

Summary of SB 2252

SB 2252 amends Section 627.912, F.S. Professional liability claims and actions; reports by insurers and health care providers; annual report by office.

The bill changes the conditions under which a claim against professional liability insurance must be reported to the state. The bill also 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 (OIR). Those entities that must report claims are:

- 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.

Section 627.912, F.S. is amended as outlined below:

Section 627.912, F.S. Section 2. Subsection (1) (a) This section as amended relates to professional liability claims and actions against health care practitioners and health care facilities and members of The Florida Bar to provide the OIR with a report of written claim or action for damages.

Section 627.912, F.S. Section 2. Subsection (1) (b) (NEW) Defines “claim” as receipt of notice of intent of litigation, summons or complaint or intent to pursue action.

Section 627.912, F.S. Section 2. Subsection (1) (c) 1.-4. (NEW) This section outlines when the reporting requirements are triggered, which includes the following:

- the entry of any judgment against any provider for which an exhaustion of right of appeals or time period for filing appeal has expired;
- the execution of an agreement that includes an indemnity payment of at least \$1 or approval of the agreement in court;
- the final payment of indemnity money for damages from professional services rendered; or
- the final disposition of a claim where no indemnity payment was made on behalf of insured but loss adjustment expenses were paid in excess of \$5,000 to allow insurer to close its file.

Section 627.912, F.S. Section 2. Subsection (1) (d) (NEW) When no claim or action for damages were filed during a previous calendar year, insurer must file a no claim submission report by April 1. If an error is discovered after filing the no claim submission report, the insurer must notify the OIR and make the correction as directed.

Section 627.912, F.S. Section 2. Subsection (1) (e) (NEW) If a claim is open, closed and then reopened it is to be treated as a new claim for reporting purposes.

Section 627.912, F.S. Section 2. Subsection (1) (g) (NEW) This qualifies that insurers are responsible for filing reports no later than 30 days after occurrence of the first event and that once filed no new or amended reports on a claim more than 1 year from the initial report are required.

This amendment takes effect July 1, 2009.

For a complete copy of the SB 2252 please click on the link below:

<http://www.flsenate.gov/data/session/2009/Senate/bills/billtext/pdf/s2252er.pdf>