Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Ryan offered the following:

Amendment (with title amendment)

Between line(s) 1490 and 1491, insert:

Section 32. Section 627.41497, Florida Statutes, is created to read:

627.41497 Medical malpractice rate standards; prior approval of rates.--

(1) In addition to any other requirements imposed by law, the rates for each self-insurance policy as authorized under s. 627.357 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services shall be set by the director of the Office of Insurance Regulation and shall not be excessive, inadequate, or unfairly discriminatory.

(2) As to all rate filings subject to approval in accordance with this section:

(a) Insurers or rating organizations shall apply for 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 to such rates, schedules, manuals, and credits, shall be filed with the Office of Insurance Regulation. The filing shall be made at least 180 days before the proposed effective date and shall not be implemented during the review of the filing by the Office of Insurance Regulation, any proceeding, or judicial review.

(b) Upon receiving a rate filing and within a reasonable time after such receipt, the Office of Insurance Regulation shall review the rate filing and set a rate or rate schedule that is not excessive, inadequate, or unfairly discriminatory. In making such determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, use the following factors:

1. Past and prospective loss experience within and without this state and the insurer's or self-insurer’s past and prospective loss experience within this state, if applicable. A medical malpractice insurer shall consider past and prospective loss experience and catastrophic hazards, if any, solely within this state. However, if there is insufficient experience within this state upon which a rate can be based, the insurer may consider experiences within any other state or states that have a similar cost of claim and frequency of claim experience as this state and, if insufficient experience is available, the insurer may use nationwide experience. The insurer, in its rate

filing or in its records, shall expressly show the rate experience it is using. In considering experience outside this state, as much weight as possible shall be given to state experience.

2. Past and prospective expenses.

3. 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, loss reserves, and surplus. The Office of Insurance Regulation may adopt rules using 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. The profit and contingency factor as specified in the filing shall be used in computing excess profits in conjunction with s. 627.215.

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

5. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.

6. The adequacy of loss reserves.

7. The cost of reinsurance.

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

9. A reasonable margin for underwriting profit and contingencies.

10. The cost of medical services.

11. Other relevant factors that impact upon the frequency or severity of claims or upon expenses.

(c) After consideration of the rate factors provided in paragraph (b), the Office of Insurance Regulation shall determine and set the appropriate rate, so long as the rate is not 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 business in this state 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 reserves or surpluses from premiums when the replenishment is attributable to investment losses, the rate is unreasonably high for the insurance provided, or expenses are unreasonably high in relation to services rendered.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to such rates, to sustain projected losses and expenses in the class of business to which they apply and the continued use of such rate endangers the solvency of the insurer using the rate.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if the plan

fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625 or the policyholder’s individual claims history or unless price differentials fail to reflect equitably the differences in expected losses and experiences.

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.

(d) In reviewing a rate filing, the Office of Insurance Regulation 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.

1. The Office of Insurance Regulation shall adopt rules that shall require each medical malpractice insurer to record and report its loss and expense experience and such other data, including reserves, as may be necessary to determine whether rates comply with the standards set forth in this section. Every medical malpractice insurer shall provide such information in such form as the director of the office may require.

2. The director shall require that the annual report and any such supplemental report that contains information of a

company's loss and loss adjustment reserves be accompanied by an opinion signed and sworn to by a qualified and independent actuary verifying that, within the 9 months prior to the submission of the report, the actuary has conducted a review and analysis of the insurance company's loss and loss adjustment reserves and the reserves are computed in accordance with accepted loss reserving standards and are fairly stated in accordance with sound loss reserving principles.

3. The director shall maintain for at least 10 years, by carrier, all reports submitted by insurers pursuant to rules adopted by the office under this section. The director shall consider such reports in determining the appropriateness of premium rates for medical malpractice insurance.

4. The director may examine and review the assignment and assessment of risk for difference classifications for different specialties or practices of medicine. The director may hold a public hearing on any filing containing a risk assignment for medical malpractice insurance to determine whether such risk assignment is reasonable and may issue orders concerning such risk assignment.

(3) With respect to the filing of rate information:

(a) Every medical malpractice insurer shall file with the Office of Insurance Regulation every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing that the insurer proposes to use in this state.

(b) The expense provisions included in the rates to be used by a medical malpractice insurer shall reflect the operating methods of the insurer and, so far as it is credible

and reasonable, the insurer's own actual and anticipated expense experience.

(c) The rates to be used by a medical malpractice insurer shall contain provisions for contingencies and an allowance permitting a reasonable rate of return. In determining a reasonable rate of return, consideration shall be given to all investment income reasonably attributable to medical malpractice insurance.

(d) Every filing shall state the proposed effective date of the filing, shall indicate the character and extent of the coverage contemplated, and shall contain supporting information. Such supporting information may include the experience or judgment of the insurer making the filing, the insurer's interpretation of any statistical data the insurer relied upon, the experience of other insurers, and any other factors the insurer deems relevant.

(4) The Office of Insurance Regulation 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 office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to set a new rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate the office has set for a period of 1 year after the effective date of the filing unless the office 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 office all information which, in the belief of the

insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall determine and set an appropriate rate within a reasonable time after receipt of the insurer’s initial response, pursuant to the procedures of paragraphs (2)(b)-(d). In such instances and in any administrative proceeding relating to the legality of any 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.

(5) When the Office of Insurance Regulation sets a new rate or rate schedule, the office shall issue an order specifying the new rate or rate schedule and the findings of the office. The order shall constitute agency action for purposes of the Administrative Procedure Act.

(6) Except as otherwise specifically provided in this chapter, the Office of Insurance Regulation 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.

(7) The establishment or variation of any rate, rating classification, rating plan, or rating schedule in violation of part IX of chapter 626 is also a violation of this section.

(8) 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 that awards punitive damages against an insurer shall 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 in which an insurer agrees to pay specific punitive damages shall not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees that is identified as being related to the bad faith and punitive damages in such judgments and settlements shall not be included in the insurer's rate base and shall not be used to justify a rate or rate change.

================ T I T L E A M E N D M E N T ================

Remove line(s) 114, and insert:

requiring prior notification of a rate increase; creating s. 627.41497, F.S.; requiring certain medical malpractice insurance rates to be set by the director of the Office of Insurance Regulation; providing for approval of rate filings; requiring insurers to apply for certain rates, schedules, and manuals; providing procedures for application and review; providing review criteria; providing approval standards; authorizing the office to require certain additional information for review; requiring adoption of certain rules; providing for reports of certain information; requiring the office to retain such reports for a time certain; requiring medical malpractice insurers to file certain information with the office; authorizing the office to review rates, schedules, manuals, or rate changes at any time 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; amending