The Florida Senate

Interim Project Report 2004-163 *January 2004*

Committee on Banking and Insurance James E. "Jim" King, Jr., President

IMPLEMENTATION OF MEDICAL MALPRACTICE INSURANCE REFORMS

SUMMARY

Medical malpractice legislation was enacted in Special Session D of 2003 in response to the problems of affordability and availability of medical malpractice insurance. This report reviews the implementation of the key insurance reforms, including the rate freeze and mandatory rate filings to reflect the savings of the bill, as determined by the Office of Insurance Regulation (OIR).

To meet its duty to determine the savings of the bill, OIR contracted with Deloitte and Touche and used the "presumed factor" determined in their report. The Deloitte report estimates that the act will have an overall impact of -7.8 percent on rates for medical malpractice insurance in Florida. Only two sections of the act were determined to result in measurable savings: the limitations on non-economic damages, estimated to be -5.3 percent, and the requirements for bad faith actions against insurers, estimated to be -2.5 percent.

All medical malpractice insurers are required to make a rate filing to reflect the savings of the act, using the presumed factor established by OIR. But an insurer that contends the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, may file the rate it contends is appropriate subject to the prior approval of OIR. As of January 5, 2004, OIR has received nineteen rate filings, all but one of which propose statewide average rate increases, even after accounting for the reduction of the presumed factor. These insurers alleged that their rates were not adequate at the time of the mandatory rate filing by a percentage greater than the presumed factor. OIR has approved rate filings by three insurers, for increases of 8 percent, 19.9 percent, and 45 percent, respectively.

In October, 2003, OIR surveyed the state's top fifteen medical malpractice insurers, asking if they were accepting new business for physicians and surgeons. Only six of these insurers stated they were accepting new business, but two were writing only on a "limited basis;" two were limiting coverage to their hospital groups only; and one conditioned its new business upon approval of a presumed factor rate filing. One additional insurer responded that it was not accepting new business until an adequate rate was established, but the subsequent approval of a 45 percent rate increase has enabled that insurer to write new business. OIR contacted four additional insurers which responded that they were accepting new business, including one new insurer and two risk retention groups.

The report compares the insurance rating laws of California to those of Florida. One key difference is the opportunity in California for policyholders and other third parties to participate in public hearings on rate filings that exceed certain thresholds.

BACKGROUND

In response to the problems of affordability and availability of medical malpractice insurance, the Legislature passed Committee Substitute for Senate Bill 2-D (act), signed by the Governor on August 14, 2003.[1] Medical malpractice insurance premiums began rising in 2000, after almost a decade of essentially flat prices. According to information obtained from the Office of Insurance Regulation (OIR), rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported December 31, 2001) ranged from 25 percent to 125 percent for the 2 and 1/2 year period from January 1, 2001, through July 1, 2003. On average, there was an 81 percent rate increase, weighted for market share, during this period.

The 2003 medical malpractice legislation comprehensively dealt with litigation reforms, patient safety issues, and insurance reforms. This report

[1] Ch. 2003-416, L.O.F.

reviews the implementation of the following insurance reforms:

- The act "freezes" medical malpractice rates for a 6-month period and requires each insurer to make a new rate filing to reflect the savings of the bill as determined by the Office of Insurance Regulation. Specifically, rates approved on or before July 1, 2003, for medical malpractice insurance must remain in effect until the effective date of the new rate filing required by the act. Insurers must make a rate filing effective no later than January 1, 2004, to reflect the savings of the act, using the presumed factor established by OIR. If the insurer contends that the rate is excessive, inadequate, or unfairly discriminatory, it may file the rate it contends is appropriate, subject to prior approval by OIR. The new rate applies to policies issued or renewed on or after the effective date of the act, requiring insurers to provide a refund for policies issued between the effective date of the act and the effective date of the rate filing.

- The closed claim reporting requirements of s. 627.912, F.S., are revised to: (1) require reporting by all types of insurance and self-insurance entities, including specified health care practitioners and facilities for claims not otherwise reported by an insurer; (2) include reports of claims resulting in nonpayment; (3) include professional license numbers; (4) provide for electronic access to the Department of Health (DOH) for all closed claim data and otherwise delete separate reporting to DOH; (5) increase penalties for nonreporting; (6) provide that violations by health care providers of reporting requirements constitutes a violation of their practice act; (7) require OIR to prepare an annual report analyzing the closed claim reports, financial reports, and rate filings of medical malpractice insurers; and (8) authorize the Financial Services Commission to adopt rules to require the reporting of data on open claims and reserves.

- The act authorizes a group of 10 or more health care providers to establish a commercial self-insurance fund for providing medical malpractice coverage.

- The act eliminates a prohibition against the formation of new medical malpractice self-insurance funds, subject to rules adopted by the Financial Services Commission.

Other insurance reforms contained in the act include the following:

- Requiring medical malpractice insurers to notify insureds at least 60 days prior to the effective date of a rate increase and at least 90 days prior to cancellation or non-renewal.

- Providing that medical malpractice rate filings disapproved by OIR may no longer be submitted to an arbitration panel, but are subject to administrative review pursuant to ch. 120, F.S.

- Requiring medical malpractice insurers to notify policyholders upon making a rate filing that would have a statewide average increase of 25 percent or greater.

- Requiring that medical malpractice insurers make a rate filing at least once annually, sworn to by at least two executive officers.

- Revising the standards for approval of medical malpractice insurance rates to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base.

- Requiring the Office of Program Policy Analysis and Government Accountability to study the feasibility and merits of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate matters.

METHODOLOGY

Committee staff reviewed the report of the impact of Senate Bill 2-D and the determination of the "presumed factor" by Deloitte and Touche, consultants to the Office of Insurance Regulation. Staff also obtained information from OIR regarding all presumed factor rate filings made to date and their status, the survey of leading writers as to which were writing new business, actions taken to implement the closed claim revisions, and rule development on self-insurance funds. Staff also obtained policy and premium data from the Florida Medical Malpractice Joint

Underwriting Association. The insurance rating laws of California were reviewed and compared to the Florida insurance rating laws.

FINDINGS

Determination of "Presumed Factor"

In order to meet its duty to determine the impact of Senate Bill 2-D on medical malpractice insurance rates, the Office of Insurance Regulation (OIR) contracted with Deloitte & Touche LLP (Deloitte) for this purpose on September 19, 2003. The Deloitte report was released by OIR on November 10, 2003, as its determination of the bill's impact.[2] The key findings of this report are summarized below.

The Deloitte report estimates that the act will have an overall impact of -7.8 percent on rates for medical malpractice insurance in Florida. This estimate was based on aggregate Florida data, so the report states that to the extent that an individual insurer's book of business varies significantly from statewide data, the presumed factor may need to be adjusted to reflect an insurer's actual exposure. The presumed factor is an overall factor for all specialties combined. No breakdown was calculated for certain high risk or low risk specialties.

Only two sections of the bill were determined to result in measurable savings: the limitations on non-economic damages (section 54), estimated to be -5.3 percent, and the requirements for bad faith actions against insurers (section 56), estimated to be -2.5 percent.

Cap on Noneconomic Damages[3] - The estimate of the savings from the cap on noneconomic damages was based on Deloitte's review of the OIR medical professional liability closed claim data base. Over 25,000 closed claims were analyzed, after eliminating claims coded with one of the three lowest severity injury types (emotional only, temporary slight, or temporary minor), and using only the six highest severity injury types. (The report makes an adjustment for the low severity claims, discussed below.) Given the limitations of the data, in certain cases, the noneconomic loss components were "grossed up" to reflect an industry benchmark ratio of noneconomic losses to total losses of 70 percent. But, in the majority of cases, no adjustments were required. Economic claim values were trended at an annual rate of 6 percent. Noneconomic claim values were trended at an annual rate of 6 percent through 1993 with a 10 percent annual trend from 1994 through 2003. Claims were grouped by (i) emergency room versus non-emergency room, (ii) practitioner versus non-practitioner, and (iii) non-pierced cap versus pierced cap.

The report provided a constitutional analysis of the caps on noneconomic damages, but for purposes of the

[2] *Review of Florida Committee Substitute for Senate Bill 2-D - Calculation of Section 40 "Presumed Factor,"* Deloitte & Touche LLP, Nov. 6, 2 003. OIR website: http://www.fldfs.com/companies/pdf/OIR_Report_Final_110620031.pdf

[3] Noneconomic damages in medical malpractice actions are limited as follows:
For most medical malpractice claims against *practitioners* (physicians, dentists, optometrists, physical therapists, nurses, etc.):
a) There is a cap of $500,000 per claimant.
b) All claimants may recover a total of $1,000,000 aggregate.
c) No practitioner is liable for more than $500,000.
For most medical malpractice claims against *nonpractitioners* (hospitals, HMOs, etc.):
a) There is a cap of $750,000 per claimant.
b) No practitioner is liable for more than $500,000.
"Pierced" cap: In cases involving death or permanent vegetative state, all claimants may recover a total of $1,000,000 from practitioners and $1,500,000 from non-practitioners. In cases that do not involve death or permanent vegetative state, the injured patient may recover a total of $1,000,000 from practitioners and $1,500,000 from non-practitioners if the patient suffers a catastrophic injury and the trial judge finds that a manifest injustice would occur if the lower cap was imposed. The bill defines *catastrophic injury* to include serious spinal cord injuries, amputations, brain injuries, serious burns, blindness, or loss of reproductive organs.
In *emergency care* situations, different caps apply:
a) There is a $150,000 cap per claimant against practitioners with $300,000 aggregate.
b) There is a $750,000 cap per claimant against non-practitioners with $1,500,000 aggregate.

estimated rate impact, it was assumed that the caps would not be held invalid.

In estimating the impact, the report emphasized the importance of the mix of policy limits purchased, noting the shift towards health care providers purchasing lower policy limits (or no coverage at all). As more physicians and surgeons shift to lower policy limits the less impact the caps on noneconomic damages will have. The following table displays the policy limit assumptions used by the report, based on policy limit information obtained from some of the top insurers and the closed claim data base:

Policy Limit Distribution (assumption used in Deloitte report)		
Policy Limit	**Selected Distribution -- Practitioners (Physicians and Surgeons, etc.)**	**Selected Distribution -- Nonpractitioners (Hospitals, HMOs, etc.)**
$100,000	2.0%	2.5%
$250,000	25.0%	17.5%
$500,000	16.0%	10.0%
$1,000,000	47.5%	50.0%
$2,000,000	7.5%	7.5%
$5,000,000	0.5%	2.5%
Other	1.5%	10.0%
TOTAL	100%	100%

The next factor considered in estimating the rate impact of caps was the number of claimants and defendants involved in each medical malpractice case. The report noted that in a non-death case, persons who can typically recover noneconomic damages are: 1) the insured person, 2) the spouse, 3) children of the injured person, regardless of age, if the child is unmarried and financially dependent on the injured person and the injury resulted in a permanent total disability, and 4) parents, if the injured person is under 18. In a wrongful death case, "survivors" who can recover noneconomic damages include: 1) the spouse, 2) children under 25 years of age, and 3) parents, if the injured person is younger than 25 years of age.

The report assumes the following distribution for the number of claimants and/or defendants:

Number of Claimants and/or Defendants (assumption used in Deloitte report)			
1/1	2/2	3/3	4/4
25%	50%	20%	5%

The Florida closed claim data base does not provide information on the number of claimants associated with each claim. The above distribution of claimants and/or defendants was based on the general assumption that, on average, the closed claim database would average approximately two claimants (e.g., husband and wife, wife and child, etc.) over the entire sample of records. The report allocated 50 percent to the other categories as displayed above.

The analysis also accounted for the fact that the cap on non-economic damages would apply only to indemnity payments, and not to an insurer's allocated loss adjustment expense (ALAE). This is the expense to the insurer for defending and settling the claim, including defense costs, court costs, medical reports, investigative reports, etc. Medical malpractice policy limits do not apply to ALAE payments, only indemnity payments, so ALAE was not adjusted to reflect the indemnity savings calculated using the closed claim database. The report reviewed Florida rate filings which indicated a ratio of ALAE to indemnity payments in the 40 percent to 55 percent range, and used an assumption of 45 percent. This ratio was higher than the 36 percent countrywide ALAE ratio reflected by A.M. Best (insurance rating organization) data for medical malpractice claims made policies. The report concluded that Florida's higher ALAE ratio was driven by Florida's heavy distribution of lower policy limits.

The report then noted that the noneconomic damage cap will likely not apply to injuries caused before September 15, 2003, and therefore the impact of the law will take time to phase in. The report selected a factor of 0.85 based upon a review of "lag factors" reflecting average numbers of years between occurrence, reporting, and closing dates. This 0.85 factor is similar to a present value factor applied to a future payment to convert it to a present dollar value.

The table below, included in the report, shows the estimated indemnity savings to insurers, by policy limits and the number of claimants and/or defendants.

Percentage Indemnity Savings Due to Cap on Noneconomic Damages In Deloitte Report

Practitioner

Policy Limits	Selected Distri-bution	Number of Claimants and/or Defendants			
		1/1	2/2	3/3	4/4
$100,000	2.0%	0.0%	0.0%	0.0%	0.7%
$250,000	25.0%	1.5%	1.3%	2.4%	3.0%
$500,000	16.0%	3.5%	3.0%	6.2%	8.6%
$1,000,000	47.5%	16.9%	10.8%	12.6%	13.5%
$2,000,000	7.5%	26.5%	16.0%	16.1%	16.1%
$5,000,000	2.0%	31.8%	19.0%	17.9%	17.5%
	100.0%	13.9%	8.4%	9.8%	10.6%

Nonpractitioner

Policy Limits	Selected Distri-bution	Number of Claimants and/or Defendants			
		1/1	2/2	3/3	4/4
$100,000	2.5%	0.0%	0.0%	0.0%	0.0%
$250,000	17.5%	0.0%	0.0%	0.0%	0.0%
$500,000	10.0%	0.0%	0.0%	0.0%	1.5%
$1,000,000	50.0%	2.3%	1.8%	5.5%	8.6%
$2,000,000	7.5%	11.8%	9.9%	14.2%	16.4%
$5,000,000	2.5%	24.0%	19.4%	19.1%	18.6%
$100,000,000	10.0%	30.2%	19.9%	19.1%	18.6%
	100.0%	8.3%	5.3%	7.2%	8.9%

Total

Policy Limits	Number of Claimants and/or Defendants			
	1/1	2/2	3/3	4/4
$100,000	0.0%	0.0%	0.0%	0.6%
$250,000	1.3%	1.2%	2.1%	2.6%
$500,000	3.1%	2.6%	5.4%	7.7%
$1,000,000	15.1%	9.7%	11.7%	12.8%
$2,000,000	24.6%	15.2%	15.8%	16.1%
$5,000,000	30.7%	19.1%	18.1%	17.6%
$100,000,000	30.2%	19.9%	19.1%	18.6%
	13.1%	**8.0%**	**9.4%**	**10.4%**

The above tables show the percentage reduction in the indemnity amounts paid by insurers at various policy limit and claimant/defendant combinations. Note that this is not the percentage reduction of an award to the plaintiff for noneconomic damages. It is the percentage reduction in the amount of noneconomic damages paid by the insurer. For example, the cap could reduce a jury verdict from $2,000,000 to $500,000, but there would be no reduction to the insurer that issued a policy with a $500,000 limit. However, in the report's examples of how the cap would affect certain awards, the "non-pierced practitioner non-emergency room cap" was described and applied as "$500,000 for the first claimant/defendant, $1,000,000 for the second claimants/defendants, $1,500,000 for the third claimants/defendants, and $2,000,000 for the fourth claimants/defendants." It appears that this incorrectly assumes caps of $1,500,000 and $2,000,000 for the third and fourth claimants/defendants, respectively, even though the act specifies that the total noneconomic damages recoverable by all claimants from all practitioner defendants shall not exceed $1,000,000 in the aggregate.[4]

The report describes the five steps taken to convert the indemnity savings shown in the "Total" table above, into a single percentage factor that reflects the overall savings in medical malpractice rates due to the cap on noneconomic damages, as follows:

Step 1: Apply policy limit distribution assumptions -- This is completed in the last line of the "Total" table, above. This shows the average indemnity savings of both the practitioner and non-practitioner cap as 13.1% for 1/1 claimant and/or defendant, 8.0% for 2/2 claimants and/or defendants, 9.4% for 3/3, and 10.4% for 4/4.

Step 2: Apply claimant/defendant assumptions (as shown in the table on page 4) -- This reduces the four percentages derived in Step 1 to a single percentage of 9.7%.

Step 3: Adjust savings for three lowest severity injury types -- The tables reflect the average indemnity savings of the six most severe types of injuries, but did not include the three lowest injury types as noted above. For these low severity injuries, the report assumed an average indemnity savings of 2.5% (rather than 9.7%), based upon the relative average severity of these claims to the more severe claims and the low probability of the cap impacting these smaller dollar claims. These low severity injury types represented over 25% of the claims, but only 8% of the indemnity payments. Applying the 2.5% savings to 8% of the indemnity payments (and applying 9.7% savings to 92% of indemnity payments) reduces the estimated 9.7% indemnity savings to 9.1%.

Step 4: Apply ALAE assumption -- The fourth adjustment was to apply the assumption that allocated loss adjustment expenses (ALAE) were 45% of indemnity amounts and that the cap would not apply to

[4] Section 766.118(2)(c), F.S., as created by section. 54 of ch. 2003-416, L.O.F.

ALAE. (In other words, ALAE represents 31% of the insurer's total payment and the indemnity payment is 69% of the insurer's total payment.) This adjustment reduces the 9.1% savings to 6.3%.

Step 5: Apply "phase-in" assumption -- The final step was to apply the 0.85 phase-in adjustment described above, to reflect the time lag in the effect of the caps, which reduces the 6.3% savings to the 5.3% presumed factor for the impact of the cap on rates.

Requirements for Bad Faith Claims - In addition to the cap on noneconomic damages, the only other section of Senate Bill 2-D that the Deloitte report concluded would measurably reduce rates was the section that addressed bad faith claims in connection with medical negligence. Among other changes, the law provides that an insurer shall not be held in bad faith for failure to pay its policy limits if it tenders those limits within certain time periods. If the insurer does not tender its policy limits by the deadlines, the law sets forth criteria for a jury to follow in determining bad faith.

The report concluded that the extended time period to investigate claims should allow insurers more time to make informed decisions about the merits of the case and arguably reduce instances of uninformed "knee jerk" settlements of policy limits in reaction to a threat of bad faith. The report noted that the new time periods may not provide any added benefit because, as a practical matter, most insurers had between seven and nine months to investigate claims before being required to make a decision to tender policy limits. But, the report further noted "strong anecdotal evidence" of situations where plaintiffs serve a demand for policy limits in the early stages of a lawsuit for which the new law will solve the problem of weighing the merits of paying policy limits.

The report found that medical malpractice insurers in Florida made bad faith payments for physicians and surgeons ranging from 3 percent to 17 percent of total loss payments limited to $250,000 from 1993 to 2002. However, the report concluded that savings to insurance companies of reduced bad faith awards resulting from the new law will not impact the presumed factor because medical malpractice insurers are not allowed to include bad faith payments in the development of their indicated manual rate changes. The law did not expressly provide this prior to Senate Bill 2-D (as it now does), but was interpreted by OIR as not allowing their inclusion. The one potential area of savings that would impact the presumed factor was the savings and leverage gained by insurers from changes in bad faith strategies.

Although certain data sources are cited, the report essentially relies upon the authors' judgment in concluding that the bad faith changes would reduce rates 2.5 percent. It concluded that by reducing the likelihood of bad faith awards in certain situations (e.g., when a plaintiff serves a demand for payment of the policy limits in the first two or three months after an injury occurs), insurers would gain some leverage in avoiding some of the truly low value/high bad faith potential cases that shouldn't have been brought to trial in the first place. The 2.5 percent factor was said to be determined by reviewing different combinations of settlement rate reductions (e.g., 2.5%, 5%, 7.5% and 10.0%), allocation of claim count reductions to severity types, and average claim severities. The 2.5 percent factor was determined by reducing a 3.5 percent selected savings by 1 percent to reflect the cost impact on insurers of reduced investment income due to the speed up of claim payments.

The report noted that Florida's settlement rate of 52 percent was significantly higher than the countrywide settlement rate of 30 percent, based on statistics provided by the Florida Insurance Council comparing Florida closed claim data submitted to OIR with national data submitted to the Physicians Insurers Association of America, from 1991 to 2000. However, Deloitte was skeptical that the ratio would move significantly closer to the countrywide average settlement rate because Florida's rate is largely driven by the lower policy limits written in Florida.

"Presumed Factor" Rate Filings

All medical malpractice insurers were required to make a rate filing effective no later than January 1, 2004, to reflect the savings of Senate Bill 2-D, using the presumed factor established by OIR. If, however, the insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, the insurer may use a different factor subject to the prior approval of OIR.

As of January 5, 2004, OIR has received nineteen rate filings, all but one of which propose statewide average rate increases, even after accounting for the reduction of the presumed factor. The expectation of legislators that the bill would result in a rate decrease was based on the apparently false assumption that medical malpractice insurers would generally have adequate rate levels at the time of the mandatory rate filings,

given the large rate increases of the last three years. However, the Deloitte report recognized the likelihood of rate increases, stating, "It is important to note that the presumed factor determined in this analysis must be considered in combination with the medical malpractice insurance company's current indicated manual rate change adjusted for the benefits of SB 2-D." Using an example of an insurer that has an indicated premium rate need of +40.0 percent, the report stated that the insurer would file a +40.0 percent increase minus the presumed factor, not just the presumed factor. The report noted the impact of the freeze of all rates approved on or before July 1, 2003, which remains in effect until the effective date of the required filing. Insurers who made or were on the verge of making a rate filing that was not approved before July 1, 2003 were required to wait until the act allowed new rates to be filed. According to the report, these insurers were likely to see their rate inadequacy build during the "freeze" period, increasing the probability that they would need to file a reduced increase, not an overall decrease. The authors expected that the majority of insurers would fall into this category.

The following chart displays the nineteen rate filings in the order received by OIR, and their status as of January 5, 2003:

Florida Office of Insurance Regulation
"Presumed Factor" Rate Filings
Received as of Jan. 5, 2004

Insurer Name (date received at OIR)	Insurer Indicated Rate Need	Proposed Statewide Average Rate Change	Proposed Effective Date	Status
Pronational Insurance Co. (10/29/03)	20.5%	17.3%	1/1/04	Pending
Medical Protective Co. (11/7/03)	77.6%	45.0%	1/1/04 (new) 3/1/04 (renewal)	Approved
First Professionals Insurance Co. (11/13/03)	17.6%	8.0%	1/1/04 (new) 3/1/04 (renewal)	Approved
MAG Mutual Insurance Co. (11/21/03)	17.6%	7.0%	1/1/04	Pending
Granite State Ins. Co. (11/24/03)	141.4%	16.8%	2/27/04	Pending
Truck Insurance Exchange (11/25/03)	53.2%	6.0%	1/1/04	Pending
Chicago Ins. Co. (Allied Health Purchasing Group) (11/26/03)	Not provided	10% to 52.1%	2/15/04	Pending
Chicago Ins. Co. (Professional Liability Nurses Purchasing Group) (11/19/03)	106.2%	8.2%	2/15/04	Pending
Podiatry Inssur. Co. of America RRG A Mutual Company (12/10/03)	Converting from risk retention group	19.9%	1/1/04	Approved
National Casualty Co. (12/9/03)	0.0%	-7.8%	1/1/04	Pending
Insurance Services Office (ISO) (12/15/03)	41.6%	25.0%	10/1/04	Pending
Continental Casualty Co. (12/16/03)	14.45%	6.65%	1/1/04	Pending
Anesthesiologist Professional Assurance Co. (12/19/03)	13.7%	10.0%	4/1/04	Pending
The Doctors Company an Interinsurance Exchange (12/19/03)	16.4%	16.1%	3/1/04	Pending
Physicians Insurance Co. (12/158/03)	14.3%	5.5%	3/1/04	Pending
Ace American Insurance Co. (12/22/03)	New program	New program	1/1/04	Pending
American Casualty Co. of Reading PA ()12/23/03)	70.6%	59.8%	1/15/04	Pending
Fortress Insurance Co. (12/23/03)	16.6%	5.0%	12/23/03	Pending
National Union Fire Ins. Co. of Pittsburgh PA (12/23/03)	35.4%	25.0%	3/26/04	Pending

Source: Office of Insurance Regulation

The second column in the above table shows the insurance company's indicated rate need *before* application of the presumed factor. But this indicated rate need is subject to review and may change during the review process until the filing is approved by OIR. Only three filings have been approved by OIR as of December 29, 2003, as indicated.

First Professionals Insurance Co. (FPIC) demonstrated an indicated rate need of 17.6 percent before application of the presumed factor. FPIC also supported use of a -5.7 percent presumed factor, rather than -7.8 percent, because of their policy limit distribution which had lower limits than the assumed distribution used in the Deloitte report. FPIC's proposed statewide average rate change of 8.0 percent was approved, which was less than the full indicated rate need after application of the presumed factor.

Medical Protective Insurance Co. (Med Pro) demonstrated an indicated rate need of 77.6 percent and made a rate filing requesting 45 percent, which was filed prior to OIR's determination of the presumed factor. Med Pro then supplemented the filing to include the -7.8 percent presumed factor, but did not change its proposed 45 percent rate increase, leaving the rest of its indicated rate level need "on the table." The OIR was satisfied that the rate was not inadequate based on tighter underwriting restrictions used by the insurer.

Medical Malpractice Insurance Market in Florida

In October, 2003 OIR surveyed the state's top fifteen medical malpractice insurers, based on written premium reported December 31, 2002, asking if they were accepting new business for physicians and surgeons. Only six of the fifteen insurers stated that they were accepting new business, but two of the six insurers said they were writing only on a "limited basis" (First Professionals Insurance Co. and The Doctors' Company, An Interinsurance Exchange); two were limiting coverage to their hospital groups only (Health Care Indemnity, Inc. and Continental Casualty Co.); and one insurer conditioned its new business upon approval a presumed factor rate filing (Pronational Insurance Co.). Only one insurer had an unqualified response that it was accepting new business (MAG Mutual Insurance Company).

One additional insurer, Medical Protective Insurance Company (Med Pro), responded to the OIR survey in October that it was not accepting new business until an adequate rate was established. In September, Med Pro mailed non-renewal notices to over 300 doctors whose policies were scheduled to renew in January, 2004, due to the company's loss experience and the uncertainties of the rate that they would be permitted to charge for these policies, given the rate freeze and the legal requirement for 90 days' notice of non-renewal. As noted, Med Pro subsequently obtained OIR approval of a 45 percent rate increase. The insurer now expects to remain active in the Florida market and was contacting policyholders to offer coverage to those that meet its underwriting guidelines.

In addition to the top fifteen insurers, OIR contacted four other insurers, all of which responded that they were accepting new business, including American Casualty Co. of Reading, PA (only on a limited basis); Physicians Insurance Co. (a new company); Ophthalmic Mutual Insurance Co.-RRG (a risk retention group for ophthalmologists only); and Preferred Physicians Medical - RRG (a risk retention group for anesthesiologists only).

The state-created Florida Medical Malpractice Joint Underwriting Association (FMMJUA) provides coverage to physicians and other health care providers unable to obtain coverage in the voluntary market. The FMMJUA has experienced tremendous growth in the number of physicians it insures, increasing from 16 in 2001, to 133 in 2002, to 1,029 as of November 30, 2003. The OIR has concluded that the FMMJUA is not subject to the requirement to make a presumed factor rate filing. Whether or not this interpretation is correct may be a relatively unimportant point, given the fact that the maximum limit of coverage offered by the FMMJUA is $250,000 per claim, so the savings from the cap is negligible. Similarly, the bad faith requirements do not benefit the FMMJUA due to the case law determination that the association is immune from bad faith awards.

Closed Claim Reporting Requirements

The act revised the requirements for the professional liability insurance closed claim reports filed by insurers and providers. The act expanded the reporting requirements to entities and persons not previously required to report as well as modified the information to be reported, as summarized on page 1. Notably, medical providers are required to self-report if an insurer is not otherwise required to do so (such as a provider who is uninsured or who has coverage with an offshore insurer not subject to state regulation).

The OIR held workshops with insurers to discuss the feasibility of obtaining additional data on closed claims in response to concerns of legislators. The debate on the noneconomic damage caps expressed legislators' desire of obtaining information regarding the number of claimants and defendants for each claim. However, the OIR workshops indicated that insurers would not be able to accurately report the number of claimants who receive payment in a typical claim. The vast majority of claims are settled with a single payment without the insurer knowing how the payment may be allocated among multiple claimants.

In December, OIR issued a "Statement of Work/Request for Quote" to solicit proposals from vendors with the expertise to evaluate and enhance the current closed claim collection system. The enhancements would include the design, programming and implementation of a web-based system for the

efficient collection, storage and reporting of certain open and closed claim information. Proposal must be received by OIR by January 9, 2004.

Self-Insurance Funds

The OIR has not yet filed any proposed rules (which must be adopted by the Financial Services Commission) to implement the provisions of the act that allow new medical malpractice self-insurance trust funds to be formed, subject to rules adopted by the Commission that ensure that a trust fund remains solvent and maintains a sufficient reserve to cover contingent liabilities in the event of dissolution. OIR representatives state that draft rules are still being circulated and discussed within OIR and are expected to be published or workshopped shortly.

A separate provision of the act allows ten or more health care providers to form a commercial self-insurance fund under s. 624.462, F.S., for the purpose of providing medical malpractice coverage. In effect, this change allows such a fund to be formed directly by a group of health care providers, rather than by a professional association meeting certain criteria, as the law previously allowed. No additional rules are necessary to implement this law. To date, only workers' compensation funds have been formed under this law even though it allows for a fund to provide any type of property and casualty coverage. No commercial self-insurance fund has been created for medical malpractice and no applications are pending. There are generally stronger financial requirements for a commercial self-insurance fund as compared to the requirements for medical malpractice self-insurance trust funds, but the new rules for such funds have yet to be proposed.

Comparison of Florida and California Insurance Rating Laws

The insurance rating requirements (as well as tort reforms) of California as contained in Proposition 103 were proposed or discussed during the medical malpractice deliberations in Florida. This section of the report summarizes the key provisions of the California insurance rating laws and how they compare to Florida's laws.

Rollback Provision - California Proposition 103 required every insurer to reduce its property and casualty rates for policies issued or renewed after November 8, 1988 to at least 20 percent less that the rates in effect on November 8, 1987. Between November 8, 1988 and November 8, 1989, rates could be increased only if the commissioner found, after a hearing, that an insurer was substantially threatened with insolvency. This was later changed by the California Supreme Court to allow companies a fair rate of return. As a result, the California Department of Insurance negotiated with each insurer to determine whether a rollback was required, and companies that made little or no profit in the rollback year were determined to owe little or no rebates.

The Florida medical malpractice act, as described above, did not specify a rate reduction, but required rate filings reflecting the "presumed factor" determined by OIR. But, similar to the requirement determined by the California Supreme Court to be constitutionally necessary, the Florida law allowed insurers to file for an appropriate rate if application of the presumed factor resulted in a rate that was excessive, inadequate, or unfairly discriminatory.

In *Smith v. Department of Insurance,*[5] the Florida Supreme Court held that the section of the 1986 Tort Reform and Insurance Act that required a rate rollback ("special credit") for commercial liability policies issued prior the effective date of the act, unconstitutionally impaired existing insurance contracts. But, the *Smith* court found that the act was constitutional with regard to policies issued on or after the effective date of the act, which required a rate freeze and for rates to be reduced by 40 percent of the premium for a three month period (equivalent to 10 percent of the annual premium). The court noted that the Legislature received evidence that savings from the tort reform provisions would reduce policy costs by at least 10 percent, and that the act clearly allowed the insurance companies an opportunity to present to the Department of Insurance (Department) all rate-making factors to determine an insurance rate that will provide each of them a reasonable rate of return on their Florida business. The act did not use the phrase "reasonable rate of return" but allowed any insurer that contended that the rate reduction would result in a rate which was "clearly inadequate" to submit a rate filing to the Department.

Prior Approval of Filings - The California property and casualty rating law[6] requires the approval of a rate filing by the Insurance Commissioner prior to use, but a rate filing is deemed approved under certain

[5] 507 So2d 1080 (Fla. 1987).
[6] Sections 1861.01-1861.16, Cal. Insurance Code.

circumstances. Insurers must file specified information as part of a rate filing and have the burden of proving that the rate change is justified.

Current Florida law provides insurers with a "use and file" or "file and use" option for property and casualty insurance rates.[7] The "file and use" option is very similar to prior approval since a rate must be filed 90 days before the proposed effective date and cannot be implemented if the OIR issues a notice of intent to disapprove the filing within this time period. Under the "use and file" option, an insurer may file rates for approval 30 days after the rate filing is implemented, but the insurer must refund the amount charged in excess the rate that is ultimately approved.

In 1996 the Florida rating law was amended to allow insurers to request binding arbitration of a rate filing as an alternative to an administrative hearing. The new medical malpractice act provides that the arbitration option is no longer available for medical malpractice insurance rates. If OIR disapproves a rate filing, the insurer may still request an administrative hearing under the Administrative Procedure Act.

Florida law does not require specific information in a rate filing, but requires OIR to consider, in accordance with generally accepted and reasonable actuarial techniques, thirteen specific factors, as well as other relevant factors which impact upon the frequency or severity of claims or upon expenses. Like California, Florida law specifies that the insurer has the burden of proving the rate change is justified. The new Florida act expressly prohibits the inclusion in the rate base of any medical malpractice rate filing any payments made by the insurer for bad faith or punitive damages, as similarly provided in California.

Public Notice and Hearings - In California, the commissioner must notify the public of every rate filing through news media and to any person who requests placement on a mailing list. If a public hearing is requested within 45 days of public notice, the commissioner must hold a public hearing if the proposed rate change exceeds 7 percent for personal lines or 15 percent for commercial lines. All rate information filed with the commissioner must be available for public inspection.

Current Florida law does not require public notice of a rate filing and does not require a public hearing. The OIR may hold a public hearing on any matter. Rate filings made with OIR are public records. The new act adds a requirement that medical malpractice insurers notify policyholders upon making a rate filing that would have a statewide average increase of 25 percent or greater.

Consumer Right to Challenge a Rate Filing - The California law provides that any person may initiate or intervene in any rate filing. The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that he or she represents the interests of consumers and has made a substantial contribution to the adoption of any order or decision by the commissioner or court. Where such advocacy occurs in response to a rate filing, the award is paid by the insurer. The commissioner must require insurers to notify policyholders of the opportunity to join an independent, non-profit corporation which advocates the interests of insurance consumers. Such an organization must be established by an interim board designated by the commissioner and operated by individuals who are elected from its membership.

The Florida law does not provide any specific way for a policyholder or other third party to intervene in a rate filing. According to OIR, there has never been a judicial or administrative determination as to whether a policyholder is considered a "substantially affected" person who would be legally entitled to intervene in a rate case pursuant to ch. 120, F.S. However the Insurance Consumer Advocate, appointed by the Chief Financial Officer, is provided standing to represent the public in any rate case.[8] The new act requires the Office of Program Policy Analysis and Government Accountability to study the effectiveness of this current authority, and to study the feasibility and merits of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate matters.

Rate Comparison -- California requires the commissioner to provide, upon request and for a reasonable fee to cover costs, a comparison of the rate in effect for each personal line of insurance for every insurer. The Florida law does not have a similar requirement.

Applicability of Antitrust and Unfair Business Practice Laws to Insurance - In California, the business of insurance is subject to the state laws applicable to any other business, including the antitrust and unfair

[7] Section 627.062, F.S.

[8] Section 627.0613, F.S. (2003).

business practices laws and the state Civil Rights Act. The law provides that these requirements do not prohibit any agreement to collect, compile and disseminate historical data on paid claims or reserves provided such data is contemporaneously transmitted to the commissioner (or other specified allowable practices listed in the act).

The Florida Antitrust Act exempts any activity or conduct that is exempt from the provisions of the antitrust laws of the United States.[9] This generally exempts insurance matters due to the exemption provided in the federal antitrust laws. However, the Florida Insurance Code prohibits insurers from entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in the business of insurance.[10]

The Florida Deceptive and Unfair Trade Practices Act does not apply to any person or activity regulated under laws administered by the Department of Financial Services or the Office of Insurance Regulation.[11] However, the Florida Insurance Code prohibits unfair methods of competition and unfair or deceptive acts or practices, as specified in s. 626.9541, F.S.

[9] Section 542.20, F.S. (2003).
[10] Section 626.9541(1)(d), F.S. (2003).
[11] Section 501.212, F.S. (2003).