By the Committee on Banking and Insurance; and Senator Peaden

311-2030-03

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.
10 624.462, F.S.; authorizing health care
11 providers to form a commercial self-insurance
12 fund; amending s. 627.062, F.S.; providing that
13 an insurer may not require arbitration of a
14 rate filing for medical malpractice; amending
15 s. 627.314, F.S.; revising certain authorized
16 actions multiple insurers may engage in
17 together; prohibiting certain conduct on the
18 part of insurers; amending s. 627.4147, F.S.;
19 revising certain notification criteria;
20 providing for application of a discount or
21 surcharge or alternative method based on loss
22 experience in determining the premium paid by a
23 health care provider; providing requirements;
24 providing a limitation; amending s. 627.912,
25 F.S.; 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; authorizing the Office
15 of Insurance Regulation to adopt rules;
16 providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Subsection (4) of section 501.212, Florida
21 Statutes, is amended to read:
22 501.212 Application.--This part does not apply to:
23 (4) ~~Any person or activity regulated under laws~~
24 ~~administered by the Department of Insurance or~~ Banks and
25 savings and loan associations regulated by the Department of
26 Banking and Finance or banks or savings and loan associations
27 regulated by federal agencies.
28 Section 2. Section 624.156, Florida Statutes, is
29 created to read:
30 624.156 Applicability of consumer protection laws to
31 the business of insurance.--

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1 (1) Notwithstanding any provision of law to the
2 contrary, the business of insurance shall be subject to the
3 laws of this state applicable to any other business,
4 including, but not limited to, the Florida Civil Rights Act of
5 1992 set forth in part I of chapter 760, the Florida Antitrust
6 Act of 1980 set forth in chapter 542, the Florida Deceptive
7 and Unfair Trade Practices Act set forth in part II of chapter
8 501, and the consumer protection provisions contained in
9 chapter 540. The protections afforded consumers by chapters
10 501, 540, 542, and 760 shall apply to insurance consumers.
11 (2) Nothing in this section shall be construed to
12 prohibit:
13 (a) Any agreement to collect, compile, and disseminate
14 historical data on paid claims or reserves for reported
15 claims, provided such data is contemporaneously transmitted to
16 the Office of Insurance Regulation and made available for
17 public inspection.
18 (b) Participation in any joint arrangement established
19 by law or the Office of Insurance Regulation to assure
20 availability of insurance.
21 (c) Any agent or broker, representing one or more
22 insurers, from obtaining from any insurer such agent or broker
23 represents information relative to the premium for any policy
24 or risk to be underwritten by that insurer.
25 (d) Any agent or broker from disclosing to an insurer
26 the agent or broker represents any quoted rate or charge
27 offered by another insurer represented by that agent or broker
28 for the purpose of negotiating a lower rate, charge, or term
29 from the insurer to whom the disclosure is made.
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1 (e) Any agents, brokers, or insurers from using, or
2 participating with multiple insurers or reinsurers for
3 underwriting, a single risk or group of risks.
4 Section 3. Subsection (2) of section 624.462, Florida
5 Statutes, is amended to read:
6 624.462 Commercial self-insurance funds.--
7 (2) As used in ss. 624.460-624.488, "commercial
8 self-insurance fund" or "fund" means a group of members,
9 operating individually and collectively through a trust or
10 corporation, that must be:
11 (a) Established by:
12 1. A not-for-profit trade association, industry
13 association, or professional association of employers or
14 professionals which has a constitution or bylaws, which is
15 incorporated under the laws of this state, and which has been
16 organized for purposes other than that of obtaining or
17 providing insurance and operated in good faith for a
18 continuous period of 1 year;
19 2. A self-insurance trust fund organized pursuant to
20 s. 627.357 and maintained in good faith for a continuous
21 period of 1 year for purposes other than that of obtaining or
22 providing insurance pursuant to this section. Each member of
23 a commercial self-insurance trust fund established pursuant to
24 this subsection must maintain membership in the self-insurance
25 trust fund organized pursuant to s. 627.357; ~~or~~
26 3. A group of 10 or more health care providers, as
27 defined in s. 627.351(4)(h); or
28 4.~~3.~~ A not-for-profit group comprised of no less than
29 10 condominium associations as defined in s. 718.103(2), which
30 is incorporated under the laws of this state, which restricts
31 its membership to condominium associations only, and which has

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1 been organized and maintained in good faith for a continuous
2 period of 1 year for purposes other than that of obtaining or
3 providing insurance.
4 (b)1. In the case of funds established pursuant to
5 subparagraph (a)2. or <u>subparagraph (a)4.</u>~~subparagraph (a)3.~~,
6 operated pursuant to a trust agreement by a board of trustees
7 which shall have complete fiscal control over the fund and
8 which shall be responsible for all operations of the fund.
9 The majority of the trustees shall be owners, partners,
10 officers, directors, or employees of one or more members of
11 the fund. The trustees shall have the authority to approve
12 applications of members for participation in the fund and to
13 contract with an authorized administrator or servicing company
14 to administer the day-to-day affairs of the fund.
15 2. In the case of funds established pursuant to
16 subparagraph (a)1. <u>or subparagraph (a)3.</u>, operated pursuant to
17 a trust agreement by a board of trustees or as a corporation
18 by a board of directors which board shall:
19 a. Be responsible to members of the fund or
20 beneficiaries of the trust or policyholders of the
21 corporation;
22 b. Appoint independent certified public accountants,
23 legal counsel, actuaries, and investment advisers as needed;
24 c. Approve payment of dividends to members;
25 d. Approve changes in corporate structure; and
26 e. Have the authority to contract with an
27 administrator authorized under s. 626.88 to administer the
28 day-to-day affairs of the fund including, but not limited to,
29 marketing, underwriting, billing, collection, claims
30 administration, safety and loss prevention, reinsurance,
31 policy issuance, accounting, regulatory reporting, and general

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administration. The fees or compensation for services under such contract shall be comparable to the costs for similar services incurred by insurers writing the same lines of insurance, or where available such expenses as filed by boards, bureaus, and associations designated by insurers to file such data. A majority of the trustees or directors shall be owners, partners, officers, directors, or employees of one or more members of the fund.

Section 4. Subsections (3) and (4) of section 627.041, Florida Statutes, are amended to read:

627.041 Definitions.--As used in this part:

(3) "Rating organization" means every person, other than an authorized insurer, whether located within or outside this state, who has as his or her object or purpose the collecting, compiling, and disseminating historical data on paid claims or reserves for reported claims ~~making of rates, rating plans, or rating systems~~. Two or more authorized insurers that act in concert for the purpose of collecting, compiling, and disseminating historical data on paid claims or reserves for reported claims ~~making rates, rating plans, or rating systems~~, and that do not operate within the specific authorizations contained in ss. 627.311, 627.314(2), ~~(4),~~ and 627.351, shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

(4) "Advisory organization" means every group, association, or other organization of insurers, whether located within or outside this state, which prepares policy forms ~~or makes underwriting rules incident to but not including the making of rates, rating plans, or rating systems or which collects and furnishes to authorized insurers or rating organizations loss or expense statistics or other~~

1 ~~statistical information and data and acts in an advisory, as~~
2 ~~distinguished from a ratemaking, capacity~~.
3 Section 5. Paragraph (a) of subsection (6) of section
4 627.062, Florida Statutes, is amended to read:
5 627.062 Rate standards.--
6 (6)(a) After any action with respect to a rate filing
7 that constitutes agency action for purposes of the
8 Administrative Procedure Act, <u>except for a rate filing for</u>
9 <u>medical malpractice,</u>an insurer may, in lieu of demanding a
10 hearing under s. 120.57, require arbitration of the rate
11 filing. Arbitration shall be conducted by a board of
12 arbitrators consisting of an arbitrator selected by the
13 department, an arbitrator selected by the insurer, and an
14 arbitrator selected jointly by the other two arbitrators. Each
15 arbitrator must be certified by the American Arbitration
16 Association. A decision is valid only upon the affirmative
17 vote of at least two of the arbitrators. No arbitrator may be
18 an employee of any insurance regulator or regulatory body or
19 of any insurer, regardless of whether or not the employing
20 insurer does business in this state. The department and the
21 insurer must treat the decision of the arbitrators as the
22 final approval of a rate filing. Costs of arbitration shall be
23 paid by the insurer.
24 Section 6. Section 627.314, Florida Statutes, is
25 amended to read:
26 627.314 Concerted action by two or more insurers.--
27 (1) Subject to and in compliance with the provisions
28 of this part authorizing insurers to be members or subscribers
29 of rating or advisory organizations or to engage in joint
30 underwriting or joint reinsurance, two or more insurers may
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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 operations in this state, no insurer shall be a member or subscriber of any such organization, group, or association that has not complied with the provisions of this part applicable to it.

1 (5)~~(6)~~ Notwithstanding any other provisions of this
2 part, insurers shall not participate directly or indirectly in
3 the deliberations or decisions of rating organizations on
4 private passenger automobile insurance. However, such rating
5 organizations shall, upon request of individual insurers, be
6 required to furnish at reasonable cost the rate indications
7 resulting from the loss and expense statistics gathered by
8 them. Individual insurers may modify the indications to
9 reflect their individual experience in determining their own
10 rates. Such rates shall be filed with the department for
11 public inspection whenever requested and shall be available
12 for public announcement only by the press, department, or
13 insurer.
14 Section 7. Section 627.4147, Florida Statutes, is
15 amended to read:
16 627.4147 Medical malpractice insurance contracts.--
17 (1) In addition to any other requirements imposed by
18 law, each self-insurance policy as authorized under s. 627.357
19 or insurance policy providing coverage for claims arising out
20 of the rendering of, or the failure to render, medical care or
21 services, including those of the Florida Medical Malpractice
22 Joint Underwriting Association, shall include:
23 (a) A clause requiring the insured to cooperate fully
24 in the review process prescribed under s. 766.106 if a notice
25 of intent to file a claim for medical malpractice is made
26 against the insured.
27 (b)1. Except as provided in subparagraph 2., a clause
28 authorizing the insurer or self-insurer to determine, to make,
29 and to conclude, without the permission of the insured, any
30 offer of admission of liability and for arbitration pursuant
31 to s. 766.106, settlement offer, or offer of judgment, if the

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1 offer is within the policy limits. It is against public policy
2 for any insurance or self-insurance policy to contain a clause
3 giving the insured the exclusive right to veto any offer for
4 admission of liability and for arbitration made pursuant to s.
5 766.106, settlement offer, or offer of judgment, when such
6 offer is within the policy limits. However, any offer of
7 admission of liability, settlement offer, or offer of judgment
8 made by an insurer or self-insurer shall be made in good faith
9 and in the best interests of the insured.
10 2.a. With respect to dentists licensed under chapter
11 466, a clause clearly stating whether or not the insured has
12 the exclusive right to veto any offer of admission of
13 liability and for arbitration pursuant to s. 766.106,
14 settlement offer, or offer of judgment if the offer is within
15 policy limits. An insurer or self-insurer shall not make or
16 conclude, without the permission of the insured, any offer of
17 admission of liability and for arbitration pursuant to s.
18 766.106, settlement offer, or offer of judgment, if such offer
19 is outside the policy limits. However, any offer for admission
20 of liability and for arbitration made under s. 766.106,
21 settlement offer, or offer of judgment made by an insurer or
22 self-insurer shall be made in good faith and in the best
23 interest of the insured.
24 b. If the policy contains a clause stating the insured
25 does not have the exclusive right to veto any offer or
26 admission of liability and for arbitration made pursuant to s.
27 766.106, settlement offer or offer of judgment, the insurer or
28 self-insurer shall provide to the insured or the insured's
29 legal representative by certified mail, return receipt
30 requested, a copy of the final offer of admission of liability
31 and for arbitration made pursuant to s. 766.106, settlement

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1 offer or offer of judgment and at the same time such offer is
2 provided to the claimant. A copy of any final agreement
3 reached between the insurer and claimant shall also be
4 provided to the insurer or his or her legal representative by
5 certified mail, return receipt requested not more than 10 days
6 after affecting such agreement.
7 (c) A clause requiring the insurer or self-insurer to
8 notify the insured no less than 90 ~~60~~ days prior to the
9 effective date of a rate increase or cancellation of the
10 policy or contract and, in the event of a determination by the
11 insurer or self-insurer not to renew the policy or contract,
12 to notify the insured no less than 90 ~~60~~ days prior to the end
13 of the policy or contract period. If cancellation or
14 nonrenewal is due to nonpayment or loss of license, 10 days'
15 notice is required.
16 (2) In determining the premium paid by any health care
17 provider, a medical malpractice insurer shall apply a discount
18 or surcharge based on the provider's loss experience,
19 including state disciplinary action, or shall establish an
20 alternative method giving due consideration to the provider s
21 loss experience. The insurer shall include a schedule of all
22 such discounts and surcharges or a description of such
23 alternative method in all filings the insurer makes with the
24 director of the Office of Insurance Regulation. Such schedule
25 or description of alternative method shall also be provided to
26 policyholders or prospective policyholders. No medical
27 malpractice liability insurer may use any rate or charge any
28 premium unless the insurer has filed such schedule or
29 alternative method with the director and the director has
30 approved such schedule or alternative method.~~Each insurer~~
31 ~~covered by this section may require the insured to be a member~~

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1 ~~in good standing, i.e., not subject to expulsion or~~
2 ~~suspension, of a duly recognized state or local professional~~
3 ~~society of health care providers which maintains a medical~~
4 ~~review committee. No professional society shall expel or~~
5 ~~suspend a member solely because he or she participates in a~~
6 ~~health maintenance organization licensed under part I of~~
7 ~~chapter 641.~~
8 (3) This section shall apply to all policies issued or
9 renewed after July 1, 2003 ~~October 1, 1985~~.
10 Section 8. Section 627.912, Florida Statutes, is
11 amended to read:
12 627.912 Professional liability claims and actions;
13 reports by insurers; annual reports.--
14 (1) Each self-insurer authorized under s. 627.357 and
15 each insurer or joint underwriting association providing
16 professional liability insurance to a practitioner of medicine
17 licensed under chapter 458, to a practitioner of osteopathic
18 medicine licensed under chapter 459, to a podiatric physician
19 licensed under chapter 461, to a dentist licensed under
20 chapter 466, to a hospital licensed under chapter 395, to a
21 crisis stabilization unit licensed under part IV of chapter
22 394, to a health maintenance organization certificated under
23 part I of chapter 641, to clinics included in chapter 390, to
24 an ambulatory surgical center as defined in s. 395.002, or to
25 a member of The Florida Bar shall report in duplicate to the
26 Department of Insurance any claim or action for damages for
27 personal injuries claimed to have been caused by error,
28 omission, or negligence in the performance of such insured's
29 professional services or based on a claimed performance of
30 professional services without consent, if the claim resulted
31 in:

1 (a) A final judgment in any amount.
2 (b) A settlement in any amount.
3
4 Reports shall be filed with the department and, if the insured
5 party is licensed under chapter 458, chapter 459, chapter 461,
6 or chapter 466, with the Department of Health, no later than
7 30 days following the occurrence of any event listed in
8 paragraph (a) or paragraph (b). The Department of Health shall
9 review each report and determine whether any of the incidents
10 that resulted in the claim potentially involved conduct by the
11 licensee that is subject to disciplinary action, in which case
12 the provisions of s. 456.073 shall apply. The Department of
13 Health, as part of the annual report required by s. 456.026,
14 shall publish annual statistics, without identifying
15 licensees, on the reports it receives, including final action
16 taken on such reports by the Department of Health or the
17 appropriate regulatory board.
18 (2) The reports required by subsection (1) shall
19 contain:
20 (a) The name, address, and specialty coverage of the
21 insured.
22 (b) The insured's policy number.
23 (c) The date of the occurrence which created the
24 claim.
25 (d) The date the claim was reported to the insurer or
26 self-insurer.
27 (e) The name and address of the injured person. This
28 information is confidential and exempt from the provisions of
29 s. 119.07(1), and must not be disclosed by the department
30 without the injured person's consent, except for disclosure by
31 the department to the Department of Health. This information

1 may be used by the department for purposes of identifying
2 multiple or duplicate claims arising out of the same
3 occurrence.
4 (f) The date of suit, if filed.
5 (g) The injured person's age and sex.
6 (h) The total number and names of all defendants
7 involved in the claim.
8 (i) The date and amount of judgment or settlement, if
9 any, including the itemization of the verdict, together with a
10 copy of the settlement or judgment.
11 (j) In the case of a settlement, such information as
12 the department may require with regard to the injured person's
13 incurred and anticipated medical expense, wage loss, and other
14 expenses.
15 (k) The loss adjustment expense paid to defense
16 counsel, and all other allocated loss adjustment expense paid.
17 (l) The date and reason for final disposition, if no
18 judgment or settlement.
19 (m) A summary of the occurrence which created the
20 claim, which shall include:
21 1. The name of the institution, if any, and the
22 location within the institution at which the injury occurred.
23 2. The final diagnosis for which treatment was sought
24 or rendered, including the patient's actual condition.
25 3. A description of the misdiagnosis made, if any, of
26 the patient's actual condition.
27 4. The operation, diagnostic, or treatment procedure
28 causing the injury.
29 5. A description of the principal injury giving rise
30 to the claim.
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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 this section. This subsection applies to claims accruing on or after October 1, 1997.

(5) Any self-insurance program established under s. 1004.24 shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the state university board of trustees through an employee or agent of the state university board of trustees, including practitioners of medicine licensed under chapter

1 458, practitioners of osteopathic medicine licensed under
2 chapter 459, podiatric physicians licensed under chapter 461,
3 and dentists licensed under chapter 466, or based on a claimed
4 performance of professional services without consent if the
5 claim resulted in a final judgment in any amount, or a
6 settlement in any amount. The reports required by this
7 subsection shall contain the information required by
8 subsection (3) and the name, address, and specialty of the
9 employee or agent of the state university board of trustees
10 whose performance or professional services is alleged in the
11 claim or action to have caused personal injury.
12 (6) Each entity required to report closed claims for
13 the classification of insurance set forth in subsection (1)
14 shall also provide to the Office of Insurance Regulation the
15 following financial information, specific to this state and
16 countrywide, if applicable, for the prior calendar year:
17 (a) Direct premiums written.
18 (b) Direct premiums earned.
19 (c) Incurred loss and loss expense developed according
20 to the formula A + B - C + D - E + F + G - H, for which A
21 equals the dollar amount of losses paid, B equals the reserves
22 for reported claims at the end of the current year, C equals
23 the reserves for reported claims at the end of the previous
24 year, D equals the reserves for incurred but not reported
25 claims at the end of the current year, E equals the reserves
26 for incurred but not reported claims at the end of the
27 previous year, F equals loss adjustment expenses paid, G
28 equals the reserves for loss adjustment expenses at the end of
29 the current year, and H equals the reserves for loss
30 adjustment expenses at the end of the previous year.
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1 (d) Incurred expenses allocated separately to
2 commissions, other acquisition costs, general expenses, taxes,
3 licenses, and fees, using appropriate estimates when
4 necessary.
5 (e) Policyholder dividends.
6 (f) Underwriting gain or loss.
7 (g) Net investment income, including net realized
8 capital gains and losses, using appropriate estimates where
9 necessary.
10 (h) Federal income taxes.
11 (i) Net income.
12 (7) The director of the Office of Insurance Regulation
13 may levy an administrative fine of $1,000 per day against any
14 insurer failing to comply with the reporting requirements of
15 this section.
16 (8) The director of the Office of Insurance Regulation
17 shall prepare an annual report no later than July 1 that
18 summarizes the information submitted pursuant to this section.
19 Such summary shall be prepared on an aggregate basis. A copy
20 of the report shall be delivered to the Governor, the
21 President of the Senate, and the Speaker of the House of
22 Representatives. The first report submitted pursuant to this
23 subsection shall be delivered on or before October 1, 2003,
24 for the calendar year 2002. Subsequent reports shall be filed
25 on or before March 1 for each prior year.
26 Section 9. Section 627.41491, Florida Statutes, is
27 created to read:
28 627.41491 Full disclosure of insurance
29 information.--The Office of Insurance Regulation shall provide
30 health care providers with a comparison of the rate in effect
31 for each medical malpractice insurer and self-insurer and the

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1 Florida Medical Malpractice Joint Underwriting Association.
2 Such rate comparison chart shall be made available to the
3 public through the Internet and other commonly used means of
4 distribution no later than July 1 of each year.
5 Section 10. Section 627.41493, Florida Statutes, is
6 created to read:
7 627.41493 Insurance rate rollback.--
8 (1) For any coverage for medical malpractice insurance
9 subject to this chapter issued or renewed on or after July 1,
10 2003, every insurer shall reduce its charges to levels that
11 are at least 20 percent less than the charges for the same
12 coverage that were in effect on January 1, 2001.
13 (2) Between July 1, 2003, and July 1, 2004, rates and
14 premiums reduced pursuant to subsection (1) may only be
15 increased if the director of the Office of Insurance
16 Regulation finds, after a hearing, that an insurer or
17 self-insurer or the Florida Medical Malpractice Joint
18 Underwriting Association is unable to earn a fair rate of
19 return.
20 (3) Commencing July 1, 2003, insurance rates for
21 medical malpractice subject to this chapter must be approved
22 by the director of the Office of Insurance Regulation prior to
23 being used.
24 (4) Any separate affiliate of an insurer is subject to
25 the provisions of this section.
26 Section 11. Section 627.41495, Florida Statutes, is
27 created to read:
28 627.41495 Consumer participation in rate review.--
29 (1) Upon the filing of a proposed rate change by a
30 medical malpractice insurer, self-insurer, or risk retention
31 group, the director of the Office of Insurance Regulation

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1 shall require the insurer, self-insurer, or risk retention
2 group to give notice to the public and to the insureds or
3 associations of insureds of the insurer, self-insurer, or risk
4 retention group making the filing.
5 (2) The rate filing shall be available for public
6 inspection. If any insureds or associations of insureds of the
7 insurer, self-insurer, or risk retention group filing the
8 proposed rate change request the director of the Office of
9 Insurance Regulation to hold a hearing within 30 days after
10 the mailing of the notification of the proposed rate changes
11 to the insureds, the director shall hold a hearing within 30
12 days after such request. Any consumer may participate in such
13 hearing, and the office shall adopt rules governing such
14 participation.
15 Section 12. The Office of Insurance Regulation may
16 adopt rules to administer this act.
17 Section 13. This act shall take effect upon becoming a
18 law.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 2080

The committee substitute does the following:

- Deletes s. 627.41497, F.S., as created by the bill, which established medical malpractice rate standards and prior approval of rates.
- Amends s. 627.062, F.S., to provide that an insurer that makes a medical malpractice rate filing may not demand binding arbitration as an alternative to an administrative hearing.
- Deletes the provision that would have allowed medical malpractice self-insurance funds to be formed under s. 627.357, F.S., and instead, would allow 10 or more health care providers to form a commercial self-insurance fund under ss. 624.460-624.488, F.S.
- Provides a different finding that the director of the Office of Insurance Regulation must make, in order for a medical malpractice rate to be increased between July 1, 2003, and July 1, 2004.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.