By the Committee on Health, Aging, and Long-Term Care; and Senator Saunders

317-1983-03

A bill to be entitled

An act relating to medical malpractice; amending s. 456.049, F.S.; requiring the Department of Health to report certain liability claims to the Office of Insurance Regulation; amending s. 627.062, F.S.; prohibiting certain bad-faith or punitive damages judgments from influencing rates or justifying rate changes; amending s. 627.357, F.S.; providing guidelines for the formation and regulation of certain self-insurance funds; amending s. 627.912, F.S.; providing for the adoption of requirements relating to certain reports filed with the Office of Insurance Regulation; requiring the office to impose certain fines; creating s. 627.9121, F.S.; requiring certain claims, judgments, or settlements to be reported to the Office of Insurance Regulation; providing penalties; requiring the Office of Program Policy Analysis and Government Accountability to study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; authorizing health care facilities to apply to the Department of Financial Services for discounts in insurance rates after reducing adverse incidents and serious events at the facility; requiring health care facilities to apply to the Department of Financial Services for the certification of programs recommended

by the Florida Center for Excellence in Health Care; requiring the Department of Financial Services to develop criteria for the certification; requiring insurers to file rates with the Department of Financial Services for review under specified circumstances; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) is added to section 456.049, Florida Statutes, to read:

456.049 Health care practitioners; reports on professional liability claims and actions.--

(3) The department must forward the information collected under this section to the Office of Insurance Regulation.

Section 2. Subsection (2) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.--

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, shall be filed with the department under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented

during the department's review of the filing and any proceeding and judicial review, then such filing shall be considered a "file and use" filing. In such case, the department shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the department of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the department does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the department to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

(b) Upon receiving a rate filing, the department shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the department shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The department may promulgate rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used in the calculation of insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus shall not be considered. The profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.0625.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. A reasonable margin for underwriting profit and contingencies.

12. The cost of medical services, if applicable.

13. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the department. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) Any portion of a judgment entered as a result of a statutory or common-law bad-faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or

common-law bad-faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(f)~~(e)~~ After consideration of the rate factors provided in paragraphs (b), (c), ~~and~~ (d), and (e), a rate may be found by the department to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed 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.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. 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 adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks 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.

(g)~~(f)~~ In reviewing a rate filing, the department may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(h)~~(g)~~ The department may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the department finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the department shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the department may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the department finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the department all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and

fairness of the rate or rate change. The department shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the department notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the department withdraws the notification, the insurer shall not alter the rate except to conform with the department's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The department may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(i)~~(h)~~ In the event the department finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the department shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the department be filed by the insurer. The department shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the department finds that an insurer's rate or rate

change is inadequate, the new rate or rate schedule filed with the department in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(j)~~(i)~~ Except as otherwise specifically provided in this chapter, the department shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

Section 3. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

(10)(a)1. An application to form a self-insurance fund under this section must be filed with the Office of Insurance Regulation ~~A self-insurance fund may not be formed under this section after October 1, 1992~~.

2. The office must ensure that self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Office of Insurance Regulation may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

Section 4. Subsections (2) and (4) of section 627.912, Florida Statutes, are amended to read:

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

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

(a) The name, address, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the department without the injured person's consent, except for disclosure by the department to the Department of Health. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number and names of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.

(j) In the case of a settlement, such information as the department may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases. The Office of Insurance Regulation shall adopt by rule requirements for additional information to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases reported by insurers under this section.

(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 must ~~may~~ impose a fine of $250 per day per case, but not to exceed a total of $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.

Section 5. Section 627.9121, Florida Statutes, is created to read:

627.9121 Required reporting of claims; penalties.--Each entity that 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 that is required to report information to the National Practitioner Data Bank under 42 U.S.C. section 11131 must also report the same information to the Office of Insurance Regulation. The Office of Insurance Regulation shall include such information in the data that it compiles under s. 627.912. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with the requirements imposed by law.

Section 6. The Office of Program Policy Analysis and Government Accountability shall complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and submit a report to the Legislature by January 1, 2004, recommending whether or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under section 766.302, Florida Statutes, should be modified.

Section 7. Patient safety discount.--A health care facility licensed pursuant to chapter 395, Florida Statutes,

may apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents, as defined in section 395.0197, Florida Statutes, which result in the reduction of serious events at that facility. The department shall develop criteria for such certification. Insurers shall file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program. A health care facility shall receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law. In reviewing filings under this section, the department shall consider whether, and the extent to which, the program certified under this section is otherwise covered under a program of risk management offered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 8. This act shall take effect upon becoming a law if SB 562, SB 564, and SB 566 or similar legislation is adopted in the same legislative session or extension thereof and becomes law.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 560

The committee substitute requires the Department of Health to forward to the Office of Insurance Regulation information that it collects from Florida-licensed physicians and dentists regarding professional liability claims that are not otherwise reported to the Office of Insurance Regulation.

The rating standards for certain property, casualty, and surety insurances are revised to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change.

The bill eliminates an existing prohibition against creating new medical malpractice self-insurance funds. The Office of Insurance Regulation is authorized to adopt rules relating to medical malpractice self-insurance funds.

The Office of Insurance Regulation is required to adopt rules regarding information about professional liability closed claims that will assist the office in analyzing the nature,causes,location,cost and damages involved in such claims and is required to impose a fine against insurers for violations of the closed claims reporting requirements. The bill requires additional entities to report medical malpractice actions or claims to the Office of Insurance Regulation.

The bill requires the Office of Program Policy Analysis and Government Accountability to study the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and report to the Legislature by January 1, 2004.

Hospitals, ambulatory surgical centers, and mobile surgical facilities are authorized to apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents. Insurers must file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program and these facilities must receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law.