The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Banking and Insurance Committee

BILL: SB 1660

INTRODUCER: Senator Peaden

SUBJECT: Insurance/Medical Malpractice

DATE: April 19, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Pre-meeting**
2.			HP	
3.			JU	
4.			GA	
5.				
6.				

I. Summary:

The bill requires each medical malpractice insurer to reduce its rates to at least 25 percent less than the rates that were in effect on October 1, 2004. The rate reduction will apply to all coverage issued or renewed on or after October 1, 2007. The bill also requires the prior approval of medical malpractice insurance rates by the OIR as of October 1, 2007.

The bill states that that because there is no justification for basing rates on the prior 5 to 10 years of loss experience and expenses in light of the 2003 medical malpractice reforms that significantly impacted both the frequency and severity of medical malpractice claims pursuant to the findings in this section:

- Medical malpractice insurance rates filed with the OIR prior to September 15, 2009, may not be based upon the loss and expense experience of more than 5 years prior to that date.
- Medical malpractice insurance rates filed with the OIR on or after September 15, 2009, may not be based upon the loss and expense experience of 2004 and thereafter.

These limitations are likely to result in a substantial drop in medical malpractice premiums.

The bill requires the OIR to only consider as part of the insurer's rate base, the insurer's loss cost adjustment expenses or defense cost and containment expenses to the extent that such expenses do not exceed the national average for such expenses for the prior calendar year.

The bill requires the OIR to adopt a schedule of appropriate ranges for credits or discounts for health care providers who have experienced no closed claims or limited indemnity and expense payments. The discount or surcharge applied to a health care provider based on the provider's loss experience must also be based on any disciplinary action taken by the federal or state

government, or a health facility or health care plan. The bill also repeals the provision that permits a medical malpractice insurer to require that the insured medical provider be a member in good standing of a recognized state or local professional society that maintains a medical review committee.

The bill revises the insurer reporting requirements for professional liability (malpractice) claims.

The bill requires the OIR to provide health care providers with a comparison chart of the rates in effect for each medical malpractice insurer, self-insurer risk retention group, and the Florida Medical Malpractice Joint Underwriting Association.

The bill requires each medical malpractice insurer, self insurance fund, and risk retention group to give notice to the public and its insureds of each rate filing. The OIR must hold a hearing if within 30 days after notice is given, any insured or association of insureds of the insurer make a request, and any consumer may participate in such a hearing. The public counsel also has standing to request a hearing.

This bill substantially amends the following sections of the Florida Statutes: 627.062, 627.912, and 627.41495.
This bill creates the following sections of the Florida Statutes: 624.156, 627.41491, and 627.41493.
This bill repeals subsection (2) of the following sections of the Florida Statutes: 627.4147.

II. Present Situation:

2003 Medical Malpractice Reforms
In response to rapidly escalating medical malpractice premiums and reduced availability, the Legislature passed SB 2-D (chapter 2003-416, L.O.F). Medical malpractice premiums had begun rising rapidly in 2000, and from January 1, 2001 through July 1, 2003, there was an 81 percent rate increase, weighted for market share, during that period. The legislation contained a number of changes including litigation reforms, patient safety issues, and insurance reforms.

Caps on Non-Economic Damages – SB 2-D placed a $500,000 cap on non-economic damages for injuries that do not result in death or a vegetative state from a single practitioner defendant, and $1 million from multiple practitioner defendants, regardless of the number of claimants. The cap for a single non-practitioner defendant is $750,000 and $1.5 million for multiple non-practitioner defendants. However, if the injury results in death or a permanent vegetative state, then the cap on non-economic damages is $1 million from all practitioner defendants, and $1.5 million from non-practitioner defendants. If the injury does not result in death or a permanent vegetative state, is catastrophic and manifest injustice would occur if the cap were applied, then the injured patient may recover $1 million from practitioners and $1.5 million from non-practitioners, respectively, regardless of the number of defendants.

Caps on non-economic damages were also enacted for situations when a practitioner who does not have a pre-existing practitioner-patient relationship provides emergency services in a hospital, or life support services including transportation. For injuries incurred prior to patient stabilization, no more than $150,000 in non-economic damages may be recovered per claimant,

with a maximum of $300,000 recoverable in non-economic damages regardless of the number of claimants or practitioner defendants.

In addition to the statutory caps, the act, requires noneconomic damages to be reduced by any settlement amount in order to prevent recovery in excess of the statutory caps. The act also stated that a defendant may avail itself of the statutory caps even if the defendant refused to accept a claimant's offer of voluntary binding arbitration. Noneconomic damages in voluntary binding medical negligence arbitration involving wrongful death were also capped by the act.

Bad Faith Actions – States that an insurer cannot be held to have acted in bad faith if it tenders policy limits and meets other reasonable conditions of settlement before the earlier of either the 210th day after service of the complaint, or the 60th day after the conclusion of specified pretrial events including mandatory mediation. The bill also provides stricter standards that a trier of fact must use in determining when an insurer has acted in bad faith.

Presuit Process & Witnesses – SB 2-A created sanctions if parties failed to cooperate with presuit investigations. The claimant also is required to execute a medical information release and authorize a defendant to take unsworn statements from the claimant's physician. Contingency fee arrangements for expert witnesses (whereby the witness would be paid an amount if the party he or she testified for won the lawsuit) were prohibited, and the statutory criteria for who is qualified to offer presuit corroborating medical expert opinions and expert witness testimony was strengthened. Presuit medical expert opinions were made subject to the discovery process.

Presumed Factor
SB 2-A required a rate freeze on medical malpractice insurance and a mandatory rate filing to reflect the savings of the bill, and placed on the Office of Insurance Regulation a duty to calculate the savings of the bill. The OIR contracted with Deloitte and Touche to analyze the savings that could be expected from the bill. The Deloitte report estimated that the act would have an overall impact of -7.8 percent on rates for medical malpractice insurance in Florida. Only two sections of the act were determined to result in measurable savings: the limitations on non-economic damages (-5.3 percent) and the requirements for bad faith actions against insurers (-2.5 percent).

Medical Malpractice Insurance Market
In the years following the medical malpractice reforms of 2003, Florida has seen substantial increases in the availability of coverage, but modest decreases in the cost of coverage. A number of facts indicate that there is increased coverage availability. From January 2004 to October 1, 2005, eighteen new companies started writing medical malpractice insurance. Additionally, membership in the Florida Medical Malpractice Joint Underwriting Association (FMMJUA) dropped from a peak of over 1,100 policies in March 2004 to approximately 300 policies by the end of 2006.

Though more insurers have entered the market and fewer providers are forced to purchase coverage from the FMMJUA, there has not been a substantial reduction in premium cost during the same time period. The following chart using data provided by the OIR contains the premium increases and decreases for the five leading writers of medical malpractice coverage in state, comprising over 60 percent of the market. The chart shows that rates continued to rise for 2004

and 2005. The 2006 and 2007 rate filings begin to show reductions, however none of the reductions to date created reductions sufficient to counteract the rate increases that have been approved in 2004 and thereafter.

Company	2004	2005	2006	2007
First Professional	8.0%	8.0%	-11.0%	N/A
MAG Mutual	7.0%	8.9%	9.2%	-7.2%
ProNational	17.3%	6.4%	0.5%	-15.8%
Doctors Company	1.1%	5.0%	-1.3%	N/A
Medical Protective	45.0%	14.6%	4.6%	-10.0%

OIR Hearing on Medical Malpractice Rates (January 20, 2007)
Pursuant to a request by then Insurance Consumer Advocate Steve Burgess, a public hearing was held on January 30, 2007, regarding rate filings by Pro National Insurance Company and other medical malpractice insurers. The Consumer Advocate stated at the hearing that the rates for medical malpractice insurance should be substantially lower than they currently are because the impact of the 2003 reforms has been far greater than contemplated in the Deloitte and Touche study. The consumer advocate noted that the expenses for medical malpractice insurers dropped dramatically in 2004 and 2005. In 2002 and 2003, Florida medical malpractice insurers annually incurred close to $1 billion in direct incurred losses and defense and cost containment expenses. That number dropped to $800 million in 2004, and under $600 million in 2005. The primary cause in the drop in losses appears to be a drastic decrease in the number of medical malpractice claims being filed. Statistics from First Professionals Insurance Company (the carrier with the largest market share in the state) show that for every 100 physicians, there were approximately 5 claims filed in 2002 and approximately 5.6 in 2003. Those claim rates dropped to approximately 2.5 per 100 in 2004 and 2005.

The Insurance Consumer Advocate's conclusion during the meeting was that the 2003 reforms have created dramatic savings for medical malpractice insurers that have not been passed on to their policyholders, instead resulting in "windfall" profits for medical malpractice insurers. The consumer advocate recommended that the OIR should only use insurer loss data from after the 2003 reforms, asserting that the reforms drastically changed the medical malpractice market for the better. However, it should be noted that the Consumer Advocate's suggestion is contrary to normal practice in a rate-filing. Usually, 5 to 10 years of claims experience and data is used in making a rate calculation. Using data from only those two years would result in large rate decreases because the increased loss data from 2000 to 2003 would not be used in the rate calculation. The Consumer Advocate's recommendation was for the OIR to adopt a presumed factor of a negative 40 percent from 2005 rate levels with all insurers required to submit a new rate filing within 90 days in consideration of the new presumed factor.

Representatives from First Professionals Insurance Company also made a presentation at the hearing, and asserted that the consumer advocate's assumption that the 2003 reforms reduced incurred losses is erroneous because the cap on non-economic damages and bad faith reform provisions address claims severity only. Instead, the reduction in loss costs is due instead to a dramatic reduction in claims frequency. First Professionals asserted that the reduction in claim frequency was caused in part by a spike in claims previous to the reforms —262 in September 2003, compared to 44 the following month so that the claims would be adjudicated without the

new damage caps and bad faith rules. This was followed by a drop in claims that FPIC states normally only lasts 12 to 24 months, but FPIC's assertion is contradicted by the fact that claims have remained at what they termed "historically low levels" 41 months after passage of SB 2-D in August 2003. First Professionals asserted that a causal connection cannot be shown between the decrease in loss costs in Florida and the 2003 reforms, noting that loss costs have fallen at similar rates nationally during that period.

First Professionals indicated that the cap on plaintiff's attorney contingent fees passed in November 2004, and the coverage limit that is placed on a medical malpractice policy are more likely to have lead to the drop in new claims. First Professionals states that 83 percent of its policyholders have policy limits of $500,000 or less, which applies to all damages while the 2003 legislation only places a cap on non-economic damages. The suggestion by the Consumer Advocate that rates be adopted using only two years of loss data also met with strong opposition because generally longer periods of time (5 to 10 years) are used in calculating rates for medical malpractice as claims can take a long period of time to wake their way through the legal system and be closed. Additionally, if the dramatic drops in loss costs are not sustained, insurers may find themselves in a situation where they have not collected sufficient premium. Additionally, such an approach could result in rapid premium increases in the event that loss costs increased sizably in a single year. First Professionals states that since 2003, insurance availability has increased, rates have stabilized and begun to decline, and that there is no evidence of excess profits. For these reasons, FPIC states that the proposals of the Consumer Advocate are unnecessary and could adversely impact the marketplace.

In the aftermath of the hearing, the key issues are whether the drastic reduction in expenses that medical malpractice insurers have experienced after 2003 are indicative of a sustained trend, or whether increased volatility in insurer expenses is likely. The question of whether the 2003 reforms are the cause of the reductions is also relevant, as a causal connection between the two reduces the likelihood that the ebb and flow of the market explains the reduction, and instead would indicate that the reforms have created a new medical malpractice claims environment in Florida. It should be noted that a factor in the ratemaking process is the prospective prediction of losses and expenses in Florida. Thus, the degree to which an insurer or regulator uses recent trends such as the increased expenses and costs insurers incurred from 2000 to 2003, or the drastic decreases in costs in 2004 and 2005 to predict the insurer's expenses will play a large role in the rates that end up being charged for medical malpractice insurance.

Florida Civil Rights Act of 1992

The Florida Civil Rights Act of 1992 (ss. 760.01 – 760.11, F.S., and s. 509.092, F.S.) is purposed to "secure for all individuals within the state freedom from discrimination because of race, color, religion, sex, national origin, age, handicap, or marital status and thereby to protect their interest in personal dignity…." The act creates the Commission on Human Relations, a 12 member panel whose primary functions are to "promote and encourage fair treatment and equal opportunity for all persons…and mutual understanding and respect among all members of all economic, social, racial, religious and ethnic groups" and to "endeavor to eliminate discrimination against, and antagonism between, religious, racial, and ethnic groups and their members."

The Attorney General has various means available to enforce the Act, including bringing civil actions for damages, injunctive relief, and civil penalties. The Commission on Human Relations

also has authority to conduct investigations, hold hearings, and act upon complaints alleging discriminatory practices. Any person aggrieved by a violation of ss. 760.01 – 760.10, F.S., may file a complaint pursuant to s. 760.11, F.S., within 365 days of the alleged violation. The Commission then may either refer the matter to a state agency or unit of government that has jurisdiction over the subject matter, or shall investigate the allegations itself and reach a determination within 180 days of whether there is reasonable cause to believe the Act has been violated. If the Commission makes a determination of reasonable cause, then the aggrieved person may bring a civil action or request an administrative hearing under ss. 120.569, F.S., and 120.57, F.S. If a civil action is elected, the court may issue an order prohibiting the discriminatory practice; provide affirmative relief from the affects of the practice, and award compensatory and punitive damages. If an administrative hearing is elected, then an order may be entered prohibiting the discriminatory practice, and affirmative relief may be provided.

Rate Standards for Insurance

Pursuant to the Rating Law, s. 627.062, F.S., prohibits property and casualty insurance rates that are excessive, inadequate, or unfairly discriminatory. The insurer is required to establish and use rates that allow the insurer a reasonable rate of return on the insurance being written. The insurer must file with the OIR a copy of the rates and various schedules used to establish the rate along with associated discounts and surcharges either 90 days before the proposed effective date of the rate filing (a “file and use” filing) or within 30 days after the filing’s effective date (a “use and file” filing).

The OIR reviews a rate filing to determine if the rate is excessive, inadequate, or unfairly discriminatory. If the filing is none of these things then it will be approved. In making the determination for a medical malpractice rate filing, the OIR analyzes a rate filing in accordance with generally accepted and reasonable actuarial techniques, and considers multiple factors. In a medical malpractice filing, the statutory factors include:

- Past and prospective (predicted) loss experience in Florida solely, or to give priority to Florida loss experience over loss experience from other states;
- past and prospective expenses,
- the amount of competition in the marketplace,
- investment income reasonably expected by the insurer,
- the reasonableness of the judgment reflected in the filing,
- Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders;
- Adequacy of loss reserves;
- Reinsurance costs;
- Trend factors, including trends in actual losses;
- A reasonable margin for underwriting profit and contingencies;
- Other relevant factors that impact upon the frequency or severity of claims or upon expenses.

The OIR has authority to require an insurer to provide all information necessary to evaluate the insurance company’s condition and the reasonableness of the rate filing. The office may find a rate to be excessive if it is likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved, if expenses are unreasonably high in relation to the services

rendered by the insurer, or if the rates established provide for the replenishment of surpluses from premiums when investment losses caused the need to the surplus to be replenished. A rate is inadequate when, combined with investment income, it is clearly insufficient to sustain projected losses and expenses. A rate is also inadequate when the discounts or credits offered exceed a reasonable reflection of expense savings and reasonably expected loss experience from a risk or group of risks. A rate is unfairly discriminatory if it the application of premium discounts, credits, or surcharges does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

Subsection (7) of s. 627.062, F.S., contains additional standards that only apply to medical malpractice rate filings. Medical malpractice insurers are required to make a rate filing at least once each calendar year. Also, judgments or settlements paid as a result of a statutory or common-law bad faith, and punitive damage awards, cannot be used to justify a rate. A medical malpractice insurer must apply a discount or surcharge based on the health care provider's loss experience in order to have a rate approved.

Subsection (6) exempts medical malpractice rate filings from the arbitration provisions of the statute. For other property and casualty lines of insurance, after the OIR takes agency action pursuant to a rate filing (usually by disapproving a rate), an insurer may require arbitration of the rate filing in lieu of an hearing under s. 120.57, F.S. By selecting arbitration, an insurer waives its right to challenge the OIR's action under the Administrative Procedures Act, unless the arbitrators fail to reach a decision within 90 days. In arbitration, the OIR and insurer select one arbitrator apiece, with the two arbitrators then selecting a third. A decision is valid if reached by at least two of the arbitrators, and the OIR and the insurer must treat the arbitrators' decision as the final approval of a rate filing.

Insurer Requirements Pursuant to a Medical Malpractice Insurance Contract
Section 627.4147(2), F.S., authorizes an insurer to require that an insured be a member in good standing of a duly recognized state or local professional society of health care providers that maintains a medical review committee. However, no professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization.

Insurer Reporting of Professional Liability Claims (ss. 627.911 – 927.919, F.S.)
Pursuant to s. 627.912, F.S., insurers (including self-insurance funds, surplus lines insurers, risk retention groups, and joint underwriting associations) that provide professional malpractice insurance to specified medical providers (such as physicians, osteopaths, podiatrists, and dentists), hospitals, attorneys and other specified entities must report to the OIR any malpractice claim or action for damages for personal injuries if the claim results in a final judgment or settlement in any amount, or for a final disposition of a medical malpractice claim that results in no indemnity payment on behalf of the insured. The information is used by the OIR to produce annual statistical summaries of the closed claims reports, and an annual report on the overall state of the medical malpractice market in Florida. The report must be filed within 30 days of the final judgment, settlement, or final disposition and include:

- The insured's name, address, professional license number, specialty coverage, and insurance policy number.
- The date of the occurrence that created the claim, the date the claim was reported, the date the suit was filed.

- The name and address of the injured person (exempt from the Sunshine laws), the injured person's age and sex.
- The total number, names, and health care provider professional license numbers of all defendants involved in the claim.
- The date and amount of the judgment or settlement, including the itemization of the verdict. Alternatively, the date and reason for final disposition if there is no judgment or settlement.
- In the case of a settlement, such information the OIR requires to determine the injured person's incurred and anticipated medical expense, wage loss, and other expenses.
- All loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.
- A summary of the occurrence that created the claim including the name of the institution where it occurred and the location in the institution where the injury occurred; the final diagnosis for which treatment was sought and the patient's actual condition; a description of any misdiagnosis made; the treatment that caused the injury; a description of the injury; and the safety management steps taken by the insured to prevent a similar occurrence less likely.

III. Effect of Proposed Changes:

Section 1. Amends s. 624.156, F.S., to specify that the business of insurance is subject to the Florida Civil Rights Act of 1992 (ss. 760.01—760.11, F.S., & s. 509.092, F.S.) and the Florida Deceptive and Unfair Trade Practices Act (ss. 501.201—501.213, F.S.), and that the consumer protections in these statutes apply to insurance consumers. Currently, the Deceptive and Unfair Trade Practices Act specifically excludes persons or activities regulated under the Florida Insurance Code from using the act to seek a remedy in s. 501.212(4)(a), F.S. Thus, the bill appears to create a conflict with this section of the Florida Statutes.

Section 2. Amends s. 627.062(7), as amended by ch. 2007-1, L.O.F. (HB 1-A), regarding the rate standards that apply to medical malpractice insurance. The bill requires the discount or surcharge applied to a health care provider based on the provider's loss experience to also be based on any disciplinary action taken by the federal or state government, or a health facility or health care plan. If the insurer establishes an alternative method of calculating the discount, it too must consider the provider's disciplinary record in addition to loss experience. The discount must be exclusive of any other discounts, credits, or rate differentials.

Current law requires a medical malpractice insurer to file with the OIR a copy of the surcharge or discount schedule, or a description of the alternative method used. The bill prohibits a medical malpractice liability insurer from using a rate or charging any premium unless the insurer has filed the required schedule or alternative method with the director of the OIR, and the director has approved it. The bill requires the OIR to adopt a schedule of appropriate ranges for credits, discounts, or alternative methods of rate reduction which will bring premium relief to health care providers who have experienced no closed claims or limited indemnity and expense payments over a specified period of time as determined by the OIR.

The bill creates a new paragraph (f) that requires the OIR to only consider as part of the insurer's rate base, the insurer's loss cost adjustment expenses or defense cost and containment expenses

to the extent that such expenses do not exceed the national average for such expenses for the prior calendar year, as determined by the OIR. The costs that an insurer incurs above the national average may not be used to justify a rate.

Section 3. Repeals subsection s. 627.4147(2), F.S., which permits a medical malpractice insurer to require that the insured medical provider be a member in good standing of a recognized state or local professional society that maintains a medical review committee.

Section 4. Amends s. 627.912, F.S., regarding the insurer reporting requirements for professional liability (malpractice) claims that result in a final judgment, settlement, or final disposition that results in no indemnity payment on behalf of the insured. Subsection (1) is amended to require that in addition to reporting the total number, names, and health care provider professional license numbers of all defendants involved in a professional liability claim, any nonparty health care provider who appeared on the jury verdict in a case would also have to be reported. The bill also specifies that reporting of the itemization of the verdict is to be from the jury verdict form.

Subsection (5) is amended to require an employee or agent of the state university board of trustees whose professional services are alleged in a claim that results in a final judgment of any amount or a settlement in any amount to report the claim to the Department of Health to be included on that employee's or agent's practitioner profile.

A new subsection (6) is created that requires malpractice insurers and other parties specified in subsection (1) to provide the OIR with the following information, specific to Florida and nationally, for the prior calendar year:

- Direct premiums written.
- Direct premiums earned.
- Incurred loss and loss expense developed according to a prescribed formula.[1]
- Incurred expenses allocated separately to commissions, other acquisition costs, general expenses, taxes, licenses, and fees, using appropriate estimates when necessary
- Policyholder dividends.
- Underwriting gain or loss.
- Net investment income, including net realized capital gains, using appropriate estimates when necessary.
- Federal income taxes.
- Net income.

The bill also creates subsection (7), which authorizes the OIR to impose an administrative fine of $1,000 per day against an insurer that fails to comply with these reporting requirements.

[1] The formula is A (dollar amount of losses paid) + B (reserves for reported claims at the end of the current year) - C (reserves for reported claims at the end of the previous year) +D (reserves for incurred but not reported claims at the end of the current year) - E (reserves for incurred but not reported claims at the end of the previous year) + F (loss adjustment expenses paid) + G (reserves for loss adjustment expenses at the end of the current year) – H (reserves for loss adjustment expenses at the end of the previous year).

Subsection (9) is amended to grant the OIR rulemaking authority regarding data reporting pursuant to this section. This is in error, as only the Financial Services Commission has rulemaking authority for rules that affect parties regulated by the OIR.

Section 5. Creates s. 627.41491, F.S., to require the OIR to provide health care providers with a comparison chart of the rates in effect for each medical malpractice insurer, self-insurer risk retention group, and the Florida Medical Malpractice Joint Underwriting Association. The chart must include a comparison of the rates for various specialties, reflect differing rates by geographic region, years in practice, and the discounts and surcharges available. The chart is to be placed on the Internet by January 1 of each year.

Section 6. Creates s. 627.41493, F.S., to require:

- Each medical malpractice insurer to reduce its rates to levels that are at least 25 percent less than the rates that were in effect on October 1, 2004. The rate reduction will apply to all coverage issued or renewed on or after October 1, 2007.
- Prior approval of rates by the OIR for all medical malpractice insurance rates before their use by an insurer as of October 1, 2007.

The provisions of this section also apply to separate affiliates of an insurer.

Section 7. Amends s. 627.41495, F.S., which currently requires a medical malpractice insurer or self-insurance fund to notify each policyholder or member upon filing for a rate increase of 25 percent or more. Instead, the bill directs the OIR to require each medical malpractice insurer, self insurance fund, and risk retention group to give notice to the public and its insureds of each rate filing. The OIR must hold a hearing if within 30 days after notice is given, any insured or association of insureds of the insurer make a request. Any consumer may participate in such a hearing, with the OIR to adopt rules governing their participation in the meeting. Additionally, the public counsel has standing to request a hearing pursuant to this section.

Section 8. States that pursuant to the findings in this section:

- Medical malpractice insurance rates filed with the OIR prior to September 15, 2009, may not be based upon the loss and expense experience of more than 5 years prior to that date.
- Medical malpractice insurance rates filed with the OIR on or after September 15, 2009, may be based upon the loss and expense experience of 2004 and thereafter.

The section expresses legislative intent that medical malpractice rates be based upon projected losses and expenses that reflect current Florida law regarding medical malpractice claims. Contains a Legislative finding that there is no justification for basing rates on the prior 5 to 10 years of loss experience and expenses in light of the 2003 legislation that significantly impacted both the frequency and severity of medical malpractice claims via caps on noneconomic damages, expert witness restrictions, and other barriers to full recovery for victims of medical malpractice and their families. Specifies that these legislative changes were purposed to make medical malpractice insurance more affordable and available, not to enrich medical malpractice insurers.

Section 9. Provides the Office of Insurance Regulation with rulemaking authority to administer this act.

Section 10. The act is effective upon becoming law.

IV. Constitutional Issues:

Municipality/County Mandates Restrictions:

None.

A. Public Records/Open Meetings Issues:

None.

B. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Section 6 of the bill requires all medical malpractice insurers to reduce their rates so that they are 25 percent lower than the insurer's rate on October 1, 2004. Section 8 of the bill, which prohibits the use of loss and expense data stemming from September 15, 2004, or earlier will result in a sizeable decrease in medical malpractice insurance premiums. However, it is not standard practice to calculate rates for medical malpractice insurance using only 2-3 years of loss experience. Should an unexpected increase in medical malpractice loss costs (perhaps through an increase in claim frequency) occur, insurers could experience losses. Additionally, the use of a limited time period in calculating rates could result in more volatile rate increases or decreases if loss costs and expenses drastically changed in the next year or two. By 2009 – 2010 five years of experience would be available to be used, which is within what is considered the standard period of experience used in rate filings in Florida.

C. Government Sector Impact:

The Office of Insurance Regulation expects a significant fiscal impact from the provisions contained in section 4 of the bill requiring mathematical calculations to be conducted for each entity that is required to report closed claim data. The reporting requirements regarding non-party health care providers that appear on the jury verdict form and that the itemization of jury verdict be made in accord with the jury verdict form will require data programming to be modified as well. Section 7 of the bill, which requires the OIR to conduct a public hearing on a rate filing upon the request of an insured, likely will result in additional hearings. The office anticipates the need to add additional staff along with additional funds for expenses in order to hold the additional public hearings required by the section.

VI. Technical Deficiencies:

The bill references the "director" of the OIR for certain decision-making processes. The convention within the insurance statutes is to refer to the "office."

Currently, the Deceptive and Unfair Trade Practices Act specifically excludes persons or activities regulated under the Florida Insurance Code from using the act to seek a remedy in s. 501.212(4)(a), F.S. Thus, the bill appears to create a conflict with this section of the Florida Statutes.

VII. Related Issues:

None.

This Senate Professional Staff Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

VIII. Summary of Amendments:

None.

This Senate Professional Staff Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.