A bill to be entitled

An act relating to medical malpractice insurance reform; creating a medical mutual insurance company; providing powers; providing purposes; providing for a board of directors; providing for membership; providing for appointment, qualifications, and terms of members; providing for the annual election of a chair; providing for compensation; providing for powers of the board; providing for the hiring of an administrator and for that administrator to act as the chief executive officer; providing duties of the administrator; requiring a bond; providing immunity from liability; providing for board determination of rates; providing for methodologies; specifying an investment policy; authorizing the board to determine such policy; authorizing the administrator to make investments; authorizing agents to sell certain policies; providing for commissions; requiring the administrator to develop a medical malpractice risk management program; providing for medical malpractice risk management plans; providing for premium effect of compliance with the program; prohibiting the company from receiving certain appropriations; providing an exception; authorizing the board to issue revenue bonds under certain circumstances; providing criteria, requirements, and procedures; limiting bonds sold to public entities; requiring audits; providing audit procedures; requiring audit reports to the Governor and Legislature; specifying report contents; requiring the administrator to formulate a budget; providing insurance carrier examination requirements for the Office of Insurance Regulation;

requiring the office to set medical malpractice rates; providing requirements, responsibilities, and authority relating to rate filings; requiring medical malpractice insurers to file certain documents with the office; providing requirements; providing review authority of the office; authorizing the office to approve or disapprove rates; providing requirements and limitations; providing for setting new rates by the office; requiring notice; prohibiting the office from restricting certain insurer activities; providing construction relating to violations; providing for alternative compliance sufficiency; specifying initial rate submissions as inadequate or excessive under certain circumstances; amending s. 627.062, F.S.; specifying nonapplication to professional medical malpractice insurance; creating s. 627.3518, F.S.; limiting rates for medical malpractice insurance; limiting rate increases to approvals by the Chief Financial Officer; creating s. 627.352, F.S.; prohibiting issuance of certain types of insurance policies without also issuing medical malpractice insurance policies; prohibiting denial of medical malpractice insurance to health care providers under certain circumstances; providing application; amending s. 627.357, F.S.; deleting a prohibition against forming a self-insurance fund; amending s. 766.314, F.S.; exempting certain persons from certain annual assessment payments; providing application; providing an effective date.

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

Section 1. Medical mutual insurance company created; powers; purpose.--The Medical Mutual Insurance Company is created as an independent public corporation for the purpose of insuring health care providers in this state against liability for loss, damage, or expense arising out of the death or injury of any person as a result of the negligence or malpractice of any health care provider. The company shall be organized and operated as a domestic mutual insurance company and shall not be a state agency. The company shall have the powers granted a general not-for-profit corporation. The company shall be a member of the state property and casualty guaranty association, and as such will be subject to assessments of the association, and the members of such association shall bear responsibility in the event of the insolvency of the company. The company shall use flexibility and experimentation in the development of types of policies and coverages offered to health care providers, subject to the approval of the director of the Office of Insurance Regulation.

Section 2. Board created; members; appointment; qualifications; terms; chair.--

(1) A board of directors is established for the company. The board shall be appointed by July 1, 2003, and shall consist of five members appointed or selected as provided in this section. The Governor shall appoint the initial five members of the board with the advice and consent of the Senate. Each director shall serve a 5-year term. Terms shall be staggered so that no more than one director’s term expires each year on July 1. The five directors initially appointed by the Governor shall determine their initial terms by lot. At the expiration of the term of any member of the board, the company’s policyholders

shall elect a new director in accordance with provisions determined by the board.

(2) Any person may be a director who:

(a) Does not have any interest as a stockholder, employee, attorney, agent, broker, or contractor of an insurance entity who writes medical malpractice insurance or whose affiliates write medical malpractice insurance.

(b) Is of good moral character and who has never pleaded guilty to, or been found guilty of, a felony.

(3) The board shall annually elect a chair and any other officers the board deems necessary for the performance of its duties. Board committees and subcommittees may also be formed.

Section 3. Hiring of administrator; qualifications; compensation; powers of board; generally.--

(1) By October 1, 2003, the board shall hire an administrator who shall serve at the pleasure of the board, and the company shall be fully prepared to be operational by January 1, 2004, and assume its responsibilities pursuant to this section. The administrator shall receive compensation as established by the board and must have proven successful experience as an executive at the general management level in the insurance business.

(2) The board is vested with full power, authority, and jurisdiction over the company. The board may perform all acts necessary or convenient in the administration of the company or in connection with the insurance business to be carried on by the company. In this regard, the board is empowered to function in all aspects as a governing body of a private insurance carrier.

Section 4. Administrator; duties; bond required; immunity

from liability; board and employees.--

(1) The administrator of the company shall act as the company's chief executive officer. The administrator shall be in charge of the day-to-day operations and management of the company.

(2) Before entering the duties of office, the administrator shall give an official bond in an amount and with sureties approved by the board. The premium for the bond shall be paid by the company.

(3) The administrator or his or her designee shall be the custodian of the moneys of the company, and all premiums, deposits, or other moneys paid to the company shall be deposited with a financial institution as designated by the administrator.

(4) No board member, officer, or employee of the company is liable in a private capacity for any act performed or obligation entered into when done in good faith, without intent to defraud, and in an official capacity in connection with the administration, management, or conduct of the company or affairs relating to it.

Section 5. Board to determine rates; methodology.--The board shall have full power and authority to establish rates to be charged by the company for insurance. The board shall contract for the services of or hire an independent actuary who is a member in good standing with the American Academy of Actuaries to develop and recommend actuarially sound rates. Rates shall be set at amounts sufficient, when invested, to carry all claims to maturity, meet the reasonable expenses of conducting the business of the company, and maintain a reasonable surplus. The company shall conduct a medical malpractice insurance program that shall be neither more nor

less than self-supporting.

Section 6. Board to determine investment policy; administrator to make investments; methodology.--The board shall formulate and adopt an investment policy and supervise the investment activities of the company. The administrator may invest and reinvest the surplus or reserves of the company subject to the limitations imposed on domestic insurance companies by state law. The company may retain an independent investment counsel. The board shall periodically review and appraise the investment strategy being followed and the effectiveness of such services. Any investment counsel retained or hired shall periodically report to the board on investment results and related matters.

Section 7. Agents may sell policies; commissions.--Any insurance agent or broker licensed to sell medical malpractice insurance in this state shall be authorized to sell insurance policies for the company in compliance with the bylaws adopted by the company. The board shall establish a schedule of commissions to pay for the services of the agent.

Section 8. Medical malpractice risk management program; administrator to formulate; effect of compliance with program on premiums.--

(1) The administrator shall formulate, implement, and monitor a medical malpractice risk management program for all policyholders.

(2) The company shall have representatives whose sole purpose is to develop with policyholders a written medical malpractice risk management plan which is based upon clearly stated goals and objectives. The company shall communicate the importance of such a plan and assist in any way to attain such

goals and objectives.

(3) The administrator or board may refuse to insure or may terminate the insurance of any insured who disregards the medical malpractice risk management plan.

(4) In determining the premium payable by an insured, the company shall consider the compliance of the insured with the company's medical malpractice risk management plan.

Section 9. Company not to receive state appropriation; exception; revenue bonds; authorization; terms; execution; procedures.--

(1) The company shall not receive any state appropriation, directly or indirectly, except as provided in subsection (2).

(2) After July 1, 2003, the director of the Office of Insurance Regulation shall make one or more loans to the company in an amount not to exceed an aggregate amount of $5 million from the General Revenue fund for startup funding and initial capitalization of the company. The board of the company shall make application to the Office of Insurance Regulation for the loans, stating the amount to be loaned to the company. The loans shall be for a term of 5 years and, at the time the application for such loans is approved, shall bear interest at an annual rate determined by the director of the Office of Insurance Regulation.

(3) In order to provide funds for the creation, continued development, and operation of the company, the board is authorized to issue revenue bonds, from time to time, in a principal amount outstanding not to exceed $40 million at any given time, payable solely from premiums received from insurance policies and other revenues generated by the company.

(4) The board may issue bonds to refund other bonds issued

pursuant to this section.

(5) The bonds shall have a maturity of no more than 10 years from the date of issuance. The board shall determine all other terms, covenants, and conditions of the bonds, except that no bonds may be redeemed prior to maturity unless the company has established adequate reserves for the risks it has insured.

(6) The bonds shall be executed with the manual or facsimile signature of the administrator or the chair of the board and attested by another member of the board. The bonds may bear the seal, if any, of the company.

(7) The proceeds of the bonds and the earnings on those proceeds shall be used by the board for the development and operation of the company, to pay expenses incurred in the preparation, issuance, and sale of the bonds, and to pay any obligations relating to the bonds and the proceeds of the bonds under the United States Internal Revenue Code.

(8) The bonds may be sold at a public or private sale. If the bonds are sold at a public sale, the notice of sale and other procedures for the sale shall be determined by the administrator or the company.

(9) This section constitutes the full authority for the issuance and sale of the bonds, and the bonds shall not be invalid for any irregularity or defect in the proceedings for their issuance and sale and shall be incontestable in the hands of bona fide purchasers or holders of the bonds for value.

(10) An amount of money from the sources specified in subsection (2) sufficient to pay the principal of and any interest on the bonds as they become due each year shall be set aside and is hereby pledged for the payment of the principal and interest on the bonds.

(11) The bonds shall be legal investments for any person or board charged with the investment of public funds and may be accepted as security for any deposit of public money, and the bonds and interest thereon are exempt from taxation by the state and any political subdivision or agency of the state.

(12) The bonds shall be payable by the company, which shall keep a complete record relating to the payment of the bonds.

(13) Not more than 50 percent of the bonds sold shall be sold to public entities.

Section 10. Audit required; procedure; report; contents; Governor and Legislature to receive; administrator to formulate budget; Office of Insurance Regulation; duties.--

(1) The board shall cause an annual audit of the books of accounts, funds, and securities of the company to be made by a competent and independent firm of certified public accountants, the cost of the audit to be charged against the company. A copy of the audit report shall be filed with the director of the Department of Insurance and the administrator. The audit shall be open to the public for inspection.

(2) The board shall submit an annual independently audited report in accordance with procedures governing annual reports adopted by the National Association of Insurance Commissioners by March 1 of each year, and the report shall be delivered to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall indicate the business conducted by the company during the previous year and contain a statement of the resources and liabilities of the company.

(3) The administrator shall annually submit to the board

for its approval an estimated budget of the entire expense of administering the company for the succeeding calendar year having due regard for the business interests and contract obligations of the company.

(4) The incurred loss experience and expense of the company shall be ascertained each year to include, but not be limited to, estimates of outstanding liabilities for claims reported to the company but not yet paid and liabilities for claims arising from injuries which have occurred but have not yet been reported to the company. If there is an excess of assets over liabilities, necessary reserves, and a reasonable surplus, a cash dividend shall be declared or a credit allowed to any health care provider who has complied with the company's medical malpractice risk management program.

(5) The Office of Insurance Regulation shall conduct an examination of the company in the manner and under the conditions provided by the statutes of the insurance code for the examination of insurance carriers. The company is subject to all provisions of law which relate to private insurance carriers and to the jurisdiction of the Office of Insurance Regulation in the same manner as private insurance carriers, except as provided by the director.

Section 11. Medical malpractice rate standards and 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, Florida Statutes, or an 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 thereto, shall be filed with the Office of Insurance Regulation. The filing must be made at least 180 days before the proposed effective date, and the filing shall not be implemented during the Office of Insurance Regulation's review of the filing and any proceeding and judicial review.

(b) Upon receiving a rate filing and within a reasonable time, 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 that determination, the Office of Insurance Regulation shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state and the insurer 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 which 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. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produces a reasonable rate of return. The profit and contingency factor as specified in the filing shall be used in computing excess profits in conjunction with s. 627.0625, Florida Statutes.

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 which impact upon the frequency or severity of claims or upon expenses.

12. Other relevant public policy considerations.

(c) After consideration of the rate factors provided in paragraph (b), the Office of Insurance Regulation shall determine and set the appropriate rate, as 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 Florida business 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 them, 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, Florida Statutes, or the policyholder’s individual claims history, 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 addition to the standards set forth in paragraph (c), the Office of Insurance Regulation shall disapprove rates that are 15 percent greater or less than the current approved rate of the insurer or self-insurer.

(e) 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 director shall adopt rules which 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 may require.

2. The director shall require that the annual report and any such supplemental report which 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, the reserves are computed in accordance with accepted loss reserving standards, and the reserves 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 director under this section. The director shall consider these 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 different 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 for medical malpractice insurance is reasonable and may issue orders concerning such risk assignment.

(3)(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 which 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, its 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 which 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 of Insurance Regulation 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 it 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)-(e). 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 chapter 627, Florida Statutes, 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, Florida Statutes, applicable to any policy or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

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

(8) The submission of rates, rating schedules, and rating

manuals to the Office of Insurance Regulation by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating schedules, and rating manuals of such organization. All such information shall be available for public inspection, upon receipt by the office, during usual business hours.

(9) The initial submission of a rate by an insurer or self-insurer shall be deemed inadequate or excessive if the rate is less than or exceeds the average aggregate rate of the individual insurer or self-insurer with at least 10-percent market share in this state for the previous calendar year.

Section 12. 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 13. Section 627.3518, Florida Statutes, is created to read:

627.3518 Rates for medical malpractice insurance.--

(1) No insurer issuing policies of medical malpractice insurance in this state may use a rate in excess of the rate such insurer used in this state on January 1, 2001. Insurers issuing polices of medical malpractice insurance if such insurer had no rates in effect in this state on January 1, 2001, may not use rates that exceed the rates used by the insurer with the most policies of medical malpractice insurance in effect in this state on January 1, 2001.

(2) Each insurer’s rates for medical malpractice insurance

may be increased only if the Chief Financial Officer determines, after a hearing, that the insurer is substantially threatened with insolvency unless its rates for medical malpractice insurance are increased. In such cases, the Chief Financial Officer shall set the medical malpractice insurance rates for such insurer. Rates set by the Chief Financial Officer may not be excessive, inadequate, or unfairly discriminatory.

Section 14. Section 627.352, Florida Statutes, is created to read:

627.352 Medical malpractice insurance; issuance required of certain insurers.--No insurer may issue policies of motor vehicle insurance, commercial property insurance, or residential property insurance in this state unless such insurer also issues policies of medical malpractice insurance in this state. No insurer issuing policies of medical malpractice insurance may deny issuance of a policy of medical malpractice insurance to any health care provider unless such denial is based on underwriting standards approved by the Chief Financial Officer.

Section 15. 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 16. Paragraph (a) of subsection (5) of section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.--

(5)(a)1. Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the

plan of operation, taking into account persons licensed subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). On January 1, 1991, and on each January 1 thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b). On July 1, 1991, and on each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a), including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.

2. Any person or entity listed in paragraph (4)(b) or paragraph (4)(c) who paid the annual assessment specified in this section for the year beginning July 1, 2001, and the year beginning July 1, 2002, shall be exempt from payment of the annual assessment for the year beginning July 1, 2003, and the year beginning July 1, 2004.

Section 17. This act shall take effect upon becoming a law and shall apply to policies issued or renewed after that date, and shall apply to all rates, rating schedules, or rating

manuals submitted to the Office of Insurance Regulation on or after July 1, 2003.