

Senate Bill 358

By: Senators Brown of the 26th, Thompson of the 33rd and Thomas of the 10th

A BILL TO BE ENTITLED  
AN ACT

1 To amend Chapter 9 of Title 33 of the Official Code of Georgia Annotated, relating to  
2 regulation of rates, underwriting rules, and related organizations with regard to insurance,  
3 so as to enact the "Medical Malpractice Insurance Premium Reform Act"; to provide a short  
4 title; to require medical malpractice insurers to file rates, rating plans, rating systems, and  
5 underwriting rules; to require that medical malpractice insurers develop rates based on each  
6 insurer's experience in this state; to provide for the content of experience filings; to prohibit  
7 the retention of excess loss reserves under certain circumstances; to provide definitions; to  
8 require medical malpractice insurers to file certain reports and information; to provide for  
9 penalties for failure to file such reports and information; to provide for a summary report to  
10 the General Assembly by the Commissioner of Insurance and the contents thereof; to  
11 authorize the Commissioner to promulgate certain rules and regulations; to provide for public  
12 hearings in connection with certain medical malpractice insurance filings; to provide for  
13 enforcement; to provide for an effective date; to repeal conflicting laws; and for other  
14 purposes.

15 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

16 **SECTION 1.**

17 This Act shall be known and may be cited as the "Medical Malpractice Insurance Premium  
18 Reform Act."

19 **SECTION 2.**

20 Chapter 9 of Title 33 of the Official Code of Georgia Annotated, relating to regulation of  
21 rates, underwriting rules, and related organizations with regard to insurance, is amended by  
22 striking subsection (b) of Code Section 33-9-21, relating to maintenance and filing of rates,  
23 rating plans, rating systems, and underwriting rules, and inserting in lieu thereof a new  
24 subsection (b) to read as follows:

1       "(b)(1) Any domestic, foreign, or alien insurer that is authorized to write insurance in this  
2 state must file with the Commissioner any rate, rating plan, rating system, or underwriting  
3 rule for all personal private passenger motor vehicle insurance and medical malpractice  
4 insurance. No such rate, rating plan, rating system, or underwriting rule will become  
5 effective, nor may any premium be collected by any insurer thereunder, unless the filing  
6 has been received by the Commissioner in his or her office and such filing has been  
7 approved by the Commissioner or a period of 45 days has elapsed from the date such  
8 filing was received by the Commissioner during which time such filing has not been  
9 disapproved by the Commissioner. The Commissioner shall be authorized to extend such  
10 45 day period by no more than 55 days at his or her discretion. If a filing is disapproved,  
11 notice of such disapproval order shall be given within 100 days of receipt of filing by the  
12 Commissioner, specifying in what respects such filing fails to meet the requirements of  
13 this chapter. The filer shall be given a hearing upon written request made within 30 days  
14 after the issuance of the disapproval order, and such hearing shall commence within 30  
15 days after such request unless postponed by mutual consent. Such hearing, once  
16 commenced, may be postponed or recessed by the Commissioner only for weekends,  
17 holidays, or after normal working hours or at any time by mutual consent of all parties  
18 to the hearing. The Commissioner may also, at his or her discretion, recess any hearing  
19 for not more than two recess periods of up to 15 consecutive days each. In connection  
20 with any hearing or judicial review with respect to the approval or disapproval of such  
21 rates, the burden of persuasion shall fall upon the affected insurer or insurers to establish  
22 that the challenged rates are adequate, not excessive, and not unfairly discriminatory.  
23 After such a hearing, the Commissioner must affirm, modify, or reverse his or her  
24 previous action within the time period provided in subsection (a) of Code Section 33-2-23  
25 relative to orders of the Commissioner. The requirement of approval or disapproval of a  
26 rate filing by the Commissioner under this subsection shall not prohibit actions by the  
27 Commissioner regarding compliance of such rate filing with the requirements of Code  
28 Section 33-9-4 brought after such approval or disapproval.

29 (2) Each domestic, foreign, and alien insurer writing or authorized to write medical  
30 malpractice insurance in this state shall develop and establish rates based upon each  
31 individual insurer's experience in this state to the extent actuarially credible. The  
32 experience filed shall include the loss ratios, allocated and unallocated loss adjustment  
33 expenses which shall segregate and identify litigation expenses related to claims,  
34 reserves, reserve development information, expenses including commissions and  
35 dividends paid, investment income and losses, pure premium data adjusted for loss  
36 development and loss trending, profits, exposure data, credit and debit information, and  
37 all other data and information used by that insurer in formulating its rates that are used

1 in this state and any other data and information required by the Commissioner. In  
 2 establishing and maintaining loss reserves, no medical malpractice insurer shall be  
 3 allowed to maintain any excess loss reserve for any claim or potential claim for more than  
 4 90 days after the amount of liability for such claim or potential claim has been  
 5 established, whether by final judgment, settlement agreement, or otherwise. This  
 6 limitation on the maintenance of loss reserves shall be enforced through this Code section  
 7 as well as through Code Section 33-9-23, relating to examination of insurers. The  
 8 Commissioner is authorized to accept such rate classifications as are reasonable and  
 9 necessary for compliance with this chapter.

10 (3) As used in paragraph (2) of this subsection, the term 'excess loss reserve' means any  
 11 reserve amount in excess of the reserve required by law."

### 12 SECTION 3.

13 Said chapter is further amended by adding new Code Sections 33-9-21.3 and 33-9-21.4 to  
 14 read as follows:

15 "33-9-21.3.

16 (a) The purpose of this Code section is to protect consumers from arbitrary insurance rate  
 17 making and practices, to encourage a competitive insurance marketplace, to provide for a  
 18 public accounting of insurance premiums, and to ensure that medical malpractice insurance  
 19 rates are fair and affordable for all Georgians.

20 (b) As used in this Code section, the term:

21 (1) 'Insurer' shall include any person engaged as an indemnitor, surety, or contractor who  
 22 issues medical malpractice insurance by whatever name called. With respect to any  
 23 nonadmitted insurer transacting business in this state, filing the report required by this  
 24 Code section shall be the obligation of the surplus lines broker or licensee originating or  
 25 accepting the insurance.

26 (2) 'Medical malpractice insurance' means insurance coverage against the legal liability  
 27 of the insured and against loss, damage, or expense incident to a claim arising out of the  
 28 death or injury of any person as a result of the negligence or malpractice in rendering  
 29 professional service by any health care provider.

30 (c) Every domestic, foreign, and alien insurer providing medical malpractice insurance to  
 31 a health care provider in this state and every health care provider in this state who  
 32 maintains professional liability coverage through a plan of self-insurance shall submit to  
 33 the Commissioner and the consumers' insurance advocate a report of all claims, including  
 34 both open claims and closed claims filed during the reporting period, for medical  
 35 malpractice made against any of its insureds in this state during the preceding three-month  
 36 period.

1 (d) The report shall be in writing on a form prescribed by the Commissioner and shall  
2 contain the following information segregated by specialty of coverage;

3 (1) The total dollar amount of premiums earned for medical malpractice insurance  
4 coverage including both primary and excess coverages;

5 (2) The number of insureds from whom medical malpractice insurance coverage  
6 premiums were collected;

7 (3) The number and amount of all reserves established for reported claims other than  
8 paid claims, paid claims that have not been paid in full, and incurred but not reported  
9 claims;

10 (4) The amounts paid in medical malpractice claims excluding all allocated and  
11 unallocated loss adjustment expenses;

12 (5) Net investment gain or loss and other income gain or loss allocated to medical  
13 malpractice insurance computed by the formula used in the annual insurance expense  
14 exhibit for allocation among lines of business;

15 (6) The actual expenses attributable solely to the defense of such medical malpractice  
16 claims;

17 (7) All other loss adjustment expenses excluding those contained in paragraph (6) of this  
18 subsection;

19 (8) The average credits and debits by type offered by the insurer;

20 (9) Total number of claims reported;

21 (10) Total number of claims closed without payment;

22 (11) Total number of claims closed with payment identifying each claim amount paid;

23 (12) Total number of legal actions filed;

24 (13) Total number of verdicts or judgments for defendants;

25 (14) Total number of verdicts or judgments for plaintiffs identifying the amount of each  
26 verdict or judgment;

27 (15) Within six months after the final disposition of the claim, the amounts paid, if any,  
28 and the date and manner of disposition whether by judgment, settlement, or otherwise;

29 (16) For each claim that has resulted in a settlement or a final judgment in favor of a  
30 plaintiff in any amount, the insurer shall report the following:

31 (A) The specialty coverage of the insured or, if a facility, the nature of the facility;

32 (B) The date of the occurrence which created the claim;

33 (C) The date that the claim was reported to the insurer or self-insurer;

34 (D) The date of suit, if filed;

35 (E) The injured person's age and gender;

36 (F) The total number of defendants involved in the claim;

- 1 (G) The date and amount of the judgment or settlement, if any, including the  
2 itemization of the verdict;
- 3 (H) Whether the claim was the subject of mediation;
- 4 (I) Such information as the Commissioner may require with regard to the injured  
5 person's incurred and anticipated medical expenses, wage loss, and other expenses;
- 6 (J) The loss adjustment expense paid to defense counsel and all other allocated loss  
7 adjustment expense paid;
- 8 (K) The date and reason for final disposition if there is no judgment or settlement;
- 9 (L) A summary of the occurrence that created the claim;
- 10 (M) The location within the institution at which the injury occurred, if applicable;
- 11 (N) The final diagnosis for which treatment was sought or rendered including the  
12 patient's actual condition;
- 13 (O) A description of the misdiagnosis made, if any, of the patient's actual condition;
- 14 (P) The operation, diagnostic, or treatment procedure causing the injury, if applicable;
- 15 (Q) A description of the principal injury giving rise to the claim;
- 16 (R) The safety management steps that have been taken by the insured to make similar  
17 occurrences or injuries less likely in the future; and
- 18 (S) Any other information required by the Commissioner to analyze and evaluate the  
19 nature, causes, location, cost, and damages involved in professional liability cases; and
- 20 (17) Such additional information as the Commissioner may require.
- 21 (e) Any insurer or entity that fails to report any information required to be reported under  
22 this Code section shall be subject to a civil monetary penalty to be imposed by the  
23 Commissioner. Upon a determination of the Commissioner that there is probable cause to  
24 believe that any insurer or entity has failed or refused to make a report required by this  
25 Code section, the Commissioner shall provide written notice to the alleged violator stating  
26 the nature of the alleged violation. Upon the written request of the alleged violator within  
27 30 days of the date of the Commissioner's written notice, the Commissioner shall notify  
28 the alleged violator of the time and place of a hearing at which the alleged violator may  
29 appear to show good cause why a civil penalty should not be imposed. The hearing shall  
30 be conducted in accordance with the provisions of Chapter 2 of this title.
- 31 (f) If the Commissioner determines that a violation of this Code section has occurred, the  
32 Commissioner shall assess a civil penalty of not less than \$1,000.00 nor more than  
33 \$10,000.00 for each violation. Anyone so assessed shall be notified of the assessment in  
34 writing and the notice shall specify the reasons for the assessment. If the alleged violator  
35 requests a hearing in accordance with subsection (e) of this Code section, the  
36 Commissioner shall not make a determination of a violation nor impose an assessment until

1 the conclusion of the hearing. The penalty collected shall be deposited into the state  
2 treasury.

3 (g) If any violator fails to pay the amount of the penalty assessed to the Commissioner  
4 within 30 days after the issuance of the penalty assessment, the Commissioner may  
5 institute a civil action in the Superior Court of Fulton County to collect such assessment.

6 (h) If medical malpractice insurance coverage includes premises and operations insurance  
7 or any other insurance delivered as a part of a package with medical malpractice insurance,  
8 only information relating to the medical malpractice insurance portion of the coverage shall  
9 be included in the report filed under this Code section.

10 (i) The Commissioner shall provide to the General Assembly in accordance with Code  
11 Section 33-2-8.1 an annual summary of the information contained in the reports submitted  
12 under this Code section which shall contain the following information:

13 (1) Identification of the number of rate increases and decreases for medical malpractice  
14 insurance that were requested, approved, and disapproved during the preceding quarter,  
15 categorized according to the amount of the increase or decrease requested, approved, and  
16 disapproved as follows:

17 (A) Five percent or less;

18 (B) Greater than 5 percent but not more than 10 percent;

19 (C) Greater than 10 percent but not more than 20 percent; and

20 (D) Greater than 20 percent.

21 Any increase or decrease that was approved in an amount different from that requested  
22 shall be noted in the report;

23 (2) A description of the condition of the medical malpractice insurance market in this  
24 state including recommendations that will encourage competition for medical malpractice  
25 insurance business in this state;

26 (3) Information regarding specific claims experiences filed with the department pursuant  
27 to this Code section;

28 (4) Recommendations concerning the medical malpractice insurance market in this state;  
29 and

30 (5) An appendix providing company-by-company the information summarized in  
31 paragraph (1) of this subsection.

32 (j) The Commissioner shall by rule or regulation promulgated not later than July 1, 2003,  
33 establish the form of the report required to be filed in accordance with this Code section,  
34 including the manner of reporting the elements of the report. The Commissioner is  
35 authorized to promulgate rules and regulations to require such reports to include  
36 information in addition to that specified in this Code section.

1 33-9-21.4.  
2 When a rate filing of a medical malpractice insurer submitted under subsection (b) of Code  
3 Section 33-9-21 will result in an increase of more than 10 percent, the Commissioner shall  
4 notify the public of the rate increase and shall hold a public hearing as to the  
5 appropriateness of the rate increase. The hearing shall be conducted in accordance with  
6 the provisions of Chapter 2 of this title. Any interested person or group may participate in  
7 any hearing held pursuant to this Code section."

8 **SECTION 4.**

9 This Act shall become effective upon its approval by the Governor or upon its becoming law  
10 without such approval.

11 **SECTION 5.**

12 All laws and parts of laws in conflict with this Act are repealed.