SUBJECT: Removing certain claims from consideration in setting malpractice rates

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Seaman, Isett, Eiland, B. Keffer, Taylor, Thompson, Van Arsdale

0 nays

1 absent — Oliveira

WITNESSES: For — Joseph Annis, Texas Medical Association

Against — Jay Thompson, Medical Protective

On — Philip Presley, Texas Department of Insurance

BACKGROUND: Insurance Code, Art. 5.15-1 regulates medical liability insurance for health care providers, which includes physicians, registered nurses, hospitals, dentists, and other health care professionals and entities. Sec. 9 permits an insurer to charge a surcharge to a liability policy based only on claims that actually were paid by an insurer as a result of a settlement or court judgment.

DIGEST: CSHB 686 would prohibit an insurer from considering, in setting a medical liability insurance premium, lawsuits that were dropped by the claimant or dismissed by the court or for which no settlement was paid. If an insurer considered these lawsuits in setting a premium, it would be required to refund the provider the difference within 30 days.

The bill would take effect September 1, 2005, and would apply to policies issued or renewed on or after January 1, 2006.

SUPPORTERS SAY: In 2003, the 78th Legislature adopted and voters approved Proposition 12, a constitutional amendment that, with HB 4 by Nixon, limited liability for health care providers. Just before the new law took effect, there was a rush for claimants to file their cases under the former, potentially more generous, law. Even though many of these cases did not result in any

actual cost to the insurer in the form of court costs, settlements, or judgments, some insurers counted them as claims and charged the health care provider a higher premium.

Health care providers should not be charged for lawsuits that do not result in any cost to the insurer. The fundamental purpose of purchasing insurance is to protect against future costs, but if there is no cost involved, the provider should not be charged.

OPPONENTS SAY:

This bill is unnecessary because it already is against the law for insurers to charge a surcharge, which includes reducing discounts, on the basis of lawsuits that did not result in a payment. Current law does not even permit them to add in defense costs because the surcharge can be based only on claims that actually were paid by an insurer as a result of a settlement or court judgment.

If insurers did increase rates because of a Prop. 12 rush to the courthouse, the insured should contact the Texas Department of Insurance, which can investigate the matter and help secure a refund for the health care provider. Because this bill only would apply to policies issued or renewed on after January 1, 2006, it would not help health care providers in the unique, one-time Prop. 12 situation anyway.

OTHER OPPONENTS SAY:

Some insurers interpret current law to allow them to offer discounts based on a provider's history of no claims because such providers constitute a lower risk for defense costs and settlements or payouts. This bill would make it financially unfeasible for insurers to offer premium discounts because they would be required to spread defense costs across all insured providers, essentially punishing providers with clean histories of claims.

This bill also only would apply to a limited population of doctors. The Texas Medical Liability Trust (TMLT), which is the largest insurer in Texas, is not regulated in the same way as other insurers. If this bill became law, doctors could obtain a claim-free discount from TMLT but not other insurers, creating a competitive disadvantage for other commercial insurers.

Including all "health care providers" in this bill could have a significant impact on the way hospitals' premiums are calculated. Health care entities' premiums often are based on experience ratings, which include a multiplier of incurred losses (actual claims paid plus exposure from

unresolved claims) for that institution versus other similar institutions. If the insurer was required to give a refund for claims that did not result in a payment, the experience rating for an institution would change even though the calculation was a snapshot of that institution's exposure at the time the policy was executed. If insurers are to be required to issue refunds, it only would be equitable for insurers also to recalculate based on claims that came in higher-than-expected after the experience rating had been calculated.

NOTES: The committee substitute would include lawsuits where no payment was made in those barred from consideration for premium-setting purposes.