A bill to be entitled

An act relating to medical malpractice insurance; providing legislative findings; amending s. 624.462, F.S.; authorizing health care providers to form a commercial self-insurance fund; amending s. 627.062, F.S.; providing that an insurer may not require arbitration of a rate filing for medical malpractice; providing additional requirements for medical malpractice insurance rate filings; providing that portions of judgments and settlements entered against a medical malpractice insurer for bad-faith actions or for punitive damages against the insurer, as well as related taxable costs and attorney's fees, may not be included in an insurer's base rate; providing for review of rate filings by the Office of Insurance Regulation for excessive, inadequate, or unfairly discriminatory rates; requiring insurers to apply a discount based on the health care provider's loss experience; amending s. 627.0645, F.S.; excepting medical malpractice insurers from certain annual filings; amending s. 627.4147, F.S.; revising certain notification criteria for medical and osteopathic physicians; requiring prior notification of a rate increase; authorizing the purchase of insurance by certain health care providers; amending s. 627.912, F.S.; increasing the limit on a fine; requiring the

Office of Insurance Regulation to adopt by rule requirements for reporting financial information; creating s. 627.41491, F.S.; requiring the Office of Insurance Regulation to require health care providers to annually publish certain rate comparison information; 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. 627.41492, F.S.; requiring the Office of Insurance Regulation to publish an annual medical malpractice report; 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; providing for a mechanism to make effective the Florida Medical Malpractice Insurance Fund in the event the roll back of medical malpractice insurance rates is not completed; creating the Florida Medical Malpractice Insurance Fund; providing purpose; providing governance by a board of governors; providing for the fund to issue medical malpractice policies to any physician regardless of specialty; providing for regulation by the Office of Insurance Regulation of the Financial Services Commission; providing applicability; providing

for initial funding; providing for tax-exempt status; providing for initial capitalization; providing for termination of the fund; providing that practitioners licensed under ch. 458 or ch. 459, F.S., must, as a licensure requirement, obtain and maintain professional liability coverage; requiring the Office of Insurance Regulation to order insurers to make rate filings effective January 1, 2004, which reflect the impact of the act; providing criteria for such rate filing; amending s. 456.049, F.S.; requiring the Department of Health to report certain liability claims to the Office of Insurance Regulation; amending s. 627.357, F.S.; providing guidelines for the formation and regulation of certain self-insurance funds; creating s. 627.9121, F.S.; requiring certain claims, judgments, or settlements to be reported to the Office of Insurance Regulation; providing penalties; requiring the Office of Program Policy Analysis and Government Accountability to study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; authorizing health care facilities to apply to the Department of Financial Services for discounts in insurance rates after reducing adverse incidents and serious events at the facility; requiring health care facilities to apply to the Department of Financial Services

for the certification of programs recommended by the Florida Center for Excellence in Health Care; requiring the Department of Financial Services to develop criteria for the certification; requiring insurers to file rates with the Department of Financial Services for review under specified circumstances; creating s. 627.0662, F.S.; providing definitions; requiring each medical liability insurer to report certain information to the Office of Insurance Regulation; providing for determination of whether excessive profit has been realized; requiring return of excessive amounts; amending s. 766.106, F.S.; providing for application of common law principles of good faith to an insurance company's bad-faith actions arising out of medical malpractice claims; providing that an insurer shall not be held to have acted in bad faith for certain activities during the presuit period and for 120 days after that period; providing legislative intent; providing for severability; providing a contingent effective date.

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

Section 1. Findings.--

(1) The Legislature finds that Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude.

(2) The Legislature finds that this crisis threatens the quality and availability of health care for all Florida citizens.

(3) The Legislature finds that the rapidly growing population and the changing demographics of Florida make it imperative that students continue to choose Florida as the place they will receive their medical educations and practice medicine.

(4) The Legislature finds that Florida is among the states with the highest medical malpractice insurance premiums in the nation.

(5) The Legislature finds that the cost of medical malpractice insurance has increased dramatically during the past decade and both the increase and the current cost are substantially higher than the national average.

(6) The Legislature finds that the increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

(7) The Governor created the Governor's Select Task Force on Healthcare Professional Liability Insurance to study and make recommendations to address these problems.

(8) The Legislature has reviewed the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance.

(9) The Legislature finds that the Governor's Select Task Force on Healthcare Professional Liability Insurance has established that a medical malpractice insurance crisis exists in the State of Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms.

(10) The Legislature finds that making high-quality health care available to the citizens of this state is an overwhelming public necessity.

(11) The Legislature finds that ensuring that physicians continue to practice in Florida is an overwhelming public necessity.

(12) The Legislature finds that ensuring the availability of affordable professional liability insurance for physicians is an overwhelming public necessity.

(13) The Legislature finds, based upon the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance, the findings and recommendations of various study groups throughout the nation, and the experience of other states, that the overwhelming public necessities of making quality health care available to the citizens of this state, of ensuring that physicians continue to practice in Florida, and of ensuring that those physicians have the opportunity to purchase affordable professional liability insurance cannot be met unless comprehensive legislation is adopted.

(14) The Legislature finds that the provisions of this act are naturally and logically connected to each other and to the purpose of making quality health care available to the citizens of Florida.

Section 2. Subsection (2) of section 624.462, Florida Statutes, is amended to read:

624.462 Commercial self-insurance funds.--

(2) As used in ss. 624.460-624.488, "commercial self-insurance fund" or "fund" means a group of members, operating individually and collectively through a trust or corporation, that must be:

(a) Established by:

1. A not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated under the laws of this state, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year;

2. A self-insurance trust fund organized pursuant to s. 627.357 and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance pursuant to this section. Each member of a commercial self-insurance trust fund established pursuant to this subsection must maintain membership in the self-insurance trust fund organized pursuant to s. 627.357; ~~or~~

3. A group of 10 or more health care providers, as defined in s. 627.351(4)(h); or

4.~~3.~~ A not-for-profit group comprised of no less than 10 condominium associations as defined in s. 718.103(2), which is incorporated under the laws of this state, which restricts its membership to condominium associations only, and which has been organized and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance.

(b)1. In the case of funds established pursuant to subparagraph (a)2. or subparagraph (a)4.~~subparagraph (a)3.~~, operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the fund and which shall be responsible for all operations of the fund. The majority of the trustees shall be owners, partners, officers, directors, or employees of one or more members of

the fund. The trustees shall have the authority to approve applications of members for participation in the fund and to contract with an authorized administrator or servicing company to administer the day-to-day affairs of the fund.

2. In the case of funds established pursuant to subparagraph (a)1. or subparagraph (a)3., operated pursuant to a trust agreement by a board of trustees or as a corporation by a board of directors which board shall:

a. Be responsible to members of the fund or beneficiaries of the trust or policyholders of the corporation;

b. Appoint independent certified public accountants, legal counsel, actuaries, and investment advisers as needed;

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

e. Have the authority to contract with an administrator authorized under s. 626.88 to administer the day-to-day affairs of the fund including, but not limited to, marketing, underwriting, billing, collection, claims administration, safety and loss prevention, reinsurance, policy issuance, accounting, regulatory reporting, and general administration. The fees or compensation for services under such contract shall be comparable to the costs for similar services incurred by insurers writing the same lines of insurance, or where available such expenses as filed by boards, bureaus, and associations designated by insurers to file such data. A majority of the trustees or directors shall be owners, partners, officers, directors, or employees of one or more members of the fund.

Section 3. Paragraph (a) of subsection (6) of section 627.062, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

627.062 Rate standards.--

(6)(a) After any action with respect to a rate filing that constitutes agency action for purposes of the Administrative Procedure Act, except for a rate filing for medical malpractice, an insurer may, in lieu of demanding a hearing under s. 120.57, require arbitration of the rate filing. Arbitration shall be conducted by a board of arbitrators consisting of an arbitrator selected by the department, an arbitrator selected by the insurer, and an arbitrator selected jointly by the other two arbitrators. Each arbitrator must be certified by the American Arbitration Association. A decision is valid only upon the affirmative vote of at least two of the arbitrators. No arbitrator may be an employee of any insurance regulator or regulatory body or of any insurer, regardless of whether or not the employing insurer does business in this state. The department and the insurer must treat the decision of the arbitrators as the final approval of a rate filing. Costs of arbitration shall be paid by the insurer.

(7)(a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad-faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base, and shall not be used to justify a rate

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

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the Office of Insurance Regulation shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility to this state's loss data.

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(e) The insurer must apply a discount or surcharge based on the health care provider's loss experience, or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and must provide a copy of such schedule or description, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

Section 4. Subsections (1) and (2) of section 627.0645, Florida Statutes, are amended to read:

627.0645 Annual filings.--

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line, ~~and~~ commercial motor vehicle, and medical malpractice,

shall make an annual base rate filing for each such line with the department no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations, except for medical malpractice, filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The department, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

Section 5. Effective October 1, 2003, 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 physicians licensed under chapter 458 or chapter 459 or 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. Physicians licensed under chapter 458 or chapter 459 and dentists licensed under chapter 466 may purchase an insurance policy pursuant to this subparagraph if such policies are available. Insurers may offer such policies, notwithstanding any other provision of law to the contrary.

(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 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.

(d) A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of a rate increase. The provisions of s. 627.4133 shall apply to such notice and to the failure of the insurer to provide such notice to the extent not in conflict with this section.

(2) ~~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 October 1, 2003 ~~1985~~.

Section 6. Subsections (2) and (4) of section 627.912, Florida Statutes, are amended to read:

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

(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 office ~~department~~ to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases. The Financial Services Commission shall adopt by rule requirements for additional information to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases reported by insurers under this section.

(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 shall ~~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.

Section 7. Section 627.41491, Florida Statutes, is created to read:

627.41491 Medical malpractice rate comparison.--The Office of Insurance Regulation shall annually publish 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 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 8. Section 627.41492, Florida Statutes, is created to read:

627.41492 Annual medical malpractice report.--The Office of Insurance Regulation shall prepare an annual report by October 1 of each year, which shall be available to the public and posted on the Internet, which includes the following information:

(1) A summary and analysis of the closed claim information required to be reported pursuant to s. 627.912.

(2) A summary and analysis of the annual and quarterly financial reports filed by each insurer writing medical malpractice insurance in this state.

Section 9. Section 627.41493, Florida Statutes, is created to read:

627.41493 Insurance rate rollback.--

(1) For medical malpractice insurance policies issued or renewed on or after July 1, 2003, and before July 1, 2004, every insurer, including the Florida Medical Malpractice Joint Underwriting Association, shall reduce its rates and premiums to levels that were in effect on January 1, 2002.

(2) For medical malpractice insurance policies issued or renewed on or after July 1, 2003, and before 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 that the rate reduced pursuant to subsection (1) would result in an inadequate rate. Any such increase must be approved by the director of the Office of Insurance Regulation prior to being used.

(3) The provisions of this section control to the extent of any conflict with the provision of s. 627.062.

Section 10. If, as of July 1, 2004, the director of the Office of Insurance Regulation determines that the rates of the medical malpractice insurers with a combined market share of 50 percent or greater, as measured by net written premium in the state for medical malpractice for the most recent calendar year, have been reduced to the level in effect January 1, 2002, but have not remained at that level for the previous year beginning July 1, 2003, or that such medical malpractice insurers have proposed increases from the January 1, 2002, level that are greater than 15 percent for either of the next 2 years beginning July 1, 2004, then the Florida Medical Malpractice Insurance Fund established by section 11 of this act shall begin offering coverage.

Section 11. Florida Medical Malpractice Insurance Fund.--

(1) FINDINGS AND PURPOSES.--The Legislature finds and declares that there is a compelling state interest in maintaining the availability and affordability of health care services to the citizens of Florida. This state interest is seriously threatened by the increased cost and decreased availability of medical malpractice insurance to physicians. To the extent that the private sector is unable to maintain a viable and orderly market for medical malpractice insurance, state actions to maintain the availability and affordability of medical malpractice insurance are a valid and necessary exercise of the police power.

(2) DEFINITIONS.--As used in this section:

(a) "Fund" means the Florida Medical Malpractice Insurance Fund, as created pursuant to this section.

(b) "Physician" means a physician licensed under chapter 458 or chapter 459, Florida Statutes.

(3) FLORIDA MEDICAL MALPRACTICE INSURANCE FUND CREATED.--Effective October 1, 2003, there is created the Florida Medical Malpractice Insurance Fund, which shall be subject to the requirements of this section. However, the fund shall not begin providing or offering coverage until the date the director of the Office of Insurance Regulation makes the determination specified in section 10 of this act.

(a) The fund shall be administered by a board of governors consisting of seven members who are appointed as follows:

1. Three members by the Governor;

2. Three members by the Chief Financial Officer; and

3. One member by the other six board members.

Board members shall serve at the pleasure of the appointing authority. Two board members must be doctors licensed in this state and the Governor and the Chief Financial Officer shall each appoint one of these doctors.

(b) The board shall submit a plan of operation, which must be approved by the Office of Insurance Regulation of the Financial Services Commission. The plan of operation and other actions of the board shall not be considered rules subject to the requirements of chapter 120, Florida Statutes.

(c) Except as otherwise provided by this section, the fund shall be subject to the requirements of state law which apply to authorized insurers.

(d) Moneys in the fund may not be expended, loaned, or appropriated except to pay obligations of the fund arising out of medical malpractice insurance policies issued to physicians

and the costs of administering the fund, including the purchase of reinsurance as the board deems prudent. The board shall enter into an agreement with the State Board of Administration, which shall invest one-third of the moneys in the fund pursuant to ss. 215.44-215.52, Florida Statutes. The board shall enter into an agreement with the Division of Treasury of the Department of Financial Services, which shall invest two-thirds of the moneys in the fund pursuant to the requirements for the investment of state funds in chapter 17, Florida Statutes. Earnings from all investments shall be retained in the fund, except as otherwise provided in this section.

(e) The fund may employ or contract with such staff and professionals as the board deems necessary for the administration of the fund.

(f) There shall be no liability on the part of any member of the board, its agents, or any employee of the state for any action taken by them in the performance of their powers and duties under this section. Such immunity does not apply to any willful tort or to breach of any contract or agreement.

(g) The fund is not a member insurer of the Florida Insurance Guaranty Association established pursuant to part II of chapter 631, Florida Statutes. The fund is not subject to sections 624.407, 624.408, 624.4095, and 624.411, Florida Statutes.

(4) MEDICAL MALPRACTICE INSURANCE POLICIES.--The board must offer medical malpractice insurance to any physician, regardless of his or her specialty, but may adopt underwriting requirements, as specified in its plan of operation. The fund shall offer limits of coverage of $250,000 per claim/$500,000

annual aggregate; $500,000 per claim/$1 million annual aggregate; and $1 million per claim/$2 million annual aggregate. The fund shall also allow policyholders to select from policies with deductibles of $100,000, $200,000, and $250,000; excess coverage limits of $250,000 per claim and $750,000 annual aggregate; $1 million per claim and $3 million annual aggregate; or $2 million and $4 million annual aggregate. The fund shall offer such other limits as specified in its plan of operation.

(5) PREMIUM RATES.--The premium rates for coverage offered by the fund must be actuarially sound and shall be subject to the same requirements that apply to authorized insurers issuing medical malpractice insurance, except that:

(a) The rates shall not include any factor for profits; and

(b) The anticipated future investment income of the fund, as projected in its rate filing, must be approximately equal to the actual investment income that the fund has earned, on average, for the prior 7 years. For those years of the prior 7 years during which the fund was not in operation, the anticipated future investment income must be approximately equal to the actual average investment income earned by the State Board of Administration for the moneys available for investment under ss. 215.44-215.53, Florida Statutes, and the average annual investment income earned by the Division of Treasury of the Department of Financial Services for the investment of state funds under chapter 17, Florida Statutes, in the same proportion as specified in paragraph (3)(d).

(6) TAX EXEMPTION.--The fund shall be a political subdivision of the state and is exempt from the corporate income tax under chapter 220, Florida Statutes, and the

premiums shall not be subject to the premium tax imposed by s. 624.509, Florida Statutes. It is also the intent of the Legislature that the fund be exempt from federal income taxation. The Financial Services Commission and the fund shall seek an opinion from the Internal Revenue Service as to the tax-exempt status of the fund and shall make such recommendations to the Legislature as the board deems necessary to obtain tax-exempt status.

(7) INITIAL CAPITALIZATION.--The fund shall enter into an agreement with the Florida Birth-Related Neurological Injury Compensation (NICA) Fund for a loan of $100 million to the fund to occur when the fund is established. Repayment of the loan by the fund shall be in five equal annual payments, each made no later than December 31, commencing during the fourth year of operation of the fund after the fund begins to offer medical malpractice insurance. Interest shall accrue on the outstanding amount of the loan at an annual rate equal to the annual rate of investment income earned by the NICA Fund. The moneys loaned to the fund pursuant to this subsection shall be considered admitted assets of the fund for purposes of chapter 625, Florida Statutes.

(8) RULES.--The Financial Services Commission may adopt rules to implement and administer the provisions of this section.

(9) REVERSION OF FUND ASSETS UPON TERMINATION.--The fund and the duties of the board under this section shall stand repealed on a date 10 years after the date the Florida Medical Malpractice Insurance Fund begins offering coverage pursuant to this section, unless reviewed and saved from repeal through reenactment by the Legislature. Upon

termination of the fund, all assets of the fund shall revert to the General Revenue Fund.

Section 12. Notwithstanding any law to the contrary, if the Florida Medical Malpractice Insurance Fund begins offering coverage pursuant to section 11 of this act, all practitioners licensed under chapter 458 or chapter 459, Florida Statutes, as a condition of licensure shall be required to maintain financial responsibility by obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $500,000, from an authorized insurer as defined under section 624.09, Florida Statutes, from a surplus lines insurer as defined under section 629.914(2), Florida Statutes, from a risk retention group as defined under section 627.942, Florida Statutes, from the Joint Underwriting Association established under section 627.357(4), Florida Statutes, or through a plan of self-insurance as provided in section 627.357 or section 624.462, Florida Statutes, or from the Medical Malpractice Insurance Fund.

(b) Physicians and osteopathic physicians who are exempt from the financial responsibility requirements under section 458.320(5)(a),(b),(c),(d),(e) and (f) and section 459.0085(5)(a),(b),(c),(d),(e), and (f), Florida Statutes, shall not be subject to the requirements of this section.

Section 13. Section 627.41495, Florida Statutes, is created to read:

627.41495 Public hearings for medical malpractice rate filings.--

(1) Upon the filing of a proposed rate change by a medical malpractice insurer or self-insurance fund, which filing would result in an average statewide increase of 25

percent, or more, pursuant to standards determined by the office, the insurer or self-insurance fund shall mail notice of such filing to each of its policyholders or members. The notices shall also inform the policyholders and members that a public hearing may be requested on the rate filing and the procedures for requesting a public hearing, as established by rule, by the Financial Services Commission.

(2) The rate filing shall be available for public inspection. If any policyholder or member of an insurer or self-insurance fund that makes a rate filing described in subsection (1) requests 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 office shall hold a hearing within 30 days after such request. Any policyholder or member may participate in such hearing. The commission shall adopt rules implementing the provisions of this section.

Section 14. (1) The Office of Insurance Regulation shall order insurers to make a rate filing effective January 1, 2004, for medical malpractice which reduces rates by a presumed factor that reflects the impact the changes contained in all medical malpractice legislation enacted by the Florida Legislature in 2003 will have on such rates, as determined by the Office of Insurance Regulation. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in section 627.062, Florida Statutes, in determining the expected impact on losses, expenses, and investment income of the insurer. Inclusion in the presumed factor of the expected impact of such legislation shall be held in abeyance during the review

of such measure's validity in any proceeding by a court of competent jurisdiction.

(2) Any insurer or rating organization that contends that the rate provided for in subsection (1) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques, as provided in section 627.062, Florida Statutes, in making any filing pursuant to this subsection. The Office of Insurance Regulation shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates filed under subsection (1). Each insurer or rating organization shall include in the filing the expected impact of all malpractice legislation enacted by the Florida Legislature in 2003 on losses, expenses, and rates. If any provision of this act is held invalid by a court of competent jurisdiction, the department shall permit an adjustment of all rates filed under this section to reflect the impact of such holding on such rates, so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

Section 15. Subsection (3) is added to section 456.049, Florida Statutes, to read:

456.049 Health care practitioners; reports on professional liability claims and actions.--

(3) The department must forward the information collected under this section to the Office of Insurance Regulation.

Section 16. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

(10)(a)1. An application to form a self-insurance fund under this section must be filed with the Office of Insurance Regulation ~~A self-insurance fund may not be formed under this section after October 1, 1992~~.

2. The Financial Services Commission must ensure that self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

Section 17. Section 627.9121, Florida Statutes, is created to read:

627.9121 Required reporting of claims; penalties.--Each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim that is required to report information to the National Practitioner Data Bank under 42 U.S.C. section 11131 must also report the same information to the Office of Insurance Regulation. The Office of Insurance Regulation shall include such information in the data that it compiles under s. 627.912. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with the requirements imposed by law.

Section 18. The Office of Program Policy Analysis and Government Accountability shall complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation

Association and submit a report to the Legislature by January 1, 2004, recommending whether or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under section 766.302, Florida Statutes, should be modified.

Section 19. Patient safety discount.--A health care facility licensed pursuant to chapter 395, Florida Statutes, may apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents, as defined in section 395.0197, Florida Statutes, which result in the reduction of serious events at that facility. The department shall develop criteria for such certification. Insurers shall file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program. A health care facility shall receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law. In reviewing filings under this section, the department shall consider whether, and the extent to which, the program certified under this section is otherwise covered under a program of risk management offered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 20. Section 627.0662, Florida Statutes, is created to read:

627.0662 Excessive profits for medical liability insurance prohibited.--

(1) As used in this section:

(a) "Medical liability insurance" means insurance that is written on a professional liability insurance policy issued

to a health care practitioner or on a liability insurance policy covering medical malpractice claims issued to a health care facility.

(b) "Medical liability insurer" means any insurance company or group of insurance companies writing medical liability insurance in this state and does not include any self-insurance fund or other nonprofit entity writing such insurance.

(2) Each medical liability insurer shall file with the Office of Insurance Regulation, prior to July 1 of each year on forms adopted by the Financial Services Commission, the following data for medical liability insurance business in this state. The data shall include both voluntary and joint underwriting association business, as follows:

(a) Calendar-year earned premium.

(b) Accident-year incurred losses and loss adjustment expenses.

(c) The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.

(d) Policyholder dividends incurred during the applicable calendar year.

(3)(a) Excessive profit has been realized if there has been an underwriting gain for the 10 most recent calendar-accident years combined which is greater than the anticipated underwriting profit plus 5 percent of earned premiums for those calendar-accident years.

(b) As used in this subsection with respect to any 10-year period, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period,

the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by business in this state. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.

(4) Each medical liability insurer shall also file a schedule of medical liability insurance loss in this state and loss adjustment experience for each of the 10 most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of March 31 of the year following the close of the accident year, developed to an ultimate basis, and at nine 12-month intervals thereafter, each developed to an ultimate basis, to the extent that a total of three evaluations is provided for each accident year. The first year to be so reported shall be accident year 2004, such that the reporting of 10 accident years will not take place until accident years 2012 and 2013 have become available.

(5) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: the sum of the accident-year incurred losses and loss adjustment expenses as of March 31 of the following year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, shall be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.

(6) For the 10 most recent calendar-accident years, the underwriting gain or loss shall be compared to the anticipated underwriting profit.

(7) If the medical liability insurer has realized an excessive profit, the office shall order a return of the excessive amounts to policyholders after affording the insurer an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded to policyholders in all instances unless the insurer affirmatively demonstrates to the office that the refund of the excessive amounts will render the insurer or a member of the insurer group financially impaired or will render it insolvent.

(8) The excessive amount shall be refunded to policyholders on a pro rata basis in relation to the final compilation year earned premiums to the voluntary medical liability insurance policyholders of record of the insurer group on December 31 of the final compilation year.

(9) Any return of excessive profits to policyholders under this section shall be provided in the form of a cash refund or a credit towards the future purchase of insurance.

(10)(a) Cash refunds to policyholders may be rounded to the nearest dollar.

(b) Data in required reports to the office may be rounded to the nearest dollar.

(c) Rounding, if elected by the insurer group, shall be applied consistently.

(11)(a) Refunds to policyholders shall be completed as follows:

1. If the insurer elects to make a cash refund, the refund shall be completed within 60 days after entry of a

final order determining that excessive profits have been realized; or

2. If the insurer elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order determining that excessive profits have been realized. If an insurer has made this election but an insured thereafter cancels his or her policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer shall immediately certify to the office that the refunds have been made.

(12) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year in which it is incurred, for purposes of reporting under this section for subsequent years.

Section 21. Present subsections (5) through (12) of section 766.106, Florida Statutes, are redesignated as subsections (6) through (13), respectively, and a new subsection (5) is added to that section, to read:

766.106 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.--

(5)(a) With regard to insurance company bad-faith causes of action arising out of medical malpractice claims, the action shall be brought pursuant to common law and not pursuant to s. 624.155.

(b) An insurer shall not be held to have acted in bad faith for failure to timely pay its policy limits if it

tenders its policy limits and meets the reasonable conditions of settlement prior to the conclusion of the presuit screening period provided for in subsection (4); during an extension provided for therein; during a period of 120 days thereafter; or during a 60-day period after the filing of an amended medical malpractice complaint alleging new facts previously unknown to the insurer.

(c) It is the intent of the Legislature to encourage all insurers, insureds, and their assigns and legal representatives to act in good faith during a medical negligence action, both during the presuit period and the litigation.

Section 22. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 23. Except as otherwise provided herein, this act shall take effect July 1, 2003, and the amendments to section 766.106, Florida Statutes, in this act shall apply to any action arising from a medical malpractice claim initiated by a notice of intent to litigate received by a potential defendant in a medical malpractice case on or after that date.