A bill to be entitled

An act relating to insurance; amending s. 501.212, F.S.; deleting an exclusion from application of deceptive and unfair trade practices provisions to the Department of Insurance; creating s. 624.156, F.S.; providing that certain consumer protection laws apply to the business of insurance; amending s. 627.041, F.S.; revising definitions; amending s. 627.062, F.S.; specifying nonapplication to professional medical malpractice insurance; amending s. 627.314, F.S.; revising certain authorized actions multiple insurers may engage in together; prohibiting certain conduct on the part of insurers; amending s. 627.357, F.S.; deleting a prohibition against forming a medical malpractice self-insurance fund; amending s. 627.4147, F.S.; revising certain notification criteria; providing for application of a discount or surcharge or alternative method based on loss experience in determining the premium paid by a health care provider; providing requirements; providing a limitation; amending s. 627.912, F.S.; increases the limit on a fine; requiring provision of certain financial information to the Office of Insurance Regulation; authorizing an administrative fine for failure to comply; requiring the director of the office to prepare and submit to the Governor and Legislature an annual report; creating s. 627.41491, F.S.; requiring the Office of Insurance Regulation to provide health care providers with a full disclosure of certain rate comparison information each year; creating s. 627.41493, F.S.; requiring a medical malpractice insurance rate rollback; providing for

subsequent increases under certain circumstances; requiring approval for use of certain medical malpractice insurance rates; creating s. 627.41495, F.S.; providing for consumer participation in review of medical malpractice rate changes; providing for public inspection; providing for adoption of rules by the Office of Insurance Regulation; creating s. 627.41497, F.S.; requiring certain medical malpractice insurance rates to be set by the director of the Office of Insurance Regulation; providing for approval of rate filings; requiring insurers to apply for certain rates, schedules, and manuals; providing procedures for application and review; providing review criteria; providing approval standards; authorizing the office to require certain additional information for review; requiring adoption of certain rules; providing for reports of certain information; requiring the office to retain such reports for a time certain; requiring medical malpractice insurers to file certain information with the office; authorizing the office to review rates, schedules, manuals, or rate changes at any time for certain purposes; providing procedures; requiring the office to issue orders for setting new rates; prohibiting the office from prohibiting insurers from paying certain acquisition costs for certain purposes; providing application; excluding certain judgment or settlement amounts, taxable costs, and attorney's fees from inclusion in an insurer's rate base; authorizing the Office of Insurance Regulation to adopt rules; providing an effective date.

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

Section 1. Subsection (4) of section 501.212, Florida Statutes, is amended to read:

501.212 Application.--This part does not apply to:

(4) ~~Any person or activity regulated under laws administered by the Department of Insurance or~~ Banks and savings and loan associations regulated by the Department of Banking and Finance or banks or savings and loan associations regulated by federal agencies.

Section 2. Section 624.156, Florida Statutes, is created to read:

624.156 Applicability of consumer protection laws to the business of insurance.--

(1) Notwithstanding any provision of law to the contrary, the business of insurance shall be subject to the laws of this state applicable to any other business, including, but not limited to, the Florida Civil Rights Act of 1992 set forth in part I of chapter 760, the Florida Antitrust Act of 1980 set forth in chapter 542, the Florida Deceptive and Unfair Trade Practices Act set forth in part II of chapter 501, and the consumer protection provisions contained in chapter 540. The protections afforded consumers by chapters 501, 540, 542, and 760 shall apply to insurance consumers.

(2) Nothing in this section shall be construed to prohibit:

(a) Any agreement to collect, compile, and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the Office of Insurance Regulation and made available for public inspection.

(b) Participation in any joint arrangement established by law or the Office of Insurance Regulation to assure availability of insurance.

(c) Any agent or broker, representing one or more insurers, from obtaining from any insurer such agent or broker represents information relative to the premium for any policy or risk to be underwritten by that insurer.

(d) Any agent or broker from disclosing to an insurer the agent or broker represents any quoted rate or charge offered by another insurer represented by that agent or broker for the purpose of negotiating a lower rate, charge, or term from the insurer to whom the disclosure is made.

(e) Any agents, brokers, or insurers from using, or participating with multiple insurers or reinsurers for underwriting, a single risk or group of risks.

Section 3. Subsections (3) and (4) of section 627.041, Florida Statutes, are amended to read:

627.041 Definitions.--As used in this part:

(3) "Rating organization" means every person, other than an authorized insurer, whether located within or outside this state, who has as his or her object or purpose the collecting, compiling, and disseminating historical data on paid claims or reserves for reported claims ~~making of rates, rating plans, or rating systems~~. Two or more authorized insurers that act in concert for the purpose of collecting, compiling, and disseminating historical data on paid claims or reserves for reported claims ~~making rates, rating plans, or rating systems~~, and that do not operate within the specific authorizations contained in ss. 627.311, 627.314(2), ~~(4),~~ and 627.351, shall be

deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

(4) "Advisory organization" means every group, association, or other organization of insurers, whether located within or outside this state, which prepares policy forms ~~or makes underwriting rules incident to but not including the making of rates, rating plans, or rating systems or which collects and furnishes to authorized insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a ratemaking, capacity~~.

Section 4. Subsection (7) is added to section 627.062, Florida Statutes, to read:

627.062 Rate standards.--

(7) This section shall not apply to professional medical malpractice insurance.

Section 5. Section 627.314, Florida Statutes, is amended to read:

627.314 Concerted action by two or more insurers.--

(1) Subject to and in compliance with the provisions of this part authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to:

(a) Collecting, compiling, and disseminating historical data on paid claims or reserve for reported claims ~~The making of rates or rating systems except for private passenger automobile insurance rates~~;

(b) The preparation or making of insurance policy or bond forms, ~~underwriting rules,~~ surveys, inspections, and investigations;

~~(c) The furnishing of loss or expense statistics or other information and data;~~ or

(c)~~(d)~~ The carrying on of research.

(2) With respect to any matters pertaining to the making of rates or rating systems; the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections, and investigations; the furnishing of loss or expense statistics or other information and data; or the carrying on of research, two or more authorized insurers having a common ownership or operating in the state under common management or control are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer. To the extent that such matters relate to cosurety bonds, two or more authorized insurers executing such bonds are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

(3)(a) Members and subscribers of rating or advisory organizations may use the ~~rates, rating systems, underwriting rules, or~~ policy or bond forms of such organizations, either consistently or intermittently~~; but, except as provided in subsection (2) and ss. 627.311 and 627.351, they shall not agree with each other or rating organizations or others to adhere thereto~~.

~~(b) The fact that two or more authorized insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization~~

~~or the underwriting rules or policy or bond forms prepared by a rating or advisory organization shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement.~~

(b)~~(c)~~ This subsection does not apply as to workers' compensation and employer's liability insurances.

~~(4) Licensed rating organizations and authorized insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to ratemaking and the application of rating systems.~~

(4)~~(5)~~ Upon compliance with the provisions of this part applicable thereto, any rating organization or advisory organization, and any group, association, or other organization of authorized insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof, may conduct operations in this state. As respects insurance risks or operations in this state, no insurer shall be a member or subscriber of any such organization, group, or association that has not complied with the provisions of this part applicable to it.

(5)~~(6)~~ Notwithstanding any other provisions of this part, insurers shall not participate directly or indirectly in the deliberations or decisions of rating organizations on private passenger automobile insurance. However, such rating organizations shall, upon request of individual insurers, be required to furnish at reasonable cost the rate indications resulting from the loss and expense statistics gathered by them.

Individual insurers may modify the indications to reflect their individual experience in determining their own rates. Such rates shall be filed with the department for public inspection whenever requested and shall be available for public announcement only by the press, department, or insurer.

Section 6. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

~~(10) A self-insurance fund may not be formed under this section after October 1, 1992.~~

Section 7. Section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.--

(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:

(a) A clause requiring the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured.

(b)1. Except as provided in subparagraph 2., a clause authorizing the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving

the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.

2.a. With respect to dentists licensed under chapter 466, a clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.

b. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the

insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

(c) A clause requiring the insurer or self-insurer to notify the insured no less than 90 ~~60~~ days prior to the effective date of a rate increase or cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 90 ~~60~~ days prior to the end of the policy or contract period. If cancellation or nonrenewal is due to nonpayment or loss of license, 10 days' notice is required.

(2) In determining the premium paid by any health care provider, a medical malpractice insurer shall apply a discount or surcharge based on the provider's loss experience, including state disciplinary action, or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer shall include a schedule of all such discounts and surcharges or a description of such alternative method in all filings the insurer makes with the director of the Office of Insurance Regulation. Such schedule or description of alternative method shall also be provided to policyholders or prospective policyholders. No medical malpractice liability insurer may use any rate or charge any premium unless the insurer has filed such schedule or alternative method with the director and the director has approved such schedule or alternative method. ~~Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which~~

~~maintains a medical review committee. No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.~~

(3) This section shall apply to all policies issued or renewed after July 1, 2003 ~~October 1, 1985~~.

Section 8. Section 627.912, Florida Statutes, is amended to read:

627.912 Professional liability claims and actions; reports by insurers; annual reports.--

(1) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

Reports shall be filed with the department and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Health, no later than 30 days following the occurrence of any event listed in paragraph (a) or paragraph (b). The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

(2) The reports required by subsection (1) shall contain:

(a) The name, address, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the department without the injured person's consent, except for disclosure by the department to the Department of Health. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number and names of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.

(j) In the case of a settlement, such information as the department may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.

(3) Upon request by the Department of Health, the department shall provide the Department of Health with any information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. For purposes of safety management, the department shall annually provide the Department of Health with copies of the reports in cases resulting in an indemnity being paid to the claimants.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer reporting hereunder or its agents or employees or the department or its employees for any action taken by them under this section. The department may impose a fine of $250 per day per case, but not to exceed a total of $10,000 ~~$1,000~~ per case, against an insurer that violates the requirements of this section. This subsection applies to claims accruing on or after October 1, 1997.

(5) Any self-insurance program established under s. 1004.24 shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the state university board of trustees through an employee or agent of the state university board of trustees, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic medicine licensed under chapter 459, podiatric physicians licensed under chapter 461, and dentists licensed

under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, or a settlement in any amount. The reports required by this subsection shall contain the information required by subsection (3) and the name, address, and specialty of the employee or agent of the state university board of trustees whose performance or professional services is alleged in the claim or action to have caused personal injury.

(6) Each entity required to report closed claims for the classification of insurance set forth in subsection (1) shall also provide to the Office of Insurance Regulation the following financial information, specific to this state and countrywide, if applicable, for the prior calendar year:

(a) Direct premiums written.

(b) Direct premiums earned.

(c) Incurred loss and loss expense developed according to the formula A + B – C + D – E + F + G – H, for which A equals the dollar amount of losses paid, B equals the reserves for reported claims at the end of the current year, C equals the reserves for reported claims at the end of the previous year, D equals the reserves for incurred but not reported claims at the end of the current year, E equals the reserves for incurred but not reported claims at the end of the previous year, F equals loss adjustment expenses paid, G equals the reserves for loss adjustment expenses at the end of the current year, and H equals the reserves for loss adjustment expenses at the end of the previous year.

(d) Incurred expenses allocated separately to commissions, other acquisition costs, general expenses, taxes, licenses, and fees, using appropriate estimates when necessary.

(e) Policyholder dividends.

(f) Underwriting gain or loss.

(g) Net investment income, including net realized capital gains and losses, using appropriate estimates where necessary.

(h) Federal income taxes.

(i) Net income.

(7) The director of the Office of Insurance Regulation may levy an administrative fine of $1,000 per day against any insurer failing to comply with the reporting requirements of this section.

(8) The director of the Office of Insurance Regulation shall prepare an annual report no later than July 1 that summarizes the information submitted pursuant to this section. Such summary shall be prepared on an aggregate basis. A copy of the report shall be delivered to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The first report submitted pursuant to this subsection shall be delivered on or before October 1, 2003, for the calendar year 2002. Subsequent reports shall be filed on or before March 1 for each prior year.

Section 9. Section 627.41491, Florida Statutes, is created to read:

627.41491 Full disclosure of insurance information.--The Office of Insurance Regulation shall provide health care providers with a comparison of the rate in effect for each medical malpractice insurer and self-insurer and the Florida Medical Malpractice Joint Underwriting Association. Such rate comparison chart shall be made available to the public through the Internet and other commonly used means of distribution no later than July 1 of each year.

Section 10. Section 627.41493, Florida Statutes, is created to read:

627.41493 Insurance rate rollback.--

(1) For any coverage for medical malpractice insurance subject to this chapter issued or renewed on or after July 1, 2003, every insurer shall reduce its charges to levels that are at least 20 percent less than the charges for the same coverage that were in effect on January 1, 2001.

(2) Between July 1, 2003, and July 1, 2004, rates and premiums reduced pursuant to subsection (1) may only be increased if the director of the Office of Insurance Regulation finds, after a hearing, that an insurer or self-insurer or the Florida Medical Malpractice Joint Underwriting Association is substantially threatened with insolvency.

(3) Commencing July 1, 2003, insurance rates for medical malpractice subject to this chapter must be approved by the director of the Office of Insurance Regulation prior to being used.

(4) Any separate affiliate of an insurer is subject to the provisions of this section.

Section 11. Section 627.41495, Florida Statutes, is created to read:

627.41495 Consumer participation in rate review.--

(1) Upon the filing of a proposed rate change by a medical malpractice insurer, self-insurer, or risk retention group, the director of the Office of Insurance Regulation shall require the insurer, self-insurer, or risk retention group to give notice to the public and to the insureds or associations of insureds of the insurer, self-insurer, or risk retention group making the filing.

(2) The rate filing shall be available for public inspection. If any insureds or associations of insureds of the insurer, self-insurer, or risk retention group filing the proposed rate change request the director of the Office of Insurance Regulation to hold a hearing within 30 days after the mailing of the notification of the proposed rate changes to the insureds, the director shall hold a hearing within 30 days after such request. Any consumer may participate in such hearing, and the office shall adopt rules governing such participation.

Section 12. Section 627.41497, Florida Statutes, is created to read:

627.41497 Medical malpractice rate standards; prior approval of rates.--

(1) In addition to any other requirements imposed by law, the rates for each self-insurance policy as authorized under s. 627.357 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services shall be set by the director of the Office of Insurance Regulation and shall not be excessive, inadequate, or unfairly discriminatory.

(2) As to all rate filings subject to approval in accordance with this section:

(a) Insurers or rating organizations shall apply for rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits, or discount schedules and surcharge schedules, and changes to such rates, schedules, manuals, and credits, shall be filed with the Office of Insurance Regulation. The filing shall be made at least 180 days before the proposed

effective date and shall not be implemented during the review of the filing by the Office of Insurance Regulation, any proceeding, or judicial review.

(b) Upon receiving a rate filing and within a reasonable time after such receipt, the Office of Insurance Regulation shall review the rate filing and set a rate or rate schedule that is not excessive, inadequate, or unfairly discriminatory. In making such determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, use the following factors:

1. Past and prospective loss experience within and without this state and the insurer's or self-insurer’s past and prospective loss experience within this state, if applicable. A medical malpractice insurer shall consider past and prospective loss experience and catastrophic hazards, if any, solely within this state. However, if there is insufficient experience within this state upon which a rate can be based, the insurer may consider experiences within any other state or states that have a similar cost of claim and frequency of claim experience as this state and, if insufficient experience is available, the insurer may use nationwide experience. The insurer, in its rate filing or in its records, shall expressly show the rate experience it is using. In considering experience outside this state, as much weight as possible shall be given to state experience.

2. Past and prospective expenses.

3. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the

amount expected on unearned premium reserves, loss reserves, and surplus. The Office of Insurance Regulation may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used in the calculation of insurance rates. The profit and contingency factor as specified in the filing shall be used in computing excess profits in conjunction with s. 627.215.

4. The reasonableness of the judgment reflected in the filing.

5. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.

6. The adequacy of loss reserves.

7. The cost of reinsurance.

8. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

9. A reasonable margin for underwriting profit and contingencies.

10. The cost of medical services.

11. Other relevant factors that impact upon the frequency or severity of claims or upon expenses.

(c) After consideration of the rate factors provided in paragraph (b), the Office of Insurance Regulation shall determine and set the appropriate rate, so long as the rate is not excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from business in this state that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses, the rate is unreasonably high for the insurance provided, or expenses are unreasonably high in relation to services rendered.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to such rates, to sustain projected losses and expenses in the class of business to which they apply and the continued use of such rate endangers the solvency of the insurer using the rate.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if the plan fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625 or the policyholder’s individual claims history or unless price differentials fail to reflect equitably the differences in expected losses and experiences.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(d) In reviewing a rate filing, the Office of Insurance Regulation may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

1. The Office of Insurance Regulation shall adopt rules that shall require each medical malpractice insurer to record and report its loss and expense experience and such other data, including reserves, as may be necessary to determine whether rates comply with the standards set forth in this section. Every medical malpractice insurer shall provide such information in such form as the director of the office may require.

2. The director shall require that the annual report and any such supplemental report that contains information of a company’s loss and loss adjustment reserves be accompanied by an opinion signed and sworn to by a qualified and independent actuary verifying that, within the 9 months prior to the submission of the report, the actuary has conducted a review and analysis of the insurance company’s loss and loss adjustment reserves and the reserves are computed in accordance with accepted loss reserving standards and are fairly stated in accordance with sound loss reserving principles.

3. The director shall maintain for at least 10 years, by carrier, all reports submitted by insurers pursuant to rules adopted by the office under this section. The director shall

consider such reports in determining the appropriateness of premium rates for medical malpractice insurance.

4. The director may examine and review the assignment and assessment of risk for difference classifications for different specialties or practices of medicine. The director may hold a public hearing on any filing containing a risk assignment for medical malpractice insurance to determine whether such risk assignment is reasonable and may issue orders concerning such risk assignment.

(3) With respect to the filing of rate information:

(a) Every medical malpractice insurer shall file with the Office of Insurance Regulation every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing that the insurer proposes to use in this state.

(b) The expense provisions included in the rates to be used by a medical malpractice insurer shall reflect the operating methods of the insurer and, so far as it is credible and reasonable, the insurer’s own actual and anticipated expense experience.

(c) The rates to be used by a medical malpractice insurer shall contain provisions for contingencies and an allowance permitting a reasonable rate of return. In determining a reasonable rate of return, consideration shall be given to all investment income reasonably attributable to medical malpractice insurance.

(d) Every filing shall state the proposed effective date of the filing, shall indicate the character and extent of the coverage contemplated, and shall contain supporting information. Such supporting information may include the experience or

judgment of the insurer making the filing, the insurer's interpretation of any statistical data the insurer relied upon, the experience of other insurers, and any other factors the insurer deems relevant.

(4) The Office of Insurance Regulation may at any time review a rate, rating schedule, rating manual, or rate change, the pertinent records of the insurer, and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to set a new rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate the office has set for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall determine and set an appropriate rate within a reasonable time after receipt of the insurer's initial response, pursuant to the procedures of paragraphs (2)(b)-(d). In such instances and in any administrative proceeding relating to the legality of any rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory.

(5) When the Office of Insurance Regulation sets a new rate or rate schedule, the office shall issue an order specifying the new rate or rate schedule and the findings of the

office. The order shall constitute agency action for purposes of the Administrative Procedure Act.

(6) Except as otherwise specifically provided in this chapter, the Office of Insurance Regulation shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

(7) The establishment or variation of any rate, rating classification, rating plan, or rating schedule in violation of part IX of chapter 626 is also a violation of this section.

(8) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered that awards punitive damages against an insurer shall not be included in the insurer's rate base and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement in which an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees that is identified as being related to the bad faith and punitive damages in such judgments and settlements shall not be included in the insurer's rate base and shall not be used to justify a rate or rate change.

Section 13. The Office of Insurance Regulation shall have the authority to adopt rules to implement the provisions of this act.

Section 14. This act shall take effect upon becoming a law.