**By** Senator Peaden

2-948-03 See HB 1129

1 A bill to be entitled
2 An act relating to insurance; amending s.
3 501.212, F.S.; deleting an exclusion from
4 application of deceptive and unfair trade
5 practices provisions to the Department of
6 Insurance; creating s. 624.156, F.S.; providing
7 that certain consumer protection laws apply to
8 the business of insurance; amending s. 627.041,
9 F.S.; revising definitions; amending s.
10 627.062, F.S.; specifying nonapplication to
11 professional medical malpractice insurance;
12 amending s. 627.314, F.S.; revising certain
13 authorized actions multiple insurers may engage
14 in together; prohibiting certain conduct on the
15 part of insurers; amending s. 627.357, F.S.;
16 deleting a prohibition against forming a
17 medical malpractice self-insurance fund;
18 amending s. 627.4147, F.S.; revising certain
19 notification criteria; providing for
20 application of a discount or surcharge or
21 alternative method based on loss experience in
22 determining the premium paid by a health care
23 provider; providing requirements; providing a
24 limitation; amending s. 627.912, F.S.;
25 increases the limit on a fine; requiring
26 provision of certain financial information to
27 the Office of Insurance Regulation; authorizing
28 an administrative fine for failure to comply;
29 requiring the director of the office to prepare
30 and submit to the Governor and Legislature an
31 annual report; creating s. 627.41491, F.S.;

1 requiring the Office of Insurance Regulation to
2 provide health care providers with a full
3 disclosure of certain rate comparison
4 information each year; creating s. 627.41493,
5 F.S.; requiring a medical malpractice insurance
6 rate rollback; providing for subsequent
7 increases under certain circumstances;
8 requiring approval for use of certain medical
9 malpractice insurance rates; creating s.
10 627.41495, F.S.; providing for consumer
11 participation in review of medical malpractice
12 rate changes; providing for public inspection;
13 providing for adoption of rules by the Office
14 of Insurance Regulation; creating s. 627.41497,
15 F.S.; requiring certain medical malpractice
16 insurance rates to be set by the director of
17 the Office of Insurance Regulation; providing
18 for approval of rate filings; requiring
19 insurers to apply for certain rates, schedules,
20 and manuals; providing procedures for
21 application and review; providing review
22 criteria; providing approval standards;
23 authorizing the office to require certain
24 additional information for review; requiring
25 adoption of certain rules; providing for
26 reports of certain information; requiring the
27 office to retain such reports for a time
28 certain; requiring medical malpractice insurers
29 to file certain information with the office;
30 authorizing the office to review rates,
31 schedules, manuals, or rate changes at any time



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for certain purposes; providing procedures;
requiring the office to issue orders for
setting new rates; prohibiting the office from
prohibiting insurers from paying certain
acquisition costs for certain purposes;
providing application; excluding certain
judgment or settlement amounts, taxable costs,
and attorney's fees from inclusion in an
insurer's rate base; 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. Subsection (4) of section 501.212, Florida Statutes, is amended to read:

501.212 Application.--This part does not apply to:

(4) ~~Any person or activity regulated under laws administered by the Department of Insurance or~~ Banks and savings and loan associations regulated by the Department of Banking and Finance or banks or savings and loan associations regulated by federal agencies.

Section 2. Section 624.156, Florida Statutes, is created to read:

624.156 Applicability of consumer protection laws to the business of insurance.--

(1) Notwithstanding any provision of law to the contrary, the business of insurance shall be subject to the laws of this state applicable to any other business, including, but not limited to, the Florida Civil Rights Act of 1992 set forth in part I of chapter 760, the Florida Antitrust



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1 Act of 1980 set forth in chapter 542, the Florida Deceptive
2 and Unfair Trade Practices Act set forth in part II of chapter
3 501, and the consumer protection provisions contained in
4 chapter 540. The protections afforded consumers by chapters
5 501, 540, 542, and 760 shall apply to insurance consumers.
6 (2) Nothing in this section shall be construed to
7 prohibit:
8 (a) Any agreement to collect, compile, and disseminate
9 historical data on paid claims or reserves for reported
10 claims, provided such data is contemporaneously transmitted to
11 the Office of Insurance Regulation and made available for
12 public inspection.
13 (b) Participation in any joint arrangement established
14 by law or the Office of Insurance Regulation to assure
15 availability of insurance.
16 (c) Any agent or broker, representing one or more
17 insurers, from obtaining from any insurer such agent or broker
18 represents information relative to the premium for any policy
19 or risk to be underwritten by that insurer.
20 (d) Any agent or broker from disclosing to an insurer
21 the agent or broker represents any quoted rate or charge
22 offered by another insurer represented by that agent or broker
23 for the purpose of negotiating a lower rate, charge, or term
24 from the insurer to whom the disclosure is made.
25 (e) Any agents, brokers, or insurers from using, or
26 participating with multiple insurers or reinsurers for
27 underwriting, a single risk or group of risks.
28 Section 3. Subsections (3) and (4) of section 627.041,
29 Florida Statutes, are amended to read:
30 627.041 Definitions.--As used in this part:
31

1 (3) "Rating organization" means every person, other
2 than an authorized insurer, whether located within or outside
3 this state, who has as his or her object or purpose the
4 collecting, compiling, and disseminating historical data on
5 paid claims or reserves for reported claims ~~making of rates,~~
6 ~~rating plans, or rating systems~~. Two or more authorized
7 insurers that act in concert for the purpose of collecting,
8 compiling, and disseminating historical data on paid claims or
9 reserves for reported claims ~~making rates, rating plans, or~~
10 ~~rating systems~~, and that do not operate within the specific
11 authorizations contained in ss. 627.311, 627.314(2),~~(4),~~and
12 627.351, shall be deemed to be a rating organization. No
13 single insurer shall be deemed to be a rating organization.
14 (4) "Advisory organization" means every group,
15 association, or other organization of insurers, whether
16 located within or outside this state, which prepares policy
17 forms ~~or makes underwriting rules incident to but not~~
18 ~~including the making of rates, rating plans, or rating systems~~
19 ~~or which collects and furnishes to authorized insurers or~~
20 ~~rating organizations loss or expense statistics or other~~
21 ~~statistical information and data and acts in an advisory, as~~
22 ~~distinguished from a ratemaking, capacity~~.
23 Section 4. Subsection (7) is added to section 627.062,
24 Florida Statutes, to read:
25 627.062 Rate standards.--
26 (7) This section shall not apply to professional
27 medical malpractice insurance.
28 Section 5. Section 627.314, Florida Statutes, is
29 amended to read:
30 627.314 Concerted action by two or more insurers.--
31



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(1) Subject to and in compliance with the provisions of this part authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to:

(a) Collecting, compiling, and disseminating historical data on paid claims or reserve for reported claims ~~The making of rates or rating systems except for private passenger automobile insurance rates~~;

(b) The preparation or making of insurance policy or bond forms, ~~underwriting rules,~~surveys, inspections, and investigations;

~~(c) The furnishing of loss or expense statistics or other information and data;~~or

(c)~~(d)~~ The carrying on of research.

(2) With respect to any matters pertaining to the making of rates or rating systems; the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections, and investigations; the furnishing of loss or expense statistics or other information and data; or the carrying on of research, two or more authorized insurers having a common ownership or operating in the state under common management or control are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer. To the extent that such matters relate to cosurety bonds, two or more authorized insurers executing such bonds are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

(3)(a) Members and subscribers of rating or advisory organizations may use the ~~rates, rating systems, underwriting rules, or~~ policy or bond forms of such organizations, either consistently or intermittently~~; but, except as provided in subsection (2) and ss. 627.311 and 627.351, they shall not agree with each other or rating organizations or others to adhere thereto~~.

~~(b) The fact that two or more authorized insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization or the underwriting rules or policy or bond forms prepared by a rating or advisory organization shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement.~~

(b)~~(c)~~ This subsection does not apply as to workers' compensation and employer's liability insurances.

~~(4) Licensed rating organizations and authorized insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to ratemaking and the application of rating systems.~~

(4)~~(5)~~ Upon compliance with the provisions of this part applicable thereto, any rating organization or advisory organization, and any group, association, or other organization of authorized insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof, may conduct operations in this state. As respects insurance risks or

1 operations in this state, no insurer shall be a member or
2 subscriber of any such organization, group, or association
3 that has not complied with the provisions of this part
4 applicable to it.
5 (5)~~(6)~~ Notwithstanding any other provisions of this
6 part, insurers shall not participate directly or indirectly in
7 the deliberations or decisions of rating organizations on
8 private passenger automobile insurance. However, such rating
9 organizations shall, upon request of individual insurers, be
10 required to furnish at reasonable cost the rate indications
11 resulting from the loss and expense statistics gathered by
12 them. Individual insurers may modify the indications to
13 reflect their individual experience in determining their own
14 rates. Such rates shall be filed with the department for
15 public inspection whenever requested and shall be available
16 for public announcement only by the press, department, or
17 insurer.
18 Section 6. Subsection (10) of section 627.357, Florida
19 Statutes, is amended to read:
20 627.357 Medical malpractice self-insurance.--
21 ~~(10) A self-insurance fund may not be formed under~~
22 ~~this section after October 1, 1992.~~
23 Section 7. Section 627.4147, Florida Statutes, is
24 amended to read:
25 627.4147 Medical malpractice insurance contracts.--
26 (1) In addition to any other requirements imposed by
27 law, each self-insurance policy as authorized under s. 627.357
28 or insurance policy providing coverage for claims arising out
29 of the rendering of, or the failure to render, medical care or
30 services, including those of the Florida Medical Malpractice
31 Joint Underwriting Association, shall include:

1 (a) A clause requiring the insured to cooperate fully
2 in the review process prescribed under s. 766.106 if a notice
3 of intent to file a claim for medical malpractice is made
4 against the insured.
5 (b)1. Except as provided in subparagraph 2., a clause
6 authorizing the insurer or self-insurer to determine, to make,
7 and to conclude, without the permission of the insured, any
8 offer of admission of liability and for arbitration pursuant
9 to s. 766.106, settlement offer, or offer of judgment, if the
10 offer is within the policy limits. It is against public policy
11 for any insurance or self-insurance policy to contain a clause
12 giving the insured the exclusive right to veto any offer for
13 admission of liability and for arbitration made pursuant to s.
14 766.106, settlement offer, or offer of judgment, when such
15 offer is within the policy limits. However, any offer of
16 admission of liability, settlement offer, or offer of judgment
17 made by an insurer or self-insurer shall be made in good faith
18 and in the best interests of the insured.
19 2.a. With respect to dentists licensed under chapter
20 466, a clause clearly stating whether or not the insured has
21 the exclusive right to veto any offer of admission of
22 liability and for arbitration pursuant to s. 766.106,
23 settlement offer, or offer of judgment if the offer is within
24 policy limits. An insurer or self-insurer shall not make or
25 conclude, without the permission of the insured, any offer of
26 admission of liability and for arbitration pursuant to s.
27 766.106, settlement offer, or offer of judgment, if such offer
28 is outside the policy limits. However, any offer for admission
29 of liability and for arbitration made under s. 766.106,
30 settlement offer, or offer of judgment made by an insurer or
31



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1 self-insurer shall be made in good faith and in the best
2 interest of the insured.
3 b. If the policy contains a clause stating the insured
4 does not have the exclusive right to veto any offer or
5 admission of liability and for arbitration made pursuant to s.
6 766.106, settlement offer or offer of judgment, the insurer or
7 self-insurer shall provide to the insured or the insured's
8 legal representative by certified mail, return receipt
9 requested, a copy of the final offer of admission of liability
10 and for arbitration made pursuant to s. 766.106, settlement
11 offer or offer of judgment and at the same time such offer is
12 provided to the claimant. A copy of any final agreement
13 reached between the insurer and claimant shall also be
14 provided to the insurer or his or her legal representative by
15 certified mail, return receipt requested not more than 10 days
16 after affecting such agreement.
17 (c) A clause requiring the insurer or self-insurer to
18 notify the insured no less than 90 ~~60~~ days prior to the
19 effective date of a rate increase or cancellation of the
20 policy or contract and, in the event of a determination by the
21 insurer or self-insurer not to renew the policy or contract,
22 to notify the insured no less than 90 ~~60~~ days prior to the end
23 of the policy or contract period. If cancellation or
24 nonrenewal is due to nonpayment or loss of license, 10 days'
25 notice is required.
26 (2) In determining the premium paid by any health care
27 provider, a medical malpractice insurer shall apply a discount
28 or surcharge based on the provider's loss experience,
29 including state disciplinary action, or shall establish an
30 alternative method giving due consideration to the provider s
31 loss experience. The insurer shall include a schedule of all



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such discounts and surcharges or a description of such alternative method in all filings the insurer makes with the director of the Office of Insurance Regulation. Such schedule or description of alternative method shall also be provided to policyholders or prospective policyholders. No medical malpractice liability insurer may 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.~~Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which maintains a medical review committee. No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.~~

(3) This section shall apply to all policies issued or renewed after July 1, 2003 ~~October 1, 1985~~.

Section 8. Section 627.912, Florida Statutes, is amended to read:

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

(1) Each self-insurer authorized under s. 627.357 and each insurer or 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

1 394, to a health maintenance organization certificated under
2 part I of chapter 641, to clinics included in chapter 390, to
3 an ambulatory surgical center as defined in s. 395.002, or to
4 a member of The Florida Bar shall report in duplicate to the
5 Department of Insurance any claim or action for damages for
6 personal injuries claimed to have been caused by error,
7 omission, or negligence in the performance of such insured's
8 professional services or based on a claimed performance of
9 professional services without consent, if the claim resulted
10 in:
11 (a) A final judgment in any amount.
12 (b) A settlement in any amount.
13
14 Reports shall be filed with the department and, if the insured
15 party is licensed under chapter 458, chapter 459, chapter 461,
16 or chapter 466, with the Department of Health, no later than
17 30 days following the occurrence of any event listed in
18 paragraph (a) or paragraph (b). The Department of Health shall
19 review each report and determine whether any of the incidents
20 that resulted in the claim potentially involved conduct by the
21 licensee that is subject to disciplinary action, in which case
22 the provisions of s. 456.073 shall apply. The Department of
23 Health, as part of the annual report required by s. 456.026,
24 shall publish annual statistics, without identifying
25 licensees, on the reports it receives, including final action
26 taken on such reports by the Department of Health or the
27 appropriate regulatory board.
28 (2) The reports required by subsection (1) shall
29 contain:
30 (a) The name, address, and specialty coverage of the
31 insured.



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1 (b) The insured's policy number.
2 (c) The date of the occurrence which created the
3 claim.
4 (d) The date the claim was reported to the insurer or
5 self-insurer.
6 (e) The name and address of the injured person. This
7 information is confidential and exempt from the provisions of
8 s. 119.07(1), and must not be disclosed by the department
9 without the injured person's consent, except for disclosure by
10 the department to the Department of Health. This information
11 may be used by the department for purposes of identifying
12 multiple or duplicate claims arising out of the same
13 occurrence.
14 (f) The date of suit, if filed.
15 (g) The injured person's age and sex.
16 (h) The total number and names of all defendants
17 involved in the claim.
18 (i) The date and amount of judgment or settlement, if
19 any, including the itemization of the verdict, together with a
20 copy of the settlement or judgment.
21 (j) In the case of a settlement, such information as
22 the department may require with regard to the injured person's
23 incurred and anticipated medical expense, wage loss, and other
24 expenses.
25 (k) The loss adjustment expense paid to defense
26 counsel, and all other allocated loss adjustment expense paid.
27 (l) The date and reason for final disposition, if no
28 judgment or settlement.
29 (m) A summary of the occurrence which created the
30 claim, which shall include:
31

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 department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.

(3) Upon request by the Department of Health, the department shall provide the Department of Health with any information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. For purposes of safety management, the department shall annually provide the Department of Health with copies of the reports in cases resulting in an indemnity being paid to the claimants.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer reporting hereunder or its agents or employees or the department or its employees for any action taken by them under this section. The department may impose a fine of $250 per day per case, but not to exceed a total of $10,000 ~~$1,000~~ per case, against an insurer that violates the requirements of



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1 this section. This subsection applies to claims accruing on or
2 after October 1, 1997.
3 (5) Any self-insurance program established under s.
4 1004.24 shall report in duplicate to the Department of
5 Insurance any claim or action for damages for personal
6 injuries claimed to have been caused by error, omission, or
7 negligence in the performance of professional services
8 provided by the state university board of trustees through an
9 employee or agent of the state university board of trustees,
10 including practitioners of medicine licensed under chapter
11 458, practitioners of osteopathic medicine licensed under
12 chapter 459, podiatric physicians licensed under chapter 461,
13 and dentists licensed under chapter 466, or based on a claimed
14 performance of professional services without consent if the
15 claim resulted in a final judgment in any amount, or a
16 settlement in any amount. The reports required by this
17 subsection shall contain the information required by
18 subsection (3) and the name, address, and specialty of the
19 employee or agent of the state university board of trustees
20 whose performance or professional services is alleged in the
21 claim or action to have caused personal injury.
22 (6) Each entity required to report closed claims for
23 the classification of insurance set forth in subsection (1)
24 shall also provide to the Office of Insurance Regulation the
25 following financial information, specific to this state and
26 countrywide, if applicable, for the prior calendar year:
27 (a) Direct premiums written.
28 (b) Direct premiums earned.
29 (c) Incurred loss and loss expense developed according
30 to the formula A + B - C + D - E + F + G - H, for which A
31 equals the dollar amount of losses paid, B equals the reserves

1 for reported claims at the end of the current year, C equals
2 the reserves for reported claims at the end of the previous
3 year, D equals the reserves for incurred but not reported
4 claims at the end of the current year, E equals the reserves
5 for incurred but not reported claims at the end of the
6 previous year, F equals loss adjustment expenses paid, G
7 equals the reserves for loss adjustment expenses at the end of
8 the current year, and H equals the reserves for loss
9 adjustment expenses at the end of the previous year.
10 (d) Incurred expenses allocated separately to
11 commissions, other acquisition costs, general expenses, taxes,
12 licenses, and fees, using appropriate estimates when
13 necessary.
14 (e) Policyholder dividends.
15 (f) Underwriting gain or loss.
16 (g) Net investment income, including net realized
17 capital gains and losses, using appropriate estimates where
18 necessary.
19 (h) Federal income taxes.
20 (i) Net income.
21 (7) The director of the Office of Insurance Regulation
22 may levy an administrative fine of $1,000 per day against any
23 insurer failing to comply with the reporting requirements of
24 this section.
25 (8) The director of the Office of Insurance Regulation
26 shall prepare an annual report no later than July 1 that
27 summarizes the information submitted pursuant to this section.
28 Such summary shall be prepared on an aggregate basis. A copy
29 of the report shall be delivered to the Governor, the
30 President of the Senate, and the Speaker of the House of
31 Representatives. The first report submitted pursuant to this

1 subsection shall be delivered on or before October 1, 2003,
2 for the calendar year 2002. Subsequent reports shall be filed
3 on or before March 1 for each prior year.
4 Section 9. Section 627.41491, Florida Statutes, is
5 created to read:
6 627.41491 Full disclosure of insurance
7 information.--The Office of Insurance Regulation shall provide
8 health care providers with a comparison of the rate in effect
9 for each medical malpractice insurer and self-insurer and the
10 Florida Medical Malpractice Joint Underwriting Association.
11 Such rate comparison chart shall be made available to the
12 public through the Internet and other commonly used means of
13 distribution no later than July 1 of each year.
14 Section 10. Section 627.41493, Florida Statutes, is
15 created to read:
16 627.41493 Insurance rate rollback.--
17 (1) For any coverage for medical malpractice insurance
18 subject to this chapter issued or renewed on or after July 1,
19 2003, every insurer shall reduce its charges to levels that
20 are at least 20 percent less than the charges for the same
21 coverage that were in effect on January 1, 2001.
22 (2) Between July 1, 2003, and July 1, 2004, rates and
23 premiums reduced pursuant to subsection (1) may only be
24 increased if the director of the Office of Insurance
25 Regulation finds, after a hearing, that an insurer or
26 self-insurer or the Florida Medical Malpractice Joint
27 Underwriting Association is substantially threatened with
28 insolvency.
29 (3) Commencing July 1, 2003, insurance rates for
30 medical malpractice subject to this chapter must be approved
31



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1 by the director of the Office of Insurance Regulation prior to
2 being used.
3 (4) Any separate affiliate of an insurer is subject to
4 the provisions of this section.
5 Section 11. Section 627.41495, Florida Statutes, is
6 created to read:
7 627.41495 Consumer participation in rate review.--
8 (1) Upon the filing of a proposed rate change by a
9 medical malpractice insurer, self-insurer, or risk retention
10 group, the director of the Office of Insurance Regulation
11 shall require the insurer, self-insurer, or risk retention
12 group to give notice to the public and to the insureds or
13 associations of insureds of the insurer, self-insurer, or risk
14 retention group making the filing.
15 (2) The rate filing shall be available for public
16 inspection. If any insureds or associations of insureds of the
17 insurer, self-insurer, or risk retention group filing the
18 proposed rate change request the director of the Office of
19 Insurance Regulation to hold a hearing within 30 days after
20 the mailing of the notification of the proposed rate changes
21 to the insureds, the director shall hold a hearing within 30
22 days after such request. Any consumer may participate in such
23 hearing, and the office shall adopt rules governing such
24 participation.
25 Section 12. Section 627.41497, Florida Statutes, is
26 created to read:
27 627.41497 Medical malpractice rate standards; prior
28 approval of rates.--
29 (1) In addition to any other requirements imposed by
30 law, the rates for each self-insurance policy as authorized
31 under s. 627.357 or insurance policy providing coverage for



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1 claims arising out of the rendering of, or the failure to
2 render, medical care or services shall be set by the director
3 of the Office of Insurance Regulation and shall not be
4 excessive, inadequate, or unfairly discriminatory.
5 (2) As to all rate filings subject to approval in
6 accordance with this section:
7 (a) Insurers or rating organizations shall apply for
8 rates, rating schedules, or rating manuals to allow the
9 insurer a reasonable rate of return on such classes of
10 insurance written in this state. A copy of rates, rating
11 schedules, rating manuals, premium credits, or discount
12 schedules and surcharge schedules, and changes to such rates,
13 schedules, manuals, and credits, shall be filed with the
14 Office of Insurance Regulation. The filing shall be made at
15 least 180 days before the proposed effective date and shall
16 not be implemented during the review of the filing by the
17 Office of Insurance Regulation, any proceeding, or judicial
18 review.
19 (b) Upon receiving a rate filing and within a
20 reasonable time after such receipt, the Office of Insurance
21 Regulation shall review the rate filing and set a rate or rate
22 schedule that is not excessive, inadequate, or unfairly
23 discriminatory. In making such determination, the office
24 shall, in accordance with generally accepted and reasonable
25 actuarial techniques, use the following factors:
26 1. Past and prospective loss experience within and
27 without this state and the insurer's or self-insurer's past
28 and prospective loss experience within this state, if
29 applicable. A medical malpractice insurer shall consider past
30 and prospective loss experience and catastrophic hazards, if
31 any, solely within this state. However, if there is

1 insufficient experience within this state upon which a rate
2 can be based, the insurer may consider experiences within any
3 other state or states that have a similar cost of claim and
4 frequency of claim experience as this state and, if
5 insufficient experience is available, the insurer may use
6 nationwide experience. The insurer, in its rate filing or in
7 its records, shall expressly show the rate experience it is
8 using. In considering experience outside this state, as much
9 weight as possible shall be given to state experience.
10 2. Past and prospective expenses.
11 3. Investment income reasonably expected by the
12 insurer, consistent with the insurer's investment practices,
13 from investable premiums anticipated in the filing, plus any
14 other expected income from currently invested assets
15 representing the amount expected on unearned premium reserves,
16 loss reserves, and surplus. The Office of Insurance Regulation
17 may adopt rules using reasonable techniques of actuarial
18 science and economics to specify the manner in which insurers
19 shall calculate investment income attributable to such classes
20 of insurance written in this state and the manner in which
21 such investment income shall be used in the calculation of
22 insurance rates. The profit and contingency factor as
23 specified in the filing shall be used in computing excess
24 profits in conjunction with s. 627.215.
25 4. The reasonableness of the judgment reflected in the
26 filing.
27 5. Dividends, savings, or unabsorbed premium deposits
28 allowed or returned to policyholders, members, or subscribers
29 in this state.
30 6. The adequacy of loss reserves.
31 7. The cost of reinsurance.

1 8. Trend factors, including trends in actual losses
2 per insured unit for the insurer making the filing.
3 9. A reasonable margin for underwriting profit and
4 contingencies.
5 10. The cost of medical services.
6 11. Other relevant factors that impact upon the
7 frequency or severity of claims or upon expenses.
8 (c) After consideration of the rate factors provided
9 in paragraph (b), the Office of Insurance Regulation shall
10 determine and set the appropriate rate, so long as the rate is
11 not excessive, inadequate, or unfairly discriminatory based
12 upon the following standards:
13 1. Rates shall be deemed excessive if they are likely
14 to produce a profit from business in this state that is
15 unreasonably high in relation to the risk involved in the
16 class of business or if expenses are unreasonably high in
17 relation to services rendered.
18 2. Rates shall be deemed excessive if, among other
19 things, the rate structure established by a stock insurance
20 company provides for replenishment of reserves or surpluses
21 from premiums when the replenishment is attributable to
22 investment losses, the rate is unreasonably high for the
23 insurance provided, or expenses are unreasonably high in
24 relation to services rendered.
25 3. Rates shall be deemed inadequate if they are
26 clearly insufficient, together with the investment income
27 attributable to such rates, to sustain projected losses and
28 expenses in the class of business to which they apply and the
29 continued use of such rate endangers the solvency of the
30 insurer using the rate.
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1 4. A rating plan, including discounts, credits, or
2 surcharges, shall be deemed unfairly discriminatory if the
3 plan fails to clearly and equitably reflect consideration of
4 the policyholder's participation in a risk management program
5 adopted pursuant to s. 627.0625 or the policyholder's
6 individual claims history or unless price differentials fail
7 to reflect equitably the differences in expected losses and
8 experiences.
9 5. A rate shall be deemed inadequate as to the premium
10 charged to a risk or group of risks if discounts or credits
11 are allowed which exceed a reasonable reflection of expense
12 savings and reasonably expected loss experience from the risk
13 or group of risks.
14 6. A rate shall be deemed unfairly discriminatory as
15 to a risk or group of risks if the application of premium
16 discounts, credits, or surcharges among such risks does not
17 bear a reasonable relationship to the expected loss and
18 expense experience among the various risks.
19 (d) In reviewing a rate filing, the Office of
20 Insurance Regulation may require the insurer to provide at the
21 insurer's expense all information necessary to evaluate the
22 condition of the company and the reasonableness of the filing
23 according to the criteria enumerated in this section.
24 1. The Office of Insurance Regulation shall adopt
25 rules that shall require each medical malpractice insurer to
26 record and report its loss and expense experience and such
27 other data, including reserves, as may be necessary to
28 determine whether rates comply with the standards set forth in
29 this section. Every medical malpractice insurer shall provide
30 such information in such form as the director of the office
31 may require.

1 2. The director shall require that the annual report
2 and any such supplemental report that contains information of
3 a company s loss and loss adjustment reserves be accompanied
4 by an opinion signed and sworn to by a qualified and
5 independent actuary verifying that, within the 9 months prior
6 to the submission of the report, the actuary has conducted a
7 review and analysis of the insurance company s loss and loss
8 adjustment reserves and the reserves are computed in
9 accordance with accepted loss reserving standards and are
10 fairly stated in accordance with sound loss reserving
11 principles.
12 3. The director shall maintain for at least 10 years,
13 by carrier, all reports submitted by insurers pursuant to
14 rules adopted by the office under this section. The director
15 shall consider such reports in determining the appropriateness
16 of premium rates for medical malpractice insurance.
17 4. The director may examine and review the assignment
18 and assessment of risk for difference classifications for
19 different specialties or practices of medicine. The director
20 may hold a public hearing on any filing containing a risk
21 assignment for medical malpractice insurance to determine
22 whether such risk assignment is reasonable and may issue
23 orders concerning such risk assignment.
24 (3) With respect to the filing of rate information:
25 (a) Every medical malpractice insurer shall file with
26 the Office of Insurance Regulation every manual of
27 classifications, rules, and rates, every rating plan, and
28 every modification of any of the foregoing that the insurer
29 proposes to use in this state.
30 (b) The expense provisions included in the rates to be
31 used by a medical malpractice insurer shall reflect the

1 operating methods of the insurer and, so far as it is credible
2 and reasonable, the insurer's own actual and anticipated
3 expense experience.
4 (c) The rates to be used by a medical malpractice
5 insurer shall contain provisions for contingencies and an
6 allowance permitting a reasonable rate of return. In
7 determining a reasonable rate of return, consideration shall
8 be given to all investment income reasonably attributable to
9 medical malpractice insurance.
10 (d) Every filing shall state the proposed effective
11 date of the filing, shall indicate the character and extent of
12 the coverage contemplated, and shall contain supporting
13 information. Such supporting information may include the
14 experience or judgment of the insurer making the filing, the
15 insurer's interpretation of any statistical data the insurer
16 relied upon, the experience of other insurers, and any other
17 factors the insurer deems relevant.
18 (4) The Office of Insurance Regulation may at any time
19 review a rate, rating schedule, rating manual, or rate change,
20 the pertinent records of the insurer, and market conditions.
21 If the office finds on a preliminary basis that a rate may be
22 excessive, inadequate, or unfairly discriminatory, the office
23 shall initiate proceedings to set a new rate and shall so
24 notify the insurer. However, the office may not disapprove as
25 excessive any rate the office has set for a period of 1 year
26 after the effective date of the filing unless the office finds
27 that a material misrepresentation or material error was made
28 by the insurer or was contained in the filing. Upon being so
29 notified, the insurer or rating organization shall, within 60
30 days, file with the office all information which, in the
31 belief of the insurer or organization, proves the



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1 reasonableness, adequacy, and fairness of the rate or rate
2 change. The office shall determine and set an appropriate rate
3 within a reasonable time after receipt of the insurer's
4 initial response, pursuant to the procedures of paragraphs
5 (2)(b)-(d). In such instances and in any administrative
6 proceeding relating to the legality of any rate, the insurer
7 or rating organization shall carry the burden of proof by a
8 preponderance of the evidence to show that the rate is not
9 excessive, inadequate, or unfairly discriminatory.
10 (5) When the Office of Insurance Regulation sets a new
11 rate or rate schedule, the office shall issue an order
12 specifying the new rate or rate schedule and the findings of
13 the office. The order shall constitute agency action for
14 purposes of the Administrative Procedure Act.
15 (6) Except as otherwise specifically provided in this
16 chapter, the Office of Insurance Regulation shall not prohibit
17 any insurer, including any residual market plan or joint
18 underwriting association, from paying acquisition costs based
19 on the full amount of premium, as defined in s. 627.403,
20 applicable to any policy or prohibit any such insurer from
21 including the full amount of acquisition costs in a rate
22 filing.
23 (7) The establishment or variation of any rate, rating
24 classification, rating plan, or rating schedule in violation
25 of part IX of chapter 626 is also a violation of this section.
26 (8) Any portion of a judgment entered as a result of a
27 statutory or common-law bad faith action and any portion of a
28 judgment entered that awards punitive damages against an
29 insurer shall not be included in the insurer's rate base and
30 shall not be used to justify a rate or rate change. Any
31 portion of a settlement entered as a result of a statutory or

1 common-law, bad-faith action identified as such and any
2 portion of a settlement in which an insurer agrees to pay
3 specific punitive damages shall not be used to justify a rate
4 or rate change. The portion of the taxable costs and
5 attorney's fees that is identified as being related to the
6 bad-faith and punitive damages in such judgments and
7 settlements shall not be included in the insurer's rate base
8 and shall not be used to justify a rate or rate change.
9 Section 13. The Office of Insurance Regulation may
10 adopt rules to administer this act.
11 Section 14. This act shall take effect upon becoming a
12 law.
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