By Senator Peaden

2-878-07

A bill to be entitled

An act relating to insurance; creating s. 624.156, F.S.; prescribing applicability of consumer protection laws to the business of insurance; amending s. 627.062, F.S.; revising determination of rate standards for medical malpractice insurance; repealing s. 627.4147(2), F.S.; deleting a provision that medical malpractice insureds may be required by their insurers to be members of certain professional societies; amending s. 627.912, F.S.; requiring that certain information be included in reports related to professional liability claims and actions; authorizing the director of the Office of Insurance Regulation to levy an administrative fine against an insurer that fails to comply with reporting requirements; creating s. 627.41491, F.S.; requiring the office to provide certain information concerning medical malpractice coverage providers; creating s. 627.41493, F.S.; requiring a rate rollback for medical malpractice insurance; amending s. 627.41495, F.S.; requiring notice of and providing for hearings on rate changes by medical malpractice insurance providers; prescribing authority of the Public Counsel with respect thereto; declaring legislative intent with respect to medical malpractice rates; 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. Section 624.156, Florida Statutes, is created to read:

624.156 Applicability of consumer protection laws to the business of insurance.--Notwithstanding any provision of law to the contrary, the business of insurance is subject to the Florida Civil Rights Act of 1992, ss. 760.01-760.11 and 509.092, and the Florida Deceptive and Unfair Trade Practices Act, ss. 501.201-501.213, and the protections afforded consumers in these statutes apply to insurance consumers.

Section 2. Paragraph (e) of subsection (7) of section 627.062, Florida Statutes, as amended by section 18 of chapter 2007-1, Laws of Florida, is amended, present paragraph (f) of that subsection is redesignated as paragraph (g), and a new paragraph (f) is added to that subsection to read:

627.062 Rate standards.--

(7)

(e) The insurer must apply a discount or surcharge, exclusive of any other discounts, credits, or rate differentials, based on the health care provider's loss experience and disciplinary action taken by the federal or state government or health care facility or health care plan or shall establish an alternative method giving due consideration to the provider's loss experience and disciplinary record. 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. A

medical malpractice liability insurer may not 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. The Office of Insurance Regulation shall adopt a schedule of appropriate ranges for such credits, discounts, or alternative methods of rate reduction which will bring premium relief to providers who have experienced no closed claims or limited indemnity and expense payments over a specified period of time as determined by the office.

(f) In reviewing any rate filing under this subsection, the office shall consider as part of the insurer's rate base the insurer's loss cost adjustment expenses or defense cost and containment expenses only to the extent that the expenses do not exceed the national average for such expenses, as determined by the office, for the prior calendar year. An insurer's loss cost adjustment expenses or defense cost and containment expenses in excess of the national average may not be used to justify a rate or rate change.

Section 3. Subsection (2) of section 627.4147, Florida Statutes, is repealed.

Section 4. Section 627.912, Florida Statutes, is amended to read:

627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.--

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and 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, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance to a member of The Florida Bar shall report to the office 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:

1. A final judgment in any amount.

2. A settlement in any amount.

3. A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured.

(b) Each health care practitioner and health care facility listed in paragraph (a) must report any claim or action for damages as described in paragraph (a), if the claim is not otherwise required to be reported by an insurer or other insuring entity.

Reports under this subsection shall be filed with the office no later than 30 days following the occurrence of any event listed in paragraph (a).

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

(a) The name, address, health care provider professional license number, 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 office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office 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, names, and health care provider professional license numbers of all defendants involved in the claim and any nonparty health care provider who appeared on the jury verdict form in any case.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict from the jury verdict form.

(j) In the case of a settlement, such information as the office 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 commission, by rule, to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases.

(3) The office shall provide the Department of Health with electronic access to all information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. 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.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting hereunder or its agents or employees or the office or its employees for any action taken by them under this section. The office may impose a fine of up to $250 per day per case, but not to exceed a total of $10,000 per case, against an insurer, commercial self-insurance fund, medical malpractice self-insurance fund, or risk retention group that violates the requirements of this section, except that the office may impose a fine of $250 per day per case, not to exceed a total of $1,000 per case, against an insurer providing professional liability insurance to a member of The Florida Bar, which insurer violates the provisions of this section. If a health care practitioner or health care facility violates the requirements of this section, it shall be considered a violation of the chapter or act under which the practitioner or facility is licensed and shall be grounds for a fine or disciplinary action as such other violations of the chapter or act. The office may adjust a fine imposed under this subsection by considering the financial condition of the licensee, premium volume written, ratio of violations to compliancy, and other mitigating factors as determined by the office.

(5) Any self-insurance program established under s. 1004.24 shall report to the office 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. Such employee or agent shall report such claim to the Department of Health to be included on that employee's or agent's practitioner profile.

(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 when 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 that fails to comply with the reporting requirements of this section.

(8)(a)~~(6)(a)~~ The office shall prepare statistical summaries of the closed claims reports for medical malpractice filed pursuant to this section, for each year that such reports have been filed, and make such summaries and closed claim reports available on the Internet by July 1, 2005.

(b) The office shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports for medical malpractice filed pursuant to this section and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include an analysis of closed claim reports of prior years, in order to show trends in the frequency and amount of claims payments, the itemization of economic and

noneconomic damages, the nature of the errant conduct, and such other information as the office determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida, including an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year, including a loss ratio analysis for medical malpractice written in Florida and a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information as the office deems relevant.

(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.

(9)~~(7)~~ The office ~~commission~~ may adopt rules requiring persons and entities required to report pursuant to this section to also report data related to the frequency and severity of open claims for the reporting period, amounts reserved for incurred claims, changes in reserves from the previous reporting period, and other information considered relevant to the ability of the office to monitor losses and claims development in the Florida medical malpractice insurance market.

Section 5. 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 rates in effect for each medical malpractice insurer, self-insurer risk retention group, and the Florida Medical Malpractice Joint Underwriting Association. The chart shall include comparison of the rates of a variety of specialties and shall reflect the differing rates by geographic region, years in practice, and the discounts and surcharges available, including those required under s. 627.4147(2) for the loss and disciplinary record of the potential insured. Such rate comparison chart shall be made available to the public through the Internet no later than January 1 of each year.

Section 6. 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 October 1, 2007, every insurer shall reduce its rates to levels that are at least 25 percent less than the rates for the same coverage which were in effect on October 1, 2004.

(2) Notwithstanding any law to the contrary, commencing October 1, 2007, 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.

(3) Any separate affiliate of an insurer is subject to this section.

Section 7. Section 627.41495, Florida Statutes, is amended to read:

627.41495 Consumer participation in rate review ~~Public notice of medical malpractice rate filings.~~--

(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 ~~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~~.

(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, within 30 days after the mailing of the notification of the proposed rate changes to the insureds, to hold a hearing, 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.

(3) The Public Counsel has standing to request a hearing in according with this section.

Section 8. It is the intent of the Legislature that medical malpractice rates be based upon projected losses and expenses that reflect the current state of the law in this state regarding medical malpractice claims. The Legislature finds that there is no justification for basing rates on the prior 5 to 10 years of loss experience and expenses when

significant restrictions on the rights of patients and their families were enacted in 2003 which have significantly impacted both the frequency and severity of medical malpractice claims, including, but not limited to, caps on noneconomic damages, expert witness restrictions, and other barriers to full recovery for victims of medical malpractice and their families. These legislative enactments were not implemented to enrich medical malpractice insurance carriers, but rather to bring about the affordability and greater availability of medical malpractice insurance products to the state's health care providers. Accordingly, notwithstanding any law, rule, policy, or industry standard to the contrary, rates for medical malpractice insurance filed with the Office of Insurance Regulation prior to September 15, 2009, may not be based upon the loss and expense experience of more than 5 years prior to that date. For rates filed with the Office of Insurance Regulation on or after September 15, 2009, insurers may base such filings on the loss and expense experience of 2004 and thereafter but may not base rates on loss and expense experience prior to that year.

Section 9. The Office of Insurance Regulation may adopt rules to administer this act.

Section 10. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Prescribes applicability of consumer protection laws to the business of insurance. Revises rate standards with respect to medical malpractice insurance. Deletes a provision under which a medical malpractice insured may be required by the insurer to be a member of a professional society. Requires additional information in reports relating to professional liability claims and actions. Authorizes an administrative fine for failure to comply with reporting requirements. Requires disclosure of information relating to medical malpractice insurers. Requires a rate rollback for medical malpractice insurance. Provides for consumer participation in rate review. (See bill for details.)