1987

# Session Law 87-020

Florida Senate & House of Representatives

A bill to be entitled

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

Section 1. Subsection (4) of section 627.351, Florida Statutes, 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. Effective October 1, 1987, the Insurance Commissioner shall appoint 3 of the 5 representatives of insurers, and the Florida Bar, the Florida Medical Association and the Florida Hospital Association shall either appoint new representatives or reappoint existing representatives. Effective October 1, 1988, the Insurance Commissioner shall

appoint the other 2 representatives of insurers. All representatives shall serve 2-year terms and may be reappointed to subsequent terms. 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, 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 ratemaking 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 in an amount not to exceed $1.5 million per claim, $5 million annual aggregate for hospitals. Such coverage for health care providers other than hospitals shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and the total limits of $250,000 per claim, $750,000 annual aggregate. The plan shall also provide tail coverage in these amounts to insureds whose claims-made coverage with another insurer or trust has or will be terminated. Such tail coverage shall provide coverage for incidents that occurred during the claims-made policy period for which a claim is made after the policy period.

5. A risk management program for insureds of the association. This program shall include, but not be limited to: investigation and analysis of frequency, severity, and causes of adverse or untoward medical injuries; development of measures to control these injuries; systematic reporting of medical incidents; investigation and analysis of patient

complaints; and auditing of association members to assure implementation of this program. The plan may refuse to insure any insured who refuses or fails to comply with the risk management program implemented by the association. Prior to cancellation or refusal to renew an insured, the association shall provide the insured 60 days' notice of intent to cancel or non-renew and shall further notify the insured of any action which must be taken to be in compliance with the risk management program.

6. A premium assurance plan, which shall provide coverage to physicians as provided herein.

a. Physicians with hospital staff privileges shall obtain coverage under the premium assurance plan in an amount equal to at least $250,000 per claim and $750,000 annual aggregate. All other physicians shall obtain coverage under the premium assurance plan in an amount equal to at least $100,000 per claim and $300,000 annual aggregate. The requirements of this paragraph shall not apply to:

(I) Any person licensed under chapter 458 or 459 who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions.

(II) Any person whose license has become inactive under chapter 458 or 459 and who is not practicing medicine in this state.

(III) Any person holding a limited license pursuant to s. 458.317 or s. 459.0075 and practicing under the scope of such limited license.

b. Each physician who is covered under a malpractice policy in effect on June 30, 1987, which policy is issued by an authorized insurance company or authorized self-insurance

trust and which meets the financial responsibility requirements of s. 458.320 or s. 459.0085, shall obtain coverage under the premium assurance plan upon the termination date of the policy, but in no event later than July 1, 1988. All other physicians shall obtain coverage beginning on July 1, 1987.

c. The premium assurance plan shall make available coverage to physicians in amounts up to $1 million per claim with a $3 million annual aggregate limit. Such amounts of coverage shall be inclusive of any amounts of coverage required to be obtained pursuant to sub-subparagraph a.

d. The premium assurance plan shall provide coverage on a claims-made basis. In order to eliminate any gaps in coverage, the initial policies issued by the premium assurance plan shall include a retroactive date for covering prior acts which date coincides with the coverage of any malpractice policy issued by an authorized insurance company or authorized self-insurance trust covering the physician or hospital immediately prior to obtaining coverage through the premium assurance plan.

e. The initial rates to be charged by the association for coverage provided under the premium assurance plan shall be established by the department based on the considerations set forth in subparagraphs 1., 2. and 3., and taking into account the rates charged for similar coverage by the five largest medical malpractice insurers operating in the state. After January 31, 1987, the association may establish new rates for the premium assurance plan in the manner provided in subparagraph 1.

f. The premiums to be paid by each physician under the premium assurance plan for coverage not to exceed $250,000 per

claim and $750,000 annual aggregate shall be reduced by a percentage amount equal to a fraction the numerator of which is the amount to be deposited in the Medical Malpractice Premium Stabilization Trust Fund during the year for which coverage is being provided and the denominator of which is the total premiums to be collected by the Association under the premium assurance plan for coverage not to exceed $250,000 per claim and $750,000 annual aggregate.

g. Notwithstanding any other provisions of this subparagraph, any physician who has incurred two or more claims resulting in indemnities exceeding $125,000 each in the preceding 5 years shall not obtain coverage under the premium assurance plan. Payment of a claim or judgment by an uninsured physician shall be considered a claim resulting in indemnity. Provided, however, that any physician who cannot obtain coverage under the premium assurance plan shall obtain the coverage required under sub-subparagraph a. from the Joint Underwriting Association, from an authorized insurer as defined in s. 624.09, or through a plan of self-insurance as provided in s. 627.357.

h. In the event an underwriting deficit exists for any policy year the premium assurance plan is in effect, any surplus which has accrued from previous years and is not projected within reasonable actuarial certainty to be needed for payment of claims in the year the surplus arose shall be used to offset the deficit to the extent available. If there is any remaining deficit under the premium assurance plan, such deficit shall be recovered from the companies participating in the joint underwriting 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 premiums for the lines of insurance defined in ss. 624.603 and 624.605(1)(b), (k), and (q), including premiums for such coverage issued under package policies. To the extent required by the provisions of this subparagraph, entities licensed to write health insurance as defined in s. 624.603 shall participate in the plan and shall be members of the Joint Underwriting Association.

i. The association shall market the policies issued under the premium assurance plan directly to physicians and is hereby prohibited from paying sales commissions.

j. There is created a Medical Malpractice Premium Stabilization Trust Fund to be administered by the department for the purposes set forth in this subparagraph. In addition to any other fees, assessments or charges imposed on physicians, each physician licensed in Florida shall pay to the Department of Professional Regulation an annual fee of $1,000 to be deposited in the Medical Malpractice Premium Stabilization Trust Fund. The annual fee is due and payable on the anniversary date of the physician's license.

k. The requirements of this subparagraph, shall be continuous conditions of a physician's licensure under chapters 458 and 459. Prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine under either of such chapters, the applicant shall demonstrate to the Department of Professional Regulation and the appropriate regulatory board that the requirements of this subparagraph have been met. If any physician fails to comply with the provisions of this

subparagraph, the agency issuing the license to practice for such physician shall immediately suspend the license of such physician. The suspension shall remain in effect until such time as the physician complies with the provisions of this subparagraph and pays all outstanding amounts due the association, together with 12 percent interest from the date the amounts were originally due.

1. As used in this subparagraph:

(I) "Physician" means any physician licensed under chapter 458 and any osteopathic physician licensed under chapter 459.

(II) "Termination date" means the last day of the policy period, the date of renewal, or the date the policy is canceled by the insurer or insured.

m. To assist the Legislature in overseeing the operation of the premium assurance plan, the association shall report, at least biennially, recommended adjustments based on its experience in operating the premium assurance plan.

(e) In the event an underwriting deficit exists for any policy year the plan is in effect, any surplus which has accrued from previous years and is not projected within reasonable actuarial certainty to be needed for payment of claims in the year the surplus arose shall be used to offset the deficit to the extent available.

1. As to remaining deficit, except those relating to deficit assessment coverage, each policyholder shall pay to the association a premium contingency assessment not to exceed 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.

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 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.

3. This paragraph shall not apply to the premium assurance plan described in subparagraph (d)6.

(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 registered 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 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.

(j) Any member of the Florida Patient's Compensation Fund established under s. 768.54 who had applied in writing for, or otherwise made written request for, the deficit assessment coverage previously available from the Joint Underwriting Association under s. 627.351(4)(d)5., F.S., 1982, as enacted by chapter 82-391, Laws of Florida, which application or request was made prior to July 1, 1983, but who was denied coverage due to the termination of the offer effective June 23, 1983, shall again be afforded the opportunity to purchase the identical coverage that had been previously available. This coverage shall cover the full amount of any or all deficit assessments issued by the Florida Patient's Compensation Fund against a member for the 1982-1983 fiscal year, limited to twice the amount of the membership fee paid by the member to the fund for the 1982-1983 fiscal year. The premium contingency assessment against policyholders authorized in paragraph (e) of this subsection 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., 3., 4., and 8. A request for this protection must be made in writing to an agent together with documentation of evidence of such previous written application or written request together with a sworn affidavit by the applicant and, if an agent was involved with the previous application, the agent, swearing that the requisite application was actually made prior to July 1, 1983. Such coverage shall be made available upon the effective date of this act and for 180 days thereafter.

(k) The Joint Underwriting Association shall grant any existing medical malpractice insurance carrier the opportunity to service the insurance contracts issued by the association to current policyholders of the carrier, in exchange for a reasonable fee.

(l) The premiums collected by the Joint Underwriting Association under this subsection are exempt from the premium tax imposed under s. 624.509.

Section 2. Section 768.605, Florida Statutes, is created to read:

768.605--

(1) All hospitals licensed under chapter 395 are liable to the maximum amount of $250,000 per claim for injuries to patients caused by its medical staff other than employees of the hospital. Medical staff other than employees shall be immune from civil liability to the extent that a hospital is liable under this section.

(2) This section shall apply only to claims made by or on behalf of patients admitted to the hospital through the emergency room due to a medical emergency. As used in this subsection, "medical emergency" means a sudden or unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention.

(3) This section shall not apply to any consequence of medical care resulting from care or lack of care rendered to a patient which is unrelated to the medical emergency which precipitated the patient's hospitalization.

Section 3. This act shall take effect upon becoming a law.

STORAGE NAME: 87h0020ap5

Date: 05/06/87
Revised: _____
Final: _____

HOUSE OF REPRESENTATIVES
COMMITTEE ON INSURANCE
STAFF ANALYSIS

BILL #: PCB INS 87-20

RELATING TO: Medical Malpractice

SPONSOR(S): Committee on Insurance

EFFECTIVE DATE: Upon becoming a law

COMPANION BILL(S): _____

OTHER COMMITTEES OF REFERENCE: (1) _____

(2) _____

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I. SUMMARY

This bill creates a "premium assurance plan" within the existing medical malpractice Joint Underwriting Association (JUA).

The bill requires all physicians licensed under chapters 458 and 459, F.S., with certain exceptions, to obtain coverage from the JUA under the premium assurance plan. Physicians with hospital staff privileges are required to purchase coverage of $250,000 per claim and $750,000 annual aggregate. Physicians who do not have hospital staff privileges are required to purchase coverage of $100,000 per claim and $300,000 annual aggregate. Physicians who are employed by governments, who hold inactive licenses and do not practice medicine in this state, and who hold a limited license are not required to obtain coverage from the premium assurance plan.

Physicians are required to obtain the required coverage on the latter of July 1, 1987, or the termination date of their current insurance policy, but in no event later than July 1, 1988.

In addition to the required coverage, the premium assurance plan will offer coverage up to $1 million per claim, $3 million annual aggregate to those physicians who wish to obtain coverage in excess of the coverage required by the bill. Physicians are free to obtain insurance coverage in excess of the required coverage from any other insurer.

The bill provides for the creation of a Medical Malpractice Premium Stabilization Trust Fund. The trust fund is to be funded by a $1,000 per year fee imposed on all physicians licensed in Florida. The trust fund is to be used to reduce the premiums charged to each physician for the coverage required under the premium assurance plan. The amount of the reduction is to be equal to a percentage

amount determined by dividing the amounts in the trust fund by the total premiums collected under the premium assurance plan for the coverage required by the plan. For example, if the trust fund will receive $25 million during the year and the premiums for required coverage will equal $250 million, the premium for required coverage will be reduced by 10 percent (25 divided by 250).

Physicians who are bad risks are prohibited from obtaining coverage under the premium assurance plan, but are required to obtain the required coverage from the regular JUA or from another insurer. The bill defines a bad risk as any physician who has had 2 claims exceeding $125,000 each in the preceding 5 years.

If the premium assurance plan has a deficit for any plan year, the deficit is to be recovered from health insurers and casualty insurers who write liability insurance, medical malpractice insurance, or miscellaneous insurance.

The bill prohibits the association from paying sales commissions on the premiums charged to physicians and requires the association to market the policies directly to physicians.

The bill grants the Insurance Commissioner the power to appoint the 5 insurer representatives serving on the JUA's board of governors. Currently, the 5 representatives are selected by the insurers participating in the JUA.

The Insurance Commissioner is given the authority to set the initial rates to be charged under the Premium Assurance Plan.

The bill also provides that hospitals will be liable to a maximum amount of $250,000 per claim for injuries to patients admitted through the emergency room, caused by the negligent acts of its medical staff.

The limit on hospital liability provided in this bill does not apply to employees of the hospital, and the liability of the hospital does not extend to any consequence of medical care rendered to the patient which is unrelated to the medical emergency which precipitated the patient's hospitalization.

"Medical emergency" is defined as an unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention.

Finally, the bill provides an exemption from premium taxes to the JUA.

## II. ECONOMIC IMPACT

### A. Public

The bill requires all physicians to carry a certain level of malpractice insurance. As such, physicians who today do not have malpractice insurance will have to purchase the coverages required by this bill. Additionally, all physicians licensed in Florida are required to pay a $1,000 annual fee to be deposited in the Medical Malpractice Premium Stabilization Trust Fund. To the extent possible, physicians will pass this cost to their customers.

Requiring physicians to obtain coverage from the premium assurance plan should result in an overall reduction in premiums paid by physicians for the coverages required by the bill. The savings are derived from the following factors:

1. Since the JUA is a non-profit organization, the profit built into the rates for policies written by for-profit insurers is removed;

2. The prohibition against paying sales commissions should result in a 6-10 percent reduction in premium costs;

3. The premium tax exemption granted the JUA by the bill should further reduce premiums by 1 to 2 percent;

4. The use of the trust fund to reduce premiums should result in reduction in premiums of approximately 10 percent.

The combination of the amounts paid into the trust fund with the provisions of the premium assurance plan should result in overall savings to most physicians who currently have medical malpractice insurance.

The transfer of liability to hospitals for the acts of physicians with staff privileges in an emergency situation will increase the costs of operating a hospital. Conversely, the medical malpractice premium costs of those physicians affected should be reduced.

### B. Government

Government-owned hospitals will see an increase in costs due to the transfer of physicians's liability for acts committed in an emergency situation.

The $1,000 annual fee imposed on physicians should generate approximately $33 million. Currently, there are 24,845 physicians and osteopaths who hold active Florida licenses and practice in Florida and 8,198 who hold active Florida licenses, but practice out-of-state. Additionally, there are approximately 8,000 physicians who hold inactive licenses. At this point, it is unclear if the $1,000 fee will be imposed on those holding inactive licenses.

III. STATE COMPREHENSIVE PLAN IMPACT
This bill is consistent with the state's policy of "ensuring that necessary health services are available to all Floridians ..." [s. 187.201(6)(b)2.]

IV. COMMENTS
None

V. AMENDMENTS
None

VI. PREPARED BY: Jose A. Diez-Arquelles

VII. STAFF DIRECTOR: Jose A. Diez-Arquelles

Section 1. Florida Hospital and Physician Liability Association.--

(1) DEFINITIONS.--As used in this section, the following terms shall have the following meanings:

(a) The term "Association" means the Florida Hospital and Physician Liability Association.

(b) The term "hospital" means any hospital licensed under chapter 395.

(c) The term "physician" means any physician licensed under chapter 458 and any osteopathic physician licensed under chapter 459.

(d) The term "member" means any hospital or physician who obtains coverage from the Florida Hospital and Physician Liability Association.

(e) The term "occurrence" means any accident or incident, including continuous or repeated exposure to conditions, which results in patient injuries not intended from the standpoint of the insured.

(f) The term "per claim" means all claims per patient arising out of an occurrence.

(g) The term "department" means the Florida Department of Insurance.

(2) CREATION; REQUIRED PARTICIPATION.--

(a) There is hereby created the Florida Hospital and Physician Liability Association. The Association shall be organized and operated to pay claims as specified in subsection (5) on behalf of member hospitals and physicians. The Association is not a state agency, board or commission. The Association shall not be subject to the premium tax specified in s. 624.509.

(b) 1. Each hospital which is covered under a malpractice policy in effect on June 30, 1987, which policy is issued by an authorized insurance company or authorized self-insurance trust and which meets the financial responsibility requirements of section 768.54, shall begin membership in the Association upon the termination date of the policy, but in no event later than July 1, 1988. All other hospitals shall begin membership in the Association on July 1, 1987.

2. Each physician who is covered under a malpractice policy in effect on June 30, 1987, which policy is issued by an authorized insurance company or authorized self-insurance trust and which meets the financial responsibility requirements of section 458.320 or section 459.0085, shall begin membership in the Association upon the termination date of the policy, but in no event later than July 1, 1988. All other physicians shall begin membership in the Association on July 1, 1987.

3. For the purposes of this paragraph, "termination date" means the last day of the policy period, the date of renewal, or such earlier date that the policy is cancelled by the policyholder or insurer.

(3) ASSOCIATION ADMINISTRATION AND OPERATION.--

(a) The Association shall operate subject to the supervision and approval of a board of governors consisting of four members with demonstrated insurance knowledge and experience appointed by the Insurance Commissioner, an attorney appointed by The Florida Bar, a representative of physicians appointed by the Florida Medical Association, two representatives of hospitals appointed by the Florida Hospital Association, and three representatives of the general public appointed by the Insurance Commissioner. The board of governors shall, during the first

meeting of each operating year, choose one of its members to serve as chairman of the board and another member to serve as vice-chairman of the board. The members of the board shall be appointed to serve terms of 4 years, except that the initial appointments of three representatives of the general public by the Insurance Commissioner and an attorney by The Florida Bar shall be for terms of 3 years; thereafter, such representatives shall be appointed for terms of 4 years. Subsequent to initial appointments for 4-year terms, the representative of physicians by the Florida Medical Association and one of the two representatives of the Florida Hospital Association shall be appointed for 2-year terms; thereafter, such representatives shall be appointed for terms of 4 years. Each appointed member may designate in writing to the chairman an alternate to act in the member's absence or incapacity. A member of the board, or his alternate, may be reimbursed from the assets of the Association for expenses incurred by him as a member, or alternate member, of the board and for committee work, but he may not otherwise be compensated by the Association for his service as a board member or alternate.

(b) There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Association or its agents or employees, professional advisers or consultants, members of the board of governors or their alternates, or the Department of Insurance or its representatives for any action taken by them in the performance of their powers and duties pursuant to this section.

(4) POWERS OF THE ASSOCIATION.--The Association has the power to:

1. Sue and be sued, and appear and defend, in all actions and proceedings in its name to the same extent as a natural person.

2. Adopt, change, amend, and repeal a plan of operation, not inconsistent with law, for the regulation and administration of the affairs of the Association. The plan and any changes thereto shall be filed with the Insurance Commissioner and are all subject to his approval before implementation by the Association. All Association members, board members, and employees shall comply with the plan of operation.

3. Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the Association 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 Association and to perform other necessary or proper functions unless prohibited by law, provided that any contract for administrative services, collection of fees and processing of claims shall be limited to persons or entities whose principal place of business is located in this state.

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

7. Indemnify any employee, agent, member of the board of governors or his alternate, or person acting on behalf of the Association 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 in acting on behalf of the Association, 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 Association and, with respect to any criminal action or proceeding, he had reasonable cause to believe his conduct was lawful.

8. Enter into contracts with any authorized medical malpractice self-insurance trust or the Florida Patients Compensation Fund to administer the affairs of such trust or fund, but not to assume liability under any contract, policy, or trust agreement issued by the trust or fund.

(5) COVERAGES.--

(a) The Association shall provide coverage to its members who are in compliance with the requirements of membership on a claims-made basis for any claim arising out of the rendering of or failure to render medical care or services, 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 member's activities. In order to eliminate any gaps in coverage, the initial policies issued by the Association shall include a retroactive date for covering prior acts which date coincides with the coverage of any malpractice policy issued by an authorized insurance company or authorized self-insurance trust covering the physician or hospital immediately prior to obtaining coverage in the Association. However, no coverage for prior acts shall be provided for any known claim or known incident likely to result in a claim.

(b) 1. Each hospital shall obtain coverage from the Association for all such claims against the hospital with a per claim limit equal to the number of licensed beds in the hospital multiplied by $10,000, not to exceed $2,500,000. Such coverage

shall apply to the officers, trustees, volunteer workers, trainees, committee members, employees of the hospital, interns, and employed physician residents, but not including employed physicians.

2. Each hospital shall also obtain coverage from the Association in the amount of at least $250,000 per claim and $750,000 annual aggregate on behalf of each employed physician and each physician who has staff privileges at such hospital for claims arising out of the rendering of or failure to render medical care or services at such hospital. The coverage required to be obtained under this sub-paragraph shall be obtained by a hospital on behalf of a physician on the same date that such physician is required to begin membership pursuant to subsection (2)(b).

3. Any hospital operated by an agency, subdivision, or instrumentality of the state is exempt from the requirements of sub-paragraph 1. of this paragraph, but is not exempt from the requirements of sub-paragraph 2. However, with regard to the requirements of sub-paragraph 2. that apply to obtaining coverage for employed physicians, the amount of the coverage that must be obtained shall be in the amount of $100,000 per claim, $300,000 annual aggregate.

4. Notwithstanding the provisions of section 768.60, hospitals may not charge or assess any physician for the cost of coverages required to be provided pursuant to this subsection.

(c) Physicians with hospital staff privileges shall obtain coverage from the Association in an amount equal to at least $250,000 per claim and $750,000 annual aggregate for all such claims arising from incidents occurring outside the hospital. All other physicians shall obtain coverage from the Association

in an amount equal to at least $100,000 per claim and $300,000 annual aggregate. The requirements of this paragraph shall not apply to:

1. Any person licensed under chapter 458 or 459 who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions.

2. Any person whose license has become inactive under chapter 458 or 459 and who is not practicing medicine in this state.

3. Any person holding a limited license pursuant to section 458.317 or section 459.0075 and practicing under the scope of such limited license.

(d) The Association shall make available coverage to hospitals in amounts up to $2,500,000 per claim with no annual aggregate and to physicians in amounts up to $2,000,000 per claim with a $2,000,000 annual aggregate limit. Such amounts of coverage shall be inclusive of any amounts of coverage required to be obtained pursuant to paragraphs (b) and (c).

(e) Any claim against a physician that is based upon an alleged misdiagnosis shall be presumed to be a claim arising from an incident occurring outside a hospital unless the facts clearly establish that any misdiagnosis could only have occurred within a hospital.

(6) CONDITION OF LICENSURE AND CERTIFICATION.--

(a) The requirements of this section that apply to hospitals shall be a continuous condition of certification to operate in this state. Annually, the Department of Health and Rehabilitative Services shall require documentation by each hospital that such hospital is in compliance, and will 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 before 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 may 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.

(b) The requirements of this section that apply to physicians shall be continuous conditions of licensure under chapters 458 and 459. Prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine under either of such chapters, the applicant shall demonstrate to the Department of Professional Regulation and the appropriate regulatory board that the requirements of this section have been met.

(c) If any hospital or physician fails to comply with the provisions of this section, or to pay any lawfully ordered fee or assessment, the agency issuing the license to practice for such hospital or physician shall immediately suspend the license of such hospital or physician. The suspension shall remain in effect until such time as the hospital or physician complies with the provisions of this section and pays all outstanding fees and assessments, together with reasonable interest from the date the fees and assessments were originally due.

(7) FEES AND ASSESSMENTS.--

(a) Each physician and hospital shall pay a membership fee on an annual basis to the Association. The Association is authorized to prospectively adjust the fees of a member to reflect the claims experience of the member. The initial policies issued on or after the effective date of this act shall be prorated to reflect any initial policy period of less than one year. Subsequently, fees shall be due on January 1 of each year and shall be established by the Association. The Association shall establish actuarially sound fees based on the following considerations:

1. Past and prospective loss and expense experience in different categories of practice and in different geographical areas within the state, not to exceed 3 areas, not necessarily contiguous;

2. The years of coverage under the claims made policy;

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

4. Risk factors for persons who are retired, semi-retired, or part-time professionals.

5. With regard to the coverage that hospitals are required by this section to obtain on behalf of physicians, rates shall be prorated among hospitals if a physician is employed by, or has staff privileges at, more than one hospital.

(b) The Association shall submit to the Insurance Department the classifications and membership fees to be charged, and the Insurance Department shall review such fees pursuant to the "file and use" procedures of section 627.062(2)(a)1. and shall approve them if they comply with all the requirements of this section and fairly reflect the considerations provided for in

this section and the applicable provisions of section 627.062. If the classifications or membership fees do not comply with this section, the Insurance Department shall disapprove them and direct the Association to make a new filing responsive to the order of disapproval.

(c) The Association may collect an initial deposit from each member based upon the anticipated fee for such membership year, subject to an adjustment at the end of the year, the performance of any necessary audits, and calculation of the actual fee for such year, which may require payment by the member of the balance of the fee that is due or payment to the member of a refund of such amount paid in excess of the actual fee.

(d) The Association shall maintain a separate accounting for each calendar year and shall also maintain separate accountings of the policies obtained by hospitals and the policies obtained by physicians. The accounting for the policies obtained by hospitals shall include policies required to be obtained by hospitals on behalf of physicians. Members included in each separate accounting shall be eligible for refunds or subject to assessments based on the results of each year. However, in the event an underwriting deficit exists for any membership year the Association is in effect, any surplus which has accrued from previous years and is not projected within reasonable actuarial certainty to be needed for payment of claims in the year the surplus arose shall be used to offset the deficit to the extent available. The Association shall establish procedures to allow members which are unable to timely pay the entire amount of any assessment to meet a reasonable payment schedule for such assessment.

(e) In any proceeding to challenge the amount of the refund or assessment requested by the Association, it is presumed that the amount of refund or assessment is correct, if the Association demonstrates that it has used reasonable claims handling and reserving procedures. If it is determined that the amount of the refund or assessment is correct, the person responsible for paying the assessment shall pay interest at the rate of 12 percent per year from the day the assessment was due.

(f) The Association may borrow money needed for current operations, if necessary, to pay claims and related expenses, fees, and costs timely for a given calendar year, from an account for another calendar 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 Association, shall be repaid from the next assessment for the given fiscal year.

(8) PAYMENT OF CLAIMS.--Payment of settlements or judgments involving the Association shall be paid in the order received within 60 days after the date of settlement or judgment, unless appealed by the Association. 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 has the right to execute against the Association to the extent that the judgment is for a claim covered in a membership year for which the Association 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 for such year. When the Association has insufficient assets to pay claims for a membership year, the

Association will not be required to post a supersedeas bond in order to stay execution of a judgment pending appeal. The Association shall retain a reasonable sum of money for payment of administrative and claims expense, which money will not be subject to execution.

(9) RECORDS.--All books, records, and audits of the Association shall be open for reasonable inspection to the general public, except that a claim file in possession of the Association, 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 Association is subject to the authority of the board of governors, which shall be responsible therefor.

(10) RISK MANAGEMENT PROGRAM.--The Association shall establish a risk management program as part of its administrative functions. All members participating in the Association shall comply with the provisions of the risk management program established by the Association. 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 members and all agents and employees of members 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 Association shall establish a schedule of fee surcharges which it shall levy upon participating members found to be in violation of the provisions of the risk management program. Such schedule shall be subject to approval by the Department of Insurance and shall provide an escalating scale of surcharges based upon the frequency and severity of the incidents in violation of the risk management program. No member 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.

(9) To the extent of any conflict between this section and s. 458.320 or s. 459.0085, the provisions of this section shall control.

Section 2. This act shall take effect upon becoming law.

STORAGE NAME: 87h019aap5

Date: 04/27/87
Revised: 05/05/87
Final:

**HOUSE OF REPRESENTATIVES**
**COMMITTEE ON INSURANCE**
**STAFF ANALYSIS**

BILL #: PCB INS 87-19

RELATING TO: Medical Malpractice Insurance

SPONSOR(S):

EFFECTIVE DATE:

COMPANION BILL(S):

OTHER COMMITTEES OF REFERENCE: (1)

(2)

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I. SUMMARY

The bill creates the "Florida Hospital and Physician Liability Association." The association's purpose is to pay medical malpractice claims made against member hospitals and physicians. All hospitals licensed under chapter 395 and all physicians licensed under chapters 458 and 459, except physicians who are government employees or who hold inactive or limited licenses, are required to be members of the association. Membership in the association is a continuous licensing requirement. The association is to be governed by a board of governors composed of eleven members: 7 appointed by the Insurance Commissioner (4 with knowledge and experience in the insurance area and 3 from the general public), 1 attorney appointed by the Florida Bar, 1 physician appointed by the Florida Medical Association, and 2 hospital representatives appointed by the Florida Hospital Association. The association is granted powers sufficient to carry out the association's purpose.

The bill requires hospitals, except government-owned hospitals, to obtain coverage from the association in an amount equal to $10,000 per bed, not to exceed $2.5 million. Additionally, these hospitals are required to obtain coverage of $250,000/claim, $750,000/annual aggregate on behalf of employed physicians and physicians with staff privileges, for claims arising out of incidents taking place in the hospital. Government-owned hospitals are exempt from the requirement that hospitals obtain coverage of $10,000 per bed; however, they must obtain coverage for employed physicians in the amount of $100,000 per claim, $300,000 annual aggregate.

Physicians with hospital staff privileges are required to obtain coverage of $250,000 per claim, $750,000 annual aggregate for claims arising out of incidents taking place outside a hospital. Physicians who do not have hospital staff privileges must obtain coverage of $100,000 per claim, $300,000 annual aggregate. The required coverage limits are the same as currently required under the Financial Responsibility Law.

Hospitals and physicians may purchase coverage from the association in amounts higher than required. The offered coverage is limited to $2.5 million per claim with with no annual aggregate for hospitals, and $2 million per claim with a $2 million annual aggregate for physicians.

The bill requires the association to set rates which are to be approved by the Department of Insurance prior to being effective. The association must keep separate accountings for the coverage purchased by hospitals and the coverage purchased by physicians. The separate accountings for each calendar year will be the basis for refunds and assessments, depending on each group's experience.

The association is to establish a risk management program for its members, and has the power to impose fee surcharges on members not in compliance with the risk management program. Finally, premiums collected by the association are exempt from the premium tax imposed by s. 624.509.

II. ECONOMIC IMPACT

A. Public
The bill will shift a portion of physician's medical malpractice insurance costs to hospitals. The Department of Insurance estimates the cost shift to be approximately $150 million.

Companies and self-insurance trusts which currently offer medical malpractice insurance will experience a decline in their business, since they will be limited to writing coverages which are in excess of those which physicians and hospitals are required to obtain from the association.

B. Government
Government-owned hospitals will be required to obtain coverage for their employed physicians and staff physicians. The amount of increased costs cannot be determined at this time. Because of the premium tax exemption provided in the bill, revenues to the state will decrease.

III. STATE COMPREHENSIVE PLAN IMPACT
None

IV. COMMENTS
None

V. AMENDMENTS
None

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VII. STAFF DIRECTOR: Jose A. Diez-Arguelles