The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	CS/SB 2252
INTRODUCER:	Banking and Insurance Committee; and Senator Baker; and others
SUBJECT:	Professional Liability Insurance
DATE:	April 2, 2009
REVISED:	4/3/09

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Woodham	Burgess	BI	**Fav/CS**
2.			GA	
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill changes the conditions under which a claim against professional liability insurance must be reported to the state. The bill provides a statutory definition for when a claim exists and creates a new set of reporting criteria for those entities which must report claims activity to the Office of Insurance Regulation.

This bill substantially amends the following section of the Florida Statutes: s. 627.912, F.S.

II. Present Situation:

Professional Liability Insurance and Claims Reporting under Florida Law

Claims reporting by professional liability insurers in this state are regulated by s. 627.912., F.S., in the Florida Insurance Code. This section provides criteria for when a claims report must be made to the OIR, and addresses the content, timing, and manner of such reports.

Pursuant to s. 627.912(1), F.S., insurers providing professional liability insurance are required to report to the OIR whenever a "claim or action" against one of their insureds is made and the claim results in:[1]

- A final judgment in any amount.
- A settlement in any amount.
- A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured.

Furthermore specified health care practitioners and providers are bound to make such reports even when an insurer is not bound.[2]

The following types of insurers are bound by these requirements:[3]

- Self-insurers authorized by s. 627.357, F.S.;
- Commercial self-insurance funds authorized under s. 624.462, F.S.;
- Authorized insurers;
- Surplus lines insurers;
- Risk retention groups; and
- Joint underwriting associations

These insurers are bound by these requirements insofar as they provide coverage for the following practitioners and entities:[4]

- A practitioner of medicine licensed under ch. 458, F.S.;
- A practitioner of osteopathic medicine licensed under ch. 459, F.S.
- A podiatric physician licensed under ch. 461, F.S.
- A dentist licensed under ch. 466, F.S.
- Members of the Florida Bar
- A hospital licensed under part IV of ch. 395 F.S.
- A crisis stabilization unit licensed under part IV of ch. 394, F.S.
- A health maintenance organization licensed under part I of ch. 641, F.S.
- Clinics included in ch. 390, F.S.
- An ambulatory surgical center as defined in s. 395.02, F.S.

History of Difficulties with Claims Reporting Under This Statute

The reporting procedure in the existing statute has long been the subject of controversy, but especially since the period of 2003-2005. During that time the OIR conducted a statewide audit to determine how many claims were being made on professional liability insurance.

As explained to committee staff both by the OIR and this bill's proponents, data received in this audit was uncertain and confusing. The audit became the subject of vigorous dispute among insurers, the OIR, and the professional associations representing the insureds. By a consensus of these parties much of the confusion and disagreement arose due to ambiguities and inadequacies

[1] Section 627.912(1)(a)1-3, F.S.
[2] Section 627.912(1)(b)
[3] Section 627.912(1)(a)
[4] Ibid.

in the procedure set forth in s. 627.912(1)(a)-(b), F.S. Of special concern is the fact that the statute does not clearly define what a claim is. Consequently many insurers and their insureds created records for a claim when either was concerned a claim might be made against them. Many of these claims never came to fruition, but were nonetheless reported under the statute. This led to the dispute in 2005 with particular disagreement over just how often claims were actually being made.

III. Effect of Proposed Changes:

Section 1

This section amends s. 627.912(1), F.S.

The section eliminates the existing criteria requiring a claims report be filed, and inserts new language to define the term claim. This section then lists new conditions that will trigger a claims report to be filed with the OIR.

The definition of "claim:"

- The receipt of a notice of written intent to initiate litigation, a summons and complaint, or a written demand from a person or his or her legal representative stating an intention to pursue an action for damages against those insureds listed under paragraph (a) of the statute.

The duty to report a claim arises at the earliest occurrence of the following:[5]

- Entry of any judgment against a provider identified in paragraph (a) of the statute for which all appeals as a matter of right have been exhausted or for which the period for filing such an appeal has expired.
- The execution of an agreement to settle damages alleged to arise from the provision of professional services between and a claimant[6] and a provider, or any other entity with a duty to report under the statute. That agreement must include payment of at least $1. If applicable statutes require court approval before the agreement becomes effective the duty to report does not arise until approval is given.
- The final payment of any indemnity money on behalf of any provider for damages alleged in the provision of professional services.
- Final disposition of a claim for which no indemnity payment was made on behalf of the insured, but for which there were loss adjustment expenses paid in excess of $5,000.00. Used in this section "final disposition" means the insurer has brought down all reserves and closed its file.

Reports triggered by any one of these four conditions must be filed with the OIR within thirty days of their earliest occurrence.

Reporting requirements in a year during which no claims were made:

Those entities bound by the statute with no claims in the preceding year will file a "No Claim Submission Report" by April 1st of the calendar year. If the entity discovers that it made this report in error it must notify the OIR promptly and take such steps as that agency directs to correct the situation.

[5] The items in the following four bullets comprise subheadings under s. 627.912(1)(c), F.S. which the bill would create.
[6] A claimant as defined under s. 766.202, F.S

Re-opening a claim previously closed:
If a claim closed without payment is later re-opened, that claim is treated as a new claim. If a claim was closed with payment, and further payments are later made, then a corrective report must be made to reflect the additional payments.

Section 2
Provides an effective date of July 1, 2009

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Upon taking effect this bill should reduce administrative costs for insurers and policy holders bound by the statute as it will reduce the number of duplicative and frivolous claims reports. To the extent duplicative and frivolous claims reports increase rates for professional liability insurance the bill may reduce those rates.

C. Government Sector Impact:

This bill would streamline and simplify the OIR's regulation of liability insurance claims reporting. To the extent the bill reduces duplicative and frivolous claims reports this bill improves the data the OIR collects and improves the OIR's regulation of the affected parties.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance Committee on April 1, 2009
The criteria which will trigger a claims report were changed so as to apply to all the entities listed in s. 627.912(1)(a), F.S., who are under a duty to report claims. These criteria now bind insurers providing professional liability insurance to members of the Florida Bar.

The third criteria which will trigger a claims report is a loss adjustment payment. The amount of a loss adjustment payment which will trigger a claim is raised to $5,000.00. Formerly it had been $2500.00.

B. Amendments:

None.