SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2080

SPONSOR: Banking and Insurance Committee and Senator Peaden

SUBJECT: Insurance

DATE: March 24, 2003 REVISED: ________ ________ ________ ________

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			AP	
4.				
5.				
6.				

I. Summary:

This bill would make the following changes affecting medical malpractice insurance:

(1) requires rates for policies issued or renewed on or after July 1, 2003, to be reduced to levels that are at least 20 percent less than the charges for the same coverage that were in effect on January 1, 2001; (2) allows a group of 10 or more health care providers to form a commercial self-insurance fund; (3) requires insurers to provide 90-days notice of a rate increase; (5) requires insurers to apply a discount or surcharge on a health care provider's premium based on the provider's loss experience, including state disciplinary action; (4) deletes a prohibition against insurers requiring the insured to be a member in good standing of a duly recognized state or local professional society of health care providers which maintains a medical review committee; (5) deletes a prohibition against a professional society expelling or suspending a member solely because he or she participates in a health maintenance organization; (6) increases the fine for insurers who violate the requirements for reporting of professional liability claims; (7) requires insurers reporting closed claims for professional liability to also report specified financial information; (8) requires the Office of Insurance Regulation to provide health care providers with a comparison of rates; and (9) requires the Office of Insurance Regulation to hold a public hearing on a rate filing upon the request of an insured.

The bill also makes the following changes, affecting insurers, generally:

(1) makes the business of insurance subject to state laws applicable to any other business, including the Florida Civil Rights Act of 1992, the Florida Antitrust Act of 1980, the Florida Deceptive and Unfair Trade Practices Act, and the consumer protection provisions in ch. 540, F.S.; (2) deletes the authority of two or more insurers to act in concert in the making of rates or

rating systems, the preparation of underwriting rules, and the furnishing of loss or expense statistics or other information and data, and similar restrictions.

This bill amends the following sections of the Florida Statutes: 501.212, 624.462, 627.041, 627.062, 627.314, 627.4147, and 627.912.

This bill creates the following sections of the Florida Statutes: 624.156, 627.41491, 627.41493, 627.41495, and one undesignated section of law.

II. Present Situation:

Availability and Affordability of Medical Malpractice Insurance

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in many areas of the country, including Florida.

After almost a decade of essentially flat prices, medical malpractice insurance premiums began rising in 2000. According to the Department of Insurance, rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported 12/31/01) ranged from a minimum of 33.5 percent to a maximum of 149.9 percent from 1/1/01 through 1/1/03. There was a 73 percent average rate increase, weighted for market share. Rate increases for the top three insurers ranged from 74.3 percent to 81.3 percent for the two-year period.

In October 2002, the Department of Insurance surveyed 18 insurers (top 15 malpractice writers in Florida and 3 other insurers known to be writing coverage) to determine the status of insurers departing the state and the status of insurers writing new business. Of the 18 insurers, five medical malpractice insurers had decided to no longer write any new or renewal business in Florida. Four additional insurers were not accepting any new business from physicians. Nine remaining insurers were still accepting new business in October 2002. As of February 28, 2003, the largest medical malpractice insurer in the state, which had not been writing new business in October 2002, decided to resume writing new business. Since that time, as of March 20, 2003, the Office of Insurance Regulation reports that there are eight insurers actively writing new physicians and surgeons medical malpractice insurance in Florida.

While there is general agreement that medical malpractice insurance premiums have risen sharply and that physicians are having a more difficult time obtaining medical malpractice insurance coverage, there appears to be little agreement on the causes of these problems. Insurers and doctors blame “predatory” trial attorneys, “frivolous” law suits, and “out of control” juries for the spike in insurance premiums. Consumer groups accuse insurance companies of “price gouging” and cite “exorbitant” rates of medical errors. Plaintiffs’ attorneys also point to medical errors, and to “predatory” pricing practices and bad business decisions of insurers during the 1990s.

There is also disagreement about possible solutions to these problems. Insurers and physicians demand tort reform, changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims' access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Whatever the causes and solutions, the effects of the rising cost of medical malpractice insurance and the reduction in the availability of such coverage are being felt in Florida's health care system. There have been numerous reports of doctors discontinuing doing risky procedures, retiring prematurely, practicing without insurance, and leaving litigious areas of the state in an effort to deal with the price of liability coverage. In some cases, the decision of high risk specialists to reduce or eliminate their services has led to further reductions in services by hospitals. Some hospitals are discontinuing services such as maternity services and trauma services because of the high cost of malpractice coverage for the specialists needed to provide these services.

Medical Malpractice Self-Insurance Funds; Commercial Self-Insurance Funds

Background - Florida law previously allowed health care providers to form medical malpractice self-insurance funds (referred to as a "medical malpractice risk management trust fund"), pursuant to s. 627.357, F.S. However, the law was amended in 1992 to prohibit the formation of any new funds under this section after October 1, 1992. Five relatively small, specialized funds are still operating (one of which is in "run-off" by assessing its members and not issuing new coverage).

But, the current law allows for the formation of commercial self-insurance funds pursuant to ss. 624.460-624.488, F.S., as approved by the Department of Insurance (now, the Office of Insurance Regulation, or "office"[1]). These funds may be formed for property and casualty insurance, including medical malpractice, but in practice have been limited to providing workers' compensation coverage. No such funds have been formed to provide medical malpractice insurance. Certain restrictions on who may establish such funds, as well as more stringent requirements than applied to the former medical malpractice self-insurance funds, may be inhibiting factors. Also, it is reported that the department has generally cautioned prospective organizers of such funds, due to a self-insurance fund's reliance on assessments against member insureds as the fallback solvency requirement, as compared to the surplus that must be maintained by authorized insurers. Insurers must generally maintain a surplus (net worth) of $4 million or 10 percent of liabilities, whichever is greater (s. 624.408, F.S.). In contrast, a commercial self-insurance fund is not subject to surplus requirements, other than a "$1" surplus requirement that the ratio of net assets to net liabilities of at least 1 to 1, and other requirements, as described below. The Department of Insurance has experienced problems with funds that attempt to collect assessments from their members and the litigation that can ensue.

[1] Legislation in 2002 (ch. 2002-404, L.O.F.), effective January 7, 2003, transferred the Department of Insurance to the Department of Financial Services and to the Financial Services Commission and its Office of Insurance Regulation. Conforming changes to the statutes have not yet been enacted, which are addressed in CS/CS/SB 1712.

With regard to rates for coverage, the absence of a profit factor (usually about 5 percent of premium) and, possibly, lower expenses, could result in lower rates as compared to authorized insurers. But, there is no particular reason why the claims experience and investment income of a self-insurance fund would be different than for an authorized insurer, so the portion of the rate that covers expected claims (discounted for expected investment income) should be approximately the same as amounts charged by an authorized insurer, subject to the actual claims experience of the insurer or fund.

If rates turn out to be inadequate and a deficit exists, member insureds of a self-insurance fund are assessed, in proportion to their premium, to fund the deficit. Authorized insurers are more likely to have available surplus to compensate for inadequate premiums. In the event of insolvency, an authorized insurer's claims are covered by the Florida Insurance Guaranty Association. There is no guaranty fund coverage for medical malpractice claims of a commercial self-insurance fund (but guaranty fund coverage is provided for workers' compensation claims of a self-insurance fund, pursuant to part V of ch. 631, F.S.).

Former medical malpractice self-insurance funds - Section 627.357, F.S., which previously authorized the formation of a medical malpractice risk management trust fund, required approval from the Department of Insurance, subject to the following requirements: (1) employment of a professional consultant for loss prevention and claims management coordination under a risk management program; (2) being subject to "regulation and investigation by the department" and "subject to rules of the department and to part IX of chapter 626, relating to trade practices and frauds"; (3) being allowed to ("may") purchase excess insurance, as necessary, and to purchase such risk management services as may be required; and (4) "to engage in prudent investment of trust funds and other activities reasonably relating to the payment of claims and to providing medical malpractice self-insurance, to the extent otherwise consistent with this section and law generally applicable to medical malpractice insurers." Such funds were authorized to insure hospital parent corporations, hospital subsidiary corporations, and committees against claims arising out of the rendering of, or failure to render, medical care or services. The department adopted rules pursuant to this section, providing more specific requirements (ch. 4-187 F.A.C.). This statute prohibits the formation of a self-insurance fund after October 1, 1992.

Current commercial self-insurance funds - Commercial self-insurance funds may be authorized by the Office of Insurance Regulation, pursuant to ss. 624.460-624.488, F.S. Such funds may be formed only 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 in Florida, 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 (medical malpractice) 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; or (3) a not-for-profit group comprised of no less than 10 condominium associations meeting certain requirements.

A commercial self-insurance fund must be operated by a board of trustees. If formed pursuant to (1), above, the board of trustees must be responsible for appointing independent certified public accountants, legal counsel, actuaries, and investment advisers as needed; approving payment of dividends to members; and contracting with an administrator authorized under s. 626.88 to

administer the affairs of the fund. A majority of the trustees or directors must be owners, partners, officers, directors, or employees of one or more members of the fund. Requirements also include: (1) an indemnity agreement binding each fund member to individual, several, and proportionate liability; (2) a plan of risk management which has established measures to minimize the frequency and severity of losses; (3) proof of competent and trustworthy persons to administer or service the fund; (4) an aggregate net worth of all members of at least $500,000; (5) a combined ratio of current assets to current liabilities of more than 1 to 1; (6) a deposit of cash or securities, or a surety bond, of $100,000; (7) specific and aggregate excess insurance with limits and retention levels satisfactory to the department (office); (8) a fidelity bond or insurance providing coverage of at least 10 percent of the funds handled annually by the fund; (9) a plan of operation designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles, and a statement by an actuary to that effect; and (10) such additional information as the department may reasonably require. After certification, additional requirements are imposed related to restrictions on premiums that may be written, annual reports, dividends, assessments, and approval of forms and rates. Rates may not be excessive, inadequate, or unfairly discriminatory and must be filed with the department (now, office) for approval. But, the standard for excessiveness is limited to a determination of whether the expense factors are not justified or are not reasonable for the benefits and services provided. A fund has the burden of proving that a rate filed is adequate if, during the first 5 years of issuing policies, the fund files a rate that is below the rate for loss and loss adjustment expenses for the same type and classification of insurance that has been filed by the Insurance Services Office and approved by the department (office). (ss. 625.460-624.482, F.S.)

Insurance Rating Law for Property and Casualty Insurers

All property and casualty insurers, including medical malpractice insurers, authorized to do business in the state are required to file rates for approval with the Office of Insurance Regulation either 90 days before the proposed effective date ("file and use") or 30 days after the rate filing is implemented ("use and file").[2] Under the file and use option, the office may finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing. These notices are "agency action" for purposes of the Administrative Procedure Act, and give the insurer the right to choose an administrative hearing or binding arbitration. Prior to approving or disapproving a rate filing, the office may request additional supporting information for the filing from the insurer, but such a request does not toll the 90-day review period. If the office fails to issue a notice of intent to approve or disapprove within the 90-day review period, the filing is deemed approved. Under the "use and file" option, an insurance company may be ordered by the office to refund a portion of the rate to the policyholder in the form of a credit or refund if it is found to be excessive.

The office may disapprove a rate filing if it determines such rates to be "excessive, inadequate, or unfairly discriminatory." These terms are defined in the Florida Statutes in the following manner:[3]

[2] See s. 627.062, F.S.

[3] S. 627.062, F.S. The staff analysis refers to the Office of Insurance Regulation ("office") which is currently authorized to approve insurance rates, pursuant to ch. 2002-404, L.O.F., rather than referring to the Department of Insurance ("department") which is still referenced in s. 627.062, F.S.

(a) Rates are "excessive" if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.[4]

(b) Rates are "inadequate" if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Also, rates are deemed "inadequate" as to premium charged to a risk if discounts or credits are allowed which exceeded a reasonable reflection of expense savings and expected loss experience from the risk.

(c) Rates are "unfairly discriminatory" as to a risk if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[5]

In making its rating decision, the office must consider, in accordance with generally accepted and reasonable actuarial techniques, thirteen factors which affect the insurer's rate filing which include: past and prospective loss experience, expenses, market competition for the risk insured, investment income, the reasonableness of the judgment reflected in the rate filing, dividends, the adequacy of loss reserves, cost of reinsurance, trend factors, catastrophe hazards, profits, medical services (if applicable), and other relevant factors which impact upon the frequency or severity of claims or upon expenses.

The rating law allows insurers to request binding arbitration of a rate filing, as an alternative to an administrative hearing. After the office issues a notice of intent to disapprove a rate filing, the insurer may request arbitration before a panel of three arbitrators. The panel is chosen as follows: one is selected by the insurer, one by the office, and the third is chosen by the two other arbitrators. An arbitrator must be certified by the American Arbitration Association and may not be the employee of any insurance company or insurance regulator. The procedures outlined in the Arbitration Code (chapter 682, F.S.) are applied to rate arbitration and the costs of arbitration are paid by the insurer. The decision of the panel, which must be made within 90 days, constitutes the final approval of a rate filing. According to a spokesperson for the Office of Insurance Regulation, to date, no arbitration proceedings have been held for a medical malpractice rate filing.

The current law related to rating organizations is discussed in Effects of Proposed Changes, below, analyzing Section 4 of the bill.

Florida Deceptive and Unfair Trade Practices Act

Part II of ch. 501, F.S., is the Florida Deceptive and Unfair Trade Practices Act. One of the purposes of the Act is to protect the consuming public and legitimate business enterprises from those who engage in unfair methods of competition, or unconscionable, deceptive, or unfair acts

[4] Rates are also *excessive* if, among other things, the rate structure established by a stock company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.
[5] A rating plan, including discounts, credits, or surcharges, shall be deemed *unfairly discriminatory* if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program.

or practices in the conduct of *any* trade or commerce. Section 501.212, F.S., states that part II of ch. 501, F.S., does not apply to a variety of persons or activities, including any person or activity regulated under laws administered by the Department of Insurance.

Section 501.204, F.S., declares unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce unlawful. The state attorneys and the Department of Legal Affairs are the enforcing authorities. Section 501.207, F.S., specifies the actions that the enforcing authority may bring and prohibits an enforcing authority from bringing an action more than 4 years after the occurrence of a violation of this part or more than 2 years after the last payment in a transaction involved in a violation of this part, whichever is later.

Section 501.2075, F.S., provides for a civil penalty of $10,000 for each violation for willful violations. This penalty is increased to $15,000 for each violation if the willful violation victimizes or attempts to victimize senior citizens or handicapped persons. Section 501.2105, F.S., provides that the prevailing party may receive reasonable attorney's fees and costs from the non-prevailing party.

Reporting of Professional Liability Closed Claims

Certain insurers providing professional liability insurance to health care practitioners, and certain physicians and dentists licensed in Florida, are required to report liability claims, once they are closed, to various governmental agencies under state and federal law.

Section 627.912, F.S., requires each medical malpractice self-insurer and each insurer or joint underwriting association providing professional liability insurance to specified health care practitioners and facilities, health maintenance organizations, and members of the Florida Bar to report to the Department of Insurance (now, 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:

- A final judgment in any amount; or
- A settlement in any amount.

The former Department of Insurance has applied the closed claim reporting requirements to those insurers over which they have regulatory control, i.e. authorized insurers that have a certificate of authority from the department to write insurance in Florida. To the extent that health care providers are obtaining medical malpractice insurance through risk retention groups, surplus lines insurers, or offshore insurers, their closed claims are not being reported under s. 627.912, F.S. Also, claims attributable to health care practitioners who are not insured are not reported to the department (office).

Under s. 456.049, F.S., Florida-licensed physicians and dentists must report to the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a

claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and the claim resulted in:

- A final judgment in any amount;
- A settlement in any amount; or
- A final disposition not resulting in payment on behalf of the licensee.

The Health Care Quality Improvement Act of 1986 requires reporting of medical malpractice payments, sanctions taken by Boards of Medical Examiners, and professional review actions taken by health care entities to the National Practitioner Data Bank. Under 42 U.S.C. section 11131, each entity (including an insurance company) which 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 shall report information respecting the payment and circumstances thereof. The information to be reported includes:

- The name of any physician or licensed health care practitioner for whose benefit the payment is made;
- The amount of the payment;
- The name (if known) of any hospital with which the physician or practitioner is affiliated or associated;
- A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and

Such other information as the Secretary of the U.S. Department of Health and Human Services determines is required for appropriate interpretation of the information reported.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had ten meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into thirteen volumes that accompany the main report.

The following findings and recommendations relating to alternative professional liability insurance products are included in the final report of the Task Force. The Task Force found that "…the healthcare community has an option to address medical malpractice self-insurance programs. Further, the Task Force finds that the Department of Insurance does not have

sufficient rule making authority to provide protection to the health care professionals and the victims of medical malpractice utilizing or making claims against self-insurance funds."

The Task Force made three recommendations regarding alternative insurance products:

> *Recommendation 1.* The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.
>
> *Recommendation 2.* The Legislature should encourage the creation of self-insurance options for healthcare providers.
>
> *Recommendation 3.* The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to insure they remain solvent and provide the insurance coverage purchased by participants.

III. Effect of Proposed Changes:

Section 1. Amends s. 501.212, F.S., relating to the application of the Florida Deceptive and Unfair Trade Practices Act, to remove an existing exemption for any person or activity regulated under laws administered by the Department of Insurance. The effect would be that the provisions of part II, ch. 501, F.S., would now apply to persons or activities regulated by the Department of Insurance.

Section 2. Creates s. 624.156, F.S., to make the business of insurance subject to the laws of this state applicable to any other business, including, but not limited to: the Florida Civil Rights Act of 1992 in part I, ch. 760, F.S.; the Florida Antitrust Act of 1980 in ch. 542, F.S.; the Florida Deceptive and Unfair Trade Practices Act in part II, ch. 501, F.S.; and the consumer protection provisions in ch. 540, F.S. The protections afforded consumers by these laws are made to apply to insurance consumers. This section may not be construed to prohibit certain insurance activities, including:

- Any agreement to collect, compile, and disseminate historical data on paid claims or reserves for reported claims, provided this data is contemporaneously transmitted to the Office of Insurance Regulation and is available for public inspection;
- Participation in joint arrangements established by law or the Office of Insurance Regulation to assure availability of insurance;
- Any agent or broker from obtaining information from an insurer the agent or broker represents relative to the premium for any policy or risk to be underwritten by the insurer;
- Any agent or broker from disclosing to an insurer the agent or broker represents any quoted rate or charge offered by another insurer for the purpose of negotiating a lower rate, charge, or term; and
- Any agents, brokers, or insurers from using, or participating with multiple insurers or reinsurers for underwriting, a single risk or group of risks.

This section appears to allow additional state agencies to potentially regulate insurance, including the Attorney General and the Commission on Human Rights. This section applies to all lines of insurance (not just medical malpractice).

Section 3. Amends s. 624.462, F.S., to allow 10 or more health care providers to form a commercial self-insurance fund under ss. 624.460-624.488. The definition of *health care provider* that is cited in s. 627.351(4)(h), F.S., includes a hospital, physician, osteopath, chiropractor, naturopath, nurse, midwife, clinical laboratory, physician assistant, physical therapist, physical therapist assistant, health maintenance organization, ambulatory surgical center, blood bank, plasma center, industrial clinic, renal dialysis facility, and other medical facilities meeting certain criteria, as well as professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

The bill, in effect, allows 10 or more health care providers to form a commercial self-insurance fund, where today such a fund for medical malpractice could be formed only if it is formed by a not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated in Florida, 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. Otherwise, all of the current requirements for such a fund, as described in Present Situation, would continue to apply.

Section 4. Amends s. 627.041, F.S., to modify the definitions of "rating organization," and "advisory organization," as those terms are used in part I, ch. 627, F.S., relating to insurance rates and rating organizations. The definition of "rating organization" is amended to change the purpose of such an organization from *making rates, rating plans, or rating systems*, to *collecting, compiling, and disseminating historical data on paid claims or reserves for reported claims*.

The definition of "advisory organization" is changed to limit the activities of such organizations to the preparation of policy forms. The bill deletes the authority of such organizations to make underwriting rules or to collect and furnish to insurers or rating organizations loss or expense statistics or other statistical information and data in an advisory capacity.

Currently rating organizations such as the Insurer Services Office (ISO) and the Automobile Insurance Plans Services Office (AIPSO) develop and file loss costs, but do not actually file rates. However, the National Council on Compensation Insurers (NCCI) does file rates on behalf of workers' compensation insurers in Florida. The bill appears to effectively change the way all such organizations and others make filings. Loss costs typically take into account information other than historical data. It is not clear if such other information could still be used, such as trend and loss development factors and incurred by not reported losses. Individual insurers would be required to have greater expertise in making rates. Insurers could apparently adopt the loss costs filed by a rating organization, but may be required to file their own loss cost multiplier, as well as trend and loss development factors. (But, see Section 6, below which further restricts concerted action by insurers.)

Section 5. Amends s. 627.062, F.S., relating to rate filings for medical malpractice insurance, under the section that provides for rate regulation of property, casualty, and surety insurance. The bill provides that an insurer that makes a medical malpractice rate filing, would not be permitted to require arbitration of the rate filing after the rate has been disapproved by the department (now, the Office of Insurance Regulation). More specifically, an insurer is currently allowed to require arbitration after "any action with respect to a rate filing that constitutes agency

action," which would no longer be allowed for an insurer that makes a medical malpractice rate filing. Therefore, if the office disapproved a medical malpractice rate filing, the insurer would only have the options available under the Administrative Procedures Act to request a formal or informal hearing.

Section 6. Amends s. 627.314, F.S., which currently authorizes two or more insurers to act in concert with each other and with others for specified purposes. The bill deletes the authorization for concerted action in the making of rates or rating systems, the preparation of underwriting rules, and the furnishing of loss or expense statistics or other information and data. In its place, the bill would allow two or more insurers to act in concert with respect to any matters pertaining to collecting, compiling, and disseminating historical data on paid claims or reserve for reported claims. The bill maintains an existing provision that states that insurers that have a common ownership or are operating in the state under common management or control are authorized to act in concert as if they constituted a single insurer.

Members and subscribers of rating or advisory organizations may no longer use the rates, rating systems, and underwriting rules of such organizations. For example, this would appear to prohibit the use of underwriting rules that are contained in ISO's commercial lien manual. The bill deletes authorization for licensed rating organizations and authorized insurers to exchange information and experience data with rating organizations and insurers in this and other states and to consult with them about ratemaking and the application of rating systems.

Section 7. Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts, to require the insurer or self-insurer to notify the insured no less than 90 days, rather than 60 days, prior to the effective data of cancellation or nonrenewal of a policy or contract. In addition, the insurer or self-insurer must give 90-days notice prior to the effective date of a rate increase. Currently, under s. 627.4133, F.S., all property and casualty insurers, which includes medical malpractice insurers, must provide at least 45-days written notice of the renewal premium.

The bill requires medical malpractice insurers to apply a discount or surcharge on a health care provider's premium based on the provider's loss experience, including state disciplinary action. The insurer may establish an alternative method of considering the provider's loss experience. The insurer must include a schedule of all discounts and surcharges or a description of alternative methods in all filings with the Office of Insurance Regulation and must also provide them to policyholders or prospective policyholders. Medical malpractice insurers may not use any rate or charge any premium unless the director of the Office of Insurance Regulation has approved such schedule or alternative method.

The bill deletes a prohibition against medical malpractice insurers requiring the insured to be a member in good standing of a duly recognized state or local professional society of health care providers which maintains a medical review committee. The bill also deletes a prohibition against a professional society expelling or suspending a member solely because he or she participates in a health maintenance organization.

The changes to s. 627.4147, F.S., are made to apply to all policies issued or renewed after July 1, 2003.

Section 8. Amends s. 627.912, F.S., relating to reporting of professional liability claims and actions by insurers, to increase the upper limit of the fine for violations of the reporting requirements by an insurer, from $1,000 per case to $10,000 per case.

The bill requires insurers reporting closed claims for professional liability to 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:

- Direct premiums written;
- Direct premiums earned;
- Incurred loss and loss expense developed according to a specified formula;
- Incurred expenses allocated separately to commissions, other acquisition costs, general expenses, taxes, licenses, and fees;
- Policyholder dividends;
- Underwriting gain or loss;
- Net investment income, including net realized capital gains and losses;
- Federal income taxes; and
- Net income.

The director of the Office of Insurance Regulation is authorized to levy an administrative fine of $1,000 per day against an insurer that fails to comply with the above reporting requirements.

The bill directs the director of the Office of Insurance Regulation to prepare an annual report no later than July 1 that summarizes the information submitted under s. 627.912, F.S. The first report, covering calendar year 2002, must be delivered to the Governor, the President of the Senate and the Speaker of the House of Representatives on or before October 1, 2003. Subsequent reports must be filed on or before March 1 for each prior year.

Section 9. Creates s. 627.41491, F.S., to require the Office of Insurance Regulation to provide health care providers with a comparison of the rate in effect for each medical malpractice insurer and self-insurer and the Florida Medical Malpractice Joint Underwriting Association (FMMJUA). The comparison chart is to be made available to the public through the Internet and other commonly used means of distribution no later than July 1 of each year.

Section 10. Creates s. 627.41493, F.S., to require medical malpractice insurance rate rollbacks. For any coverage for medical malpractice insurance subject to ch. 627, F.S., that is issued or renewed on or after July 1, 2003, every insurer must reduce its charges to levels that are at least 20 percent less than the charges for the same coverage that were in effect on January 1, 2001. According to the Office of Insurance Regulation, this equates to about a 60 percent rate rollback compared to rates that are currently in effect.

Between July 1, 2003, and July 1, 2004, rates and premiums that have been reduced as prescribed above may only be increased if the director of the Office of Insurance Regulation finds, after a hearing, that an insurer or self-insurer or the FMMJUA is unable to earn a fair rate of return. Beginning July 1, 2003, insurance rates for medical malpractice must be approved by

the director of the Office of Insurance Regulation prior to being used. Each separate affiliate of an insurer is subject to this section.

Section 11. Creates s. 627.41495, F.S., to require consumer participation in rate review. Medical malpractice insurers, self-insurers, or risk retention groups, upon the filing of a proposed rate change, must give notice to the public and to its insureds. The rate filing must be available for public inspection. If the insureds request a hearing within 30 days after the mailing of the notification of the proposed rate changes, the director of the Office of Insurance Regulation must hold a hearing within 30 days after such request. Any consumer may participate in the hearing. The Office of Insurance Regulation is authorized to adopt rules governing participation by consumers.

Section 12. Authorizes the Office of Insurance Regulation to adopt rules to administer this act.

Section 13. Provides that this act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The requirement for insurers to roll back rates by 20 percent below the rate in effect for January 1, 2001, even if such rates are inadequate, may raise constitutional issues of substantive due process and unlawful taking of property.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There is no apparent actuarial justification for the requirement for a rate rollback of medical malpractice rates to 20 percent below January 1, 2001 levels, which the Office of Insurance Regulation estimates equates to about a 60 percent rollback from rates currently in effect. If insurers continue writing medical malpractice insurance, they are likely to experience financial losses. More likely, by requiring rate rollbacks, rate

hearing, and 90 days notice of rate increases, the eight remaining medical malpractice insurers that are currently issuing coverage in Florida, may elect to terminate or restrict the offering of such coverage. Other insurers may be unwilling to enter the Florida insurance market under such restrictions.

The bill would allow the insurer to increase rates beginning July 1, 2003, until July 1, 2004, if the director of the Office of Insurance Regulation finds, after a hearing that the insurer is unable to earn a fair rate of return. It is not clear how much time may elapse between the effective date of the rollback (the date on or after July 1, 2003, when a policy is issued or renewed) and the date of the possibly increased rate (the effective date of a policy on or after July 1, 2003, and before July 1, 2004, for which the office approves an increased rate). Given the 90-day notice and public hearing requirements, there would appear to be some period where the rolled back rates must be in effect, for which the insurer may simply refuse to issue or renew coverage until a higher rate has been approved.

Also, the change in law regarding the uses of national rate and form filings could also discourage insurers from writing insurance in Florida.

The bill generally eliminates the authority for rating organizations to file rates and loss costs. All property and casualty insurers would be required to collect data an individually develop rates, rating manuals and underwriting manuals. This may increase competition, but would result in administrative costs to insurers. This appears to have the most significant impact on worker's compensation insurance, by eliminating the ability of NCCI to produce rates for its members. Each insurer writing worker's compensation would appear to be required to file their own rates and rating plans.

To the extent that medical malpractice insurers are willing to offer coverage in Florida, health care providers would enjoy a significant decrease in their rates for coverage, and would be provided greater protections against rate increases.

The bill allows the formation of a commercial self-insurance fund by 10 or more health care providers. The current law provides a fair degree of solvency standards for such funds, but member assessments remain the ultimate solvency requirement, rather than a surplus requirement. With regard to rates for coverage, the absence of a profit factor (usually about 5 percent of premium) and, possibly, lower expenses, could result in lower rates as compared to authorized insurers. But, the portion of the rate that covers expected claims (discounted for expected investment income) should be approximately the same as amounts charged by an authorized insurer, subject to the actual claims experience of the insurer or fund. If rates turn out to be inadequate and a deficit exists, member insureds of a self-insurance fund must be assessed.

C. Government Sector Impact:

Unknown. The Office of Insurance Regulation has not been able to estimate the impact of this bill, but anticipates additional costs due to the following:

- requiring the creation of a rate filing program to receive historical data on claims or reserves for reported claims;
- requiring the OIR to issue an annual report requiring new information and re-formatting of excerpts from data that are otherwise filed with financial solvency reporting and claims experience information associated with rate change filings;
- requiring the creation of a new rate program to be available to all health care providers.
- requiring a public hearing upon request of any insured affected by a medical malpractice rate change.

VI. Technical Deficiencies:

The amendment to s. 627.4147, F.S., requiring 90-days notice of a rate increase for medical malpractice, applies to all policies issued or renewed after July 1, 2003. The notice of a rate increase for a policy renewed on July 1 would have to be provided by around April 1, which is prior to the date the bill would become law.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.