House
Legislative
Analysis
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MED. MALPRACTICE INSURANCE

House Bill 4403
Sponsor: Rep. Lynn Owen

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House Bill 4405
Sponsor: Rep. Nelson W. Saunders

House Bill 4406
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Committee: Judiciary

Complete to 3-22-93

A SUMMARY OF HOUSE BILLS 4403-4406 AS INTRODUCED 3-2-93

The bills would:

** make a hospital liable for any injuries caused by the negligence of any health care provider directly or indirectly providing health care at the hospital, and require hospitals to provide for the indemnification of that liability (House Bill 4404);

** limit the proportion of premium that a medical malpractice insurer may spend on certain overhead costs, set minimum allowable loss ratios for medical malpractice insurance, require medical malpractice insurers to lower rates, and require medical malpractice insurers to develop and implement risk management plans (House Bill 4405); and,

** require insurers and hospitals to report certain information to the state (all four bills).

The bills are not tie-barred; each could take effect independently of the others. A more detailed explanation follows.

House Bill 4403 would amend the Insurance Code (MCL 500.2477) to require each medical malpractice insurer to annually report the following to the insurance commissioner:

** the number of medical malpractice lawsuits filed; the number dismissed or settled prior to mediation; the number that go to trial; the number dismissed prior to trial; the number in which the defendant wins; the number in which the plaintiff wins; the number that are mediated, settled in mediation, or dismissed as a result of mediation; the number that involve multiple defendants; the number determined to be frivolous; and the number for which costs are assessed against the plaintiff or his or her attorney, plus the total dollar of such costs.

** the total amount of defense costs incurred for medical malpractice litigation and the amount incurred for each category listed above.

Each medical malpractice insurer also would have to submit an annual report that included the following:

** medical malpractice administrative expenses, loss adjustment expenses, and legal defense costs with the percentage of premium attributable to each and the percentage of premium attributable to payment of damages.

** the amount of savings attributable to risk management activities, broken down according to specific risk management techniques.

** the insurer's pure premium loss ratio. If the ratio of paid losses to earned premiums was not at least 85 percent, or if the percentage of premium attributable to administrative expenses and loss adjustment costs combined exceeded five percent of premium, the insurer would have to explain how these levels would be attained.

House Bill 4404 would amend the Public Health Code (MCL 333.20204 et al.) to make a licensed health facility or agency liable for any injury or death caused by negligence or malpractice of any health care provider directly or indirectly providing health care at that facility. The facility would have to establish a means of determining claims for contribution or indemnification by doing one or more of the following, which would be the only remedies to apportion liability that a facility could use against health care personnel:

** indemnifying the health care personnel.

** making contracts for binding arbitration to settle liability disputes between the facility and personnel.

** making contracts to agree to an apportionment of liability between the facility and personnel.

Each hospital would have to have an annual independent financial audit performed by a certified public accountant. Audit results would be reported to the Department of Public Health, and, if the hospital was self-insured or insured through a risk retention plan, to the insurance commissioner.

In addition, the Department of Public Health would contract with an independent auditor to annually audit each hospital to determine if unauthorized procedures had been performed there. If an audit uncovered such a situation, the department could, in addition to currently available sanctions, issue a cease and desist order, and, after opportunity for hearing, impose an administrative fine of up to $5,000 for each time the procedure was performed. A hospital that continued in violation would be subject to a fine of up to $50,000 for each time the procedure was performed.

Within one year after the bill took effect, and biennially thereafter, hospitals would have to report the following to the Department of Public Health:

** each medical malpractice claim brought against the hospital during the ten years immediately preceding the effective date of the bill or during a subsequent two-year reporting period.

** the amount paid by the hospital for each claim, itemized by amount paid for a judgment, award, or settlement, and the cost of processing and defending the claim.

** the court file number or arbitration file number of each claim.

** whether licensure for a procedure was an issue under the claim.

** the medical diagnoses and procedures that are the subject of or basis for each claim.

** the method of settlement or other means of disposing of each claim.

Each hospital would have to make this report available upon request to the insurance commissioner.

A hospital would be forbidden from using financial consideration in credentialing or granting admitting privileges to a physician.

House Bill 4405 would amend the Insurance Code (MCL 500.2403 et al.) to do the following with regard to medical malpractice insurance:

** require the insurance commissioner in determining the reasonableness of the underwriting profit margin to consider all reserves attributable to medical malpractice insurance, as well as the factors used to determine the amount of the reserves.

** forbid administrative costs, other overhead costs, and loss adjustment costs other than defense costs from exceeding five percent of premium.

** establish a minimum allowable pure premium loss ratio of 85 percent.

** require each physician medical malpractice insurer to file base rates that were 20 percent lower than the rates for all coverages in effect July 1, 1992 for the two physician malpractice insurers with the largest market share; the new rates would have to be filed by July 1, 1993. Hospital insurers would have to do the same thing, with the reduction being based on the rates charged by the single hospital insurer with the largest market share. In addition, each medical malpractice insurer would have to reduce base rates to accurately reflect any savings resulting from the application of risk management procedures and plans (see below).

An independent actuarial panel would be set up to hear insurers' petitions for relief from the limits on administrative costs, loss ratios, and rates. The three-member panel, to be established by May 15, 1993, would consist of one actuary appointed by the Senate Majority Leader, one appointed by the Speaker of the House, and one appointed by the other two members. The insurance commissioner would review the panel's recommendations, but would not be bound by them.

The insurance commissioner could not grant an insurer's petition for relief unless he or she found in writing that relief was necessary to prevent the insurer from becoming insolvent or becoming unable to earn a fair rate of return on its overall book of medical malpractice insurance. The relief would have to be necessary even taking into account investment income and savings from risk management plans. The commissioner could not grant an insurer's petition for relief if doing so would accommodate insurer inefficiencies or maintain excessive or unsubstantiated reserves.

The bill would require the medical malpractice premium surcharge now allowed under the code to be standardized as prescribed by the insurance commissioner, and would make a surcharge plan subject to commissioner approval. An insured provider or group of providers would only be subject to a surcharge if it had three or more claims in one year, had at least one claim that resulted in a $30,000 settlement or judgment, or had a claim that resulted from an activity outside the scope of the insured provider's licensure. An insured hospital would only be subject to a surcharge if it had eight or more claims in a year, had at least one $30,000 judgment or settlement, or had a claim stemming from an activity outside the scope of the hospital's licensure.

Each medical malpractice insurer would have to file and implement a risk management plan within 18 months after the bill took effect. Each risk management plan would have to be designed to prevent maloccurences and iatrogenic injuries, based on the insurer's own data and risk management expertise and on the commissioner's recommendations (which would be developed after considering national risk management studies). Upon request, a risk management plan would give an insured party risk management information tailored to the specialty or practice of the insured. Within 30 months after the bill took effect, the insurance commissioner would issue the first of a series of annual reports that used information on risk management plans and all reported medical malpractice claims data to evaluate the effect of risk management plans on quality of care and cost savings. Medical malpractice insurers would have to report on the results of their risk management plans.

House Bill 4406 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1402a), which regulates Blue Cross/Blue Shield of Michigan, to require the corporation to provide to the insurance commissioner certain information upon request. The information would be in a format prescribed by the commissioner and would include detailed payment information, procedure codes, and diagnosis codes for health care claims that are the subject of medical malpractice disputes. The information gathered by the corporation could not be used by the corporation in any way.