 million annual aggregate. The bill raises the coverage exemption to $5 million per claim with a $10 million annual aggregate.

4. Presently individual health care providers in the PCF are subject to a potential assessment equal to two times (200%) the fees paid for the year in which a deficit occurs. Hospitals are subject to unlimited assessments. The bill eliminates the cap on assessments of individual health care providers. They would also be potentially subject to unlimited assessments.

5. A "self-destruct" mechanism is provided. If the PCF does not collect at least $5 million from all health care providers other than hospitals, then it must discontinue writing coverage for such providers. If the PCF does not collect at
I. SUMMARY AND PURPOSE

This bill substantially reforms the two state-created medical malpractice insurance funds, the Florida Medical Malpractice Joint Underwriting Association (FMMJUA) and the Florida Patient's Compensation Fund (PCF). For the PCF, maximum limits are lowered, the cap is removed for assessments against physicians, and a "self-destruct" mechanism is provided to terminate PCF writings if the premium volume does not meet a certain level. For the FMMJUA, maximum limits are established and assessments against insureds are increased.

II. CURRENT LAW AND EFFECT OF CHANGES

Florida Medical Malpractice Joint Underwriting Association -- The FMMJUA, created statutorily, provides medical malpractice insurance to any health care provider, as defined. The limits provided are not established by statute, but by the plan of operation adopted by the Board of Governors and approved by the Department of Insurance. Until recently the plan provided for maximum limits of $250,000 per claim, $750,000 annual aggregate. However on March 18, 1983, the FMMJUA Board of Governors voted to increase its maximum limits to $2 million per claim, $4 million annual aggregate, in addition to lower limits. An order to this effect has been issued by the department. The bill requires these same maximum limits by statute. This coverage must be offered both as primary coverage and as excess coverage over and above the physician's primary coverage. The FMMJUA currently offers hospitals maximum limits of $2.5 million per claim, $2.5 million annual aggregate. (The Board has not voted to change these limits.) The bill raises these hospital limits to $5 million per claim, $10 million annual aggregate.
least $12.5 million from hospitals, then it must stop writing
coverage for hospitals.

(6) If a fund member objects to an assessment, he would
be required to pay the assessment as a condition precedent to
legally contesting the assessment.

(7) Claimants would be prohibited from executing a
judgment against the fund to the extent that the judgment is for
a claim covered in a membership year for which the fund has
insufficient assets to pay the claim through fees, interest
income, and assessments. If the fund does not have sufficient
assets, it is authorized to appeal a judgment without posting a
bond, and to retain a reasonable sum of money for administrative
and claims expenses.

(8) If there are insufficient assets to satisfy a claim,
an automatic stay of execution is provided in favor of the
insured fund member for the amount of the fund coverage. The
stay of execution shall be in effect until adequate assessments
are collected by the fund to pay the claim. Upon competent proof
that any portion of a claim is uncollectable, the member's stay
of execution may be vacated by the court.

(9) Specific administrative powers are granted to the
PCF.

III. ECONOMIC IMPACT CONSIDERATIONS

A. PRIVATE SECTOR CONSIDERATIONS

The cap on assessments against individuals insured by the
PCF is eliminated. This is done in order to provide a source of
funds in the event a deficit occurs that cannot be covered by the
present 200 percent assessment cap. Although present law places
no cap on assessments against hospitals, there are no hospitals
left in the PCF. This will increase potential assessments
against physicians, but it will also prevent an individual
physician from being held personally liable for a judgment if the
PCF cannot assess sufficient funds.

In addition, the maximum limits in the PCF are reduced
from $10 million per claim to $2 million per claim. This should
reduce the potential assessments.

The Florida Medical Malpractice Joint Underwriting
Association (FMMJUA) will be required to write limits up to $2
million per claim, $4 million annual aggregate. If the PCF
"self-destructs" as provided in this bill (by not collecting
enough premiums in advance of the July 1, 1983 membership year),
the FMMJUA would be the only malpractice insurer required to
offer malpractice coverage. The maximum assessment against
physicians in the FMMJUA is increased from 33 1/3% to 50% of the
annual premium. This would lessen the likelihood of the next
level of assessments against casualty insurers (and their
policyholders) in the event a deficit still exists after
assessing physicians.

B. PUBLIC SECTOR CONSIDERATIONS

No substantial impact.

IV. COMMENTS

V. AMENDMENTS
The bill makes the following changes to the FMMJUA:

(1) The bill establishes the maximum limits that must be offered by the FMMJUA at $250,000 per claim, $750,000 annual aggregate. This coverage must be offered both as primary coverage and as excess coverage over the physician's primary coverage, so that the total limits would be $250,000 per claim, $750,000 annual aggregate.

(2) The FMMJUA currently offers hospitals maximum limits of $2.5 million per claim, $2.5 million annual aggregate. The bill establishes the maximum limits for hospitals at $10,000 per bed per claim, not to exceed $2.5 million annual aggregate. This is the amount of insurance that meets the financial responsibility requirements for a hospital to opt out of the Patient's Compensation Fund.

(3) The bill provides additional rate approval standards for the FMMJUA. The FMMJUA is required to develop a means of obtaining loss and expense experience to be included in a rate filing with the department. Within 60 days of a rate filing, the department would be required to approve rates as are fully supported by the filing. The rate-making formula may include a factor for projected claims trending and a margin for contingencies.

(4) The bill provides immunity from liability to insurers, their agents and employees, FMMJUA agents and employees, the board of governors, and department representatives for actions taken in performance of their powers and duties under this statute.

(5) A one-time provision was added last session to allow PCF members to buy insurance from the FMMJUA to cover potential assessments in the PCF for membership year 1982-1983. This provision is repealed since it is no longer applicable.

Patient's Compensation Fund--

The Patient's Compensation Fund (PCF) is a separate medical malpractice fund created by s. 768.54, Florida Statutes. The PCF presently provides excess coverage up to $10 million per claim over a "deductible" of $100,000. (The deductible is scheduled to increase to $150,000 per claim on July 1, 1983.)

The following changes are made to the PCF:

(1) The maximum PCF limits that must be offered to health care providers other than hospitals are lowered to $2 million per claim, $4 million annual aggregate.

(2) In the case of coverage for a hospital, the maximum coverage that must be offered is lowered to $7.5 million per claim with no annual aggregate.

(3) The PCF will be prohibited from writing any coverage for any health care provider in those years that it does not collect at least $5 million in membership fees from health care providers other than hospitals. The PCF will be prohibited from writing any coverage for hospitals in those years that it does not collect at least $12.5 million from hospitals. It has been determined that the PCF may not write coverage for membership year 1983-1984 due to insufficient fees, based on applications submitted.

(4) Presently individual health care providers in the PCF are subject to a potential assessment equal to two times (200%) the fees paid for the year in which a deficit occurs. Hospitals
Bill Analysis

Florida House of Representatives
H. Lee Mofitt, Speaker
Steve Pajcic, Speaker pro tempore
Committee on Commerce

Samuel P. Bell, III
Chairman
Dexter W. Lehtinen
Vice Chairman

FINAL STAFF SUMMARY

HB 1302 by Commerce
(as enacted by the Legislature)
relating to medical malpractice insurance

Committee Consideration:
House Commerce

Identical*/Similar Bills:
SB 561

Date: June 30, 1983
Became Law: June 23, 1983
Ch. 83-206, Laws of Florida

Effective Date: June 23, 1983

I. SUMMARY AND PURPOSE

This bill makes changes to the two state-created medical malpractice insurance funds, the Florida Medical Malpractice Joint Underwriting Association (FMMJUA) and the Florida Patient's Compensation Fund (PCF). For the PCF, maximum limits are lowered, the cap is removed for assessments against physicians, and an annual "self-destruct" mechanism is provided to prohibit PCF writings for years in which the premium volume does not meet a certain level. For the FMMJUA, maximum limits are established at $250,000 per claim, $750,000 annual aggregate.

II. CURRENT LAW AND EFFECT OF CHANGES

There are two state-created medical malpractice insurance funds, the Florida Medical Malpractice Joint Underwriting Association (FMMJUA), and the Patient's Compensation Fund (PCF).

Florida Medical Malpractice Joint Underwriting Association--

The FMMJUA, created by s. 627.351(4), Florida Statutes, provides medical malpractice insurance to any health care provider, as defined. Presently, the limits provided are not established by statute, but by the plan of operation adopted by the Board of Governors and approved by the Department of Insurance. The plan provides for maximum limits of $250,000 per claim, $750,000 annual aggregate. However, on March 18, 1983, the FMMJUA Board of Governors voted to increase its maximum limits to $2 million per claim, $4 million annual aggregate. An order to this effect was then issued by the department. However, there was some question whether the department had statutory authority to order this level of coverage.
limits in the PCF are reduced from $10 million per claim to $2 million per claim. This should reduce the potential assessments.

B. PUBLIC SECTOR CONSIDERATIONS

No substantial impact.

IV. COMMENTS

On May 17, 1983, the First District Court of Appeals in Southeast Volusia Hospital District v. State of Florida, Department of Insurance, Case no. AN-412, AN-367, declared s. 768.54(3)(C), Florida Statutes, creating the Florida Patient's Compensation Fund, unconstitutional. On June 9, 1983, the Florida Supreme Court reversed the decision of the district court and held the statute to be constitutional on its face and as applied in Department of Insurance, State of Florida v. Southeast Volusia Hospital District, Case no. 63,698, 63,699, and 63,751. The one-page decision of the court stated that an opinion explaining its rationale and discussing other issues would be filed at a later date. At this writing the later opinion has not yet been filed.

V. LEGISLATIVE HISTORY

House Bill 1302 began as PCB 83-44. As originally drafted PCB 83-44 increased the limits in the FMMJUA to $2 million per claim, $4 million annual aggregate. The bill also had a "self-destruct" mechanism terminating the PCF if it did not generate a certain level of premiums. (This was a one-time determination which differed from the annual determination in the enacted bill.)

PCB 83-44 was first heard in the Subcommittee on Health Care and Life and Health Insurance of the Commerce Committee on April 19, 1983. Testimony was heard on the bill but no subcommittee action was taken on this date. On April 26, 1983, the subcommittee heard the bill again, passed five amendments, and voted out the bill (All of the amendments were eventually enacted in HB 1302. The most important amendment limited a claimant's right to execute against the fund when there are insufficient assets.) On this same date the bill was heard by the full Commerce Committee which adopted all of the amendments approved in subcommittee. No final action was taken by the full committee on this date.

On May 3, 1983, the Commerce Committee heard PCB 83-44 for the second time. Three additional amendments were passed (which were eventually enacted in HB 1302). These amendments provided specific powers and duties to the PCF board of governors and provided a limited stay of execution in favor of PCF members for the amount of coverage provided. The bill was approved and introduced as HB 1302.

On May 25, 1983, HB 1302 was read for the second time and three amendments were adopted. One of the amendments altered the time period for determining when the PCF had sufficient membership fees to continue to write coverage. (This was still a one-time determination.) On May 26, 1983, the bill was passed by the House, as amended, 115-0 (HJ 642).

On June 2, 1983, the Senate adopted amendments to HB 1302 that substantially changed the bill. The major change was a reduction in the amount of coverage required to be offered by the FMMJUA. While the House Bill required coverage of $2 million per claim, $4 million annual aggregate, the Senate amendment reduced coverage to $250,000 per claim, $750,000 annual aggregate. The second major change was a provision for an annual
are subject to unlimited assessments. However, there are no hospitals presently insured with the PCF. All hospitals have met the financial responsibility requirements of this section and have thereby opted out of the PCF. The bill eliminates the cap on assessments of individual health care providers. They are now potentially subject to unlimited assessments.

(5) Additional standards and procedures are provided for establishing rates for PCF coverage and for levying assessments in the event of a deficit. Present law requires PCF rates to be actuarially sound, which are to be set by the Insurance Commissioner after consultation with the board of governors of the fund. The bill maintains the actuarial soundness standard, and requires the fund to submit to the Insurance Commissioner the classifications and fees to be charged. The Insurance Commissioner is required to review the fees and to approve them if they comply with all the requirements of s. 768.54 and fairly reflect the considerations provided for in this section. If the classifications or fees do not comply with this section, the Insurance Commissioner is required to set classifications or fees which do comply. With regard to assessments, the bill requires the Insurance Commissioner to approve the fund's request to levy an assessment provided that the assessment fairly reflects the same considerations and classifications upon which the fees were based. The assessment must be in an amount sufficient to satisfy reserve requirements for known claims including expenses to satisfy the claims made against the account for a given fiscal year.

(6) If a fund member objects to an assessment, he would be required to pay the assessment as a condition precedent to legally contesting the assessment.

(7) Claimants would be prohibited from executing a judgment against the fund to the extent that the judgment is for a claim covered in a membership year for which the fund has insufficient assets to pay the claim through fees, interest income, and assessments. If the fund does not have sufficient assets, it is authorized to appeal a judgment without posting a bond, and to retain a reasonable sum of money for administrative and claims expenses.

(8) If there are insufficient assets to satisfy a claim, an automatic stay of execution is provided in favor of the insured fund member for the amount of the fund coverage. The stay of execution shall be in effect until adequate assessments are collected by the fund to pay the claim. Upon competent proof that any portion of a claim is uncollectable, the member's stay of execution may be vacated by the court.

(9) Specific administrative powers are granted to the PCF and immunity from liability is provided to various persons for actions taken by them in the performance of their powers and duties pursuant to s. 768.54, Florida Statutes.

III. ECONOMIC IMPACT

A. PRIVATE SECTOR CONSIDERATIONS

The cap on assessments against individuals insured by the PCF is eliminated. This is done in order to provide a source of funds in the event a deficit occurs that cannot be covered by the present 200 percent assessment cap. Although present law places no cap on assessments against hospitals, there are no hospitals left in the PCF. This will increase potential assessments against physicians, but it will also prevent an individual physician from being held personally liable for a judgment if the PCF cannot assess sufficient funds. In addition, the maximum
determination in the PCF (rather than a one-time determination) whether the PCF would receive $5 million in premiums from health care providers, other than hospitals, in order to be authorized to write coverage for that year. The bill was passed as amended, 38-0 (SJ 823).

On June 3, 1983, the House concurred in the Senate amendments, and passed the bill as amended, 116-0 (HJ 1136).

On June 23, 1983, HB 1103 was approved by the Governor, Chapter 83-206, Laws of Florida.

Prepared by: \[Signature\]

Staff Director: \[Signature\]
A bill to be entitled
An act relating to professional malpractice;
creating s. 395.0031, Florida Statutes;
establishing financial responsibility
requirements for ambulatory surgical centers;
creating s. 395.0041, Florida Statutes;
requiring hospitals and ambulatory surgical
centers to provide medical malpractice coverage
for certain anesthesiologists; amending s.
395.0115(1), (2), Florida Statutes, 1982
Supplement; requiring licensed facilities to
discipline staff members for certain conduct;
requiring investigation by the governing board
of licensed facilities of certain conduct by
staff members; creating s. 458.321, Florida
Statutes; establishing financial responsibility
requirements for physicians; amending s.
458.331(1)(t), Florida Statutes, 1982
Supplement, and adding subsection (5) to said
section; providing definitions; requiring the
Board of Medical Examiners to investigate
certain physicians; creating s. 459.011,
Florida Statutes; establishing financial
responsibility requirements for osteopaths;
amending s. 627.351(4), Florida Statutes, 1982
Supplement; requiring the Florida Medical
Malpractice Joint Underwriting Association to
make certain levels of coverage available to
physicians, osteopaths, hospitals, and
ambulatory surgical centers; increasing
potential assessments against members; deleting
accordance with it, except, if the settlement involves a minor, the court shall retain the right to review the terms of the offer and acceptance to protect the interest of the minor as authorized by law. The fact that an offer is not accepted does not preclude a subsequent offer.

(3) If an offer of judgment is not accepted and the judgment finally obtained by the plaintiff is the same or less favorable to him than the offer made by the defendant, the plaintiff shall pay all taxable costs incurred by the defendant from the date the plaintiff received the offer, and the amount of the judgment shall be decreased by 15 percent.

(4) If the judgment finally obtained by the plaintiff is more favorable to him than the offer made by the defendant, interest on the judgment shall accrue from the earlier or 90 days after receipt of the notice of intent to initiate litigation or the date the plaintiff received the offer, and the amount of the judgment shall be increased by 15 percent.

(5) This section shall apply to all causes of action with respect to which suit is not filed prior to October 1, 1963.

Section 17. Subsections (2) and (3) of section 768.54, Florida Statutes, 1982 Supplement, are amended to read:

768 54 LIMITATION OF LIABILITY and Patient's compensation fund --

(2) COVERAGE LIABILITY --

(a) All hospitals, unless exempted under this paragraph or paragraph (c), shall, and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to

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subsection (3). Any hospital operated by an agency of the
state shall be exempt from the provisions of this section and
shall not be required to participate in the fund. The fund
may establish reasonable criteria for rejecting health care
providers, other than hospitals, having adverse claims
experience.

(b) Whenever a claim covered under subsection (3)
results in a settlement or judgment against a health care
provider, the fund shall pay to the extent of its coverage
shall be liable to the extent of the coverage if the health
care provider has paid the fees and any assessments required
pursuant to subsection (3) for the year in which the incident
occurred for which the claim is filed, provides an adequate
defense for the fund, and pays the initial amount of the claim
up to the applicable amount set forth in paragraph (f) or the
maximum limit of the underlying coverage maintained by the
health care provider on the date when the incident occurred
for which the claim is filed, whichever is greater. Coverages
for such claims shall be provided on an occurrence basis by
the fund independently for each fiscal year, such fiscal year
to run from July 1 to June 30. The fund may also provide
coverages for portions of each fiscal year. The limits
maximum limit of such coverage afforded by insufficiency of the
fund for each health care provider other than a hospital shall
not exceed total limits for both entry level and fund coverage
of be $1 million per claim with a $3 million annual aggregate,
or $2 million per claim with a $4 million annual aggregate, $3
million per claim; $5 million per claim; $8 million per claim;
or $10 million per claim; as selected elected by the health
care provider. In the case of coverage for a hospital, the
limit of coverage afforded by the fund shall not exceed total

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limits for both entry level and fund coverage of $5 million per claim with no annual aggregate. The health care provider who makes such election is responsible for the payment of any amount of a claim in excess of the elected limit. The fund shall not be responsible for payment of punitive damages awarded for actual or direct negligence of the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods:

1. A bond in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses, however a total bond amount for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required. The bond shall be purchased from a licensed surety company.

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses, however a total escrow account for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required.

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from

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private insurers or the Joint Underwriting Association

established under s. 627.351(7); or

4. Self-insurance as provided in s. 627.357, providing

coverage in the applicable amount set forth in paragraph (f)
or more per claim and 3 times the applicable per-claim limit
in the aggregate per year.

(c) Any hospital that can meet one of the following

provisions demonstrating financial responsibility to pay

claims and costs ancillary thereto arising out of the

rendering of or the failure to render medical care or services

and for bodily injury or property damage to the person or

property of any patient arising out of the activities of the

hospital in this state or arising out of the activities of

covered individuals listed in paragraph (e) shall not be

required to participate in the fund:

1. Post bond in an amount equivalent to $5 million per
claim with a $10 million annual aggregate $50,000 per claim
for each hospital bed in such hospital, not to exceed a
$2,500,000 annual aggregate.

2. Establish an escrow account in an amount equivalent
to $5 million per claim with a $10 million annual aggregate
$50,000 per claim for each hospital bed in such hospital, not
to exceed a $2,500,000 annual aggregate, to the satisfaction
of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in the an
amount of $5 million per claim with a $10 million annual
aggregate equivalent to $50,000 or more per claim for each bed
in such hospital from a private insurer, from the Joint
Underwriting Association established under s. 627.351(4), or
through a plan of self-insurance as provided in s. 627.357

CODING Words in struck through type are deletions from existing law, words underlined are additions.
However, no hospital shall be required to obtain such coverage in an amount exceeding a $2,500,000 annual aggregate.

(d) Any health care provider who does not participate in the fund or participates in the fund and who does not meet the provisions of paragraph (b), shall not be covered by the fund be subject to insolvency under law without regard to the provisions of this section.

2. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and shall remain in compliance, with the provisions of this section. The department shall review the documentation and then deliver the documentation to the board of governors. At least 60 days prior to the time a license will be issued or renewed, the department shall request from the board of governors a certification that each hospital is in compliance with the provisions of this section. The board of governors shall not be liable under the law for any erroneous certification. The department shall not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the department.

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopaths, podiatrists, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, physician's assistants licensed under chapter 458, osteopaths licensed under chapter 459, and...
dentists licensed under chapter 466, and podiatrists licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physicians in a resident training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients, or anesthesiologists with staff privileges at the hospital or ambulatory surgical center when acting within the scope of such privileges. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

(f) Each health care provider shall be responsible for paying the amount of each settlement or judgment for each claim up to the fund entry level ± amount it selects. The selected entry level shall be not less than of each claim up to the following amounts:

1. As of July 1, 1983: $100,000 per claim or $500,000 per occurrence.
2. As of July 1, 1983: $150,000 per claim or $500,000 per occurrence.
3. As of July 1, 1986: $200,000 per claim or $500,000 per occurrence.
4. As of July 1, 1989: $250,000 per claim or $500,000 per occurrence.

As of July 1, 1989 the minimum entry level amount shall be indexed to the medical component of the consumer price index and shall be adjusted by the fund each year thereafter accordingly.

(3) PATIENT'S COMPENSATION FUND.--
**BILL ACTION REPORT**

**3-75: File with Secretary of Senate**

(SX#H) BILL NO. 561

**COMMITTEE ON**

**Commerce**

**DATE**
2:00 - 5:00 p.m.

**DATE REPORTED**
5/20/83

**ROOM**
Room "A"

**FINAL ACTION:**
Favorably with amendments

**OTHER COMMITTEE REFERENCES:**
Favorably with Committee Substitute
Unfavorably

**OTHER:**
Temporarily Passed
Reconsidered
Not Considered

**THE VOTE WAS:**

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**X**

**TOTAL**

Aye | Nay | Aye | Nay | Aye | Nay | Aye | Nay | Aye | Nay | Aye | Nay

(Attach additional page if necessary)

Please Complete: The key sponsor appeared
A Senator appeared
Sponsor's aide appeared
Other appearance
The Vote Was:

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With Secretary of Senate)

(S) [OK] BILL NO. 561

Page No. 2

ACTION REPORT (Continued)

(To be used for additional amendments and motions)
Judgment. The bill also includes a settlement for medical malpractice involving negligent conduct.

Presently, hospital governing board members, its agents, and medical staff are immune from liability for actions taken in good faith and without malice in disciplinary proceedings. The bill provides immunity from liability for any action taken without fraud. The bill also extends such immunity to investigators, witnesses, or other persons carrying out the provisions of this (disciplinary) section. (Compare to section 10.)

Section 3. Establishes mandatory malpractice insurance for physicians in the amount of $150,000 per claim, $450,000 annual aggregate. Alternative methods of establishing financial responsibility are a bond, escrow account, or qualified self-insurance method. Financial responsibility requirements for other health care providers are addressed in sections 1, 5, and 9.

Section 4. Section 458.331 lists grounds for disciplinary action against a physician which may be taken by the Board of Medical Examiners. Presently it is grounds for discipline if there is "repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances." Disciplinary actions include refusal to certify, revocation or suspension of a license, restriction of practice, administrative fine, reprimand, and conditional probation. The bill specifies that "repeated malpractice" includes but is not limited to having two or more claims for malpractice within the previous 5-year period resulting in a judgment or monetary settlement and which involved negligent conduct. The bill also provides that "gross malpractice" or the failure to practice medicine with the recognized level of care shall not be construed to require more than one instance or act.

The bill requires the Board to investigate and determine if disciplinary action is warranted upon being notified by the Department of Insurance of a physician having two or more claims with indemities (judgment or monetary settlement). (The new requirement for the Department of Insurance to make this notification is provided in section 8 of the bill.)

Section 5. Mandatory financial responsibility for osteopaths in the same amount and method as provided for physicians in section 3.

Section 6. Florida Medical Malpractice Joint Underwriting Association -- The FMMJUA, created statutorily, provides medical malpractice insurance to any health care provider, as defined. The limits provided are not established by statute, but by the plan of operation adopted by the Board of Governors and approved by the Department of Insurance. Until recently the plan provided for maximum limits of $250,000 per claim, $750,000 annual aggregate. However on March 18, 1983, the FMMJUA Board of Governors voted to increase its maximum limits to $2 million per claim, $4 million annual aggregate, in addition to lower limits. An order to this effect has been issued by the department. The bill raises these hospital limits to $5 million per claim, $10 million annual aggregate.
I. SUMMARY AND PURPOSE

This bill substantially reforms various provisions relating to medical malpractice. Major points include authorizing defendants to elect to pay a structured judgment; mandatory financial responsibility for certain health care providers; mandatory investigation of a physician by the Board of Medical Examiners under certain circumstances; increasing the limits in the Florida Medical Malpractice Joint Underwriting Association; and providing a method for the arbitration of damages.

II. CURRENT LAW AND EFFECT OF CHANGES

For ease of understanding a section by section analysis of the bill follows.

Section 1. Establishes mandatory malpractice insurance for an ambulatory surgical center in the amount of $150,000 per claim, $450,000 annual aggregate. Alternative methods of establishing financial responsibility are a bond, escrow account, or qualified self-insurance plan. (Financial responsibility for other health care providers is provided in sections 3, 5, and 9.)

Section 2. Presently the governing board of a hospital "is authorized" to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause, as defined. The bill makes it mandatory for the governing board to investigate and determine whether good cause exists if it is aware of the possible existence of conduct which may constitute good cause. If good cause is found to exist, the board is required to suspend, deny, revoke, or curtail the staff privileges of the responsible member. The definition of "good cause" is also amended. "Good cause" currently includes a medical malpractice
Section 10. The bill expands the civil immunity provided to members of a medical review committee of a hospital or professional society for acts performed within the scope of the functions of the committee. As amended, the immunity is provided, even if the member acts with malice, but there would still be no immunity if the member acts fraudulently. The bill also extends this immunity to any person acting within the scope of the committee, including witnesses, reporters, and investigators. The immunity is also extended to persons acting within the scope of the functions of a peer review committee of an insurer (required to be established in section 9).

(Note: On page 20, lines 10-14, language is stricken which could indicate that the persons mentioned above are immune from a medical malpractice action which is not intended. However, the language in lines 18-26 provides that there is no immunity for acts outside the scope of the functions of the committee.)

Section 11. As proposed, the Department of Health and Rehabilitative Services would be required to review reports of malpractice claims furnished annually by the Department of Insurance. (See section 8.) HRS would be required to notify hospitals of any identified patterns of conduct giving rise to adverse incidents. HRS would also be required to report to the Senate and House of Representatives determinations reached.

Section 12. The bill limits the discretion of a court to determine whether a health care provider may testify as an expert witness. Presently, an expert witness must be trained and experienced in the same specialty as the defendant, unless the court determines that the witness possesses sufficient training, experience, and knowledge in the given area. As amended, the court's determination must be based on the witness' practice or teaching in the defendant's specialty or in a related field.

Section 13. This is the major tort reform section of the bill. In summary, for any jury award for future medical expenses and lost wages in a medical malpractice action, the defendant would be given the option of paying a lump sum or making periodic payments. (Periodic payment of general damages, such as pain and suffering, may not be elected by the defendant.)

If periodic payment is elected, the defendant must pay all future medical expenses whether or not the medical expenses are related to the medical negligence. Medical benefits are paid until the claimant dies. For lost wages, the court must determine the amount of the periodic payments, and the jury determines the period of time over which the payments are made. Lost wages are paid for at least the life of the claimant. If the claimant's death was proximately caused by the medical malpractice, the remaining balance is paid to those persons entitled to damages in a wrongful death action. If the claimant's death was not proximately caused by the malpractice, lost wage payments shall cease.

With regard to the payment of the attorney's fee, the bill requires that the attorney fee attributable to the medical expenses of the claimant be paid in addition to the award. However, that portion of the attorney fee attributable to lost wages is payable from the award. For calculating the fee, either the present value of these damages as determined by the jury is used, or the actual cost of purchasing an annuity to make such payments is used, whichever is less.

There is no provision specifically addressing disputes between an insurer and a claimant concerning non-payment. However, (1) the defendant must post security or otherwise
This proposal on the FMMJUA ties into the proposal for the Patient's Compensation Fund in section 15. The PCF is a separate malpractice fund created by statute. The bill adds a "self-destruct" mechanism that will terminate the PCF unless it receives $5 million in premiums from individual health care providers. The PCF presently provides excess coverage up to $10 million per claim over a "deductible" of $100,000. As proposed, the maximum PCF limits would be reduced to $2 million per claim, $4 million annual aggregate, the same maximum limits proposed for the FMMJUA. (See further discussion in section 15.)

A primary difference between the PCF and the FMMJUA is the assessment method in the event of a deficit. Physicians may be assessed up to 200 percent of their annual premium in the PCF. Hospitals are subject to an unlimited assessment, but no hospitals remain in the PCF today. In the FMMJUA insureds may be assessed up to 33 1/3% of their premium. The bill increases this potential assessment to 50% of the annual premium. As presently provided, casualty insurance companies may be assessed for any additional deficit. (A one-time provision was added last session to allow PCF members to buy insurance from the FMMJUA to cover potential assessments in the PCF for 1982-83. This provision is repealed since it is no longer applicable.)

The bill also provides that members, agents, and employees of the FMMJUA are immune from liability for actions taken by them in the performance of their duties.

Additional rate standards are specified for the FMMJUA, including a requirement that the department approve rates within 60 days of a filing if the rates are fully supported by the filing.

Section 7. As proposed, all malpractice insurance policies must contain a clause requiring the insured to cooperate with the "peer review" process of the insurer when a claim is filed. Section 18 of the bill requires insurers to conduct a peer review when a claim is filed. Policies must also include a clause authorizing the insurer to offer an admission of liability and for arbitration, a settlement, or an offer of judgment without the permission of the insured. The new procedure for an admission of liability and for arbitration is also provided in section 16.

Section 8. Insurers are currently required by s. 627.912 to file medical malpractice claims data with the Department of Insurance. The bill applies these requirements to self-insurers, and to policies covering hospitals, and requires more detailed claims information. These reports are currently confidential except for bona fide research and education purposes. The bill eliminates this confidentiality provision.

The Department of Insurance is required by the bill to annually send to the Department of Professional Regulation and the Board of Medical Examiners copies of reports of any physicians or osteopaths having two or more claims with indemnities within a 5-year period.

The Department of Insurance would also be required to annually provide the Department of Health and Rehabilitative Services with copies of reports in cases resulting in an indemnity. (The subsequent duties of HRS is addressed in section 13.)

Section 9. Establishes mandatory malpractice insurance for health maintenance organizations in the amount of $150,000 per claim, $450,000 annual aggregate. Alternative methods of providing financial security are provided.
above, to judgments outstanding on July 1, 1983. If such application is held to be unconstitutional, the provisions shall apply to judgments entered on or after July 1, 1983.

(9) Specific administrative powers are granted to the PCF.

Section 16. Another tort reform proposal is presented. Ninety days prior to filing a malpractice claim, a claimant would be required to file a notice of intent to initiate litigation. The defendant's insurer would be required to conduct a peer review process during this 90-day period. At the end of this period the insurer may (1) reject the claim ("sue me"), (2) make a settlement offer or offer of judgment, or (3) make an admission of liability and an offer to arbitrate the damages. If offer (3) is made, the plaintiff may reject it and file suit. If the plaintiff accepts it, the parties go to arbitration. At arbitration each party makes an offer, and the arbitration panel must select one of the two offers and no other.

Section 17. Section 768.56 is repealed which presently requires the loser in a malpractice suit to pay the attorney's fee of the winner.

Section 18. Technical provision to conform to the scheduled sunset of chapter 395 on October 1, 1992.

Section 19. Technical provision to conform to the scheduled sunset of chapters 458 and 459 on October 1, 1986.

Section 20. The amendments to s. 768.54(3)(f) 4. and 5., relating to stays of execution on judgments against the PCF and its members is applied to judgments outstanding on July 1, 1983. If such application is held to be unconstitutional, it shall apply to judgments entered on or after July 1, 1983.

Section 21. Effective date of July 1, 1983, except for the PCF "self-destruct" mechanism provided in s. 768.54(3)(g) which shall take effect upon becoming a law, and an October 1, 1983, effective date for those sections mandating financial responsibility for health care providers, requiring peer review clauses in contracts, and the offer of judgment section.

III. ECONOMIC IMPACT CONSIDERATIONS

A. PRIVATE SECTOR CONSIDERATIONS

1. This bill establishes mandatory financial responsibility for physicians, osteopaths, health maintenance organizations, and ambulatory surgical centers, in the amount of $150,000 per claim, $450,000 annual aggregate. To the extent that such providers do not presently have at least this amount of insurance, the cost of obtaining it would be incurred. Presently, in the FMMJUA, the highest rated classification is an orthopedic surgeon who would pay $26,990 in Dade Broward or $22,148 in the rest of the state for this level of coverage. By comparison, a general practitioner in the FMMJUA would pay $3,037 or $2,493 in these two territories.

2. The cap on assessments against individuals insured by the PCF is eliminated. This is done in order to provide a source of funds in the event a deficit occurs that cannot be covered by the present 200 percent assessment cap. Although present law places no cap on assessments against hospitals, there are no hospitals left in the PCF. This will increase potential assessments against physicians, but it will also prevent an individual physician from being held personally liable for a judgment if the PCF cannot assess sufficient funds.
adequately assure full payment as a condition to periodic payment, and (2) if there is a continuing pattern of non-payment the court must find the debtor in contempt and must order the payment of damages and attorney fees.

Section 14. This tort reform proposal applies if the defendant makes an offer of judgment that is rejected by the plaintiff. If the eventual verdict is less than or equal to the offer, the judgment shall be reduced by 15%. If the judgment is greater than the defendant's offer, the judgment shall be increased by 15% and interest paid from the earlier of the date of the offer or 90 days after notice of intent to initiate litigation.

Section 15. The Patient's Compensation Fund currently offers excess malpractice insurance to all health care providers, as defined. The bill makes the following changes:

(1) The PCF would be authorized to reject coverage for health care providers other than hospitals, having adverse claims experience.

(2) The maximum limits would be reduced from $10 million per claim, to $2 million per claim with a $4 million annual aggregate. For hospitals the maximum coverage would be $5 million per claim with no (unlimited) annual aggregate.

(3) Presently, hospitals are required to join the PCF unless they obtain coverage equal to $10,000 per claim for each bed, not to exceed $2.5 million annual aggregate. The bill raises this coverage exemption to $5 million per claim with a $10 million annual aggregate.

(4) Presently individual health care providers in the PCF are subject to a potential assessment equal to two times (200%) the fees paid for the year in which a deficit occurs. Hospitals are subject to unlimited assessments. The bill eliminates the cap on assessments of individual health care providers. They would also be potentially subject to unlimited assessments.

(5) A "self-destruct" mechanism is provided. If the PCF does not collect at least $5 million from all health care providers other than hospitals, then it must discontinue writing coverage for such providers. If the PCF does not collect at least $12.5 million from hospitals, then it must stop writing coverage for hospitals.

(6) If a fund member objects to an assessment, he would be required to pay the assessment as a condition precedent to legally contesting the assessment.

(7) Claimants would be prohibited from executing a judgment against the fund to the extent that the judgment is for a claim covered in a membership year for which the fund has insufficient assets to pay the claim through fees, interest income, and assessments. If the fund does not have sufficient assets, it is authorized to appeal a judgment without posting a bond, and to retain a reasonable sum of money for administrative and claims expenses.

(8) If there are insufficient assets to satisfy a claim, an automatic stay of execution is provided in favor of the insured fund member for the amount of the fund coverage. The stay of execution shall be in effect until adequate assessments are collected by the fund to pay the claim. Upon competent proof that any portion of a claim is uncollectable, the member's stay of execution may be vacated by the court. Section 18 of the bill applies these provisions and the provisions summarized in (7)
In addition, the maximum limits in the PCF are reduced from $10 million per claim to $2 million per claim. This should reduce the potential assessments.

3. The Florida Medical Malpractice Joint Underwriting Association (FMMJUA) will be required to write limits up to $2 million per claim, $4 million annual aggregate. If the PCF "self-destructs" as provided in this bill (by not collecting enough premiums in advance of the July 1, 1983 membership year), the FMMJUA would be the only malpractice insurer required to offer malpractice coverage. The maximum assessment against physicians in the FMMJUA is increased from 33 1/3% to 50% of the annual premium. This would lessen the likelihood of the next level of assessments against casualty insurers (and their policyholders) in the event a deficit still exists after assessing physicians.

4. The tort reform proposals (such as mandating structured judgments at the defendant's request and providing arbitration of damages procedures) are intended to lower the costs of malpractice insurance without prejudicing the rights or needs of claimants. By allowing the medical expenses and lost wages to be paid periodically, the defendant would be able to retain the use of his funds and the claimant would be guaranteed that his economic needs are met. In the event the claimant dies, medical expenses would cease. Under present law, if the defendant is required to pay a lump sum, money for medical expenses would go to the estate of the claimant in the event he dies.

B. PUBLIC SECTOR CONSIDERATIONS

No substantial impact.

IV. COMMENTS

Sections 6 and 15 of this bill, relating to the Florida Medical Malpractice Joint Underwriting Association and the Patient's Compensation Fund are also contained in HB 1303 by Commerce.

V. AMENDMENTS

Prepared by: Brian Neff

Staff Director: Wyatt Martin
A bill to be entitled An act relating to professional malpractice; amending s. 627.351(4), Florida Statutes, 1982 Supplement; requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, hospitals, and ambulatory surgical centers, deleting obsolete language, amending s 768.54(2), (3), Florida Statutes, 1982 Supplement; permitting the Florida Patient's Compensation Fund to reject certain risks, increasing financial responsibility limits for hospitals not participating in the fund; increasing the fund entry level; requiring approval of fund membership fees and assessments by the Insurance Commissioner; removing limitations on deficit assessments to fund members, providing for termination of coverage by the fund under certain conditions and for cessation of coverage by the fund; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 627.351, Florida Statutes, 1982 Supplement, is amended to read.

627.351 Insurance risk apportionment plans.--
(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--

CODING: Words in struck through type are deletions from existing law, words underlined are additions.
2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for:
   a. Insureds who are retired or semiretired.
   b. The estates of deceased insureds.
   c. Part-time professionals.

4. Protection in an amount to be determined by the Insurance Commission.

5. Protection to members of the Florida Patients' Compensation Fund established under s. 768-54. which will cover the full amount of any or all deficit assessments issued by the fund against a member for the 1982-1983 fiscal year.

The premium contingency assessment against policyholders authorized in paragraph (e) does not apply to policies issued pursuant to this paragraph. The rate charged for such protection shall not exceed one-third of the membership fee charged the member by the fund. This protection shall only be available to fund members as defined in s. 768-54(1)(b)2-7 and 3-7. A request for this protection must be made in writing to an agent. Such coverage shall be made available no later than the first day of the fiscal year being covered and shall be purchased at no later than the first day of such fiscal year. This subparagraph shall stand repealed July 1, 1983.

The Insurance Commissioner may, in his discretion, require that insurers participating in the Joint Underwriting Association offer excess coverage. The plan shall make available coverage with limits of $1 million per claim, $3 million annual aggregate, and coverage with limits of $2 million per claim, $4 million annual aggregate, to physicians.
licensed under chapter 458 and to osteopaths licensed under chapter 459. Such coverage shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and limits of $1 million per claim, $3 million annual aggregate, and limits of $2 million per claim, $4 million annual aggregate, and, in addition, various lesser levels of coverage may be made available. The plan shall make available coverage to hospitals of $5 million per claim, $10 million annual aggregate and may make lesser levels of coverage available.

Section 2. Subsections (2) and (3) of section 768.54, Florida Statutes, 1982 Supplement, are amended to read:

768 54 Limitation of liability and Patient's compensation fund.--

(2) COVERAGE LIABILITY.--

(a) All hospitals, unless exempted under this paragraph or paragraph (c), shall, and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to subsection (3) Any hospital operated by an agency of the state shall be exempt from the provisions of this section and shall not be required to participate in the fund. The fund may establish reasonable criteria for rejecting health care providers, other than hospitals, having adverse claims experience.

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage shall be liable to the extent of the coverage if the health

CODING Words in struck through type are deletions from existing law, words underlined are additions.
care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from July 1 to June 30. The fund may also provide coverages for portions of each fiscal year. The limits maximum limit of such coverage afforded by insurability of the fund for each health care provider other than a hospital shall not exceed total limits for both entry level and fund coverage of be $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, $3 million per claim, $5 million per claim, $8 million per claim, or $10 million per claim, as selected elected by the health care provider. In the case of coverage for a hospital, the limit of coverage afforded by the fund shall not exceed total limits for both entry level and fund coverage of $5 million per claim with no annual aggregate. The health care provider who makes such election is responsible for the payment of insurable for any amount of a claim in excess of the elected limit. The fund shall not be responsible for payment of punitive damages awarded for actual or direct negligence of the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment
when due or may provide underlying financial responsibility by one of the following methods:

1. A bond in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total bond amount for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required. The bond shall be purchased from a licensed surety company;

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total escrow account for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required;

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from private insurers or the Joint Underwriting Association established under s. 627.351(7); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or the failure to render medical care or services

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and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $5 million per claim with a $10 million annual aggregate $10,000 per claim for each hospital bed in such hospital not to exceed a $2,500,000 annual aggregate.

2. Establish an escrow account in an amount equivalent to $5 million per claim with a $10 million annual aggregate $10,000 per claim for each hospital bed in such hospital not to exceed a $2,500,000 annual aggregate, to the satisfaction of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in the amount of $5 million per claim with a $10 million annual aggregate equivalent to $10,000 per claim for each bed in such hospital from a private insurer, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

However, no hospital shall be required to obtain such coverage in an amount exceeding a $2,500,000 annual aggregate:

(d)1. Any health care provider who does not participate in the fund, or participates in the fund and who and does not meet the provisions of paragraph (b), shall not be covered by the fund be subject to liability under law without regard to the provisions of this section.

2. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and shall remain in compliance, with the provisions of this section. The
department shall review the documentation and then deliver the
documentation to the board of governors. At least 60 days
prior to the time a license will be issued or renewed, the
department shall request from the board of governors a
certification that each hospital is in compliance with the
provisions of this section. The board of governors shall not
be liable under the law for any erroneous certification. The
department shall not issue or renew the license of any
hospital which has not been certified by the board of
governors. The license of any hospital that fails to remain
in compliance or fails to provide such documentation shall be
revoked or suspended by the department.

(e) The coverage afforded by the fund for a
participating hospital or ambulatory surgical center shall
apply to the officers, trustees, volunteer workers, trainees,
committee members (including physicians, osteopaths,
podiatrists, and dentists), and employees of the hospital or
ambulatory surgical center, other than employed physicians
licensed under chapter 458, physician's assistants licensed
under chapter 458, osteopaths licensed under chapter 459,
dentists licensed under chapter 466, and podiatrists licensed
under chapter 461. However, the coverage afforded by the fund
for a participating hospital shall apply to house physicians,
interns, employed physicians in a resident training program,
or physicians performing purely administrative duties for the
participating hospitals other than the treatment of patients.
This coverage shall apply to the hospital or ambulatory
surgical center and those included in this subsection as one
health care provider.

(f) Each health care provider shall be responsible for
paying the amount of each settlement or judgment for each

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claim up to the fund entry level amount it selects. The selected entry level shall be not less than of each claim up to the following amounts:

1. As of July 1, 1982: $1,000,000 per claim or $500,000 per occurrence.
2. As of July 1, 1983: $150,000 per claim or $500,000 per occurrence.
3. As of July 1, 1986: $200,000 per claim or $500,000 per occurrence.
4. As of July 1, 1989: $250,000 per claim or $500,000 per occurrence.

As of July 1, 1989 the minimum entry level amount shall be indexed to the medical component of the consumer price index and shall be adjusted by the fund each year thereafter accordingly.

(3) PATIENT'S COMPENSATION FUND.--
(a) The fund.--There is created a "Florida Patient's Compensation Fund" for the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members' activities for those health care providers set forth in subparagraphs (1)(b)1., 5., 6., and 7. which is in excess of the fund entry level selected limits as set forth in paragraph (2)(f) and less than the maximum limit selected elected under paragraph (2)(b). The fund shall be responsible only for payment of claims against health care providers who are in compliance with the provisions of...
A bill to be entitled
An act relating to professional malpractice;
amending s. 627.351(4), Florida Statutes, 1982
Supplement; requiring the Florida Medical
Malpractice Joint Underwriting Association to
make certain levels of coverage available to
physicians, osteopaths, hospitals, and
ambulatory surgical centers; deleting obsolete
language; amending s. 768.54(2), (3), Florida
Statutes, 1982 Supplement; increasing financial
responsibility limits for hospitals not
participating in the fund; increasing the fund
entry level; requiring approval of fund
membership fees and assessments by the
Insurance Commissioner; removing limitations on
deficit assessments to fund members; providing
immunity for board members; providing certain
powers to the fund; providing conditions for
protesting assessments; providing for stay of
execution against the fund; providing effective
dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 627.351, Florida
Statutes, 1982 Supplement, is amended to read:

627.351 Insurance risk apportionment plans.--
(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
(a) The department shall, after consultation with
insurers as set forth in paragraph (b), adopt a joint
underwriting plan as set forth in paragraph (d).
1. Classifications of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas. To assure that plan rates are adequate to pay claims and expenses, the Joint Underwriting Association shall develop a means of obtaining loss and expense experience; and the plan shall file such experience, when available, with the department in sufficient detail to make a determination of rate adequacy. Within 60 days after a rate filing, the department shall approve such rates or rate revisions as are fully supported by the filing. In addition to provisions for claims and expenses, the rate-making formula may include a factor for projected claims trending and a margin for contingencies. The use of trend factors shall not be found to be inappropriate.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for:
   a. Insureds who are retired or semiretired.
   b. The estates of deceased insureds.
   c. Part-time professionals.

4. Protection in an amount not to exceed $250,000 per claim, $750,000 annual aggregate. Such coverage shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and total limits of $250,000 per claim, $750,000 annual aggregate to be determined by the Insurance Commissioner.

5. Protection to members of the Florida Patients Compensation Fund established under s. 768.54, which will cover the full amount of any or all deficit assessments issued by the fund against a member for the 1982-1983 fiscal year.
The premium contingency assessment against policyholders authorized in paragraph (c) does not apply to policies issued pursuant to this paragraph. The rate charged for such protection shall not exceed one-third of the membership fee charged the member by the fund. This protection shall only be available to fund members as defined in § 768.54(1)(b)2.7, 8-T and 8. A request for this protection must be made in writing to an agent. Such coverage shall be made available no later than the first day of the fiscal year being covered and shall be purchased; if at all, no later than the last day of such fiscal year. This subparagraph shall stand repealed July 1, 1983.

The insurance Commissioner may, in his discretion, require that insurers participating in the joint underwriting association offer excess coverage.

Section 2. Subsections (2) and (3) of section 768.54, Florida Statutes, 1982 Supplement, are amended to read:

768.54 Limitation of liability and Patient's compensation fund.—

(2) COVERAGE LIABILITY.—

(a) All hospitals, unless exempted under this paragraph or paragraph (c), shall, and all health care providers other than hospitals may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to subsection (3). Any hospital operated by an agency of the state shall be exempt from the provisions of this section and shall not be required to participate in the fund.
(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage shall be liable to the extent of the coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from July 1 to June 30. The fund may also provide coverages for portions of each fiscal year. The limits maximum limit of such coverage afforded by liability of the fund for each health care provider other than a hospital shall not exceed total limits for both entry level and fund coverage of $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, $3 million per claim, $5 million per claim, $6 million per claim, or $10 million per claim as selected elected by the health care provider. In the case of coverage for a hospital, the limit of coverage afforded by the fund shall not exceed total limits for both entry level and fund coverage of $5 million per claim with no annual aggregate. The health care provider who makes such election is responsible for the payment of liable for any amount of a claim in excess of the elected limit. The fund shall not be responsible for payment of punitive damages awarded for actual or direct negligence of
the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods:

1. A bond in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total bond amount for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required. The bond shall be purchased from a licensed surety company;

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however a total escrow account for all years equal to reserved loss and expense amounts for known cases plus three times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required;

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from private insurers or the Joint Underwriting Association established under s. 627.351(7); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.
(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or the failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $5 million per claim with a $10 million annual aggregate $10,000 per claim for each hospital bed in such hospital, not to exceed a $2,500,000 annual aggregate.

2. Establish an escrow account in an amount equivalent to $5 million per claim with a $10 million annual aggregate $10,000 per claim for each hospital bed in such hospital, not to exceed a $2,500,000 annual aggregate, to the satisfaction of the Department of Health and Rehabilitative Services.

3. Obtain professional liability coverage in the amount of $5 million per claim with a $10 million annual aggregate equivalent to $10,000 or more per claim for each bed in such hospital from a private insurer, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

(d) 1. Any health care provider who does not participate in the fund or participates in the fund and who and does not meet the provisions of paragraph (b), shall not be covered by the fund be subject to liability under law without regard to the provisions of this section.
2. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and shall remain in compliance, with the provisions of this section. The department shall review the documentation and then deliver the documentation to the board of governors. At least 60 days prior to the time a license will be issued or renewed, the department shall request from the board of governors a certification that each hospital is in compliance with the provisions of this section. The board of governors shall not be liable under the law for any erroneous certification. The department shall not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the department.

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopaths, podiatrists, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, physician's assistants licensed under chapter 458, osteopaths licensed under chapter 459, dentists licensed under chapter 466, and podiatrists licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physician residents physicians in a resident training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to
the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

(f) Each health care provider shall be responsible for paying the amount of each settlement or judgment for each claim up to the fund entry level amount it selects. The selected entry level shall be not less than the following amounts:

- As of July 1, 1982: $100,000 per claim or $500,000 per occurrence.
- As of July 1, 1983: $150,000 per claim or $500,000 per occurrence.
- As of July 1, 1986: $200,000 per claim or $500,000 per occurrence.
- As of July 1, 1989: $250,000 per claim or $500,000 per occurrence.

As of July 1, 1989 the minimum entry level amount shall be indexed to the medical component of the consumer price index and shall be adjusted by the fund each year thereafter accordingly.

(3) PATIENT'S COMPENSATION FUND.--

(a) The fund.--There is created a "Florida Patient's Compensation Fund" for the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members' activities for those health care providers set forth in subparagraphs (1)(b)(1), 5., 6., and 7. which is in excess of the fund entry level selected limits as set forth
Provides for certain limits of coverage to be offered by the Florida Medical Malpractice Joint Underwriting Association; provides for certain limits of coverage to be offered by the Patient's Compensation Fund; provides for assessments for fund members.
This bill incorporates some portions of the Commissioner's recommendations to make the Florida Patient Compensation Fund actuarially sound and self-sustaining; and to address concerns of the First District Court of Appeal, which recently declared the statute unconstitutional.

It does not shift coverage over to the Florida Medical Malpractice Joint Underwriting Association, where losses could be shifted to homeowners and shopkeepers.

1. Incorporates rating and assessment standards from the Commissioner's bill (original SB 561). This addresses the concerns stated by the First District Court of Appeal, which declared the PCF rating and assessment provisions unconstitutional.

2. Provides that the PCF will be actuarially sound and self-sustaining without subsidy from other sources, by providing standards for the Department to approve actuarially sound rates (or set sound rates if the one proposed to him don't meet the standards) and by taking the cap off of members' assessments. Taking the cap off now would also allow the possibility of lower rates. All of this language is from the Commissioner's original bill.

3. Reduces PCF limits from $10 million to $2 million per claim, $4 million annual aggregate. This also is from the original bill and should allow lower PCF rates while still providing adequate coverage.

4. Enhances constitutionality of JUA statute by putting the present limits written by the JUA ($250,000/claim $750,000 annual aggregate) into the statute. That statute is presently under attack on the same grounds that resulted in the PCF statute being stricken. It does not shift higher limits coverage to the JUA and does not increase exposure to homeowners and shopkeepers' insurers.
I. SUMMARY:
A. Present Situation:

In 1975, the Legislature created the Florida Medical Malpractice Joint Underwriting Association (FMMJUA) and the Florida Patient's Compensation Fund (PCF) to ensure the availability of medical malpractice insurance. The FMMJUA provides first dollar coverage, while the PCF provides excess coverage after a large deductible (currently $100,000).

The FMMJUA currently offers maximum coverage of $250,000 per claim, $750,000 annual aggregate. If a deficit exists for any policy year, each policyholder is subject to an assessment not to exceed one-third of the annual premium paid by the policyholder. If this assessment is insufficient to make up the deficit, insurance companies participating in the plan are liable for payment of the remaining deficit. The results of the FMMJUA's first seven years of operation have been generally satisfactory; there has never been an underwriting deficit and, in 1982, a refund was issued to policyholders for the first time.

On March 18, 1983, the FMMJUA Board of Governors, at the request of the Insurance Commissioner, voted to increase the maximum limits offered to physicians by the FMMJUA to $2 million per claim, $4 million annual aggregate. The Board did not change the maximum coverage available to hospitals (currently $2.5 million per claim, annual aggregate).

The PCF offers excess coverage of up to $10 million per claim, after a deductible of $100,000 (this deductible will be raised to $150,000 on July 1, 1983, $200,000 on July 1, 1986, and $250,000 as of July 1, 1989). Prior to changes enacted by the 1982 Legislature, the PCF provided unlimited coverage to its members. If a deficit exists for a given fund year, the PCF may look only to its members to make up the deficit. Physicians may be assessed up to 200% of their annual premium, while hospitals in the fund are subject to an unlimited assessment. There are no hospitals currently in the PCF. (In 1982, the Legislature enacted temporary relief for the PCF by allowing fund members to purchase "assessment insurance" from the FMMJUA to cover any potential assessments that may be necessary for fund-year 1982-83).

B. Effect of Proposed Changes:

The bill requires the FMMJUA to offer the increased coverage recently adopted by the Board of Governors. Under this proposal, the FMMJUA would offer primary and excess coverage with limits of $1 million per claim, $3 million annual aggregate, or $2 million per claim, with a $4 million annual
aggregate. Coverage offered to hospitals would be increased to $5 million per claim, with a $10 million annual aggregate.

The bill authorizes the PCF to establish reasonable underwriting standards, i.e., the PCF could refuse coverage to "bad risks."

The maximum coverage offered by the PCF would be lowered to $2 million per claim with a $4 million annual aggregate. (the same amounts that the FMMJUA would be required to offer under this proposal). Maximum coverage available to a hospital would be $5 million per claim, with no annual aggregate. Health care providers would be liable for any amount of a claim in excess of the elected coverage.

Hospitals would be required to participate in the PCF unless financial responsibility can be shown equivalent to $5 million per claim with a $10 million annual aggregate. Currently, hospitals need coverage equal to $10,000 per claim for each bed in order to opt out of the PCF.

The cap on assessments on health care providers (currently at 200% of the fee paid for the year in which a deficit occurs) would be removed by this bill. Health care providers and hospitals would both be subject to unlimited assessments.

The bill establishes a "self-destruct" mechanism for the PCF. If the PCF fails to collect at least $5 million in premiums from non-hospital health care providers before the beginning of the July 1, 1983 membership year, it could no longer write coverage. If the PCF does not collect at least $12.5 million in premiums from hospitals, the fund could no longer offer coverage to hospitals. This "self-destruct" mechanism ties in with the bill's provisions calling for the FMMJUA to offer excess coverage. If the PCF should stop writing coverage, health care providers would be assured of obtaining coverage, both primary and excess, from the FMMJUA.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

If the PCF fails to collect at least $5 million in premiums from physicians for the 1983-84 fund year, and thus does not offer coverage due to the procedures contained in this bill, members of the PCF would presumably purchase medical malpractice insurance from either the private market or the FMMJUA. According to a spokesman from the Department of Insurance, the rates charged by private carriers for the same limits as offered by the PCF would be 2 or 3 times the PCF rate - assuming that such coverage is available. Occurrence coverage, which is offered by the PCF, is not generally available in the private market, especially with the high limits currently offered by the PCF; most private carriers offer maximum coverage of $2 or $3 million. The rates charged by the FMMJUA could also be twice as much as the rates charged by the PCF for comparable excess coverage. The rate could be as much as three times as high for certain specialists, depending upon the locality of their practice. These increased rates would presumably be passed on to patients. Should the FMMJUA incur a deficit, its insureds would be subject to a possible assessment of up to one-third of the annual premium paid. If this assessment fails to cover the deficit, casualty insurers that are required to participate in the FMMJUA would be responsible for paying any remaining deficit. Presumably, these insurers would pass such a loss on to their policyholders, with a corresponding increase in premiums.
If the PCF continues to offer coverage, individual health care providers and hospitals that belong to the PCF would both be subject to an unlimited assessment should a deficit occur in the fund. If such assessments are required, these costs would presumably be passed on to individual patients in the form of higher fees charged for medical services.

B. Government:

No substantial impact.

III. COMMENTS:

IV. AMENDMENTS:
I. SUMMARY:

A. Present Situation:

In 1975, the Legislature created the Florida Medical Malpractice Joint Underwriting Association (FMMJUA) and the Florida Patient's Compensation Fund (PCF) to ensure the availability of medical malpractice insurance. The FMMJUA provides first dollar coverage, while the PCF provides excess coverage after a large deductible (currently $100,000).

The FMMJUA currently offers maximum coverage of $250,000 per claim, $750,000 annual aggregate. If a deficit exists for any policy year, each policyholder is subject to an assessment not to exceed one-third of the annual premium paid by the policyholder. If this assessment is insufficient to make up the deficit, insurance companies participating in the plan are liable for payment of the remaining deficit. The results of the FMMJUA's first seven years of operation have been generally satisfactory; there has never been an underwriting deficit and, in 1982, a refund was issued to policyholders for the first time.

On March 18, 1983, the FMMJUA Board of Governors, at the request of the Insurance Commissioner, voted to increase the maximum limits offered to physicians by the FMMJUA to $2 million per claim, $4 million annual aggregate. The Board did not change the maximum coverage available to hospitals (currently $2.5 million per claim, annual aggregate).

The PCF offers excess coverage of up to $10 million per claim, after a deductible of $100,000 (this deductible will be raised to $150,000 on July 1, 1983, $200,000 on July 1, 1986, and $250,000 as of July 1, 1989). Prior to changes enacted by the 1982 Legislature, the PCF provided unlimited coverage to its members. If a deficit exists for a given fund year, the PCF may look only to its members to make up the deficit. Physicians may be assessed up to 200% of their annual premium, while hospitals in the fund are subject to an unlimited assessment. There are no hospitals currently in the PCF. (In 1982, the Legislature enacted temporary relief for the PCF by allowing fund members to purchase "assessment insurance" from the FMMJUA to cover any potential assessments that may be necessary for fund-year 1982-83).

B. Effect of Proposed Changes:

The bill provides that the FMMJUA may offer maximum coverage to physicians of $250,000 per claim, $750,000 annual aggregate. The bill deletes the Insurance Commissioner's authority to order the FMMJUA to offer excess coverage.
Under this proposal, the maximum coverage offered by the PCF would be $2 million per claim, $4 million annual aggregate. Health care providers participating in the PCF will be subject to unlimited assessments if such assessments are needed to make up a deficit in the fund.

The bill also provides certain standards for the Insurance Commissioner to use in approving rates, refunds, and assessments. The PCF is given authority to reimburse board members for expenses and immunity is granted to fund employees and agents for their official actions. Claimants are prohibited from executing against the fund to the extent that the fund does not have sufficient assets to pay the claim. Fund members that protest any assessments must first pay the amount assessed into the fund as a condition precedent to contesting the assessment in a legal action.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

Individual health care providers and hospitals that belong to the PCF will both be subject to unlimited assessments should a deficit occur in the fund. If such assessments are required, these costs would presumably be passed on to individual patients in the form of higher fees charged for medical services.

B. Government:

No substantial impact.

III. COMMENTS:

On May 17, 1983, the First District Court of Appeal held that section 768.54(3)(c), Florida Statutes, relating to the PCF's authority to set fees and assessments, was an unconstitutional delegation of legislative power, Southeast Volusia Hospital District v. Department of Insurance (Case No. AN-412, AN-367, May 17, 1983). The court held that the statute did not contain sufficient standards and guidelines for the Insurance Commissioner or the PCF to set rates and assessments. The Department of Insurance is appealing this decision to the Florida Supreme Court. The Supreme Court has granted expedited review of the case and oral argument is scheduled for June 6, 1983.

IV. AMENDMENTS: