THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF THE

FLORIDA PATIENT'S COMPENSATION FUND

AS OF

April 25, 2014

FLORIDA COMPANY CODE: 99011

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

PURPOSE AND SCOPE OF EXAMINATION 4

OPERATIONS REVIEW 5

CORPORATE RECORDS 5

GENERAL OPERATIONS 6

GOVERNANCE 8

COMPLAINT HANDLING 9

RATING AND UNDERWRITING 9

GENERAL CLAIMS REVIEW 9

LEGISLATIVE CHANGES 10

PENDING LITIGATION 11

EXAMINATION FINAL REPORT SUBMISSION 11

EXECUTIVE SUMMARY

An operational review of the Florida Patient's Compensation Fund (Fund) current systems and controls was performed. The review included the evaluation of processes for corporate records, general operations, accounting, complaint handling, underwriting and rating, premiums, general claims, investments, legislative changes, and pending litigation. The following information represents general findings; specific details are found in each section of the report. No violations were noted; however, the report incorporates several recommendations based upon observations noted during the review.

PURPOSE AND SCOPE OF EXAMINATION

The Florida Office of Insurance Regulation (Office), Market Investigations, conducted a Target Market Conduct Examination of the Florida Patient's Compensation Fund (Fund) pursuant to Section 624.3161, Florida Statutes. The examination was conducted by the Office. The scope period of this examination was January 1, 2010, through December 31, 2012. The examination began October 3, 2013, and ended October 10, 2013. Subsequent to the conclusion of the original on-site examination work, additional on-site review was conducted and concluded on April 25, 2014.

The purpose of the examination was to determine if the Fund is operating according to its filed plan of operations, internal procedures, and in accordance with Florida Statutes and the Florida Administrative Code. The operational review of current systems and controls included evaluating the Fund's processes for maintaining corporate records, general operations, accounting, information systems, complaint handling, premiums, general claims, investments, pending litigation, and legislative changes.

The Fund commenced operations on July 1, 1975, in accordance with Section 766.105, Florida Statutes. As provided by law and the Articles of Association, Section I.B., the Fund was established to pay medical provider professional liability claims resulting from rendering or failing to render medical care or services, or arising from committee activities. The Fund also pays specified health care facility and health maintenance organization professional liability claims resulting from patient bodily injury or property damage, including death. The Fund is a political subdivision of the state; however, it is not a state agency, board, or commission. On June 30, 1983, the Fund ceased accepting new members.

The Fund is domiciled in Tallahassee, Florida, and records were examined at the Fund's home office located at 2286 Wednesday Street, Tallahassee, Florida. Documentation utilized in this report was provided by the Fund, the independent auditors, and other external sources.

This Final Report is based upon information from the examination draft report, additional research conducted by the Office, and additional information provided by the Fund. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

OPERATIONS REVIEW

CORPORATE RECORDS

The Fund is a residual market association authorized to conduct business in the State of Florida on July 1, 1975. In response to unfavorable market conditions, the Florida Legislature created the Fund in order to provide medical malpractice coverage to doctors, practitioners, hospitals, and health care facilities that are unable to purchase coverage on the open market. It is structured as a non-profit, but functions the same as a medical malpractice insurer. In 1979, the Internal Revenue Service ruled the Fund meets the definition of an insurance company per Section I.801-3(a) of the federal tax code. The Office approves the Fund's plan of operation and its amendments. This is the fourth examination of the Fund.

To become members of the Fund, all licensed Florida hospitals and health care providers electing to enroll in the fund pay an annual membership fee and any applicable assessments based upon past and prospective loss and expense experience; prior claims experience of the members covered under the fund; and risk factors for persons who are retired, semi-retired, or part-time professionals. Hospitals with sovereign immunity are not required to be members of the Fund. Members receive coverage for claims arising from rendering or failure to render medical care or services resulting in injury or death to a patient. Health care providers choose between two coverage limits afforded by the Fund. Coverage may not exceed $1 million per claim, $3 million annual aggregate, or $2 million per claim, $4 million annual aggregate. Health care providers are responsible for paying claim amounts in excess of the selected limit and the Fund is not responsible for paying punitive damages that may be awarded to plaintiffs. Coverage limits afforded by the Fund to hospitals may not exceed $2.5 million per claim and does not provide an annual aggregate.

The Fund is subject to the supervision of a Board of Governors consisting of 11 representatives. Seven representatives, one each from the insurance industry, physicians' insurance, physicians' self-insurance, hospital insurance, hospital self-insurance, osteopathic or podiatric physicians' insurance or self-insurance, and the general public, are appointed by the State of Florida Chief Financial Officer. One attorney is appointed by The Florida Bar, a physician's representative is appointed by the Florida Medical Association, and two hospital representatives are appointed by the Florida Hospital Association.

The examination testing procedures included reviewing the Fund:

- Plan of Operation;
- Board and Committee Meeting Minutes;
- Reports of External Audits;
- Organizational Chart;
- Assessments;
- Investment Plan and results;
- Expenditures;
- Claims;
- Litigation;
- Complaints;
- Legislative Changes; and
- Examination Report as of December 31, 1997.

Findings:
No exceptions were noted.

> **Fund Response:**
> "All licensed Florida hospitals are required to join the Fund unless opting-out by meeting any one of three alternatives listed in F.S. 766.105(2)(c)1.2.3. Hospitals that enjoy Sovereign Immunity were not required to join the Fund. Membership in the Fund was elective for other healthcare providers…During the period which the Fund provided membership benefits, [coverage] was not "limited coverage" as currently stated in F.S. 766.105, but "provided its members, in good standing, an unlimited Limitation of Liability."

GENERAL OPERATIONS

Each year, the Board of Governors (Board) submits proposed classification and membership fees to the Office for approval. The Fund operates independently of preceding fiscal years and participants are only liable for claim assessments from years during which they were members. The Board possesses the authority to levy assessments, subject to the approval of the Office, in the event a deficit occurs. If the Fund determines the amount of money in an account for a given fiscal year is in excess of or insufficient to pay claims, the Fund certifies the amount and requests the Office to refund or levy an assessment against the participants for that fiscal year. Refunds and assessments are prorated based on the number of days of participation during the fiscal year.

The Fund may borrow money needed to fund current operations, pay claims, related expenses, fees, and costs for a given fiscal year from an account for another fiscal year until such time as sufficient funds are obtained through the assessment process. Borrowed amounts are repaid from subsequent assessments and include the interest earned on the Fund's investment portfolio.

Accounting:
A review of the Fund's accounting processes and procedures was completed for the scope period. The testing verified:

- Trial balances agreed with the filed Annual Statement dated December 31, 2012; and
- All filings required by the Office and the Florida Department of Financial Services (DFS) were completed.

Annual audits were completed on the Fund's financial statements for the reporting periods ending December 31, 2010, 2011, and 2012. The Certified Public Accounting firm of Carr, Riggs, and Ingram issued qualified opinions for each year audited. No exceptions noted.

Operating Expenditures:
The Board annually approves the Fund's budget. Operating expenditures for years 2010, 2011, and 2012 were $330,950, $338,700, and $359,700, respectively. The increase in operating expenses is attributed to data processing costs associated with the recovery of the Refund Program data-loss event in 2009. The expenditures allotted for professional services and contracts increased 33% while other expenses, including salaries, rent, utilities, and operations remained steady or decreased during the

scope period. Fiscally conservative management of the Fund has allowed returns to general revenue in the amounts of $17,924, $24,806, and $63,973 in 2010, 2011, and 2012, respectively.

Findings:
The Fund demonstrated adequate processes and controls for monitoring expenditures. No exceptions noted.

Assessments:
The decision to collect fees and assessments is based on the operational needs of the Fund as authorized by the Board each year. The Fund has not collected fees or levied assessments since 1991 due to favorable changes in the insurance market for private placement of coverage, declining membership and positive investment returns.

Findings:
The Fund demonstrated adequate processes and controls for monitoring assessments. No exceptions noted.

Refunds:
The Board may authorize refunds when revenues exceed known liabilities and expenses. Excesses are refunded to members in proportion to the contributions made in accordance with procedures adopted by the Board and approved by the Office. The Fund has certified to the Office twelve assessments, eleven refunds have been approved. The last year the hospitals contributed member fees was in 1982; the last year the doctor class contributed member fees was in 1983. The last refund approved by the Office was in March 2004.

Findings:
The Fund demonstrated adequate processes and controls for monitoring refunds. No exceptions noted.

Fidelity Coverage:
Section 766.105(2)(e)3, Florida Statutes, states in part, "…[persons] authorized to receive deposits, issue vouchers, withdraw or otherwise disburse any Fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect Fund assets." The Fund carries fidelity coverage issued through The Hartford Insurance Company.

Findings:
The Fund carries $50,000 in fidelity coverage through an Employee Dishonesty Coverage endorsement attached to its commercial property package policy.

Information Systems:
Soon after digitalizing paper records of the Member and Refund Program, the Fund experienced a catastrophic computer failure in 2009. Prior to digitalization, paper records of prior members and refunds, including refund ratios for each classification by Fund year were converted to microfilm. The microfilms were the basis of rebuilding the lost digital records. The restoration of Member and Refund Program Records was completed in 2011. The Fund currently relies upon a stand-alone IBM-based desktop, two laptop computers and portable external backup systems for storing and retrieving records.

Subsequent to the 2009 event, the Fund contracted with a systems consultant to install automatic backup programs on all computers used by the Fund Management and the Fund acknowledges backup programs are utilized.

GOVERNANCE

The Board meets semi-annually at various locations throughout the state to review Fund activities. Board members serve four year terms and may be reappointed. Representatives of the osteopathic or podiatric physicians' insurance or self-insurance and the hospital self-insurance are appointed for two year terms and may be reappointed for four year terms. The Fund's General Manager is the sole employee and has been employed with the Fund for 33 years.

Findings:
The Fund's General Manager does not receive formal annual performance evaluations.

Recommendation:
It is recommended the Fund adopt procedures to provide formal annual performance evaluations.

Fund Response to Recommendation:
A formal evaluation will be performed in December of every year.

Conflicts Of Interest:
Section VI.16 of the Approved Plan of Operation (Plan) provides that the Fund adopt policies, procedures, and standards of conduct to prevent conflicts of interest for members of the Board. In 2006, the Office approved the Fund's amended Plan which establishes standards for the conduct of directors, officers, senior management, and/or other employees, providing greater transparency and accountability. The Fund requires members of the Board to execute Conflict of Interest statements upon appointment. A review of the executed conflict of interest statements was conducted.

Findings:
The Fund Conflict of Interest statement records reflect most were executed by sitting board members in 2005.

Recommendation:
It is recommended the Board amend its current procedures to require execution of new conflict of interest statements upon board member appointment, re-appointment, or re-election, if not annually; and for professional services contractors, at the time services are contracted.

Fund Response to Recommendation:
Conflict of Interest Statements will be obtained in December of every year.

Elections:
Elections of the Chairman and Vice Chairman are conducted annually in accordance with Section V.D of the Articles of Association. Other officers are elected by the Board from among its members. The Board Chairman appoints committee members from the Board, the affected industry, or the public. The Vice Chairman of the Board serves as the Chairman of the Operations Committee. No exceptions noted.

COMPLAINT HANDLING

The Fund's General Manager is responsible for responding to complaints. Complaints requiring the attention of the Board, Committees, or Counsel are referred when appropriate.

Findings:
The Fund demonstrated adequate processes and controls for monitoring, communicating, and responding to complaints. No exceptions noted.

RATING AND UNDERWRITING

The Fund's Retrospective Rating Plan was approved in 1992 and provides a method of equitable return to its members. Refunds are not made until at least five years after the completion of the membership period.

Findings:
The Fund demonstrated adequate processes and controls for monitoring rating and underwriting. No exceptions noted.

Premiums:
The Fund does not rely on premiums to finance operations. No exceptions noted.

GENERAL CLAIMS REVIEW

The Fund's Internal Claims Handling Procedures were reviewed. No new claims were filed or paid during the scope period. A claims procedure manual is maintained in the event the Fund resumes paying claims. Review of the prior exam report found no exceptions in regards to claims handling procedures.

Findings:
The Fund demonstrated adequate processes and controls for monitoring claims. No exceptions noted.

Reserves:
In 1979, the Internal Revenue Service held that the Fund's reserves for rate credits are includable in unearned premiums when determining premiums earned under Section 832(b)(I)(a) of the federal tax code. No income tax liability exists for each year reviewed during the examination. The amounts held each year in Reserves for Unearned Fees and Liabilities and Reserves for Unearned Fees during the scope period was as follows:

Year	Reserves for Unearned Fees:	Liabilities and Reserves for Unearned Fees:
2010	$15,527,967	$15,745,465
2011	$15,632,465	$15,837,572
2012	$15,715,505	$15,874,825

INVESTMENTS

The assets of the Fund are conservatively invested in fixed income securities. The primary objective of the investment policy is to achieve a high rate of return from current income consistent with the objective of maintaining principal. Cash and money market investments are invested in US Treasury, Agency, AAA, AA, or A, rated Bonds and Funds. The current Fund manager assumed management of investments in June 2002. Withdrawals from investments are used to fund operations. A decrease in contributions taken from investments in 2010 is attributed to excess funds allocated to the prior year that were not spent by year-end. Cumulative Investment Results from 2010 through 2012 and Inception to Date (June 9, 2002 – April 30, 2013)* were as follows:

Year	Beginning Market Value	Contributions	Investment Results	Ending Market Value
2010	$15,451,306	($152,331)	$370,862	$15,669,837
2011	$15,669,837	($402,335)	$457,020	$15,724,522
2012	$15,724,522	($427,353)	$445,435	$15,742,604
Inception to 4/30/13*	$21,242,069	($11,655,959)	$6,053,664	$15,639,774

Allocations:
Investments are distributed between fixed-income U.S. Government Bonds and Corporate Bonds. In response to volatile market conditions, the Fund reallocated assets away from Corporate Bonds in 2011 to U.S. Government Bonds. Investments during the review period were distributed as follows:

Year	2010	2011	2012
U.S. Government Bonds	$ 7,668,685	$12,126,069	$12,370,694
Corporate Bonds	$ 7,773,074	$ 3,509,797	$ 3,246,884
Total Investments	$15,461,759	$15,635,866	$15,617,578
Total Assets	$15,745,465	$15,837,572	$15,874,825

In 2004, the Fund conducted an actuarial study to determine potential liabilities in the event of a catastrophic collapse of its annuities portfolio. Based on those results, the Board elected to post reserves equaling the total excess amounts in each year's liabilities. The Fund's annuities are held with 21 different insurers. Nearly all of the annuity insurers maintain investment grade ratings.

Findings:
The Fund demonstrated adequate processes and controls for monitoring its investment portfolio.
No exceptions noted.

LEGISLATIVE CHANGES

For purposes of its tax-exempt status, the Fund is a political subdivision of the state. The Fund processes and controls for monitoring and communicating legislative changes affecting operations were reviewed. The Board has established a Legislative Committee that monitors and reports statutory and administrative rule changes.

Findings:
The Fund demonstrated adequate processes and controls for monitoring and communicating legislative changes to the Board and Management. No exceptions noted.

PENDING LITIGATION

The Fund may be named in legal actions arising from the normal course of business operations and routinely receives and responds to Notices of Intent. The Fund is a claimant in a pending legal action, *National Organization of Life and Health Insurance Guaranty Associations, et al vs. Artemis, S.A.*, which seeks the recovery of assets from the insolvent insurer, Executive Life Insurance Company. Initiated in 1991, the suit seeks to recover lost annuities valued at $7.6 million. To date, the Fund has successfully recovered more than $3.6 million. With appeals pending, the Fund believes it has the potential to recover an additional $4 million. The Fund was not named as a defendant in any legal proceedings during the scope period.

Findings:
The Fund demonstrated adequate processes and controls for monitoring and managing litigation. No exceptions noted.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issued this Final Report based upon information from the examination draft report, additional research conducted by the Office, and additional information provided by the Florida Patient's Compensation Fund.