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 General Government Appropriations Committee

BILL:	CS/CS/SB 2252
INTRODUCER:	General Government Appropriations Committee, Banking and Insurance Committee, Senator Baker, and others
SUBJECT:	Professional Liability Insurance
DATE:	April 15, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Woodham	Burgess	BI	**Fav/CS**
2.	Frederick	DeLoach	GA	**Fav/CS**
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 (office).

According to the office, implementation of the provisions in this bill will simplify regulation of liability insurance claims reporting by eliminating duplicative and frivolous claims reports. These changes will improve the quality of data the office collects and the office's regulation of the affected parties, at no additional cost.

This bill substantially amends section 627.912, Florida Statutes.

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 Office of Insurance Regulation, 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 office whenever a "claim or action" against one of their insured 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.
- 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.

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

- 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, especially since the period of 2003-2005. During that time the office conducted a statewide audit to determine how many claims were being made on professional liability insurance.

The office indicates that data received in this audit was unclear. The audit became the subject of vigorous dispute among insurers, the office, and the professional associations representing the insured. By a consensus of these parties, much of the confusion and disagreement arose due to ambiguities and inadequacies 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 insured 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 how often claims were actually being made.

III. Effect of Proposed Changes:

The bill amends s. 627.912(1), F.S., to eliminate the existing criteria requiring a claims report be filed and to provide new language to define "claim." The bill establishes new conditions that will trigger a claims report to be filed with the office.

"Claim" is defined as 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 insured 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. The "final disposition" means the insurer has brought down all reserves and closed its file.

[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

Reports triggered by any one of these four conditions must be filed with the office within 30 days of their earliest occurrence.

The bill provides that insurers listed under s. 627.912(1), F.S., with no claims in the preceding year 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 office promptly and take steps to correct the situation, as directed by the office.

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.

The bill 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:

This bill will potentially reduce administrative costs for insurers and policy holders under s. 627.912(1), F.S., by reducing 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 simplifies regulation of liability insurance claims reporting by the Office of Insurance Regulation. To the extent that the bill reduces duplicative and frivolous claims reports, it improves the quality of data the office collects and the office's regulation of the affected parties at no additional cost.

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/CS by General Government Appropriations Committee on April 15, 2009:

The committee substitute makes a technical correction.

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. Formerly it had been $2,500.

B. Amendments:

None.