By the Committee on Governmental Oversight and Productivity

302-1991A-00

1 A bill to be entitled
2 An act relating to governmental reorganization;
3 creating s. 17.001, F.S.; establishing the
4 Office of the Chief Financial Officer; creating
5 s. 20.121, F.S.; creating the Department of
6 Financial Services; providing for the Office of
7 the Commissioner of Insurance; providing for
8 the Office of the Commissioner of Financial
9 Institutions; providing for the Office of the
10 Commissioner of Securities and Finance;
11 providing for the office of the Commissioner of
12 the Treasury; establishing the manner of
13 appointment; providing qualifications;
14 transferring the Department of Banking and
15 Finance to the Department of Financial
16 Services; transferring the Department of
17 Insurance to the Department of Financial
18 Services; repealing s. 20.12, F.S.; abolishing
19 the Department of Banking and Finance;
20 repealing s. 20.13, F.S.; abolishing the
21 Department of Insurance; amending s. 20.165,
22 F.S.; transferring the Division of Certified
23 Public Accounting and the Board of Accountancy,
24 of the Department of Business and Professional
25 Regulation to the Department of Financial
26 Services; amending s. 350.061, F.S.;
27 authorizing the Public Counsel to represent the
28 public before the Insurance Rating Commission;
29 amending s. 350.0611, F.S.; authorizing the
30 Public Counsel to represent the public before
31 the Insurance Rating Commission; amending s.

1 350.0613, F.S.; requiring the Insurance Rating
2 Commission to furnish pleadings to the Public
3 Counsel; creating s. 624.055, F.S.; defining
4 the term "commission"; redesignating parts of
5 ch. 624, F.S.; creating sections
6 624.37-624.377, F.S.; creating the Insurance
7 Rating Commission; establishing its powers and
8 duties; providing for the appointment and
9 confirmation of commissioners; establishing
10 terms of office and qualifications of
11 commissioners; establishing standards of
12 conduct; regulating ex parte communications;
13 amending ss. 175.141, 185.12, 408.701, 651.018,
14 F.S.; conforming references; amending s.
15 624.19, F.S.; authorizing the use of forms;
16 amending s. 624.307, F.S.; removing requirement
17 to employ actuaries; amending s. 624.321, F.S.;
18 conforming provisions to include the Insurance
19 Rating Commission; amending s. 624.322, F.S.;
20 conforming provisions to include the Insurance
21 Rating Commission; amending s. 626.9541, F.S.;
22 conforming provisions to substitute the
23 Insurance Rating Commission for the Department
24 of Insurance; amending s. 626.9926, F.S.;
25 conforming provisions to include the Insurance
26 Rating Commission; amending s. 627.031, F.S.;
27 substituting the Insurance Rating Commission
28 for the Department of Insurance; amending s.
29 627.0612, F.S.; conforming provisions to
30 include the commission; amending s. 627.0613,
31 F.S.; removing authority of the consumer

1 advocate; amending s. 627.062, F.S.; conforming
2 provisions to substitute the commission for the
3 department; repealing arbitration provisions;
4 amending s. 627.0628, F.S.; modifying
5 membership on the Florida Commission on
6 Hurricane Loss Projection Methodology; amending
7 ss. 627.0645, 627.06501, 627.0651, 627.0653,
8 627.06535, 627.0654, 627.066, 627.072, 627.091,
9 627.0915, 627.0916, 627.096, 627.101, 627.111,
10 627.141, 627.151, 627.192, 627.211, 627.212,
11 627.215, 627.221, 627.231, F.S.; substituting
12 the Insurance Rating Commission for the
13 department; amending ss. 627.241, 627.281,
14 627.291, 627.301, 627.311, 627.314, 627.331,
15 627.351, 627.3512, 627.357, 627.361, 627.410,
16 627.411, 627.6475, 627.6498, 627.6675,
17 627.6699, 627.6745, 627.678, 627.682, 627.727,
18 627.780, 627.782, 627.7825, 627.783, 627.793,
19 627.9407, 636.017, 641.19, 641.31, 641.3903,
20 641.3922, 641.402, 641.42, 642.027, 648.33,
21 F.S.; conforming provisions to changes made by
22 this act; authorizing the Governor to make
23 appointments to the Insurance Rating
24 Commission; transferring regulatory authority
25 related to rates to the Insurance Rating
26 Commission; directing the Division of Statutory
27 Revision to prepare draft legislation;
28 establishing the Financial Services Transition
29 Task Force; providing membership; establishing
30 duties; creating ss. 442.0011 and
31 633.801-633.825, F.S.; transferring to the

1 Division of State Fire Marshal, Department of
2 Insurance, all powers, duties, and
3 responsibilities of chapter 442, excluding ss.
4 442.101 through 442.127, which relate to
5 firefighter employers, firefighter employees,
6 and firefighter places of employment, from the
7 Division of Safety, Department of Labor and
8 Employment Security; providing an effective
9 date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Effective January 7, 2003, section 17.001,
14 Florida Statutes, is created to read:
15 17.001 Financial Officer.--As provided in s. 4(c),
16 Art. IV of the State Constitution, the Chief Financial Officer
17 is the chief fiscal officer of the state and is responsible
18 for settling and approving accounts against the state and
19 keeping all state funds and securities.
20 Section 2. Effective January 7, 2003, section 20.121,
21 Florida Statutes, is created to read:
22 20.121 Department of Financial Services.--There is
23 created a Department of Financial Services.
24 (1) The head of the Department of Financial Services
25 is the Chief Financial Officer.
26 (2)(a) The Division of Administration is created
27 within the Office of the Chief Financial Officer. The division
28 is headed by a director who is appointed by and serves at the
29 pleasure of the Chief Financial Officer. A Bureau of Financial
30 and Support Services is created within the division.
31

1 (b) The Division of Financial Investigations is
2 created within the Office of the Chief Financial Officer. Its
3 responsibilities include, but are not limited to, conducting
4 investigations of insurance fraud. The division is headed by a
5 director who is appointed by and serves at the pleasure of the
6 Chief Financial Officer.
7 (3) Notwithstanding the requirements of s. 20.04 and
8 except as otherwise provided in this section, the principal
9 policy and program development unit of the department is the
10 "office." Each office is headed by a commissioner who is
11 appointed by and serves at the pleasure of the Chief Financial
12 Officer. Each commissioner shall perform such duties as are
13 specified in this section and such other duties as are
14 assigned by the Chief Financial Officer. The principal unit of
15 each office is the "division." Each division is headed by a
16 "director."
17 (4)(a) The Office of the Commissioner of Insurance is
18 established in the Department of Financial Services. The
19 office shall be headed by the Commissioner of Insurance. Prior
20 to appointment as commissioner, the Commissioner of Insurance
21 must have had, within the previous 10 years, at least 5 years
22 of experience as a senior officer of an insurer, as defined in
23 s. 624.03, or insurance agency, as defined in s. 626.094, or
24 as an examiner or other senior employee of a state or federal
25 agency having regulatory responsibility over insurers or
26 insurance agencies.
27 (b) The Office of the Commissioner of Insurance shall
28 consider of the following divisions:
29 1. Division of Insurance Agents and Agencies;
30 2. Division of Insurance Consumer Services;
31 3. Division of Insurer Services;

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1 4. Division of Rehabilitation and Liquidation;
2 5. Division of Risk Management; and
3 6. Division of State Fire Marshal.
4 (5)(a) The Office of the Commissioner of Financial
5 Institutions is established in the Department of Financial
6 Services. The office shall be headed by the Commissioner of
7 Financial Institutions. Prior to appointment, the Commissioner
8 of Financial Institutions must have had, within the previous
9 10 years, at least 5 years of experience as a senior officer
10 of a financial institution, as defined in s. 655.005(h), or as
11 an examiner or other senior employee of a state or federal
12 agency having regulatory responsibility over financial
13 institutions.
14 (b) The Office of the Commissioner of Financial
15 Institutions shall consist of the following divisions:
16 1. Division of Banking; and
17 2. Division of Credit Unions.
18 (c) For purposes of chapter 120, the Commissioner of
19 Financial Institutions is the agency head for all divisions
20 within the Office of the Commissioner of Financial
21 Institutions. The commissioner shall be responsible for, and
22 take final agency action related to, the implementation and
23 enforcement of all statutes and rules within the regulatory
24 authority delegated to the Office of the Commissioner of
25 Financial Institutions and the divisions created within that
26 office. The Commissioner of Financial Institutions may serve
27 as the Director of the Division of Banking or the Director of
28 the Division of Credit Unions, or both.
29 (6)(a) The Office of the Commissioner of Securities
30 and Finance is established within the Department of Financial
31 Services. The office shall be headed by the Commissioner of

1 Securities and Finance. Prior to appointment, the Commissioner
2 of Securities and Finance must have had, within the previous
3 10 years, at least 5 years of experience as a senior officer
4 of a securities or finance company or as an examiner or other
5 senior employee of a state or federal agency having regulatory
6 responsibility over securities or finance companies.
7 (b) The Office of the Commissioner of Securities and
8 Finance shall consist of the following divisions:
9 1. Division of Securities and Finance; and
10 2. Division of Certified Public Accounting.
11 (c) For purposes of chapter 120, the Commissioner of
12 Securities and Finance is the agency head for all divisions
13 within the Office of the Commissioner of Securities and
14 Finance. The commissioner shall be responsible for, and take
15 final agency action related to, the implementation and
16 enforcement of all statutes and rules within the regulatory
17 authority delegated to the Office of the Commissioner of
18 Securities and Finance. The Commissioner of Securities and
19 Finance may serve as Director of the Division of Securities
20 and Finance.
21 (7)(a) The Office of the Commissioner of Treasury is
22 established in the Department of Financial Services. The
23 office shall be headed by the Commissioner of the Treasury.
24 The Commissioner of the Treasury must possess sufficient
25 education, business experience, and managerial ability to
26 effectively perform his or her duties.
27 (b) The Office of the Commissioner of the Treasury
28 shall consist of the following divisions:
29 1. Division of Accounting and Auditing, which is
30 responsible for, without limitation, unclaimed property;
31 2. Division of Information Services; and

1 3. Division of Treasury. A section of Government
2 Employee Deferred Compensation is created within the Division
3 of Treasury which shall administer the Government Employees
4 Deferred Compensation Plan established under s. 112.215 for
5 state employees.
6 Section 3. Effective January 7, 2003, the Department
7 of Banking and Finance is transferred by a type two transfer,
8 as defined in section 20.06, Florida Statutes, to the
9 Department of Financial Services.
10 Section 4. Effective January 7, 2003, the Department
11 of Insurance is transferred by a type two transfer, as defined
12 in section 20.06, Florida Statutes, to the Department of
13 Financial Services.
14 Section 5. Effective January 7, 2003, section 20.12,
15 Florida Statutes, is repealed.
16 Section 6. Effective January 7, 2003, section 20.13,
17 Florida Statutes, is repealed.
18 Section 7. Effective January 7, 2003, subsections (2)
19 and (4) of section 20.165, Florida Statutes, are amended to
20 read:
21 20.165 Department of Business and Professional
22 Regulation.--There is created a Department of Business and
23 Professional Regulation.
24 (2) The following divisions of the Department of
25 Business and Professional Regulation are established:
26 (a) Division of Administration.
27 (b) Division of Alcoholic Beverages and Tobacco.
28 ~~(c) Division of Certified Public Accounting.~~
29 ~~1. The director of the division shall be appointed by~~
30 ~~the secretary of the department, subject to approval by a~~
31 ~~majority of the Board of Accountancy.~~

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~~2. The offices of the division shall be located in Gainesville.~~

(c)~~(d)~~ Division of Florida Land Sales, Condominiums, and Mobile Homes.

(d)~~(e)~~ Division of Hotels and Restaurants.

(e)~~(f)~~ Division of Pari-mutuel Wagering.

(f)~~(g)~~ Division of Professions.

(g)~~(h)~~ Division of Real Estate.

1. The director of the division shall be appointed by the secretary of the department, subject to approval by a majority of the Florida Real Estate Commission.

2. The offices of the division shall be located in Orlando.

(h)~~(i)~~ Division of Regulation.

(i)~~(j)~~ Division of Technology, Licensure, and Testing.

(4)(a) The following boards are established within the Division of Professions:

1. Board of Architecture and Interior Design, created under part I of chapter 481.

2. Florida Board of Auctioneers, created under part VI of chapter 468.

3. Barbers' Board, created under chapter 476.

4. Florida Building Code Administrators and Inspectors Board, created under part XII of chapter 468.

5. Construction Industry Licensing Board, created under part I of chapter 489.

6. Board of Cosmetology, created under chapter 477.

7. Electrical Contractors' Licensing Board, created under part II of chapter 489.

8. Board of Employee Leasing Companies, created under part XI of chapter 468.

9. Board of Funeral Directors and Embalmers, created under chapter 470.

10. Board of Landscape Architecture, created under part II of chapter 481.

11. Board of Pilot Commissioners, created under chapter 310.

12. Board of Professional Engineers, created under chapter 471.

13. Board of Professional Geologists, created under chapter 492.

14. Board of Professional Surveyors and Mappers, created under chapter 472.

15. Board of Veterinary Medicine, created under chapter 474.

(b) The following board and commission are established within the Division of Real Estate:

1. Florida Real Estate Appraisal Board, created under part II of chapter 475.

2. Florida Real Estate Commission, created under part I of chapter 475.

~~(c) The following board is established within the Division of Certified Public Accounting:~~

~~1. Board of Accountancy, created under chapter 473.~~

Section 8. Effective January 7, 2003, the Division of Certified Public Accounting and the Board of Accountancy created under chapter 473, Florida Statutes, are transferred to the Department of Financial Services by a type two transfer, as defined in section 20.06, Florida Statutes.

Section 9. Subsection (1) of section 350.061, Florida Statutes, is amended to read:

1 350.061 Public Counsel; appointment; oath;
2 restrictions on Public Counsel and his or her employees.--
3 (1) The Joint Legislative Auditing Committee shall
4 appoint a Public Counsel by majority vote of the members of
5 the committee to represent the ~~general~~ public ~~of Florida~~
6 before the Florida Public Service Commission <u>and the Insurance</u>
7 <u>Rating Commission</u>. The Public Counsel shall be an attorney
8 admitted to practice before the Florida Supreme Court and
9 shall serve at the pleasure of the Joint Legislative Auditing
10 Committee, subject to annual reconfirmation by the committee.
11 Vacancies in the office shall be filled in the same manner as
12 the original appointment.
13 Section 10. Section 350.0611, Florida Statutes, is
14 amended to read:
15 350.0611 Public Counsel; duties and powers.--It shall
16 be the duty of the Public Counsel to provide legal
17 representation for the people of the state in proceedings
18 before the <u>Public Service</u> Commission <u>and the Insurance Rating</u>
19 <u>Commission</u>. <u>As used in this section, the term "commission"</u>
20 <u>includes both such commissions.</u> The Public Counsel shall have
21 such powers as are necessary to carry out the duties of his or
22 her office, including, but not limited to, the following
23 specific powers:
24 (1) To recommend to the commission, by petition, the
25 commencement of any proceeding or action or to appear, in the
26 name of the state or its citizens, in any proceeding or action
27 before the commission and urge therein any position which he
28 or she deems to be in the public interest, whether consistent
29 or inconsistent with positions previously adopted by the
30 commission, and utilize therein all forms of discovery
31 available to attorneys in civil actions generally, subject to

1 protective orders of the commission which shall be reviewable
2 by summary procedure in the circuit courts of this state;
3 (2) To have access to and use of all files, records,
4 and data of the commission available to any other attorney
5 representing parties in a proceeding before the commission;
6 (3) In any proceeding in which he or she has
7 participated as a party, to seek review of any determination,
8 finding, or order of the commission, or of any hearing
9 examiner designated by the commission, in the name of the
10 state or its citizens;
11 (4) To prepare and issue reports, recommendations, and
12 proposed orders to the commission, the Governor, and the
13 Legislature on any matter or subject within the jurisdiction
14 of the commission, and to make such recommendations as he or
15 she deems appropriate for legislation relative to commission
16 procedures, rules, jurisdiction, personnel, and functions;
17 (5) To appear before other state agencies, federal
18 agencies, and state and federal courts in connection with
19 matters under the jurisdiction of the commission, in the name
20 of the state or its citizens.
21 Section 11. Section 350.0613, Florida Statutes, is
22 amended to read:
23 350.0613 Public Counsel; employees; receipt of
24 pleadings.--The committee may authorize the Public Counsel to
25 employ clerical and technical assistants whose qualifications,
26 duties, and responsibilities the committee shall from time to
27 time prescribe. The committee may from time to time authorize
28 retention of the services of additional attorneys or experts
29 to the extent that the best interests of the people of the
30 state will be better served thereby, including the retention
31 of expert witnesses and other technical personnel for

1 participation in contested proceedings before the commission.
2 The Public Service Commission and the Insurance Rating
3 Commission shall furnish the Public Counsel with copies of the
4 initial pleadings in all proceedings before the commission,
5 and if the Public Counsel intervenes as a party in any
6 proceeding he or she shall be served with copies of all
7 subsequent pleadings, exhibits, and prepared testimony, if
8 used. Upon filing notice of intervention, the Public Counsel
9 shall serve all interested parties with copies of such notice
10 and all of his or her subsequent pleadings and exhibits.
11 Section 12. Section 624.055, Florida Statutes, is
12 created to read:
13 624.055 "Commission" defined.--As used in the Florida
14 Insurance Code, the term "commission" means the Insurance
15 Rating Commission as established pursuant to s. 624.37.
16 Section 13. Sections 624.401-624.489, Florida
17 Statutes, are redesignated as part IV of chapter 624, Florida
18 Statutes; sections 624.501-624.610, Florida Statutes, are
19 redesignated as part V of chapter 624, Florida Statutes;
20 sections 624.601-624.610, Florida Statutes, are redesignated
21 as part VI of chapter 624, Florida Statutes; and sections
22 624.80-624.91, Florida Statutes, are redesignated as part VII
23 of chapter 624, Florida Statutes.
24 Section 14. Part III of chapter 624, Florida Statutes,
25 consisting of sections 624.37, 624.371, 624.372, 624.373,
26 624.374, 624.375, 624.376, and 624.377, Florida Statutes, is
27 created to read:
28 Part III
29 Insurance Rating Commission
30 624.37 Insurance Rating Commission; creation;
31 legislative intent.--There is created the Insurance Rating

1 Commission, an independent commission housed within the
2 Department of Insurance. The Insurance Rating Commission shall
3 have authority to approve rates for insurance as provided in
4 this code, effective January 1, 2001, and shall exercise the
5 powers and duties with respect to insurance rates which are
6 provided to the department.
7 624.371 Insurance Rating Commission; terms of
8 commissioners.--
9 (1) The Insurance Rating Commission is
10 administratively housed in, but independent of, the
11 department. The commission shall have such powers and duties
12 regarding rates for insurance policies and health maintenance
13 organization contracts as are provided in the Florida
14 Insurance Code.
15 (2) The commission shall consist of five full-time,
16 salaried commissioners appointed by the Governor and confirmed
17 by the Senate.
18 (3) For the initial appointment of the commission, two
19 members must be appointed for 2-year terms, one member must be
20 appointed for a 3-year term, and two members must be appointed
21 for 4-year terms. All subsequent appointments of commissioners
22 will be for 4-year terms. Vacancies on the commission shall be
23 filled for the unexpired portion of the term.
24 (4) One member of the commission shall be elected by
25 majority vote to serve as chair for a term of 2 years. A
26 member may not serve two consecutive terms as chair.
27 (5) The primary duty of the chair is to serve as chief
28 administrative officer of the commission. The chair may also
29 participate in any proceedings pending before the commission.
30 The chair may assign the various proceedings pending before
31 the commission requiring hearings to two or more commissioners

1 or to the commission's office of hearing examiners under the
2 supervision of the office of general counsel. Only those
3 commissioners assigned to a proceeding requiring hearings may
4 participate in the final decision of the commission as to that
5 proceeding; however, if only two commissioners are assigned to
6 a proceeding requiring hearings and they cannot agree on a
7 final decision, the chair shall cast the deciding vote for
8 final disposition of the proceeding. If more than two
9 commissioners are assigned to any proceeding, a majority of
10 the members assigned constitutes a quorum and a majority vote
11 of the members assigned is required for final commission
12 disposition of those proceedings requiring actual
13 participation by the commissioners. If a commissioner becomes
14 unavailable after assignment to a particular proceeding, the
15 chair shall assign a substitute commissioner. In those
16 proceedings assigned to a hearing examiner, following the
17 conclusion of the hearings, the designated hearing examiner
18 shall prepare recommendations for final disposition by a
19 majority vote of the commission. A petition for
20 reconsideration must be voted upon by those commissioners
21 participating in the final disposition of the proceedings.
22 (6) A majority of the commissioners may determine that
23 the full commission will sit in any proceeding. The public
24 counsel or a person or entity whose rates are regulated by the
25 commission and substantially affected by a proceeding may file
26 a petition requesting that the proceeding be assigned to the
27 full commission. Within 15 days after receipt by the
28 commission of any petition or application, the full commission
29 shall dispose of the petition by majority vote and render a
30 written decision thereon prior to assignment of less than the
31 full commission to a proceeding. In disposing of a petition,

1 the commission shall consider the overall public interest and
2 impact of the pending proceeding, including, but not limited
3 to, the magnitude of a rate filing, the number of
4 policyholders and insureds affected, and the total premium
5 revenues requested.
6 (7) This section does not prohibit a commissioner who
7 is designated by the chair from conducting a hearing as
8 provided under ss. 120.569 and 120.57(1) and the rules of the
9 commission adopted pursuant thereto.
10 624.372 Qualifications of commissioners.--
11 (1) Each member of the commission must be competent
12 and knowledgeable, based on actual experience, in at least one
13 of the following subject areas or disciplines: insurance;
14 accounting; actuarial science; law; or finance.
15 (2) A commissioner may not, at the time of appointment
16 or during his or her term of office:
17 (a) Have any financial interest, other than ownership
18 of shares in a mutual fund or interest as a policyholder or
19 contract holder of a stock or mutual insurer or health
20 maintenance organization, in any business entity that,
21 directly or indirectly, owns or controls any person or entity
22 regulated by the commission, in any person or entity regulated
23 by the commission, or in any business entity that, either
24 directly or indirectly, is an affiliate or subsidiary of any
25 person or entity regulated by the commission.
26 (b) Be employed by or engaged in any business activity
27 with any business entity that, directly or indirectly, owns or
28 controls any person or entity regulated by the commission, any
29 person or entity regulated by the commission, or any business
30 entity that, directly or indirectly, is an affiliate or
31

1 subsidiary of any person or entity regulated by the
2 commission.
3 (3) If any commissioner becomes disqualified, he or
4 she shall at once remove such disqualification or resign, and
5 upon his or her failure to do so, he or she shall be suspended
6 from office by the Governor.
7 624.373 Commissioners; standards of conduct.--
8 (1) LEGISLATIVE INTENT.--In addition to the provision
9 of part III of chapter 112, which are applicable to insurance
10 rating commissioners by virtue of their being public officers
11 and full-time employees of the executive branch of government,
12 the conduct of insurance rating commissioners is governed by
13 the standards of conduct provided in this section. In the
14 event of a conflict between this section and part III of
15 chapter 112, the more restrictive provision shall apply.
16 (2) STANDARDS OF CONDUCT.--
17 (a) A commissioner may not accept anything from any
18 business or entity that, directly or indirectly, owns or
19 controls any person or entity regulated by the commission,
20 from any person or entity regulated by the commission, or from
21 any business entity that, directly or indirectly, is an
22 affiliate or subsidiary of any person or entity regulated by
23 the commission.
24 (b) If a commissioner acquires any financial interest
25 prohibited by s. 624.372 during his or her term of office as a
26 result of events or actions beyond the commissioner's control,
27 he or she shall immediately sell such financial interest or
28 place such financial interest in a blind trust at a financial
29 institution. A commissioner may not attempt to influence or
30 exercise any control over decisions regarding the blind trust.
31

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1 (c) A commissioner may not accept anything from a
2 party in a proceeding pending before the commission.
3 (d) A commissioner, while in office, may not serve as
4 the representative of any political party or on any executive
5 committee or other governing body of a political party; serve
6 as an executive officer or employee of any political party,
7 committee, organization, or association; receive remuneration
8 for activities on behalf of any candidate for public office;
9 engage on behalf of any candidate for public office in the
10 solicitation of votes or other activities on behalf of such
11 candidacy; or become a candidate for election to any public
12 office.
13 (e) A commissioner, during his or her term of office,
14 may not make any public comment regarding the merits of any
15 proceeding under ss. 120.569 and 120.57 which is pending
16 before the commission.
17 (f) A commissioner may not conduct himself or herself
18 in an unprofessional manner at any time during the performance
19 of his or her duties.
20 (3) The Commission on Ethics shall accept and
21 investigate any alleged violations of this section pursuant to
22 the procedures contained in ss. 112.322-112.3241. The
23 Commission on Ethics shall provide the Governor with a report
24 of its findings and recommendations. The Governor may enforce
25 the findings and recommendations of the Commission on Ethics,
26 pursuant to part III of chapter 112. An insurance rating
27 commissioner may request an advisory opinion from the
28 Commission on Ethics, pursuant to s. 112.322(3)(a), regarding
29 the standards of conduct or prohibitions set forth in this
30 section and in ss. 624.372, 624.374, and 624.377.
31 624.374 Ex parte communications.--

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1 (1) A commissioner should accord to every person who
2 is legally interested in a proceeding, or the person's
3 attorney, full right to be heard according to law, and except
4 as authorized by law, may not initiate or consider ex parte
5 communications concerning the merits, threat, or offer of
6 reward in any proceeding other than a proceeding under s.
7 120.54 or s. 120.565, workshops, or internal-affairs meetings.
8 No individual may discuss ex parte with a commissioner the
9 merits of any issue that he or she knows will be filed with
10 the commission within 90 days. This subsection does not apply
11 to commission staff.
12 (2) This section does not prohibit any individual
13 policyholder from communicating with a commissioner, provided
14 that the policyholder is representing only himself or herself
15 without compensation.
16 (3) This section does not apply to oral communications
17 or discussions in scheduled and noticed open public meetings
18 of educational programs or of a conference or other meeting of
19 an association of regulatory agencies.
20 (4) If a commissioner knowingly receives an ex parte
21 communication relative to a proceeding, other than as set
22 forth in subsection (1), to which he or she is assigned, he or
23 she must place on the record of the proceeding copies of all
24 written communications received and all written responses to
25 the communications and a memorandum stating the substance of
26 all oral communications received and all oral responses made,
27 and shall give written notice to all parties to the
28 communication that such matters have been placed on the
29 record. Any party who wishes to respond to an ex parte
30 communication may do so. The response must be received by the
31 commission within 10 days after receiving notice that the ex

1 parte communication has been placed on the record. The
2 commissioner may, if he or she considers it necessary to avert
3 the effects of an ex parte communication received by him or
4 her, withdraw from the proceeding, in which case the chair
5 shall substitute another commissioner for the proceeding.
6 (5) Any individual who makes an ex parte communication
7 shall submit to the commission a written statement that
8 describes the nature of the communication and includes the
9 name of the person making the communication, the name of the
10 commissioner or commissioners receiving the communication,
11 copies of all written communications made and all written
12 responses to the communication, and a memorandum stating the
13 substance of all oral communications received on all oral
14 responses made. The commission shall place on the record of a
15 proceeding all such communications.
16 (6) Any commissioner who knowingly fails to place on
17 the record any ex parte communications, in violation of this
18 section, within 15 days after the date of such communication
19 is subject to removal and may be assessed a civil penalty not
20 to exceed $5,000.
21 (7)(a) It is the duty of the Commission on Ethics to
22 receive and investigate sworn complaints of violations of this
23 section pursuant to the procedures contained in ss.
24 112.322-112.3241.
25 (b) If the Commission on Ethics finds that there has
26 been a violation of this section by a public service
27 commissioner, it shall provide the Governor with a report of
28 its findings and recommendations. The Governor may enforce the
29 findings and recommendations of the Commission on Ethics
30 pursuant to part III of chapter 112.
31

1 (c) If a commissioner fails or refuses to pay the
2 Commission on Ethics any civil penalty assessed under this
3 section, the Commission on Ethics may bring an action in any
4 circuit court to enforce the penalty.
5 624.375 Enforcement and interpretation.--Any violation
6 of s. 624.372, s. 624.373, or s. 624.374, or s. 624.377 by a
7 commissioner, former commissioner, or former employee is be
8 punishable as provided in ss. 112.317 and 112.324. The
9 Commission on Ethics may investigate complaints of violation
10 of such sections in the manner provided in part III of chapter
11 112. A commissioner may request an advisory opinion from the
12 Commission of Ethics as provided by s. 112.322(3)(a).
13 624.376 Place of meeting; expenditures; employment of
14 personnel.--
15 (1) The offices of the commission must be located in
16 the vicinity of Tallahassee, but the commissioners may hold
17 sessions or hearings anywhere in the state at their
18 discretion.
19 (2) The commission constitutes a separate budget
20 entity to be funded by appropriations from the Insurance
21 Commissioner's Regulatory Trust Fund.
22 (3) The commission may employ clerical, technical, and
23 professional personnel reasonably necessary for the
24 performance of its duties.
25 (4) The commission may employ actuaries, who shall be
26 at-will employees and who shall serve at the pleasure of the
27 commission. Actuaries employed under this subsection must be
28 members of the Society of Actuaries or the Casualty Actuarial
29 Society and are exempt from the Career Service System
30 established under chapter 110. The commission shall set the
31 salaries of the actuaries employed under this subsection in

1 accordance with s. 216.251(2)(a)5. at levels that are
2 commensurate with salary levels paid to actuaries by the
3 insurance industry.
4 624.377 Former commissioners and employees;
5 representation of clients before commission.--
6 (1) Any former commissioner of the Insurance Rating
7 Commission is prohibited, for a period of 2 years following
8 termination of service on the commission, from representing
9 before the commission any client regulated by the commission.
10 (2) Any former employee of the commission is
11 prohibited from representing before the commission any client
12 regulated by the commission on any matter that was pending at
13 the time of the employee's termination and in which such
14 former employee had participated.
15 (3) For a period of 2 years following termination of
16 service on the commission, a former member may not accept
17 employment by or compensation from a business entity that,
18 directly or indirectly, owns or controls a person or entity
19 regulated by the commission, from a person or entity regulated
20 by the commission, from a business entity that, directly or
21 indirectly, is an affiliate or subsidiary of a person or
22 entity regulated by the commission, or from a business entity
23 or trade association that has been a party to a commission
24 proceeding that was pending within the 2 years preceding the
25 member's termination of service on the commission.
26 Section 15. Section 175.141, Florida Statutes, is
27 amended to read:
28 175.141 Payment of excise tax credit on similar state
29 excise or license tax.--The tax herein authorized to be
30 imposed by each municipality and each special fire control
31 district shall in nowise be in addition to any similar state

1 excise or license tax imposed by part V ~~IV~~ of chapter 624, but
2 the payor of the tax hereby authorized shall receive credit
3 therefor on his or her said state excise or license tax and
4 the balance of said state excise or license tax shall be paid
5 to the Department of Revenue as provided by law.
6 Section 16. Section 185.12, Florida Statutes, is
7 amended to read:
8 185.12 Payment of excise tax credit on similar state
9 excise or license tax.--The tax herein authorized shall in
10 nowise be additional to the similar state excise or license
11 tax imposed by part V ~~IV~~, chapter 624, but the payor of the
12 tax hereby authorized shall receive credit therefor on his or
13 her state excise or license tax and the balance of said state
14 excise or license tax shall be paid to the Department of
15 Revenue as provided by law.
16 Section 17. Subsection (14) of section 408.701,
17 Florida Statutes, is amended to read:
18 408.701 Community health purchasing; definitions.--As
19 used in ss. 408.70-408.706, the term:
20 (14) "Health insurer" or "insurer" means an
21 organization licensed by the department under part IV ~~III~~ of
22 chapter 624 or part I of chapter 641.
23 Section 18. Section 651.018, Florida Statutes, is
24 amended to read:
25 651.018 Administrative supervision.--The department
26 may place a facility in administrative supervision pursuant to
27 part VII ~~VI~~ of chapter 624.
28 Section 19. Section 624.19, Florida Statutes, is
29 amended to read:
30 624.19 Existing forms and filings.--Every form of
31 insurance document and every rate or other filing lawfully in

use immediately prior to October 1, 1959, may continue to be so used or be effective until the department or commission otherwise prescribes pursuant to this code.

Section 20. Subsections (6) and (7) of section 624.307, Florida Statutes, are amended to read:

624.307 General powers; duties.--

~~(6) The department may employ actuaries who shall be at-will employees and who shall serve at the pleasure of the Insurance Commissioner. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society and shall be exempt from the Career Service System established under chapter 110. The salaries of the actuaries employed pursuant to this paragraph by the department shall be set in accordance with s. 216.251(2)(a)5. and shall be set at levels which are commensurate with salary levels paid to actuaries by the insurance industry.~~

(6)~~(7)~~ The department shall, within existing resources, develop and implement an outreach program for the purpose of encouraging the entry of additional insurers into the Florida market.

Section 21. Subsection (1) of section 624.321, Florida Statutes, is amended to read:

624.321 Witnesses and evidence.--

(1) As to any examination, investigation, or hearing being conducted under this code, the Insurance Commissioner ~~and Treasurer~~ or her or his designee or a member of the Insurance Rating Commission or his or her designee:

(a) May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence; and

(b) Shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the

1 production of books, papers, records, files, correspondence,
2 documents, or other evidence which is relevant to the inquiry.
3 Section 22. Section 624.322, Florida Statutes, is
4 amended to read:
5 624.322 Testimony compelled; immunity from
6 prosecution.--
7 (1) If any natural person asks to be excused from
8 attending or testifying or from producing any books, papers,
9 records, contracts, documents, or other evidence in connection
10 with any examination, hearing, or investigation being
11 conducted by the department or the commission or the examiners
12 of either ~~its examiner~~, on the ground that the testimony or
13 evidence required of her or him may tend to incriminate the
14 person or subject her or him to a penalty or forfeiture, and
15 shall notwithstanding be directed to give such testimony or
16 produce such evidence, the person must, if so directed by the
17 department or commission and the Department of Legal Affairs,
18 nonetheless comply with such direction; but she or he shall
19 not thereafter be prosecuted or subjected to any penalty or
20 forfeiture for or on account of any transaction, matter, or
21 thing concerning which she or he may have so testified or
22 produced evidence; and no testimony so given or evidence
23 produced shall be received against the person upon any
24 criminal action, investigation, or proceeding. However, no
25 such person so testifying shall be exempt from prosecution or
26 punishment for any perjury committed by her or him in such
27 testimony, and the testimony or evidence so given or produced
28 shall be admissible against her or him upon any criminal
29 action, investigation, or proceeding concerning such perjury.
30 No license or permit conferred or to be conferred to such
31

1 person shall be refused, suspended, or revoked based upon the
2 use of such testimony.
3 (2) Any such individual may execute, acknowledge, and
4 file in the office of the Department of Insurance or
5 commission, whichever is applicable, a statement expressly
6 waiving such immunity or privilege in respect to any
7 transaction, matter, or thing specified in such statement; and
8 thereupon the testimony of such individual or such evidence in
9 relation to such transaction, matter, or thing may be received
10 or produced before any judge or justice, court, tribunal,
11 grand jury, or otherwise; and, if so received or produced,
12 such individual shall not be entitled to any immunity or
13 privileges on account of any testimony she or he may so give
14 or evidence so produced.
15 Section 23. Paragraph (o) of subsection (1) of section
16 626.9541, Florida Statutes, is amended to read:
17 626.9541 Unfair methods of competition and unfair or
18 deceptive acts or practices defined.--
19 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR
20 DECEPTIVE ACTS.--The following are defined as unfair methods
21 of competition and unfair or deceptive acts or practices:
22 (o) Illegal dealings in premiums; excess or reduced
23 charges for insurance.--
24 1. Knowingly collecting any sum as a premium or charge
25 for insurance, which is not then provided, or is not in due
26 course to be provided, subject to acceptance of the risk by
27 the insurer, by an insurance policy issued by an insurer as
28 permitted by this code.
29 2. Knowingly collecting as a premium or charge for
30 insurance any sum in excess of or less than the premium or
31 charge applicable to such insurance, in accordance with the

1 applicable classifications and rates as filed with and
2 approved by the <u>commission</u> ~~department~~, and as specified in the
3 policy; or, in cases when classifications, premiums, or rates
4 are not required by this code to be so filed and approved,
5 premiums and charges in excess of or less than those specified
6 in the policy and as fixed by the insurer. This provision
7 shall not be deemed to prohibit the charging and collection,
8 by surplus lines agents licensed under part VIII of this
9 chapter, of the amount of applicable state and federal taxes,
10 or fees as authorized by s. 626.916(4), in addition to the
11 premium required by the insurer or the charging and
12 collection, by licensed agents, of the exact amount of any
13 discount or other such fee charged by a credit card facility
14 in connection with the use of a credit card, as authorized by
15 subparagraph (q)3., in addition to the premium required by the
16 insurer. This subparagraph shall not be construed to prohibit
17 collection of a premium for a universal life or a variable or
18 indeterminate value insurance policy made in accordance with
19 the terms of the contract.
20 3.a. Imposing or requesting an additional premium for
21 a policy of motor vehicle liability, personal injury
22 protection, medical payment, or collision insurance or any
23 combination thereof or refusing to renew the policy solely
24 because the insured was involved in a motor vehicle accident
25 unless the insurer's file contains information from which the
26 insurer in good faith determines that the insured was
27 substantially at fault in the accident.
28 b. An insurer which imposes and collects such a
29 surcharge or which refuses to renew such policy shall, in
30 conjunction with the notice of premium due or notice of
31 nonrenewal, notify the named insured that he or she is

1 entitled to reimbursement of such amount or renewal of the
2 policy under the conditions listed below and will subsequently
3 reimburse him or her or renew the policy, if the named insured
4 demonstrates that the operator involved in the accident was:
5 (I) Lawfully parked;
6 (II) Reimbursed by, or on behalf of, a person
7 responsible for the accident or has a judgment against such
8 person;
9 (III) Struck in the rear by another vehicle headed in
10 the same direction and was not convicted of a moving traffic
11 violation in connection with the accident;
12 (IV) Hit by a "hit-and-run" driver, if the accident
13 was reported to the proper authorities within 24 hours after
14 discovering the accident;
15 (V) Not convicted of a moving traffic violation in
16 connection with the accident, but the operator of the other
17 automobile involved in such accident was convicted of a moving
18 traffic violation;
19 (VI) Finally adjudicated not to be liable by a court
20 of competent jurisdiction;
21 (VII) In receipt of a traffic citation which was
22 dismissed or nolle prossed; or
23 (VIII) Not at fault as evidenced by a written
24 statement from the insured establishing facts demonstrating
25 lack of fault which are not rebutted by information in the
26 insurer's file from which the insurer in good faith determines
27 that the insured was substantially at fault.
28 c. In addition to the other provisions of this
29 subparagraph, an insurer may not fail to renew a policy if the
30 insured has had only one accident in which he or she was at
31 fault within the current 3-year period. However, an insurer

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1 may nonrenew a policy for reasons other than accidents in
2 accordance with s. 627.728. This subparagraph does not
3 prohibit nonrenewal of a policy under which the insured has
4 had three or more accidents, regardless of fault, during the
5 most recent 3-year period.
6 4. Imposing or requesting an additional premium for,
7 or refusing to renew, a policy for motor vehicle insurance
8 solely because the insured committed a noncriminal traffic
9 infraction as described in s. 318.14 unless the infraction is:
10 a. A second infraction committed within an 18-month
11 period, or a third or subsequent infraction committed within a
12 36-month period.
13 b. A violation of s. 316.183, when such violation is a
14 result of exceeding the lawful speed limit by more than 15
15 miles per hour.
16 5. Upon the request of the insured, the insurer and
17 licensed agent shall supply to the insured the complete proof
18 of fault or other criteria which justifies the additional
19 charge or cancellation.
20 6. No insurer shall impose or request an additional
21 premium for motor vehicle insurance, cancel or refuse to issue
22 a policy, or refuse to renew a policy because the insured or
23 the applicant is a handicapped or physically disabled person,
24 so long as such handicap or physical disability does not
25 substantially impair such person's mechanically assisted
26 driving ability.
27 7. No insurer may cancel or otherwise terminate any
28 insurance contract or coverage, or require execution of a
29 consent to rate endorsement, during the stated policy term for
30 the purpose of offering to issue, or issuing, a similar or
31 identical contract or coverage to the same insured with the

1 same exposure at a higher premium rate or continuing an
2 existing contract or coverage with the same exposure at an
3 increased premium.
4 8. No insurer may issue a nonrenewal notice on any
5 insurance contract or coverage, or require execution of a
6 consent to rate endorsement, for the purpose of offering to
7 issue, or issuing, a similar or identical contract or coverage
8 to the same insured at a higher premium rate or continuing an
9 existing contract or coverage at an increased premium without
10 meeting any applicable notice requirements.
11 9. No insurer shall, with respect to premiums charged
12 for motor vehicle insurance, unfairly discriminate solely on
13 the basis of age, sex, marital status, or scholastic
14 achievement.
15 10. Imposing or requesting an additional premium for
16 motor vehicle comprehensive or uninsured motorist coverage
17 solely because the insured was involved in a motor vehicle
18 accident or was convicted of a moving traffic violation.
19 11. No insurer shall cancel or issue a nonrenewal
20 notice on any insurance policy or contract without complying
21 with any applicable cancellation or nonrenewal provision
22 required under the Florida Insurance Code.
23 12. No insurer shall impose or request an additional
24 premium, cancel a policy, or issue a nonrenewal notice on any
25 insurance policy or contract because of any traffic infraction
26 when adjudication has been withheld and no points have been
27 assessed pursuant to s. 318.14(9) and (10). However, this
28 subparagraph does not apply to traffic infractions involving
29 accidents in which the insurer has incurred a loss due to the
30 fault of the insured.
31

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1 Section 24. Section 626.9926, Florida Statutes, is
2 amended to read:
3 626.9926 Rate regulation not authorized.--Nothing in
4 this act shall be construed to authorize the department <u>or</u>
5 <u>commission</u> to directly or indirectly regulate the amount paid
6 as consideration for entry into a viatical settlement contract
7 or viatical settlement purchase agreement.
8 Section 25. Subsection (2) of section 627.031, Florida
9 Statutes, is amended to read:
10 627.031 Purposes of this part; interpretation.--
11 (2) It is the purpose of this part to protect
12 policyholders and the public against the adverse effects of
13 excessive, inadequate, or unfairly discriminatory insurance
14 rates, and to authorize the <u>commission</u> ~~department~~ to regulate
15 such rates. If at any time the <u>commission</u> ~~department~~ has
16 reason to believe any such rate is excessive, inadequate, or
17 unfairly discriminatory under the law, it is directed to take
18 the necessary action to cause such rate to comply with the
19 laws of this state.
20 Section 26. Section 627.0612, Florida Statutes, is
21 amended to read:
22 627.0612 Administrative proceedings in rating
23 determinations.--In any proceeding to determine whether rates,
24 rating plans, or other matters governed by this part comply
25 with the law, the appellate court shall set aside a final
26 order of the department <u>or commission</u> if the department <u>or</u>
27 <u>commission</u> has violated s. 120.57(1)(k) by substituting its
28 findings of fact for findings of an administrative law judge
29 which were supported by competent substantial evidence.
30 Section 27. Subsection (3) of section 627.0613,
31 Florida Statutes, is amended to read:

627.0613 Consumer advocate.--The Insurance Commissioner must appoint a consumer advocate who must represent the general public of the state before the department. The consumer advocate must report directly to the Insurance Commissioner, but is not otherwise under the authority of the department or of any employee of the department. The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(3) Examine ~~rate and~~ form filings submitted to the department, hire consultants as necessary to aid in the review process, and recommend to the department any position deemed by the consumer advocate to be in the public interest.

Section 28. Subsections (2), (3), and (6) of section 627.062, Florida Statutes, are amended to read:

627.062 Rate standards.--

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, shall be filed with the commission ~~department~~ under one of the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented during the commission's ~~department's~~ review of the filing and any proceeding and judicial review, ~~then~~ such filing shall be considered a "file and use" filing. In such case, the commission ~~department~~ shall finalize its review by issuance of

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a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the commission ~~department~~ of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the commission ~~department~~ does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the commission ~~department~~ to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

(b) Upon receiving a rate filing, the commission ~~department~~ shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the commission ~~department~~ shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission ~~department~~ may adopt ~~promulgate~~ rules using ~~utilizing~~ reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used in the calculation of insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus shall not be considered. The profit and contingency factor as specified in the filing shall be used ~~utilized~~ in computing excess profits in conjunction with s. 627.0625.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. A reasonable margin for underwriting profit and contingencies.

12. The cost of medical services, if applicable.

13. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the commission ~~department~~. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), a rate may be found by the commission ~~department~~ to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

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1 2. Rates shall be deemed excessive if, among other
2 things, the rate structure established by a stock insurance
3 company provides for replenishment of surpluses from premiums,
4 when the replenishment is attributable to investment losses.
5 3. Rates shall be deemed inadequate if they are
6 clearly insufficient, together with the investment income
7 attributable to them, to sustain projected losses and expenses
8 in the class of business to which they apply.
9 4. A rating plan, including discounts, credits, or
10 surcharges, shall be deemed unfairly discriminatory if it
11 fails to clearly and equitably reflect consideration of the
12 policyholder's participation in a risk management program
13 adopted pursuant to s. 627.0625.
14 5. A rate shall be deemed inadequate as to the premium
15 charged to a risk or group of risks if discounts or credits
16 are allowed which exceed a reasonable reflection of expense
17 savings and reasonably expected loss experience from the risk
18 or group of risks.
19 6. A rate shall be deemed unfairly discriminatory as
20 to a risk or group of risks if the application of premium
21 discounts, credits, or surcharges among such risks does not
22 bear a reasonable relationship to the expected loss and
23 expense experience among the various risks.
24 (f) In reviewing a rate filing, the commission
25 ~~department~~ may require the insurer to provide at the insurer's
26 expense all information necessary to evaluate the condition of
27 the company and the reasonableness of the filing according to
28 the criteria enumerated in this section.
29 (g) The commission ~~department~~ may at any time review a
30 rate, rating schedule, rating manual, or rate change; the
31 pertinent records of the insurer; and market conditions. If

1 the commission ~~department~~ finds on a preliminary basis that a
2 rate may be excessive, inadequate, or unfairly discriminatory,
3 the commission ~~department~~ shall initiate proceedings to
4 disapprove the rate and shall so notify the insurer. However,
5 the commission ~~department~~ may not disapprove as excessive any
6 rate for which it has given final approval or which has been
7 deemed approved for a period of 1 year after the effective
8 date of the filing unless the commission ~~department~~ finds that
9 a material misrepresentation or material error was made by the
10 insurer or was contained in the filing. Upon being so
11 notified, the insurer or rating organization shall, within 60
12 days, file with the commission ~~department~~ all information
13 which, in the belief of the insurer or organization, proves
14 the reasonableness, adequacy, and fairness of the rate or rate
15 change. The commission ~~department~~ shall issue a notice of
16 intent to approve or a notice of intent to disapprove pursuant
17 to the procedures of paragraph (a) within 90 days after
18 receipt of the insurer's initial response. In such instances
19 and in any administrative proceeding relating to the legality
20 of the rate, the insurer or rating organization shall carry
21 the burden of proof by a preponderance of the evidence to show
22 that the rate is not excessive, inadequate, or unfairly
23 discriminatory. After the commission ~~department~~ notifies an
24 insurer that a rate may be excessive, inadequate, or unfairly
25 discriminatory, unless the commission ~~department~~ withdraws the
26 notification, the insurer shall not alter the rate except to
27 conform with the commission's ~~department's~~ notice until the
28 earlier of 120 days after the date the notification was
29 provided or 180 days after the date of the implementation of
30 the rate. The commission ~~department~~ may, subject to chapter
31 120, disapprove without the 60-day notification any rate

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1 increase filed by an insurer within the prohibited time period
2 or during the time that the legality of the increased rate is
3 being contested.
4 (h) In the event the commission ~~department~~ finds that
5 a rate or rate change is excessive, inadequate, or unfairly
6 discriminatory, the commission ~~department~~ shall issue an order
7 of disapproval specifying that a new rate or rate schedule
8 which responds to the findings of the commission ~~department~~ be
9 filed by the insurer. The commission ~~department~~ shall further
10 order, for any "use and file" filing made in accordance with
11 subparagraph (a)2., that premiums charged each policyholder
12 constituting the portion of the rate above that which was
13 actuarially justified be returned to such policyholder in the
14 form of a credit or refund. If the commission ~~department~~ finds
15 that an insurer's rate or rate change is inadequate, the new
16 rate or rate schedule filed with the commission ~~department~~ in
17 response to such a finding shall be applicable only to new or
18 renewal business of the insurer written on or after the
19 effective date of the responsive filing.
20 (i) Except as otherwise specifically provided in this
21 chapter, the commission ~~department~~ shall not prohibit any
22 insurer, including any residual market plan or joint
23 underwriting association, from paying acquisition costs based
24 on the full amount of premium, as defined in s. 627.403,
25 applicable to any policy, or prohibit any such insurer from
26 including the full amount of acquisition costs in a rate
27 filing.
28
29 The provisions of this subsection shall not apply to workers'
30 compensation and employer's liability insurance and to motor
31 vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the commission ~~department~~ and which have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for a period of at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

~~(6)(a) After any action with respect to a rate filing that constitutes agency action for purposes of the Administrative Procedure Act, an insurer may, in lieu of demanding a hearing under s. 120.57, require arbitration of the rate filing. Arbitration shall be conducted by a board of arbitrators consisting of an arbitrator selected by the department, an arbitrator selected by the insurer, and an arbitrator selected jointly by the other two arbitrators. Each arbitrator must be certified by the American Arbitration~~

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~~Association. A decision is valid only upon the affirmative vote of at least two of the arbitrators. No arbitrator may be an employee of any insurance regulator or regulatory body or of any insurer, regardless of whether or not the employing insurer does business in this state. The department and the insurer must treat the decision of the arbitrators as the final approval of a rate filing. Costs of arbitration shall be paid by the insurer.~~

~~(b) Arbitration under this subsection shall be conducted pursuant to the procedures specified in ss. 682.06-682.10. Either party may apply to the circuit court to vacate or modify the decision pursuant to s. 682.13 or s. 682.14. The department shall adopt rules for arbitration under this subsection, which rules may not be inconsistent with the arbitration rules of the American Arbitration Association as of January 1, 1996.~~

~~(c) Upon initiation of the arbitration process, the insurer waives all rights to challenge the action of the department under the Administrative Procedure Act or any other provision of law; however, such rights are restored to the insurer if the arbitrators fail to render a decision within 90 days after initiation of the arbitration process.~~

Section 29. Subsection (2) and (3) of section 627.0628, Florida Statutes, are amended to read:

627.0628 Florida Commission on Hurricane Loss Projection Methodology.--

(2) COMMISSION CREATED.--

(a) There is created the Florida Commission on Hurricane Loss Projection Methodology, which is assigned to the State Board of Administration. The commission shall be administratively housed within the State Board of

Administration, but it shall independently exercise the powers and duties specified in this section.

(b) The commission shall consist of the following 11 members:

1. The Public Counsel or his or her designee from the Office of the Public Counsel ~~insurance consumer advocate~~.

2. The Chief Operating Officer of the Florida Hurricane Catastrophe Fund.

3. The Executive Director of the Residential Property and Casualty Joint Underwriting Association.

4. The Director of the Division of Emergency Management of the Department of Community Affairs.

5. The actuary member of the Florida Hurricane Catastrophe Fund Advisory Council.

6. Six members appointed by the Insurance Rating Commission ~~Commissioner~~, as follows:

a. An employee of the Insurance Rating Commission ~~Department of Insurance~~ who is an actuary responsible for property insurance rate filings.

b. An actuary who is employed full time by a property and casualty insurer which was responsible for at least 1 percent of the aggregate statewide direct written premium for homeowner's insurance in the calendar year preceding the member's appointment to the commission.

c. An expert in insurance finance who is a full time member of the faculty of the State University System and who has a background in actuarial science.

d. An expert in statistics who is a full time member of the faculty of the State University System and who has a background in insurance.

e. An expert in computer system design who is a full time member of the faculty of the State University System.

f. An expert in meteorology who is a full time member of the faculty of the State University System and who specializes in hurricanes.

(c) Members designated under subparagraphs (b)1.-5. shall serve on the commission as long as they maintain the respective offices designated in subparagraphs (b)1.-5. Members appointed by the Insurance Rating Commission ~~Commissioner~~ under subparagraph (b)6. shall serve on the Florida Commission on Hurricane Loss Projection Methodology for a 4-year term ~~until the end of the term of office of the Insurance Commissioner who appointed them~~, unless earlier removed by the Insurance Rating Commission ~~Commissioner~~ for cause. Vacancies on the Florida Commission on Hurricane Loss Projection Methodology shall be filled in the same manner as the original appointment.

(d) The State Board of Administration shall annually appoint one of the members of the commission to serve as chair.

(e) Members of the commission shall serve without compensation, but shall be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(f) The State Board of Administration shall, as a cost of administration of the Florida Hurricane Catastrophe Fund, provide for travel, expenses, and staff support for the commission.

(g) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the commission, any member of the State Board of Administration, or any employee of the State Board of

Administration for any action taken in the performance of their duties under this section. In addition, the commission may, in writing, waive any potential cause of action for negligence of a consultant, contractor, or contract employee engaged to assist the commission.

(3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.--

(a) The commission shall consider any actuarial methods, principles, standards, models, or output ranges that have the potential for improving the accuracy of or reliability of the hurricane loss projections used in residential property insurance rate filings. The commission shall, from time to time, adopt findings as to the accuracy or reliability of particular methods, principles, standards, models, or output ranges.

(b) In establishing reimbursement premiums for the Florida Hurricane Catastrophe Fund, the State Board of Administration must, to the extent feasible, employ actuarial methods, principles, standards, models, or output ranges found by the commission to be accurate or reliable.

(c) With respect to a rate filing under s. 627.062, an insurer may employ actuarial methods, principles, standards, models, or output ranges found by the commission to be accurate or reliable to determine hurricane loss factors for use in a rate filing under s. 627.062, which findings and factors are admissible and relevant in consideration of a rate filing by the Insurance Rating Commission ~~department~~ or in any ~~arbitration or~~ administrative or judicial review.

(d) The commission shall adopt ~~initial~~ actuarial methods, principles, standards, models, or output ranges ~~no later than December 31, 1995~~. The commission shall adopt revisions to such actuarial methods, principles, standards,

1 models, or output ranges at least annually thereafter. ~~As soon~~
2 ~~as possible, but no later than July 1, 1996,~~The commission
3 shall adopt revised actuarial methods, principles, standards,
4 models, or output ranges which include specification of
5 acceptable computer models or output ranges derived from
6 computer models.
7 Section 30. Persons who are members of the Florida
8 Commission on Hurricane Loss Projection Methodology on
9 December 31, 2000, shall remain members of the commission
10 until new members are appointed pursuant to section 627.0628,
11 Florida Statutes, as amended by this act, except that the
12 Public Counsel or his or her designee from the Office of the
13 Public Counsel shall become a member effective January 1,
14 2001, and the Insurance Consumer Advocate shall cease to be a
15 member on that date.
16 Section 31. Subsections (1), (2), (3), (6), (7), and
17 (9) of section 627.0645, Florida Statutes, are amended to
18 read:
19 627.0645 Annual filings.--
20 (1) Each rating organization filing rates for, and
21 each insurer writing, any line of property or casualty
22 insurance to which this part applies, except:
23 (a) Workers' compensation and employer's liability
24 insurance; or
25 (b) Commercial property and casualty insurance as
26 defined in s. 627.0625(1) other than commercial multiple line
27 and commercial motor vehicle,
28
29 shall make an annual base rate filing for each such line with
30 the commission ~~department~~ no later than 12 months after its
31

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1 previous base rate filing, demonstrating that its rates are
2 not inadequate.
3 (2)(a) Deviations filed by an insurer to any rating
4 organization's base rate filing are not subject to this
5 section.
6 (b) The commission ~~department~~, after receiving a
7 request to be exempted from the provisions of this section,
8 may, for good cause due to insignificant numbers of policies
9 in force or insignificant premium volume, exempt a company, by
10 line of coverage, from filing rates or rate certification as
11 required by this section.
12 (3) The filing requirements of this section shall be
13 satisfied by one of the following methods:
14 (a) A rate filing prepared by an actuary which
15 contains documentation demonstrating that the proposed rates
16 are not excessive, inadequate, or unfairly discriminatory
17 pursuant to the applicable rating laws and pursuant to rules
18 of the commission ~~department~~.
19 (b) If no rate change is proposed, a filing which
20 consists of a certification by an actuary that the existing
21 rate level produces rates which are actuarially sound and
22 which are not inadequate, as defined in s. 627.062.
23 (6) If at the time a filing is required under this
24 section an insurer is in the process of completing a rate
25 review, the insurer may apply to the commission ~~department~~ for
26 an extension of up to an additional 30 days in which to make
27 the filing. The request for extension must be received by the
28 commission ~~department~~ no later than the date the filing is
29 due.
30 (7) Nothing in this section limits the commission's
31 ~~department's~~ authority to review rates at any time or to find

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1 that a rate or rate change is excessive, inadequate, or
2 unfairly discriminatory pursuant to s. 627.062.
3 (9) If an insurer fails to meet the filing
4 requirements of this section and does not submit the filing
5 within 60 days after the date the filing is due, the
6 commission ~~department~~ may, in addition to any other penalty
7 authorized by law, order the insurer to discontinue the
8 issuance of policies for the line of insurance for which the
9 required filing was not made until ~~such time as~~ the commission
10 ~~department~~ determines that the required filing is properly
11 submitted.
12 Section 32. Subsection (1) of section 627.06501,
13 Florida Statutes, is amended to read:
14 627.06501 Insurance discounts for certain persons
15 completing driver improvement course.--
16 (1) Any rate, rating schedule, or rating manual for
17 the liability, personal injury protection, and collision
18 coverages of a motor vehicle insurance policy filed with the
19 commission ~~department~~ may provide for an appropriate reduction
20 in premium charges as to such coverages when the principal
21 operator on the covered vehicle has successfully completed a
22 driver improvement course approved and certified by the
23 Department of Highway Safety and Motor Vehicles which is
24 effective in reducing crash or violation rates, or both, as
25 determined pursuant to s. 318.1451(5). Any discount, not to
26 exceed 10 percent, used by an insurer is presumed to be
27 appropriate unless credible data demonstrates otherwise.
28 Section 33. Subsections (1), (2), (5), (9), (10),
29 (11), and (13) of section 627.0651, Florida Statutes, are
30 amended to read:
31

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627.0651 Making and use of rates for motor vehicle insurance.--

(1) Insurers shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on motor vehicle insurance written in this state. A copy of rates, rating schedules, and rating manuals, and changes therein, shall be filed with the commission ~~department~~ under one of the following procedures:

(a) If the filing is made at least 60 days before the proposed effective date and the filing is not implemented during the commission's ~~department's~~ review of the filing and any proceeding and judicial review, such filing shall be considered a "file and use" filing. In such case, the commission ~~department~~ shall initiate proceedings to disapprove the rate and so notify the insurer or shall finalize its review within 60 days after receipt of the filing. Notification to the insurer by the commission ~~department~~ of its preliminary findings shall toll the 60-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the commission ~~department~~ does not issue notice to the insurer of its preliminary findings within 60 days after the filing.

(b) If the filing is not made in accordance with the provisions of paragraph (a), such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the commission ~~department~~ to return to policyholders portions of rates found to be excessive, as provided in subsection (11).

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1 (2) Upon receiving notice of a rate filing or rate
2 change, the commission ~~department~~ shall review the rate or
3 rate change to determine if the rate is excessive, inadequate,
4 or unfairly discriminatory. In making that determination, the
5 commission ~~department~~ shall in accordance with generally
6 accepted and reasonable actuarial techniques consider the
7 following factors:
8 (a) Past and prospective loss experience within and
9 outside this state.
10 (b) The past and prospective expenses.
11 (c) The degree of competition among insurers for the
12 risk insured.
13 (d) Investment income reasonably expected by the
14 insurer, consistent with the insurer's investment practices,
15 from investable premiums anticipated in the filing, plus any
16 other expected income from currently invested assets
17 representing the amount expected on unearned premium reserves
18 and loss reserves. Such investment income shall not include
19 income from invested surplus. The commission ~~department~~ may
20 adopt ~~promulgate~~ rules using ~~utilizing~~ reasonable techniques
21 of actuarial science and economics to specify the manner in
22 which insurers shall calculate investment income attributable
23 to motor vehicle insurance policies written in this state and
24 the manner in which such investment income is used in the
25 calculation of insurance rates. Such manner shall contemplate
26 the use of a positive underwriting profit allowance in the
27 rates that will be compatible with a reasonable rate of return
28 plus provisions for contingencies. The total of the profit and
29 contingency factor as specified in the filing shall be
30 utilized in computing excess profits in conjunction with s.
31 627.066. In adopting ~~promulgating~~ such rules, the commission

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~~department~~ shall in all instances adhere to and implement the provisions of this paragraph.

(e) The reasonableness of the judgment reflected in the filing.

(f) Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

(g) The cost of repairs to motor vehicles.

(h) The cost of medical services, if applicable.

(i) The adequacy of loss reserves.

(j) The cost of reinsurance.

(k) Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

(l) Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(5)(a) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

(b) The commission ~~Insurance Commissioner~~ shall have the responsibility to ensure that rates for private passenger vehicle insurance are adequate. To that end, the commission ~~department~~ shall adopt ~~promulgate~~ rules and regulations establishing standards defining inadequate rates on private passenger vehicle insurance as defined in s. 627.041(8). If ~~In the event that~~ the commission ~~department~~ finds that a rate or rate change is inadequate, the commission ~~department~~ shall order that a new rate or rate schedule be thereafter filed by the insurer and shall further provide information as to the manner in which noncompliance of the standards may be corrected. When a violation of this provision occurs, the

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1 department shall impose an administrative fine pursuant to s.
2 624.4211.
3 (9) In reviewing the rate or rate change filed, the
4 commission ~~department~~ may require the insurer to provide at
5 the insurer's expense all information necessary to evaluate
6 the condition of the company and the reasonableness of the
7 filing according to the criteria enumerated herein.
8 (10) The commission ~~department~~ may, at any time,
9 review a rate or rate change, the pertinent records of the
10 insurer, and market conditions; and, if the commission
11 ~~department~~ finds on a preliminary basis that the rate or rate
12 change may be excessive, inadequate, or unfairly
13 discriminatory, the commission ~~department~~ shall so notify the
14 insurer. However, the commission ~~department~~ may not
15 disapprove as excessive any rate for which it has given final
16 approval or which has been deemed approved for a period of 1
17 year after the effective date of the filing unless the
18 commission ~~department~~ finds that a material misrepresentation
19 or material error was made by the insurer or was contained in
20 the filing. Upon being so notified, the insurer or rating
21 organization shall, within 60 days, file with the commission
22 ~~department~~ all information which, in the belief of the insurer
23 or organization, proves the reasonableness, adequacy, and
24 fairness of the rate or rate change. In such instances and in
25 any administrative proceeding relating to the legality of the
26 rate, the insurer or rating organization shall carry the
27 burden of proof by a preponderance of the evidence to show
28 that the rate is not excessive, inadequate, or unfairly
29 discriminatory. After the commission ~~department~~ notifies an
30 insurer that a rate may be excessive, inadequate, or unfairly
31 discriminatory, unless the commission ~~department~~ withdraws the

notification, the insurer shall not increase the rate until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The commission ~~department~~ may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(11) If ~~In the event~~ the commission ~~department~~ finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the commission ~~department~~ shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the commission ~~department~~ be filed by the insurer. The commission ~~department~~ shall further order for any "use and file" filing made in accordance with paragraph (1)(b), that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the commission ~~department~~ finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the commission ~~department~~ in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(13)(a) Underwriting rules not contained in rating manuals shall be filed for private passenger automobile insurance and homeowners' insurance.

(b) The submission of rates, rating schedules, and rating manuals to the commission ~~department~~ by a licensed rating organization of which an insurer is a member or

1 subscriber will be sufficient compliance with this subsection
2 for any insurer maintaining membership or subscribership in
3 such organization, to the extent that the insurer uses the
4 rates, rating schedules, and rating manuals of such
5 organization. All such information shall be available for
6 public inspection, upon receipt by the commission ~~department~~,
7 during usual business hours.
8 Section 34. Section 627.0653, Florida Statutes, is
9 amended to read:
10 627.0653 Insurance discounts for specified motor
11 vehicle equipment.--
12 (1) Any rates, rating schedules, or rating manuals for
13 the liability, personal injury protection, and collision
14 coverages of a motor vehicle insurance policy filed with the
15 commission ~~department~~ shall provide a premium discount if the
16 insured vehicle is equipped with factory-installed, four-wheel
17 antilock brakes.
18 (2) Each insurer writing motor vehicle comprehensive
19 coverage in this state shall include in its rating manual
20 discount provisions for comprehensive coverage which
21 specifically relate to an antitheft device or vehicle recovery
22 system utilized in the insured vehicle which are factory
23 installed or approved by the commission ~~department~~. The
24 commission ~~department~~ shall adopt, by rule, procedures under
25 which manufacturers, distributors, or sellers may apply to the
26 commission ~~department~~ for approval of non-factory-installed
27 devices under this subsection. The rules must include, at a
28 minimum, the test results that must accompany the application
29 and the standards for approval.
30 (3) Any rates, rating schedules, or rating manuals for
31 personal injury protection coverage and medical payments

1 coverage, if offered, of a motor vehicle insurance policy
2 filed with the commission ~~department~~ shall provide a premium
3 discount if the insured vehicle is equipped with one or more
4 air bags which are factory installed.
5 (4) The removal of a discount or credit does not
6 constitute the imposition of, or request for, additional
7 premium or a surcharge if the basis for the discount or credit
8 no longer exists or is substantially eliminated.
9 (5) Each insurer writing motor vehicle comprehensive
10 coverage in this state may provide a premium discount for this
11 coverage if the insured vehicle has the complete
12 manufacturer's vehicle identification number permanently
13 etched on the windshield and all windows of the vehicle. The
14 etching must be by a tool or process that does not destroy the
15 integrity of the glass or visibility for the operator of the
16 motor vehicle. The identification numbers and letters must be
17 at least 1/4 inch in height. A sticker may identify the
18 presence of this identification system. The commission
19 ~~department~~ may, by rule, set forth appropriate guidelines to
20 implement this subsection.
21 Section 35. Section 627.06535, Florida Statutes, is
22 amended to read:
23 627.06535 Electric vehicles; restrictions on imposing
24 surcharges.--An insurer may not impose a surcharge on the
25 premium for motor vehicle insurance written on an electric
26 vehicle, as defined in s. 320.01, if the surcharge is based on
27 a factor such as new technology, passenger payload,
28 weight-to-horsepower ratio, or types of materials, including
29 composite materials or aluminum, used to manufacture the
30 vehicle, unless the commission ~~Department of Insurance~~
31

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determines from actuarial data submitted to it that the surcharge is justified.

Section 36. Subsection (1) of section 627.0654, Florida Statutes, is amended to read:

627.0654 Insurance discounts for buildings with fire sprinklers.--

(1) Any rates, rating schedules, or rating manuals for a new or renewal fire insurance policy for an existing or newly constructed building, whether used for commercial or residential purposes, must provide for a premium discount if a fire sprinkler system has been installed in the building in accordance with nationally accepted fire sprinkler design standards, as adopted by the commission ~~department~~, and if the fire sprinkler system is maintained in accordance with nationally accepted standards.

Section 37. Subsections (2), (7), (10), (11), and (13) of section 627.066, Florida Statutes, are amended to read:

627.066 Excessive profits for motor vehicle insurance prohibited.--

(2) Each Florida private passenger automobile insurer group shall file with the commission ~~department~~, prior to July 1 of each year on forms prescribed by the commission ~~department~~, the following data for Florida private passenger automobile business. The data filed for the group shall be a consolidation of the data of the individual insurers of the group. The data shall include both voluntary and joint underwriting association business, as follows:

(a) Calendar-year total limits earned premium.

(b) Accident-year incurred losses and loss adjustment expenses.

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(c) The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.

(d) Policyholder dividends incurred during the applicable calendar year.

(7) If the insurer group has realized an excessive profit, the commission ~~department~~ shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the commission ~~department~~ that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.

(10)(a) Cash refunds to policyholders may be rounded to the nearest dollar.

(b) Data in required reports to the commission ~~department~~ may be rounded to the nearest dollar.

(c) Rounding, if elected by the insurer group, shall be applied consistently.

(11)(a) Refunds shall be completed in one of the following ways:

1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days of entry of a final order indicating that excessive profits have been realized.

2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final

order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels his or her policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the commission ~~department~~ that the refunds have been made.

~~(13) Since it appears to the Legislature that private passenger automobile insurer groups have realized excessive profits during all or part of the years 1977, 1978, and 1979 and that such profits were realized in part due to statutory changes for which rates were not adequately adjusted, it is the desire and intent of the Legislature that the provisions of this section, as amended by chapter 80-236, Laws of Florida, shall apply retroactively to excessive profits realized during the years 1977, 1978, and 1979. In the event that such retroactive application is judicially determined to be unconstitutional, it is the intent of the Legislature that the act be given prospective application as stated hereinafter. Prior to July 1, 1982, the data required by this section shall be submitted to the department for the years 1979, 1980, and 1981. Excessive profits shall be calculated in accordance with the provisions of this section. However, only the excessive profits realized by the insurer group in 1981 shall be refunded to policyholders, and such refunds shall be made in accordance with this section. Prior to July 1, 1983, the data required by this section shall be submitted to the department for the years 1980, 1981, and 1982. Excessive profits shall be calculated in accordance with this~~

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~~section; however, refunds shall only be made for excessive profits realized in the years 1981 and 1982. Thereafter, excessive profits shall be calculated and refunded on the basis of 3 years as set forth in this section.~~

Section 38. Subsection (4) of section 627.072, Florida Statutes, is amended to read:

627.072 Making and use of rates.--

(4)(a) In the case of workers' compensation and employer's liability insurance, the commission ~~department~~ shall consider using ~~utilizing~~ the following methodology in rate determinations: Premiums, expenses, and expected claim costs would be discounted to a common point of time, such as the initial point of a policy year, in the determination of rates; the cash-flow pattern of premiums, expenses, and claim costs would be determined initially by using data from 8 to 10 of the largest insurers writing workers' compensation insurance in the state; such insurers may be selected for their statistical ability to report the data on an accident-year basis and in accordance with subparagraphs (b)1., 2., and 3., for at least 2 1/2 years; such a cash-flow pattern would be modified when necessary in accordance with the data and whenever a radical change in the payout pattern is expected in the policy year under consideration.

(b) If the methodology set forth in paragraph (a) is used ~~utilized~~, to facilitate the determination of such a cash-flow pattern methodology:

1. Each insurer shall include in its statistical reporting to the rating bureau and the commission ~~department~~ the accident year by calendar quarter data for paid-claim costs;

1 2. Each insurer shall submit financial reports to the
2 rating bureau and the commission ~~department~~ which shall
3 include total incurred claim amounts and paid-claim amounts by
4 policy year and by injury types as of December 31 of each
5 calendar year; and
6 3. Each insurer shall submit to the rating bureau and
7 the commission ~~department~~ paid-premium data on an individual
8 risk basis in which risks are to be subdivided by premium size
9 as follows:
10
11-12

Number of Risks in Premium Range	Standard Premium Size
...(to be filled in by carrier)...	$300--999
...(to be filled in by carrier)...	1,000--4,999
...(to be filled in by carrier)...	5,000--49,999
...(to be filled in by carrier)...	50,000--99,999
...(to be filled in by carrier)...	100,000 or more
Total:	

20
21 4. Each insurer which does not have the capability of
22 reporting in accordance with subparagraphs 1., 2., and 3.
23 shall be required to commence such reporting procedures as of
24 January 1, 1980.
25 ~~(c) The Insurance Commissioner is directed to consider~~
26 ~~using the methodology specified in paragraph (a) prior to~~
27 ~~March 31, 1980; and, in the event the Insurance Commissioner~~
28 ~~decides not to use this methodology, she or he shall report~~
29 ~~such decision and the reasons therefor to the committees of~~
30 ~~substance in the area of insurance in each house of the~~
31 ~~Legislature by March 31, 1980.~~

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Section 39. Subsections (1), (5), and (6) of section 627.091, Florida Statutes, are amended to read:

627.091 Rate filings; workers' compensation and employer's liability insurances.--

(1) As to workers' compensation and employer's liability insurances, every insurer shall file with the commission ~~department~~ every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing which it proposes to use. Every insurer is authorized to include deductible provisions in its manual of classifications, rules, and rates. Such deductibles shall in all cases be in a form and manner which is consistent with the underlying purpose of chapter 440.

(5) Pursuant to the provisions of s. 624.3161, the commission ~~department~~ may examine the underlying statistical data used in such filings.

(6) Whenever the committee of a recognized rating organization with responsibility for workers' compensation and employer's liability insurance rates in this state meets to discuss the necessity for, or a request for, Florida rate increases or decreases, the determination of Florida rates, the rates to be requested, and any other matters pertaining specifically and directly to such Florida rates, such meetings shall be held in this state and shall be subject to s. 286.011. The committee of such a rating organization shall provide at least 3 weeks' prior notice of such meetings to the commission ~~department~~ and shall provide at least 14 days' prior notice of such meetings to the public by publication in the Florida Administrative Weekly.

Section 40. Section 627.0915, Florida Statutes, is amended to read:

1 627.0915 Rate filings; workers' compensation,
2 drug-free workplace, and safe employers.--The commission
3 ~~Department of Insurance~~ shall approve rating plans for
4 workers' compensation insurance that give specific
5 identifiable consideration in the setting of rates to
6 employers that either implement a drug-free workplace program
7 pursuant to rules adopted by the Division of Workers'
8 Compensation of the Department of Labor and Employment
9 Security or implement a safety program approved by the
10 Division of Safety pursuant to rules adopted by the Division
11 of Safety of the Department of Labor and Employment Security
12 or implement both a drug-free workplace program and a safety
13 program. The Division of Safety may by rule require that the
14 client of a help supply services company comply with the
15 essential requirements of a workplace safety program as a
16 condition for receiving a premium credit. The plans must take
17 effect January 1, 1994, must be actuarially sound, and must
18 state the savings anticipated to result from such drug-testing
19 and safety programs.
20 Section 41. Section 627.0916, Florida Statutes, is
21 amended to read:
22 627.0916 Agricultural horse farms.--Notwithstanding
23 any other provision of this chapter to the contrary, any
24 rates, rating schedules, or rating manuals for workers'
25 compensation and employer's liability insurance filed with the
26 commission ~~Department of Insurance~~ shall provide for the rates
27 of an agricultural horse farm engaged in breeding or training
28 to be separated into the following three rate classifications
29 and the premium paid shall be applied proportionately
30 according to payroll: breeding activity involving stallions;
31

breeding activity not involving stallions, including but not limited to boarding and foaling; and training.

Section 42. Subsection (1) of section 627.096, Florida Statutes, is amended to read:

627.096 Workers' Compensation Rating Bureau.--

(1) There is created within the commission ~~department~~ a Workers' Compensation Rating Bureau, which shall make an investigation and study of all insurers authorized to issue workers' compensation and employer's liability coverage in this state. Such bureau shall study the data, statistics, schedules, or other information as it may deem necessary to assist and advise the commission ~~department~~ in its review of filings made by or on behalf of workers' compensation and employer's liability insurers. The commission ~~department~~ shall have the authority to adopt ~~promulgate~~ rules requiring all workers' compensation and employer's liability insurers to submit to the rating bureau any data, statistics, schedules, and other information deemed necessary to the rating bureau's study and advisement.

Section 43. Section 627.101, Florida Statutes, is amended to read:

627.101 When filing becomes effective; workers' compensation and employer's liability insurances.--

(1) The commission ~~department~~ shall review filings as to workers' compensation and employer's liability insurances as soon as reasonably possible after they have been made in order to determine whether they meet the applicable requirements of this part. If the commission ~~department~~ determines that part of a rate filing does not meet the applicable requirements of this part, it may reject so much of

the filing as does not meet these requirements, and approve the remainder of the filing.

(2) The commission ~~department~~ shall specifically approve the filing before it becomes effective, unless the commission ~~department~~ has concluded it to be in the public interest to hold a public hearing to determine whether the filing meets the requirements of this chapter and has given notice of such hearing to the insurer or rating organization that made the filing, and in which case the effectiveness of the filing shall be subject to the further order of the commission ~~department~~ made as provided in s. 627.111. If the commission ~~department~~ specifically disapproves the filing, the provisions of subsection (4) shall apply.

(3) An insurer or rating organization may, at the time it makes a filing with the commission ~~department~~, request a public hearing thereon. In such event, the commission ~~department~~ shall give notice of the hearing.

(4) If the commission ~~department~~ disapproves a filing, it shall promptly give notice of such disapproval to the insurer or rating organization that made the filing, stating the respects in which it finds that the filing does not meet the requirements of this chapter. If the commission ~~department~~ approves a filing, it shall give prompt notice thereof to the insurer or rating organization that made the filing, and in which case the filing shall become effective upon such approval or upon such subsequent date as may be satisfactory to the commission ~~department~~ and the insurer or rating organization that made the filing.

Section 44. Section 627.111, Florida Statutes, is amended to read:

627.111 Effective date of filing.--

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1 (1) If, pursuant to s. 627.101(2), the commission
2 ~~department~~ determines to hold a public hearing as to a filing,
3 or it holds such a public hearing pursuant to request therefor
4 under s. 627.101(3), it shall give written notice thereof to
5 the rating organization or insurer that made the filing and
6 shall hold such hearing within 30 days, and not less than 10
7 days prior to the date of the hearing, it shall give written
8 notice of the hearing to the insurer or rating organization
9 that made the filing. The commission ~~department~~ may also, in
10 its discretion, give advance public notice of such hearing by
11 publication of notice in one or more daily newspapers of
12 general circulation in this state.
13 (2) If the order of the commission ~~department~~
14 disapproves the filing, the filing shall not become effective
15 during the effectiveness of such order. If the order of the
16 commission ~~department~~ approves the filing, the filing shall
17 become effective upon the date of the order or upon such
18 subsequent date as may be satisfactory to the insurer or
19 rating organization that made the filing.
20 Section 45. Section 627.141, Florida Statutes, is
21 amended to read:
22 627.141 Subsequent disapproval of filing; workers'
23 compensation and employer's liability insurances.--If at any
24 time after a filing has been approved by it or has otherwise
25 become effective the commission ~~department~~ finds that the
26 filing no longer meets the requirements of this chapter, it
27 shall issue an order specifying in what respects it finds that
28 such filing fails to meet such requirements and stating when,
29 within a reasonable period thereafter, such filing shall be
30 deemed no longer effective. The order shall not affect any
31

1 insurance contract or policy made or issued prior to the
2 expiration of the period set forth in the order.
3 Section 46. Subsection (1) of section 627.151, Florida
4 Statutes, is amended to read:
5 627.151 Basis of approval or disapproval of workers'
6 compensation or employer's liability insurance filing; scope
7 of disapproval power.--
8 (1) In determining at any time whether to approve or
9 disapprove a filing as to workers' compensation or employer's
10 liability insurance, or to permit the filing otherwise to
11 become effective, the commission ~~department~~ shall give
12 consideration only to the applicable standards and factors
13 referred to in ss. 627.062 and 627.072.
14 Section 47. Paragraph (f) of subsection (2) of section
15 627.192, Florida Statutes, is amended to read:
16 627.192 Workers' compensation insurance; employee
17 leasing arrangements.--
18 (2) For purposes of the Florida Insurance Code:
19 (f) "Premium subject to dispute" means that the
20 insured has provided a written notice of dispute to the
21 insurer or service carrier, has initiated any applicable
22 proceeding for resolving such disputes as prescribed by law or
23 rating organization procedures approved by the commission
24 ~~department~~, or has initiated litigation regarding the premium
25 dispute. The insured must have detailed the specific areas of
26 dispute and provided an estimate of the premium the insured
27 believes to be correct. The insured must have paid any
28 undisputed portion of the bill.
29 Section 48. Section 627.211, Florida Statutes, is
30 amended to read:
31

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1 627.211 Deviations; workers' compensation and
2 employer's liability insurances.--
3 (1) Every member or subscriber to a rating
4 organization shall, as to workers' compensation or employer's
5 liability insurance, adhere to the filings made on its behalf
6 by such organization; except that any such insurer may make
7 written application to the commission ~~department~~ for
8 permission to file a uniform percentage decrease or increase
9 to be applied to the premiums produced by the rating system so
10 filed for a kind of insurance, for a class of insurance which
11 is found by the commission ~~department~~ to be a proper rating
12 unit for the application of such uniform percentage decrease
13 or increase, or for a subdivision of workers' compensation or
14 employer's liability insurance:
15 (a) Comprised of a group of manual classifications
16 which is treated as a separate unit for ratemaking purposes;
17 or
18 (b) For which separate expense provisions are included
19 in the filings of the rating organization.
20
21 Such application shall specify the basis for the modification
22 and shall be accompanied by the data upon which the applicant
23 relies. A copy of the application and data shall be sent
24 simultaneously to the rating organization.
25 (2) Every member or subscriber to a rating
26 organization may, as to workers' compensation and employer's
27 liability insurance, file a plan or plans to use deviations
28 that vary according to factors present in each insured's
29 individual risk. The insurer that files for the deviations
30 provided in this subsection shall file the qualifications for
31 the plans, schedules of rating factors, and the maximum

1 deviation factors which shall be subject to the approval of
2 the commission ~~department~~ pursuant to s. 627.091. The actual
3 deviation which shall be used for each insured that qualifies
4 under this subsection may not exceed the maximum filed
5 deviation under that plan and shall be based on the merits of
6 each insured's individual risk as determined by using
7 schedules of rating factors which shall be applied uniformly.
8 Insurers shall maintain statistical data in accordance with
9 the schedule of rating factors. Such data shall be available
10 to support the continued use of such varying deviations.
11 (3) In considering an application for the deviation,
12 the commission ~~department~~ shall give consideration to the
13 applicable principles for ratemaking as set forth in ss.
14 627.062 and 627.072, the financial condition of the insurer,
15 and the impact of the deviation on the current market
16 conditions including the composition of the market, the
17 stability of rates, and the level of competition in the
18 market. In evaluating the financial condition of the insurer,
19 the commission ~~department~~ may consider:~~(1)~~the insurer's
20 audited financial statements and whether the statements
21 provide unqualified opinions or contain significant
22 qualifications or "subject to" provisions;~~(2)~~any independent
23 or other actuarial certification of loss reserves;~~(3)~~whether
24 workers' compensation and employer's liability reserves are
25 above the midpoint or best estimate of the actuary's reserve
26 range estimate;~~(4)~~the adequacy of the proposed rate;~~(5)~~
27 historical experience demonstrating the profitability of the
28 insurer;~~(6)~~the existence of excess or other reinsurance that
29 contains a sufficiently low attachment point and maximums that
30 provide adequate protection to the insurer; and~~(7)~~other
31 factors considered relevant to the financial condition of the

insurer by the commission ~~department~~. The commission ~~department~~ shall approve the deviation if it finds it to be justified, it would not endanger the financial condition of the insurer, it would not adversely affect the current market conditions including the composition of the market, the stability of rates, and the level of competition in the market, and that the deviation would not constitute predatory pricing. It shall disapprove the deviation if it finds that the resulting premiums would be excessive, inadequate, or unfairly discriminatory, would endanger the financial condition of the insurer, or would adversely affect current market conditions including the composition of the marketplace, the stability of rates, and the level of competition in the market, or would result in predatory pricing. The insurer may not use a deviation unless the deviation is specifically approved by the commission ~~department~~.

~~(4) No filing for a deviation may be made pursuant to this section prior to January 1, 1997. Notwithstanding the provisions of this subsection, the department may extend or renew any deviation filed and approved prior to the effective date of this subsection.~~

(4)~~(5)~~ Each deviation permitted to be filed shall be effective for a period of 1 year unless terminated, extended, or modified with the approval of the commission ~~department~~. If at any time after a deviation has been approved the commission ~~department~~ finds that the deviation no longer meets the requirements of this code, it shall notify the insurer in what respects it finds that the deviation fails to meet such requirements and specify when, within a reasonable period thereafter, the deviation shall be deemed no longer effective.

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The notice shall not affect any insurance contract or policy made or issued prior to the expiration of the period set forth in the notice.

(5)~~(6)~~ For purposes of this section, the commission ~~department~~, when considering the experience of any insurer, shall consider the experience of any predecessor insurer when the business and the liabilities of the predecessor insurer were assumed by the insurer pursuant to an order of the department which approves the assumption of the business and the liabilities.

Section 49. Section 627.212, Florida Statutes, is amended to read:

627.212 Workplace safety program surcharge.--The commission ~~department~~ shall approve a rating plan for workers' compensation coverage insurance that provides for carriers voluntarily to impose a surcharge of no more than 10 percent on the premium of a policyholder or fund member if that policyholder or fund member has been identified by the Department of Labor and Employment Security as having been required to implement a safety program and having failed to establish or maintain, either in whole or in part, a safety program. The division shall adopt rules prescribing the criteria for the employee safety programs.

Section 50. Subsections (1), (9), and (12) of section 627.215, Florida Statutes, are amended to read:

627.215 Excessive profits for workers' compensation, employer's liability, commercial property, and commercial casualty insurance prohibited.--

(1)(a) Each insurer group writing workers' compensation and employer's liability insurance as defined in s. 624.605(1)(c), commercial property insurance as defined in

1 s. 627.0625, commercial umbrella liability insurance as
2 defined in s. 627.0625, or commercial casualty insurance as
3 defined in s. 627.0625 shall file with the commission
4 ~~department~~ prior to July 1 of each year, on a form prescribed
5 by the commission ~~department~~, the following data for the
6 component types of such insurance as provided in the form:
7 1. Calendar-year earned premium.
8 2. Accident-year incurred losses and loss adjustment
9 expenses.
10 3. The administrative and selling expenses incurred in
11 this state or allocated to this state for the calendar year.
12 4. Policyholder dividends applicable to the calendar
13 year.
14
15 Nothing herein is intended to prohibit an insurer from filing
16 on a calendar-year basis.
17 (b) The data filed for the group shall be a
18 consolidation of the data of the individual insurers of the
19 group. However, an insurer may elect to either consolidate
20 commercial umbrella liability insurance data with commercial
21 casualty insurance data or to separately file data for
22 commercial umbrella liability insurance. Each insurer shall
23 elect its method of filing commercial umbrella liability
24 insurance at the time of filing data for accident year 1987
25 and shall thereafter continue filing under the same method. In
26 the case of commercial umbrella liability insurance data
27 reported separately, a separate excessive profits test shall
28 be applied and the test period shall be 10 years. ~~In the case~~
29 ~~of workers' compensation and employer's liability insurance,~~
30 ~~the final report for the test period including accident years~~
31 ~~1984, 1985, and 1986 must be filed prior to July 1, 1988. In~~

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1 ~~the case of commercial property and commercial casualty~~
2 ~~insurance, the final report for the test period including~~
3 ~~accident years 1987, 1988, and 1989 must be filed prior to~~
4 ~~July 1, 1991.~~
5 (9) If the insurer group has realized an excessive
6 profit, the department shall order a return of the excessive
7 amounts after affording the insurer group an opportunity for
8 hearing and otherwise complying with the requirements of
9 chapter 120. Such excessive amounts shall be refunded in all
10 instances unless the insurer group affirmatively demonstrates
11 to the <u>commission</u> ~~department~~ that the refund of the excessive
12 amounts will render a member of the insurer group financially
13 impaired or will render it insolvent under the provisions of
14 the Florida Insurance Code.
15 (12)(a) Refunds shall be completed in one of the
16 following ways:
17 1. If the insurer group elects to make a cash refund,
18 the refund shall be completed within 60 days of entry of a
19 final order indicating that excessive profits have been
20 realized.
21 2. If the insurer group elects to make refunds in the
22 form of a credit to renewal policies, such credits shall be
23 applied to policy renewal premium notices which are forwarded
24 to insureds more than 60 calendar days after entry of a final
25 order indicating that excessive profits have been realized.
26 If an insurer group has made this election but an insured
27 thereafter cancels her or his policy or otherwise allows the
28 policy to terminate, the insurer group shall make a cash
29 refund not later than 60 days after termination of such
30 coverage.
31

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(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the commission ~~department~~ that the refunds have been made.

Section 51. Subsection (1) of section 627.221, Florida Statutes, is amended to read:

627.221 Rating organizations; licensing; fee.--

(1) A person, whether located within or outside this state, may make application to the commission ~~department~~ for a license as a rating organization. As to property or inland marine insurance, the application shall be for such kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof as are specified in the application. As to casualty and surety insurances, the application shall be for such kinds of insurance or subdivisions thereof as are specified in the application. The applicant shall file with its application:

(a) A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) The name and address of a resident of this state upon whom notices or orders of the department or process affecting such rating organization may be served; and

(d) A statement of its qualifications as a rating organization.

If the commission ~~department~~ finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and

1 its bylaws, rules, and regulations governing the conduct of
2 its business conform to the requirements of law, it shall
3 issue a license specifying (in the case of a casualty or
4 surety rating organization) the kinds of insurance or
5 subdivisions thereof, or (in the case of a property insurance
6 rating organization) the kinds of insurance or subdivisions
7 thereof or classes of risk or a part or combination thereof,
8 for which the applicant is authorized to act as a rating
9 organization.
10 Section 52. Section 627.231, Florida Statutes, is
11 amended to read:
12 627.231 Subscribers to rating organizations.--
13 (1) Subject to rules and regulations which have been
14 approved by the commission ~~department~~ as reasonable, each
15 rating organization shall permit any insurer, not a member, to
16 subscribe to its rating services. As to property and marine
17 rating organizations, an insurer shall be so permitted to
18 subscribe to rating services for any kind of insurance,
19 subdivision thereof, or class of risk or a part or combination
20 thereof for which the rating organization is authorized so to
21 act. As to casualty and surety rating organizations, an
22 insurer shall be so permitted to subscribe to rating services
23 for any kind of insurance or subdivision thereof for which the
24 rating organization is authorized so to act. The rating
25 organization shall give notice to subscribers of proposed
26 changes in such rules and regulations.
27 (2) The reasonableness of any rule or regulation in
28 its application to subscribers, or the refusal of any rating
29 organization to admit an insurer as a subscriber, shall, at
30 the request of any subscriber or any such insurer, be reviewed
31 by the commission ~~department~~. If the commission ~~department~~

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finds that such rule or regulation is unreasonable in its application to subscribers, it shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within 30 days after it was made, the insurer may request a review by the commission ~~department~~ as if the application had been rejected. If the commission ~~department~~ finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, it shall order the rating organization to admit the insurer as a subscriber. If it finds that the action of the rating organization was justified, it shall make an order affirming its action.

(3) Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

Section 53. Section 627.241, Florida Statutes, is amended to read:

627.241 Notice of changes.--Every rating organization shall notify the commission ~~department~~ promptly of every change in:

(1) Its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business;

(2) Its list of members and subscribers; and

(3) The name and address of the resident of this state designated by it upon whom notices or orders of the department or process affecting such rating organization may be served.

Section 54. Section 627.281, Florida Statutes, is amended to read:

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1 627.281 Appeal from rating organization; workers'
2 compensation and employer's liability insurance filings.--
3 (1) Any member or subscriber to a rating organization
4 may appeal to the <u>commission</u> ~~department~~ from the action or
5 decision of such rating organization in approving or rejecting
6 any proposed change in or addition to the workers'
7 compensation or employer's liability insurance filings of such
8 rating organization, and the <u>commission</u> ~~department~~ shall issue
9 an order approving the decision of such rating organization or
10 directing it to give further consideration to such proposal.
11 If such appeal is from the action or decision of the rating
12 organization in rejecting a proposed addition to its filings,
13 the <u>commission</u> ~~department~~ may, <u>if</u> ~~in the event that~~ it finds
14 that such action or decision was unreasonable, issue an order
15 directing the rating organization to make an addition to its
16 filings, on behalf of its members and subscribers, in a manner
17 consistent with its findings, within a reasonable time after
18 the issuance of such order.
19 (2) If such appeal is based upon the failure of the
20 rating organization to make a filing on behalf of such member
21 or subscriber which is based on a system of expense provisions
22 which differs, in accordance with the right granted in s.
23 627.072(2), from the system of expense provisions included in
24 a filing made by the rating organization, the <u>commission</u>
25 ~~department~~ shall, if it grants the appeal, order the rating
26 organization to make the requested filing for use by the
27 appellant. In deciding such appeal, the <u>commission</u> ~~department~~
28 shall apply the applicable standards set forth in ss. 627.062
29 and 627.072.
30 Section 55. Subsection (2) of section 627.291, Florida
31 Statutes, is amended to read:

1 627.291 Information to be furnished insureds; appeal
2 by insureds; workers' compensation and employer's liability
3 insurances.--
4 (2) As to workers' compensation and employer's
5 liability insurances, every rating organization and every
6 insurer which makes its own rates shall provide within this
7 state reasonable means whereby any person aggrieved by the
8 application of its rating system may be heard, in person or by
9 his or her authorized representative, on his or her written
10 request to review the manner in which such rating system has
11 been applied in connection with the insurance afforded him or
12 her. If the rating organization or insurer fails to grant or
13 rejects such request within 30 days after it is made, the
14 applicant may proceed in the same manner as if his or her
15 application had been rejected. Any party affected by the
16 action of such rating organization or insurer on such request
17 may, within 30 days after written notice of such action,
18 appeal to the <u>commission</u> ~~department~~, which may affirm or
19 reverse such action.
20 Section 56. Section 627.301, Florida Statutes, is
21 amended to read:
22 627.301 Advisory organizations.--
23 (1) No advisory organization shall conduct its
24 operations in this state unless and until it has filed with
25 the <u>commission</u> ~~department~~:
26 (a) A copy of its constitution, articles of
27 incorporation, articles of agreement or of association, and
28 bylaws or rules and regulations governing its activities, all
29 duly certified by the custodian of the originals thereof;
30 (b) A list of its members and subscribers; and
31

1 (c) The name and address of a resident of this state
2 upon whom notices or orders of the department or process may
3 be served.
4 (2) Every such advisory organization shall notify the
5 commission ~~department~~ promptly of every change in:
6 (a) Its constitution;
7 (b) Its articles of incorporation, agreement, or
8 association;
9 (c) Its bylaws, rules and regulations governing the
10 conduct of its business;
11 (d) The list of members and subscribers; and
12 (e) The name and address of the resident of this state
13 designated by it upon whom notices or orders of the commission
14 ~~department~~ or process affecting such organization may be
15 served.
16 (3) No such advisory organization shall engage in any
17 unfair or unreasonable practice with respect to such
18 activities.
19 Section 57. Subsection (4) of section 627.311, Florida
20 Statutes, is amended to read:
21 627.311 Joint underwriters and joint reinsurers.--
22 (4)(a) ~~Effective upon this act becoming a law,~~The
23 department shall, after consultation with insurers, approve a
24 joint underwriting plan of insurers which shall operate as a
25 nonprofit entity. For the purposes of this subsection, the
26 term "insurer" includes group self-insurance funds authorized
27 by s. 624.4621, commercial self-insurance funds authorized by
28 s. 624.462, assessable mutual insurers authorized under s.
29 628.6011, and insurers licensed to write workers' compensation
30 and employer's liability insurance in this state. The purpose
31 of the plan is to provide workers' compensation and employer's

1 liability insurance to applicants who are required by law to
2 maintain workers' compensation and employer's liability
3 insurance and who are in good faith entitled to but who are
4 unable to purchase such insurance through the voluntary
5 market. The joint underwriting plan shall issue policies
6 beginning January 1, 1994. The plan must have actuarially
7 sound rates that assure that the plan is self-supporting.
8 (b) The operation of the plan is subject to the
9 supervision of a 13-member board of governors. The board of
10 governors shall be comprised of:
11 1. Five of the 20 domestic insurers, as defined in s.
12 624.06(1), having the largest voluntary direct premiums
13 written in this state for workers' compensation and employer's
14 liability insurance, which shall be elected by those 20
15 domestic insurers;
16 2. Five of the 20 foreign insurers as defined in s.
17 624.06(2) having the largest voluntary direct premiums written
18 in this state for workers' compensation and employer's
19 liability insurance, which shall be elected by those 20
20 foreign insurers;
21 3. One person, who shall serve as the chair, appointed
22 by the Insurance Commissioner;
23 4. One person appointed by the largest property and
24 casualty insurance agents' association in this state; and
25 5. The consumer advocate appointed under s. 627.0613
26 or the consumer advocate's designee.
27
28 Each board member shall serve a 4-year term and may serve
29 consecutive terms. No board member shall be an insurer which
30 provides service to the plan or which has an affiliate which
31 provides services to the plan or which is serviced by a

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1 service company or third-party administrator which provides
2 services to the plan or which has an affiliate which provides
3 services to the plan. The minutes, audits, and procedures of
4 the board of governors are subject to chapter 119.
5 (c) The operation of the plan shall be governed by a
6 plan of operation that is prepared at the direction of the
7 board of governors. The plan of operation may be changed at
8 any time by the board of governors or upon request of the
9 department or commission. The plan of operation and all
10 changes thereto are subject to the approval of the department,
11 except that all changes related to rates are subject to
12 approval of the commission. The plan of operation shall:
13 1. Authorize the board to engage in the activities
14 necessary to implement this subsection, including, but not
15 limited to, borrowing money.
16 2. Develop criteria for eligibility for coverage by
17 the plan, including, but not limited to, documented rejection
18 by at least two insurers which reasonably assures that
19 insureds covered under the plan are unable to acquire coverage
20 in the voluntary market. Any insured may voluntarily elect to
21 accept coverage from an insurer for a premium equal to or
22 greater than the plan premium if the insurer writing the
23 coverage adheres to the provisions of s. 627.171.
24 3. Require notice from the agent to the insured at the
25 time of the application for coverage that the application is
26 for coverage with the plan and that coverage may be available
27 through an insurer, group self-insurers' fund, commercial
28 self-insurance fund, or assessable mutual insurer through
29 another agent at a lower cost.
30
31

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1 4. Establish programs to encourage insurers to provide
2 coverage to applicants of the plan in the voluntary market and
3 to insureds of the plan, including, but not limited to:
4 a. Establishing procedures for an insurer to use in
5 notifying the plan of the insurer's desire to provide coverage
6 to applicants to the plan or existing insureds of the plan and
7 in describing the types of risks in which the insurer is
8 interested. The description of the desired risks must be on a
9 form developed by the plan.
10 b. Developing forms and procedures that provide an
11 insurer with the information necessary to determine whether
12 the insurer wants to write particular applicants to the plan
13 or insureds of the plan.
14 c. Developing procedures for notice to the plan and
15 the applicant to the plan or insured of the plan that an
16 insurer will insure the applicant or the insured of the plan,
17 and notice of the cost of the coverage offered; and developing
18 procedures for the selection of an insuring entity by the
19 applicant or insured of the plan.
20 d. Provide for a market-assistance plan to assist in
21 the placement of employers. All applications for coverage in
22 the plan received 45 days before the effective date for
23 coverage shall be processed through the market-assistance
24 plan. A market-assistance plan specifically designed to serve
25 the needs of small good policyholders as defined by the board
26 must be finalized by January 1, 1994.
27 5. Provide for policy and claims services to the
28 insureds of the plan of the nature and quality provided for
29 insureds in the voluntary market.
30
31

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1 6. Provide for the review of applications for coverage
2 with the plan for reasonableness and accuracy, using any
3 available historic information regarding the insured.
4 7. Provide for procedures for auditing insureds of the
5 plan which are based on reasonable business judgment and are
6 designed to maximize the likelihood that the plan will collect
7 the appropriate premiums.
8 8. Authorize the plan to terminate the coverage of and
9 refuse future coverage for any insured that submits a
10 fraudulent application to the plan or provides fraudulent or
11 grossly erroneous records to the plan or to any service
12 provider of the plan in conjunction with the activities of the
13 plan.
14 9. Establish service standards for agents who submit
15 business to the plan.
16 10. Establish criteria and procedures to prohibit any
17 agent who does not adhere to the established service standards
18 from placing business with the plan or receiving, directly or
19 indirectly, any commissions for business placed with the plan.
20 11. Provide for the establishment of reasonable safety
21 programs for all insureds in the plan.
22 12. Authorize the plan to terminate the coverage of
23 and refuse future coverage to any insured who fails to pay
24 premiums or surcharges when due; who, at the time of
25 application, is delinquent in payments of workers'
26 compensation or employer's liability insurance premiums or
27 surcharges owed to an insurer, group self-insurers' fund,
28 commercial self-insurance fund, or assessable mutual insurer
29 licensed to write such coverage in this state; or who refuses
30 to substantially comply with any safety programs recommended
31 by the plan.

1 13. Authorize the board of governors to provide the
2 services required by the plan through staff employed by the
3 plan, through reasonably compensated service providers who
4 contract with the plan to provide services as specified by the
5 board of governors, or through a combination of employees and
6 service providers.
7 14. Provide for service standards for service
8 providers, methods of determining adherence to those service
9 standards, incentives and disincentives for service, and
10 procedures for terminating contracts for service providers
11 that fail to adhere to service standards.
12 15. Provide procedures for selecting service providers
13 and standards for qualification as a service provider that
14 reasonably assure that any service provider selected will
15 continue to operate as an ongoing concern and is capable of
16 providing the specified services in the manner required.
17 16. Provide for reasonable accounting and
18 data-reporting practices.
19 17. Provide for annual review of costs associated with
20 the administration and servicing of the policies issued by the
21 plan to determine alternatives by which costs can be reduced.
22 18. Authorize the acquisition of such excess insurance
23 or reinsurance as is consistent with the purposes of the plan.
24 19. Provide for an annual report to the department on
25 a date specified by the department and containing such
26 information as the department reasonably requires.
27 20. Establish multiple rating plans for various
28 classifications of risk which reflect risk of loss, hazard
29 grade, actual losses, size of premium, and compliance with
30 loss control. At least one of such plans must be a
31 preferred-rating plan to accommodate small-premium

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1 policyholders with good experience as defined in
2 sub-subparagraph 22.a.
3 21. Establish agent commission schedules.
4 22. Establish three subplans as follows:
5 a. Subplan "A" must include those insureds whose
6 annual premium does not exceed $2,500 and who have neither
7 incurred any lost-time claims nor incurred medical-only claims
8 exceeding 50 percent of their premium for the immediate 2
9 years.
10 b. Subplan "B" must include insureds that are
11 employers identified by the board of governors as high-risk
12 employers due solely to the nature of the operations being
13 performed by those insureds and for whom no market exists in
14 the voluntary market, and whose experience modifications are
15 less than 1.00.
16 c. Subplan "C" must include all other insureds within
17 the plan.
18 (d) The plan must be funded through actuarially sound
19 premiums charged to insureds of the plan. The plan may issue
20 assessable policies only to those insureds in subplan "C."
21 Those assessable policies must be clearly identified as
22 assessable by containing, in contrasting color and in not less
23 than 10-point type, the following statements: "This is an
24 assessable policy. If the plan is unable to pay its
25 obligations, policyholders will be required to contribute on a
26 pro rata earned premium basis the money necessary to meet any
27 assessment levied." The plan may issue assessable policies
28 with differing terms and conditions to different groups within
29 the plan when a reasonable basis exists for the
30 differentiation. The plan may offer rating, dividend plans,
31 and other plans to encourage loss prevention programs.

(e) The plan shall establish and use its rates and rating plans, and the plan may establish and use changes in rating plans at any time, but no more frequently than two times per any rating class for any calendar year. By December 1, 1993, and December 1 of each year thereafter, the board shall establish and use actuarially sound rates for use by the plan to assure that the plan is self-funding while those rates are in effect. Such rates and rating plans must be filed with the commission ~~department~~ within 30 calendar days after their effective dates, and shall be considered a "use and file" filing. Any disapproval by the commission ~~department~~ must have an effective date that is at least 60 days from the date of disapproval of the rates and rating plan and must have prospective effect only. The plan may not be subject to any order by the commission ~~department~~ to return to policyholders any portion of the rates disapproved by the commission ~~department~~. The commission ~~department~~ may not disapprove any rates or rating plans unless it demonstrates that such rates and rating plans are excessive, inadequate, or unfairly discriminatory.

(f) No later than June 1 of each year, the plan shall obtain an independent actuarial certification of the results of the operations of the plan for prior years, and shall furnish a copy of the certification to the commission ~~department~~. If, after the effective date of the plan, the projected ultimate incurred losses and expenses and dividends for prior years exceed collected premiums, accrued net investment income, and prior assessments for prior years, the certification is subject to review and approval by the commission ~~department~~ before it becomes final.

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1 (g) Whenever a deficit exists, the plan shall, within
2 90 days, provide the department <u>and the commission</u> with a
3 program to eliminate the deficit within a reasonable time. The
4 deficit may be funded both through increased premiums charged
5 to insureds of the plan for subsequent years and through
6 assessments on insureds in the plan if the plan uses
7 assessable policies.
8 (h) Any premium or assessments collected by the plan
9 in excess of the amount necessary to fund projected ultimate
10 incurred losses and expenses of the plan and not paid to
11 insureds of the plan in conjunction with loss prevention or
12 dividend programs shall be retained by the plan for future
13 use.
14 (i) The decisions of the board of governors do not
15 constitute final agency action and are not subject to chapter
16 120.
17 (j) Policies for insureds shall be issued by the plan.
18 (k) The plan created under this subsection is liable
19 only for payment for losses arising under policies issued by
20 the plan with dates of accidents occurring on or after January
21 1, 1994.
22 (l) Plan losses are the sole and exclusive
23 responsibility of the plan, and payment for such losses must
24 be funded in accordance with this subsection and must not
25 come, directly or indirectly, from insurers or any guaranty
26 association for such insurers.
27 (m) Each joint underwriting plan or association
28 created under this section is not a state agency, board, or
29 commission. However, for the purposes of s. 199.183(1) only,
30 the joint underwriting plan is a political subdivision of the
31 state and is exempt from the corporate income tax.

1 (n) Each joint underwriting plan or association may
2 elect to pay premium taxes on the premiums received on its
3 behalf or may elect to have the member insurers to whom the
4 premiums are allocated pay the premium taxes if the member
5 insurer had written the policy. The joint underwriting plan or
6 association shall notify the member insurers and the
7 Department of Revenue by January 15 of each year of its
8 election for the same year. As used in this paragraph, the
9 term "premiums received" means the consideration for
10 insurance, by whatever name called, but does not include any
11 policy assessment or surcharge received by the joint
12 underwriting association as a result of apportioning losses or
13 deficits of the association pursuant to this section.
14 (o) Effective midnight, December 31, 1993, the Florida
15 Workers' Compensation Insurance Plan, administered by the
16 National Council on Compensation Insurance, shall terminate,
17 except with respect to workers' compensation policies issued
18 pursuant to such Florida Workers' Compensation Insurance Plan
19 with inception dates on or before December 31, 1993.
20 (p) Neither the plan nor any member of the board of
21 governors is liable for monetary damages to any person for any
22 statement, vote, decision, or failure to act, regarding the
23 management or policies of the plan, unless:
24 1. The member breached or failed to perform her or his
25 duties as a member; and
26 2. The member's breach of, or failure to perform,
27 duties constitutes:
28 a. A violation of the criminal law, unless the member
29 had reasonable cause to believe her or his conduct was
30 unlawful. A judgment or other final adjudication against a
31 member in any criminal proceeding for violation of the

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1 criminal law estops that member from contesting the fact that
2 her or his breach, or failure to perform, constitutes a
3 violation of the criminal law; but does not estop the member
4 from establishing that she or he had reasonable cause to
5 believe that her or his conduct was lawful or had no
6 reasonable cause to believe that her or his conduct was
7 unlawful;
8 b. A transaction from which the member derived an
9 improper personal benefit, either directly or indirectly; or
10 c. Recklessness or any act or omission that was
11 committed in bad faith or with malicious purpose or in a
12 manner exhibiting wanton and willful disregard of human
13 rights, safety, or property. For purposes of this
14 sub-subparagraph, the term "recklessness" means the acting, or
15 omission to act, in conscious disregard of a risk:
16 (I) Known, or so obvious that it should have been
17 known, to the member; and
18 (II) Known to the member, or so obvious that it should
19 have been known, to be so great as to make it highly probable
20 that harm would follow from such act or omission.
21 (q) No insurer shall provide workers' compensation and
22 employer's liability insurance to any person who is delinquent
23 in the payment of premiums, assessments, penalties, or
24 surcharges owed to the plan.
25 (5) As used in this section and ss. 215.555 and
26 627.351, the term "collateral protection insurance" means
27 commercial property insurance of which a creditor is the
28 primary beneficiary and policyholder and which protects or
29 covers an interest of the creditor arising out of a credit
30 transaction secured by real or personal property. Initiation
31 of such coverage is triggered by the mortgagor's failure to

maintain insurance coverage as required by the mortgage or other lending document. Collateral protection insurance is not residential coverage.

Section 58. Subsection (6) of section 627.314, Florida Statutes, is amended to read:

627.314 Concerted action by two or more insurers.--

(6) Notwithstanding any other provisions of this part, insurers shall not participate directly or indirectly in the deliberations or decisions of rating organizations on private passenger automobile insurance. However, such rating organizations shall, upon request of individual insurers, be required to furnish at reasonable cost the rate indications resulting from the loss and expense statistics gathered by them. Individual insurers may modify the indications to reflect their individual experience in determining their own rates. Such rates shall be filed with the commission ~~department~~ for public inspection whenever requested and shall be available for public announcement only by the press, commission ~~department~~, or insurer.

Section 59. Section 627.331, Florida Statutes, is amended to read:

627.331 Recording and reporting of loss, expense, and claims experience; rating information.--

(1) The commission ~~department~~ may adopt ~~promulgate~~ rules and statistical plans which shall thereafter be used by each insurer in the recording and reporting of its loss, expense, and claims experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the department in determining whether the insurer's activities comply with the applicable standards of this code.

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(2) In adopting ~~promulgating~~ such rules and plans, the commission ~~department~~ shall give due consideration to the rating systems in use in this state and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it, except for motor vehicle insurance as otherwise provided by law.

(3) The commission ~~department~~ may designate one or more rating organizations or other agencies to assist it in gathering such experience and making compilations thereof; and such compilations shall be made available, subject to reasonable rules adopted ~~promulgated~~ by the commission ~~department~~, to insurers and rating organizations.

Section 60. Subsections (1), (2), (4), (5), and (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.--

(1) MOTOR VEHICLE INSURANCE RISK APPORTIONMENT.--Agreements may be made among casualty and surety insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but are unable to, procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance. Such agreements and rate modifications shall be subject to the approval of the department. The department shall, after consultation with the insurers licensed to write automobile liability insurance in this state, adopt a reasonable plan or plans for the equitable

apportionment among such insurers of applicants for such insurance who are in good faith entitled to, but are unable to, procure such insurance through ordinary methods, and, when such plan has been adopted, all such insurers shall subscribe thereto and shall participate therein. Such plan or plans shall include rules for classification of risks and rates therefor. The plan or plans shall make available noncancelable coverage as provided in s. 627.7275(2). Any insured placed with the plan shall be notified of the fact that insurance coverage is being afforded through the plan and not through the private market, and such notification shall be given in writing within 10 days of such placement. To assure that plan rates are made adequate to pay claims and expenses, insurers shall develop a means of obtaining loss and expense experience at least annually, and the plan shall file such experience, when available, with the commission ~~department~~ in sufficient detail to make a determination of rate adequacy. Prior to the filing of such experience with the commission ~~department~~, the plan shall poll each member insurer as to the need for an actuary who is a member of the Casualty Actuarial Society and who is not affiliated with the plan's statistical agent to certify the plan's rate adequacy. If a majority of those insurers responding indicate a need for such certification, the plan shall include the certification as part of its experience filing. Such experience shall be filed with the commission ~~department~~ not more than 9 months following the end of the annual statistical period under review, together with a rate filing based on that ~~said~~ experience. The commission ~~department~~ shall initiate proceedings to disapprove the rate and so notify the plan or shall finalize its review within 60 days after ~~of~~ receipt of

1 the filing. Notification to the plan by the commission
2 ~~department~~ of its preliminary findings, which include a point
3 of entry to the plan pursuant to chapter 120, shall toll the
4 60-day period during any such proceedings and subsequent
5 judicial review. The rate shall be deemed approved if the
6 commission ~~department~~ does not issue notice to the plan of its
7 preliminary findings within 60 days of the filing. In
8 addition to provisions for claims and expenses, the ratemaking
9 formula shall include a factor for projected claims trending
10 and 5 percent for contingencies. In no instance shall the
11 formula include a renewal discount for plan insureds. However,
12 the plan shall reunderwrite each insured on an annual basis,
13 based upon all applicable rating factors approved by the
14 department. Trend factors shall not be found to be
15 inappropriate if not in excess of trend factors normally used
16 in the development of residual market rates by the appropriate
17 licensed rating organization. Each application for coverage
18 in the plan shall include, in boldfaced 12-point type
19 immediately preceding the applicant's signature, the following
20 statement:
21
22 "THIS INSURANCE IS BEING AFFORDED THROUGH THE
23 FLORIDA JOINT UNDERWRITING ASSOCIATION AND NOT
24 THROUGH THE PRIVATE MARKET. PLEASE BE ADVISED
25 THAT COVERAGE WITH A PRIVATE INSURER MAY BE
26 AVAILABLE FROM ANOTHER AGENT AT A LOWER COST.
27 AGENT AND COMPANY LISTINGS ARE AVAILABLE IN THE
28 LOCAL YELLOW PAGES."
29
30
31

1 The plan shall annually report to the commission
2 ~~department~~ the number and percentage of plan insureds
3 who are not surcharged due to their driving record.
4 (2) WINDSTORM INSURANCE RISK APPORTIONMENT.--
5 (a) Agreements may be made among property insurers
6 with respect to the equitable apportionment among them of
7 insurance which may be afforded applicants who are in good
8 faith entitled to, but are unable to procure, such insurance
9 through ordinary methods; and such insurers may agree among
10 themselves on the use of reasonable rate modifications for
11 such insurance. Such agreements and rate modifications shall
12 be subject to the applicable provisions of this chapter.
13 (b) The department shall require all insurers holding
14 a certificate of authority to transact property insurance on a
15 direct basis in this state, other than joint underwriting
16 associations and other entities formed pursuant to this
17 section, to provide windstorm coverage to applicants from
18 areas determined to be eligible pursuant to paragraph (c) who
19 in good faith are entitled to, but are unable to procure, such
20 coverage through ordinary means; or it shall adopt a
21 reasonable plan or plans for the equitable apportionment or
22 sharing among such insurers of windstorm coverage, which may
23 include formation of an association for this purpose. As used
24 in this subsection, the term "property insurance" means
25 insurance on real or personal property, as defined in s.
26 624.604, including insurance for fire, industrial fire, allied
27 lines, farmowners multiperil, homeowners' multiperil,
28 commercial multiperil, and mobile homes, and including
29 liability coverages on all such insurance, but excluding
30 inland marine as defined in s. 624.607(3) and excluding
31 vehicle insurance as defined in s. 624.605(1)(a) other than

1 insurance on mobile homes used as permanent dwellings. The
2 department shall adopt rules that provide a formula for the
3 recovery and repayment of any deferred assessments.
4 1. For the purpose of this section, properties
5 eligible for such windstorm coverage are defined as dwellings,
6 buildings, and other structures, including mobile homes which
7 are used as dwellings and which are tied down in compliance
8 with mobile home tie-down requirements prescribed by the
9 Department of Highway Safety and Motor Vehicles pursuant to s.
10 320.8325, and the contents of all such properties. An
11 applicant or policyholder is eligible for coverage only if an
12 offer of coverage cannot be obtained by or for the applicant
13 or policyholder from an admitted insurer at approved rates.
14 2.a.(I) All insurers required to be members of such
15 association shall participate in its writings, expenses, and
16 losses. Surplus of the association shall be retained for the
17 payment of claims and shall not be distributed to the member
18 insurers. Such participation by member insurers shall be in
19 the proportion that the net direct premiums of each member
20 insurer written for property insurance in this state during
21 the preceding calendar year bear to the aggregate net direct
22 premiums for property insurance of all member insurers, as
23 reduced by any credits for voluntary writings, in this state
24 during the preceding calendar year. For the purposes of this
25 subsection, the term "net direct premiums" means direct
26 written premiums for property insurance, reduced by premium
27 for liability coverage and for the following if included in
28 allied lines: rain and hail on growing crops; livestock;
29 association direct premiums booked; National Flood Insurance
30 Program direct premiums; and similar deductions specifically
31 authorized by the plan of operation and approved by the

1 department. A member's participation shall begin on the first
2 day of the calendar year following the year in which it is
3 issued a certificate of authority to transact property
4 insurance in the state and shall terminate 1 year after the
5 end of the calendar year during which it no longer holds a
6 certificate of authority to transact property insurance in the
7 state. The commissioner, after review of annual statements,
8 other reports, and any other statistics that the commissioner
9 deems necessary, shall certify to the association the
10 aggregate direct premiums written for property insurance in
11 this state by all member insurers.
12 (II) The plan of operation shall provide for a board
13 of directors consisting of the Insurance Consumer Advocate
14 appointed under s. 627.0613, 1 consumer representative
15 appointed by the Insurance Commissioner, 1 consumer
16 representative appointed by the Governor, and 12 additional
17 members appointed as specified in the plan of operation. One
18 of the 12 additional members shall be elected by the domestic
19 companies of this state on the basis of cumulative weighted
20 voting based on the net direct premiums of domestic companies
21 in this state. Nothing in the 1997 amendments to this
22 paragraph terminates the existing board or the terms of any
23 members of the board.
24 (III) The plan of operation shall provide a formula
25 whereby a company voluntarily providing windstorm coverage in
26 affected areas will be relieved wholly or partially from
27 apportionment of a regular assessment pursuant to
28 sub-sub-subparagraph d.(I) or sub-sub-subparagraph d.(II).
29 (IV) A company which is a member of a group of
30 companies under common management may elect to have its
31 credits applied on a group basis, and any company or group may

1 elect to have its credits applied to any other company or
2 group.
3 (V) There shall be no credits or relief from
4 apportionment to a company for emergency assessments collected
5 from its policyholders under sub-sub-subparagraph d.(III).
6 (VI) The plan of operation may also provide for the
7 award of credits, for a period not to exceed 3 years, from a
8 regular assessment pursuant to sub-sub-subparagraph d.(I) or
9 sub-sub-subparagraph d.(II) as an incentive for taking
10 policies out of the Residential Property and Casualty Joint
11 Underwriting Association. In order to qualify for the
12 exemption under this sub-sub-subparagraph, the take-out plan
13 must provide that at least 40 percent of the policies removed
14 from the Residential Property and Casualty Joint Underwriting
15 Association cover risks located in Dade, Broward, and Palm
16 Beach Counties or at least 30 percent of the policies so
17 removed cover risks located in Dade, Broward, and Palm Beach
18 Counties and an additional 50 percent of the policies so
19 removed cover risks located in other coastal counties, and
20 must also provide that no more than 15 percent of the policies
21 so removed may exclude windstorm coverage. With the approval
22 of the department, the association may waive these geographic
23 criteria for a take-out plan that removes at least the lesser
24 of 100,000 Residential Property and Casualty Joint
25 Underwriting Association policies or 15 percent of the total
26 number of Residential Property and Casualty Joint Underwriting
27 Association policies, provided the governing board of the
28 Residential Property and Casualty Joint Underwriting
29 Association certifies that the take-out plan will materially
30 reduce the Residential Property and Casualty Joint
31 Underwriting Association's 100-year probable maximum loss from

1 hurricanes. With the approval of the department, the board
2 may extend such credits for an additional year if the insurer
3 guarantees an additional year of renewability for all policies
4 removed from the Residential Property and Casualty Joint
5 Underwriting Association, or for 2 additional years if the
6 insurer guarantees 2 additional years of renewability for all
7 policies removed from the Residential Property and Casualty
8 Joint Underwriting Association.
9 b. Assessments to pay deficits in the association
10 under this subparagraph shall be included as an appropriate
11 factor in the making of rates as provided in s. 627.3512.
12 c. The Legislature finds that the potential for
13 unlimited deficit assessments under this subparagraph may
14 induce insurers to attempt to reduce their writings in the
15 voluntary market, and that such actions would worsen the
16 availability problems that the association was created to
17 remedy. It is the intent of the Legislature that insurers
18 remain fully responsible for paying regular assessments and
19 collecting emergency assessments for any deficits of the
20 association; however, it is also the intent of the Legislature
21 to provide a means by which assessment liabilities may be
22 amortized over a period of years.
23 d.(I) When the deficit incurred in a particular
24 calendar year is 10 percent or less of the aggregate statewide
25 direct written premium for property insurance for the prior
26 calendar year for all member insurers, the association shall
27 levy an assessment on member insurers in an amount equal to
28 the deficit.
29 (II) When the deficit incurred in a particular
30 calendar year exceeds 10 percent of the aggregate statewide
31 direct written premium for property insurance for the prior

1 calendar year for all member insurers, the association shall
2 levy an assessment on member insurers in an amount equal to
3 the greater of 10 percent of the deficit or 10 percent of the
4 aggregate statewide direct written premium for property
5 insurance for the prior calendar year for member insurers. Any
6 remaining deficit shall be recovered through emergency
7 assessments under sub-sub-subparagraph (III).
8 (III) Upon a determination by the board of directors
9 that a deficit exceeds the amount that will be recovered
10 through regular assessments on member insurers, pursuant to
11 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
12 board shall levy, after verification by the department,
13 emergency assessments to be collected by member insurers and
14 by underwriting associations created pursuant to this section
15 which write property insurance, upon issuance or renewal of
16 property insurance policies other than National Flood
17 Insurance policies in the year or years following levy of the
18 regular assessments. The amount of the emergency assessment
19 collected in a particular year shall be a uniform percentage
20 of that year's direct written premium for property insurance
21 for all member insurers and underwriting associations,
22 excluding National Flood Insurance policy premiums, as
23 annually determined by the board and verified by the
24 department. The department shall verify the arithmetic
25 calculations involved in the board's determination within 30
26 days after receipt of the information on which the
27 determination was based. Notwithstanding any other provision
28 of law, each member insurer and each underwriting association
29 created pursuant to this section shall collect emergency
30 assessments from its policyholders without such obligation
31 being affected by any credit, limitation, exemption, or

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1 deferment. The emergency assessments so collected shall be
2 transferred directly to the association on a periodic basis as
3 determined by the association. The aggregate amount of
4 emergency assessments levied under this sub-sub-subparagraph
5 in any calendar year may not exceed the greater of 10 percent
6 of the amount needed to cover the original deficit, plus
7 interest, fees, commissions, required reserves, and other
8 costs associated with financing of the original deficit, or 10
9 percent of the aggregate statewide direct written premium for
10 property insurance written by member insurers and underwriting
11 associations for the prior year, plus interest, fees,
12 commissions, required reserves, and other costs associated
13 with financing the original deficit. The board may pledge the
14 proceeds of the emergency assessments under this
15 sub-sub-subparagraph as the source of revenue for bonds, to
16 retire any other debt incurred as a result of the deficit or
17 events giving rise to the deficit, or in any other way that
18 the board determines will efficiently recover the deficit. The
19 emergency assessments under this sub-sub-subparagraph shall
20 continue as long as any bonds issued or other indebtedness
21 incurred with respect to a deficit for which the assessment
22 was imposed remain outstanding, unless adequate provision has
23 been made for the payment of such bonds or other indebtedness
24 pursuant to the document governing such bonds or other
25 indebtedness. Emergency assessments collected under this
26 sub-sub-subparagraph are not part of an insurer's rates, are
27 not premium, and are not subject to premium tax, fees, or
28 commissions; however, failure to pay the emergency assessment
29 shall be treated as failure to pay premium.
30 (IV) Each member insurer's share of the total regular
31 assessments under sub-sub-subparagraph (I) or

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1 sub-sub-subparagraph (II) shall be in the proportion that the
2 insurer's net direct premium for property insurance in this
3 state, for the year preceding the assessment bears to the
4 aggregate statewide net direct premium for property insurance
5 of all member insurers, as reduced by any credits for
6 voluntary writings for that year.
7 (V) If regular deficit assessments are made under
8 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), or by
9 the Residential Property and Casualty Joint Underwriting
10 Association under sub-subparagraph (6)(b)3.a. or
11 sub-subparagraph (6)(b)3.b., the association shall levy upon
12 the association's policyholders, as part of its next rate
13 filing, or by a separate rate filing solely for this purpose,
14 a market equalization surcharge in a percentage equal to the
15 total amount of such regular assessments divided by the
16 aggregate statewide direct written premium for property
17 insurance for member insurers for the prior calendar year.
18 Market equalization surcharges under this sub-sub-subparagraph
19 are not considered premium and are not subject to commissions,
20 fees, or premium taxes; however, failure to pay a market
21 equalization surcharge shall be treated as failure to pay
22 premium.
23 e. The governing body of any unit of local government,
24 any residents of which are insured under the plan, may issue
25 bonds as defined in s. 125.013 or s. 166.101 to fund an
26 assistance program, in conjunction with the association, for
27 the purpose of defraying deficits of the association. In order
28 to avoid needless and indiscriminate proliferation,
29 duplication, and fragmentation of such assistance programs,
30 any unit of local government, any residents of which are
31 insured by the association, may provide for the payment of

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1 losses, regardless of whether or not the losses occurred
2 within or outside of the territorial jurisdiction of the local
3 government. Revenue bonds may not be issued until validated
4 pursuant to chapter 75, unless a state of emergency is
5 declared by executive order or proclamation of the Governor
6 pursuant to s. 252.36 making such findings as are necessary to
7 determine that it is in the best interests of, and necessary
8 for, the protection of the public health, safety, and general
9 welfare of residents of this state and the protection and
10 preservation of the economic stability of insurers operating
11 in this state, and declaring it an essential public purpose to
12 permit certain municipalities or counties to issue bonds as
13 will provide relief to claimants and policyholders of the
14 association and insurers responsible for apportionment of plan
15 losses. Any such unit of local government may enter into such
16 contracts with the association and with any other entity
17 created pursuant to this subsection as are necessary to carry
18 out this paragraph. Any bonds issued under this
19 sub-subparagraph shall be payable from and secured by moneys
20 received by the association from assessments under this
21 subparagraph, and assigned and pledged to or on behalf of the
22 unit of local government for the benefit of the holders of
23 such bonds. The funds, credit, property, and taxing power of
24 the state or of the unit of local government shall not be
25 pledged for the payment of such bonds. If any of the bonds
26 remain unsold 60 days after issuance, the department shall
27 require all insurers subject to assessment to purchase the
28 bonds, which shall be treated as admitted assets; each insurer
29 shall be required to purchase that percentage of the unsold
30 portion of the bond issue that equals the insurer's relative
31 share of assessment liability under this subsection. An

1 insurer shall not be required to purchase the bonds to the
2 extent that the department determines that the purchase would
3 endanger or impair the solvency of the insurer. The authority
4 granted by this sub-subparagraph is additional to any bonding
5 authority granted by subparagraph 6.
6 3. The plan shall also provide that any member with a
7 surplus as to policyholders of $20 million or less writing 25
8 percent or more of its total countrywide property insurance
9 premiums in this state may petition the department, within the
10 first 90 days of each calendar year, to qualify as a limited
11 apportionment company. The apportionment of such a member
12 company in any calendar year for which it is qualified shall
13 not exceed its gross participation, which shall not be
14 affected by the formula for voluntary writings. In no event
15 shall a limited apportionment company be required to
16 participate in any apportionment of losses pursuant to
17 sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II)
18 in the aggregate which exceeds $50 million after payment of
19 available plan funds in any calendar year. However, a limited
20 apportionment company shall collect from its policyholders any
21 emergency assessment imposed under sub-sub-subparagraph
22 2.d.(III). The plan shall provide that, if the department
23 determines that any regular assessment will result in an
24 impairment of the surplus of a limited apportionment company,
25 the department may direct that all or part of such assessment
26 be deferred. However, there shall be no limitation or
27 deferment of an emergency assessment to be collected from
28 policyholders under sub-sub-subparagraph 2.d.(III).
29 4. The plan shall provide for the deferment, in whole
30 or in part, of a regular assessment of a member insurer under
31 sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II),

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1 but not for an emergency assessment collected from
2 policyholders under sub-sub-subparagraph 2.d.(III), if, in the
3 opinion of the commissioner, payment of such regular
4 assessment would endanger or impair the solvency of the member
5 insurer. In the event a regular assessment against a member
6 insurer is deferred in whole or in part, the amount by which
7 such assessment is deferred may be assessed against the other
8 member insurers in a manner consistent with the basis for
9 assessments set forth in sub-sub-subparagraph 2.d.(I) or
10 sub-sub-subparagraph 2.d.(II).
11 5.a. The plan of operation may include deductibles and
12 rules for classification of risks and rate modifications
13 consistent with the objective of providing and maintaining
14 funds sufficient to pay catastrophe losses.
15 b. ~~The association may require arbitration of a rate~~
16 ~~filing under s. 627.062(6).~~It is the intent of the
17 Legislature that the rates for coverage provided by the
18 association be actuarially sound and not competitive with
19 approved rates charged in the admitted voluntary market such
20 that the association functions as a residual market mechanism
21 to provide insurance only when the insurance cannot be
22 procured in the voluntary market. The plan of operation shall
23 provide a mechanism to assure that, beginning no later than
24 January 1, 1999, the rates charged by the association for each
25 line of business are reflective of approved rates in the
26 voluntary market for hurricane coverage for each line of
27 business in the various areas eligible for association
28 coverage.
29 c. The association shall provide for windstorm
30 coverage on residential properties in limits up to $10 million
31 for commercial lines residential risks and up to $1 million

1 for personal lines residential risks. If coverage with the
2 association is sought for a residential risk valued in excess
3 of these limits, coverage shall be available to the risk up to
4 the replacement cost or actual cash value of the property, at
5 the option of the insured, if coverage for the risk cannot be
6 located in the authorized market. The association must accept
7 a commercial lines residential risk with limits above $10
8 million or a personal lines residential risk with limits above
9 $1 million if coverage is not available in the authorized
10 market. The association may write coverage above the limits
11 specified in this subparagraph with or without facultative or
12 other reinsurance coverage, as the association determines
13 appropriate.
14 d. The plan of operation must provide objective
15 criteria and procedures, approved by the department, to be
16 uniformly applied for all applicants in determining whether an
17 individual risk is so hazardous as to be uninsurable. In
18 making this determination and in establishing the criteria and
19 procedures, the following shall be considered:
20 (I) Whether the likelihood of a loss for the
21 individual risk is substantially higher than for other risks
22 of the same class; and
23 (II) Whether the uncertainty associated with the
24 individual risk is such that an appropriate premium cannot be
25 determined.
26
27 The acceptance or rejection of a risk by the association
28 pursuant to such criteria and procedures must be construed as
29 the private placement of insurance, and the provisions of
30 chapter 120 do not apply.
31

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1 e. The policies issued by the association must provide
2 that if the association obtains an offer from an authorized
3 insurer to cover the risk at its approved rates under either a
4 standard policy including wind coverage or, if consistent with
5 the insurer's underwriting rules as filed with the department,
6 a basic policy including wind coverage, the risk is no longer
7 eligible for coverage through the association. Upon
8 termination of eligibility, the association shall provide
9 written notice to the policyholder and agent of record stating
10 that the association policy must be canceled as of 60 days
11 after the date of the notice because of the offer of coverage
12 from an authorized insurer. Other provisions of the insurance
13 code relating to cancellation and notice of cancellation do
14 not apply to actions under this sub-subparagraph.
15 f. Association policies and applications must include
16 a notice that the association policy could, under this
17 section, be replaced with a policy issued by an authorized
18 insurer that does not provide coverage identical to the
19 coverage provided by the association. The notice shall also
20 specify that acceptance of association coverage creates a
21 conclusive presumption that the applicant or policyholder is
22 aware of this potential.
23 6.a. The plan of operation may authorize the formation
24 of a private nonprofit corporation, a private nonprofit
25 unincorporated association, a partnership, a trust, a limited
26 liability company, or a nonprofit mutual company which may be
27 empowered, among other things, to borrow money by issuing
28 bonds or by incurring other indebtedness and to accumulate
29 reserves or funds to be used for the payment of insured
30 catastrophe losses. The plan may authorize all actions
31

1 necessary to facilitate the issuance of bonds, including the
2 pledging of assessments or other revenues.
3 b. Any entity created under this subsection, or any
4 entity formed for the purposes of this subsection, may sue and
5 be sued, may borrow money; issue bonds, notes, or debt
6 instruments; pledge or sell assessments, market equalization
7 surcharges and other surcharges, rights, premiums, contractual
8 rights, projected recoveries from the Florida Hurricane
9 Catastrophe Fund, other reinsurance recoverables, and other
10 assets as security for such bonds, notes, or debt instruments;
11 enter into any contracts or agreements necessary or proper to
12 accomplish such borrowings; and take other actions necessary
13 to carry out the purposes of this subsection. The association
14 may issue bonds or incur other indebtedness, or have bonds
15 issued on its behalf by a unit of local government pursuant to
16 subparagraph (g)2., in the absence of a hurricane or other
17 weather-related event, upon a determination by the association
18 subject to approval by the department that such action would
19 enable it to efficiently meet the financial obligations of the
20 association and that such financings are reasonably necessary
21 to effectuate the requirements of this subsection. Any such
22 entity may accumulate reserves and retain surpluses as of the
23 end of any association year to provide for the payment of
24 losses incurred by the association during that year or any
25 future year. The association shall incorporate and continue
26 the plan of operation and articles of agreement in effect on
27 the effective date of chapter 76-96, Laws of Florida, to the
28 extent that it is not inconsistent with chapter 76-96, and as
29 subsequently modified consistent with chapter 76-96. The board
30 of directors and officers currently serving shall continue to
31 serve until their successors are duly qualified as provided

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1 under the plan. The assets and obligations of the plan in
2 effect immediately prior to the effective date of chapter
3 76-96 shall be construed to be the assets and obligations of
4 the successor plan created herein.
5 c. In recognition of s. 10, Art. I of the State
6 Constitution, prohibiting the impairment of obligations of
7 contracts, it is the intent of the Legislature that no action
8 be taken whose purpose is to impair any bond indenture or
9 financing agreement or any revenue source committed by
10 contract to such bond or other indebtedness issued or incurred
11 by the association or any other entity created under this
12 subsection.
13 7. On such coverage, an agent's remuneration shall be
14 that amount of money payable to the agent by the terms of his
15 or her contract with the company with which the business is
16 placed. However, no commission will be paid on that portion of
17 the premium which is in excess of the standard premium of that
18 company.
19 8. Subject to approval by the department, the
20 association may establish different eligibility requirements
21 and operational procedures for any line or type of coverage
22 for any specified eligible area or portion of an eligible area
23 if the board determines that such changes to the eligibility
24 requirements and operational procedures are justified due to
25 the voluntary market being sufficiently stable and competitive
26 in such area or for such line or type of coverage and that
27 consumers who, in good faith, are unable to obtain insurance
28 through the voluntary market through ordinary methods would
29 continue to have access to coverage from the association. When
30 coverage is sought in connection with a real property
31 transfer, such requirements and procedures shall not provide

1 for an effective date of coverage later than the date of the
2 closing of the transfer as established by the transferor, the
3 transferee, and, if applicable, the lender.
4 9. Notwithstanding any other provision of law:
5 a. The pledge or sale of, the lien upon, and the
6 security interest in any rights, revenues, or other assets of
7 the association created or purported to be created pursuant to
8 any financing documents to secure any bonds or other
9 indebtedness of the association shall be and remain valid and
10 enforceable, notwithstanding the commencement of and during
11 the continuation of, and after, any rehabilitation,
12 insolvency, liquidation, bankruptcy, receivership,
13 conservatorship, reorganization, or similar proceeding against
14 the association under the laws of this state or any other
15 applicable laws.
16 b. No such proceeding shall relieve the association of
17 its obligation, or otherwise affect its ability to perform its
18 obligation, to continue to collect, or levy and collect,
19 assessments, market equalization or other surcharges,
20 projected recoveries from the Florida Hurricane Catastrophe
21 Fund, reinsurance recoverables, or any other rights, revenues,
22 or other assets of the association pledged.
23 c. Each such pledge or sale of, lien upon, and
24 security interest in, including the priority of such pledge,
25 lien, or security interest, any such assessments, emergency
26 assessments, market equalization or renewal surcharges,
27 projected recoveries from the Florida Hurricane Catastrophe
28 Fund, reinsurance recoverables, or other rights, revenues, or
29 other assets which are collected, or levied and collected,
30 after the commencement of and during the pendency of or after
31

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1 any such proceeding shall continue unaffected by such
2 proceeding.
3 d. As used in this subsection, the term "financing
4 documents" means any agreement, instrument, or other document
5 now existing or hereafter created evidencing any bonds or
6 other indebtedness of the association or pursuant to which any
7 such bonds or other indebtedness has been or may be issued and
8 pursuant to which any rights, revenues, or other assets of the
9 association are pledged or sold to secure the repayment of
10 such bonds or indebtedness, together with the payment of
11 interest on such bonds or such indebtedness, or the payment of
12 any other obligation of the association related to such bonds
13 or indebtedness.
14 e. Any such pledge or sale of assessments, revenues,
15 contract rights or other rights or assets of the association
16 shall constitute a lien and security interest, or sale, as the
17 case may be, that is immediately effective and attaches to
18 such assessments, revenues, contract, or other rights or
19 assets, whether or not imposed or collected at the time the
20 pledge or sale is made. Any such pledge or sale is effective,
21 valid, binding, and enforceable against the association or
22 other entity making such pledge or sale, and valid and binding
23 against and superior to any competing claims or obligations
24 owed to any other person or entity, including policyholders in
25 this state, asserting rights in any such assessments,
26 revenues, contract, or other rights or assets to the extent
27 set forth in and in accordance with the terms of the pledge or
28 sale contained in the applicable financing documents, whether
29 or not any such person or entity has notice of such pledge or
30 sale and without the need for any physical delivery,
31 recordation, filing, or other action.

1 f. There shall be no liability on the part of, and no
2 cause of action of any nature shall arise against, any member
3 insurer or its agents or employees, agents or employees of the
4 association, members of the board of directors of the
5 association, or the department or its representatives, for any
6 action taken by them in the performance of their duties or
7 responsibilities under this subsection. Such immunity does not
8 apply to actions for breach of any contract or agreement
9 pertaining to insurance, or any willful tort.
10 (c) The provisions of paragraph (b) are applicable
11 only with respect to:
12 1. Those areas that were eligible for coverage under
13 this subsection on April 9, 1993; or
14 2. Any county or area as to which the department,
15 after public hearing, finds that the following criteria exist:
16 a. Due to the lack of windstorm insurance coverage in
17 the county or area so affected, economic growth and
18 development is being deterred or otherwise stifled in such
19 county or area, mortgages are in default, and financial
20 institutions are unable to make loans;
21 b. The county or area so affected has adopted and is
22 enforcing the structural requirements of the State Minimum
23 Building Codes, as defined in s. 553.73, for new construction
24 and has included adequate minimum floor elevation requirements
25 for structures in areas subject to inundation; and
26 c. Extending windstorm insurance coverage to such
27 county or area is consistent with and will implement and
28 further the policies and objectives set forth in applicable
29 state laws, rules, and regulations governing coastal
30 management, coastal construction, comprehensive planning,
31 beach and shore preservation, barrier island preservation,

1 coastal zone protection, and the Coastal Zone Protection Act
2 of 1985.
3
4 Any time after the department has determined that the criteria
5 referred to in this subparagraph do not exist with respect to
6 any county or area of the state, it may, after a subsequent
7 public hearing, declare that such county or area is no longer
8 eligible for windstorm coverage through the plan.
9 (d) For the purpose of evaluating whether the criteria
10 of paragraph (c) are met, such criteria shall be applied as
11 the situation would exist if policies had not been written by
12 the Florida Residential Property and Casualty Joint
13 Underwriting Association and property insurance for such
14 policyholders was not available.
15 (e) Notwithstanding the provisions of subparagraph
16 (c)2. or paragraph (d), eligibility shall not be extended to
17 any area that was not eligible on March 1, 1997, except that
18 the department may act with respect to any petition on which a
19 hearing was held prior to May 9, 1997.
20 (4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
21 (a) The department shall, after consultation with
22 insurers as set forth in paragraph (b), adopt a joint
23 underwriting plan as set forth in paragraph (d).
24 (b) Entities licensed to issue casualty insurance as
25 defined in s. 624.605(1)(b), (k), and (q) and self-insurers
26 authorized to issue medical malpractice insurance under s.
27 627.357 shall participate in the plan and shall be members of
28 the Joint Underwriting Association.
29 (c) The Joint Underwriting Association shall operate
30 subject to the supervision and approval of a board of
31 governors consisting of representatives of five of the

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1 insurers participating in the Joint Underwriting Association,
2 an attorney to be named by The Florida Bar, a physician to be
3 named by the Florida Medical Association, a dentist to be
4 named by the Florida Dental Association, and a hospital
5 representative to be named by the Florida Hospital
6 Association. The board of governors shall choose, during the
7 first meeting of the board after June 30 of each year, one of
8 its members to serve as chair of the board and another member
9 to serve as vice chair of the board. There shall be no
10 liability on the part of, and no cause of action of any nature
11 shall arise against, any member insurer, self-insurer, or its
12 agents or employees, the Joint Underwriting Association or its
13 agents or employees, members of the board of governors, or the
14 department or its representatives for any action taken by them
15 in the performance of their powers and duties under this
16 subsection.
17 (d) The plan shall provide coverage for claims arising
18 out of the rendering of, or failure to render, medical care or
19 services and, in the case of health care facilities, coverage
20 for bodily injury or property damage to the person or property
21 of any patient arising out of the insured's activities, in
22 appropriate policy forms for all health care providers as
23 defined in paragraph (h). The plan shall include, but shall
24 not be limited to:
25 1. Classifications of risks and rates which reflect
26 past and prospective loss and expense experience in different
27 areas of practice and in different geographical areas. To
28 assure that plan rates are adequate to pay claims and
29 expenses, the Joint Underwriting Association shall develop a
30 means of obtaining loss and expense experience; and the plan
31 shall file such experience, when available, with the

1 commission ~~department~~ in sufficient detail to make a
2 determination of rate adequacy. Within 60 days after a rate
3 filing, the commission ~~department~~ shall approve such rates or
4 rate revisions as are fully supported by the filing. In
5 addition to provisions for claims and expenses, the ratemaking
6 formula may include a factor for projected claims trending and
7 a margin for contingencies. The use of trend factors shall
8 not be found to be inappropriate.
9 2. A rating plan which reasonably recognizes the prior
10 claims experience of insureds.
11 3. Provisions as to rates for:
12 a. Insureds who are retired or semiretired.
13 b. The estates of deceased insureds.
14 c. Part-time professionals.
15 4. Protection in an amount not to exceed $250,000 per
16 claim, $750,000 annual aggregate for health care providers
17 other than hospitals and in an amount not to exceed $1.5
18 million per claim, $5 million annual aggregate for hospitals.
19 Such coverage for health care providers other than hospitals
20 shall be available as primary coverage and as excess coverage
21 for the layer of coverage between the primary coverage and the
22 total limits of $250,000 per claim, $750,000 annual aggregate.
23 The plan shall also provide tail coverage in these amounts to
24 insureds whose claims-made coverage with another insurer or
25 trust has or will be terminated. Such tail coverage shall
26 provide coverage for incidents that occurred during the
27 claims-made policy period for which a claim is made after the
28 policy period.
29 5. A risk management program for insureds of the
30 association. This program shall include, but not be limited
31 to: investigation and analysis of frequency, severity, and

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1 causes of adverse or untoward medical injuries; development of
2 measures to control these injuries; systematic reporting of
3 medical incidents; investigation and analysis of patient
4 complaints; and auditing of association members to assure
5 implementation of this program. The plan may refuse to insure
6 any insured who refuses or fails to comply with the risk
7 management program implemented by the association. Prior to
8 cancellation or refusal to renew an insured, the association
9 shall provide the insured 60 days' notice of intent to cancel
10 or nonrenew and shall further notify the insured of any action
11 which must be taken to be in compliance with the risk
12 management program.
13 (e) In the event an underwriting deficit exists for
14 any policy year the plan is in effect, any surplus which has
15 accrued from previous years and is not projected within
16 reasonable actuarial certainty to be needed for payment of
17 claims in the year the surplus arose shall be used to offset
18 the deficit to the extent available.
19 1. As to remaining deficit, except those relating to
20 deficit assessment coverage, each policyholder shall pay to
21 the association a premium contingency assessment not to exceed
22 one-third of the premium payment paid by such policyholder to
23 the association for that policy year. The association shall
24 pay no further claims on any policy for the policyholder who
25 fails to pay the premium contingency assessment.
26 2. If there is any remaining deficit under the plan
27 after maximum collection of the premium contingency
28 assessment, such deficit shall be recovered from the companies
29 participating in the plan in the proportion that the net
30 direct premiums of each such member written during the
31 calendar year immediately preceding the end of the policy year

1 for which there is a deficit assessment bear to the aggregate
2 net direct premiums written in this state by all members of
3 the association. The term "premiums" as used herein means
4 premiums for the lines of insurance defined in s.
5 624.605(1)(b), (k), and (q), including premiums for such
6 coverage issued under package policies.
7 (f) The plan shall provide for one or more insurers
8 able and willing to provide policy service through licensed
9 resident agents and claims service on behalf of all other
10 insurers participating in the plan. In the event no insurer
11 is able and willing to provide such services, the Joint
12 Underwriting Association is authorized to perform any and all
13 such services.
14 (g) All books, records, documents, or audits relating
15 to the Joint Underwriting Association or its operation shall
16 be open to public inspection, except that a claim file in the
17 possession of the Joint Underwriting Association is
18 confidential and exempt from the provisions of s. 119.07(1)
19 during the processing of that claim. Any information
20 contained in these files that identifies an injured person is
21 confidential and exempt from the provisions of s. 119.07(1).
22 (h) As used in this subsection:
23 1. "Health care provider" means hospitals licensed
24 under chapter 395; physicians licensed under chapter 458;
25 osteopathic physicians licensed under chapter 459; podiatric
26 physicians licensed under chapter 461; dentists licensed under
27 chapter 466; chiropractic physicians licensed under chapter
28 460; naturopaths licensed under chapter 462; nurses licensed
29 under chapter 464; midwives licensed under chapter 467;
30 clinical laboratories registered under chapter 483; physician
31 assistants licensed under chapter 458 or chapter 459; physical

1 therapists and physical therapist assistants licensed under
2 chapter 486; health maintenance organizations certificated
3 under part I of chapter 641; ambulatory surgical centers
4 licensed under chapter 395; other medical facilities as
5 defined in subparagraph 2.; blood banks, plasma centers,
6 industrial clinics, and renal dialysis facilities; or
7 professional associations, partnerships, corporations, joint
8 ventures, or other associations for professional activity by
9 health care providers.
10 2. "Other medical facility" means a facility the
11 primary purpose of which is to provide human medical
12 diagnostic services or a facility providing nonsurgical human
13 medical treatment, to which facility the patient is admitted
14 and from which facility the patient is discharged within the
15 same working day, and which facility is not part of a
16 hospital. However, a facility existing for the primary
17 purpose of performing terminations of pregnancy or an office
18 maintained by a physician or dentist for the practice of
19 medicine shall not be construed to be an "other medical
20 facility."
21 3. "Health care facility" means any hospital licensed
22 under chapter 395, health maintenance organization
23 certificated under part I of chapter 641, ambulatory surgical
24 center licensed under chapter 395, or other medical facility
25 as defined in subparagraph 2.
26 (i) The manager of the plan or the manager's assistant
27 is the agent for service of process for the plan.
28 (5) PROPERTY AND CASUALTY INSURANCE RISK
29 APPORTIONMENT.--The department shall adopt by rule a joint
30 underwriting plan to equitably apportion among insurers
31 authorized in this state to write property insurance as

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1 defined in s. 624.604 or casualty insurance as defined in s.
2 624.605, the underwriting of one or more classes of property
3 insurance or casualty insurance, except for the types of
4 insurance that are included within property insurance or
5 casualty insurance for which an equitable apportionment plan,
6 assigned risk plan, or joint underwriting plan is authorized
7 under s. 627.311 or subsection (1), subsection (2), subsection
8 (3), subsection (4), or subsection (6) and except for risks
9 eligible for flood insurance written through the federal flood
10 insurance program to persons with risks eligible under
11 subparagraph (a)1. and who are in good faith entitled to, but
12 are unable to, obtain such property or casualty insurance
13 coverage, including excess coverage, through the voluntary
14 market. For purposes of this subsection, an adequate level of
15 coverage means that coverage which is required by state law or
16 by responsible or prudent business practices. The Joint
17 Underwriting Association shall not be required to provide
18 coverage for any type of risk for which there are no insurers
19 providing similar coverage in this state. The department may
20 designate one or more participating insurers who agree to
21 provide policyholder and claims service, including the
22 issuance of policies, on behalf of the participating insurers.
23 (a) The plan shall provide:
24 1. A means of establishing eligibility of a risk for
25 obtaining insurance through the plan, which provides that:
26 a. A risk shall be eligible for such property
27 insurance or casualty insurance as is required by Florida law
28 if the insurance is unavailable in the voluntary market,
29 including the market assistance program and the surplus lines
30 market.
31

1 b. A commercial risk not eligible under
2 sub-subparagraph a. shall be eligible for property or casualty
3 insurance if:
4 (I) The insurance is unavailable in the voluntary
5 market, including the market assistance plan and the surplus
6 lines market;
7 (II) Failure to secure the insurance would
8 substantially impair the ability of the entity to conduct its
9 affairs; and
10 (III) The risk is not determined by the Risk
11 Underwriting Committee to be uninsurable.
12 c. In the event the Federal Government terminates the
13 Federal Crime Insurance Program established under 44 C.F.R.
14 ss. 80-83, Florida commercial and residential risks previously
15 insured under the federal program shall be eligible under the
16 plan.
17 d.(I) In the event a risk is eligible under this
18 paragraph and in the event the market assistance plan receives
19 a minimum of 100 applications for coverage within a 3-month
20 period, or 200 applications for coverage within a 1-year
21 period or less, for a given class of risk contained in the
22 classification system defined in the plan of operation of the
23 Joint Underwriting Association, and unless the market
24 assistance plan provides a quotation for at least 80 percent
25 of such applicants, such classification shall immediately be
26 eligible for coverage in the Joint Underwriting Association.
27 (II) Any market assistance plan application which is
28 rejected because an individual risk is so hazardous as to be
29 practically uninsurable, considering whether the likelihood of
30 a loss for such a risk is substantially higher than for other
31 risks of the same class due to individual risk

1 characteristics, prior loss experience, unwillingness to
2 cooperate with a prior insurer, physical characteristics and
3 physical location shall not be included in the minimum
4 percentage calculation provided above. In the event that there
5 is any legal or administrative challenge to a determination by
6 the department that the conditions of this subparagraph have
7 been met for eligibility for coverage in the Joint
8 Underwriting Association for a given classification, any
9 eligible risk may obtain coverage during the pendency of any
10 such challenge.
11 e. In order to qualify as a quotation for the purpose
12 of meeting the minimum percentage calculation in this
13 subparagraph, the quoted premium must meet the following
14 criteria:
15 (I) In the case of an admitted carrier, the quoted
16 premium must not exceed the premium available for a given
17 classification currently in use by the Joint Underwriting
18 Association or the premium developed by using the rates and
19 rating plans on file with the department by the quoting
20 insurer, whichever is greater.
21 (II) In the case of an authorized surplus lines
22 insurer, the quoted premium must not exceed the premium
23 available for a given classification currently in use by the
24 Joint Underwriting Association by more than 25 percent, after
25 consideration of any individual risk surcharge or credit.
26 f. Any agent who falsely certifies the unavailability
27 of coverage as provided by sub-subparagraphs a. and b., is
28 subject to the penalties provided in s. 626.611.
29 2. A means for the equitable apportionment of profits
30 or losses and expenses among participating insurers.
31

1 3. Rules for the classification of risks and rates
2 which reflect the past and prospective loss experience.
3 4. A rating plan which reasonably reflects the prior
4 claims experience of the insureds. Such rating plan shall
5 include at least two levels of rates for risks that have
6 favorable loss experience and risks that have unfavorable loss
7 experience, as established by the plan.
8 5. Reasonable limits to available amounts of
9 insurance. Such limits may not be less than the amounts of
10 insurance required of eligible risks by Florida law.
11 6. Risk management requirements for insurance where
12 such requirements are reasonable and are expected to reduce
13 losses.
14 7. Deductibles as may be necessary to meet the needs
15 of insureds.
16 8. Policy forms which are consistent with the forms in
17 use by the majority of the insurers providing coverage in the
18 voluntary market for the coverage requested by the applicant.
19 9. A means to remove risks from the plan once such
20 risks no longer meet the eligibility requirements of this
21 paragraph. For this purpose, the plan shall include the
22 following requirements: At each 6-month interval after the
23 activation of any class of insureds, the board of governors or
24 its designated committee shall review the number of
25 applications to the market assistance plan for that class. If,
26 based on these latest numbers, at least 90 percent of such
27 applications have been provided a quotation, the Joint
28 Underwriting Association shall cease underwriting new
29 applications for such class within 30 days, and notification
30 of this decision shall be sent to the Insurance Commissioner,
31 the major agents' associations, and the board of directors of

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1 the market assistance plan. A quotation for the purpose of
2 this subparagraph shall meet the same criteria for a quotation
3 as provided in sub-subparagraph d. All policies which were
4 previously written for that class shall continue in force
5 until their normal expiration date, at which time, subject to
6 the required timely notification of nonrenewal by the Joint
7 Underwriting Association, the insured may then elect to
8 reapply to the Joint Underwriting Association according to the
9 requirements of eligibility. If, upon reapplication, those
10 previously insured Joint Underwriting Association risks meet
11 the eligibility requirements, the Joint Underwriting
12 Association shall provide the coverage requested.
13 10. A means for providing credits to insurers against
14 any deficit assessment levied pursuant to paragraph (c), for
15 risks voluntarily written through the market assistance plan
16 by such insurers.
17 11. That the Joint Underwriting Association shall
18 operate subject to the supervision and approval of a board of
19 governors consisting of 13 individuals appointed by the
20 Insurance Commissioner, and shall have an executive or
21 underwriting committee. At least four of the members shall be
22 representatives of insurance trade associations as follows:
23 one member from the American Insurance Association, one member
24 from the Alliance of American Insurers, one member from the
25 National Association of Independent Insurers, and one member
26 from an unaffiliated insurer writing coverage on a national
27 basis. Two representatives shall be from two of the statewide
28 agents' associations. Each board member shall be appointed to
29 serve for 2-year terms beginning on a date designated by the
30 plan and shall serve at the pleasure of the commissioner.
31 Members may be reappointed for subsequent terms.

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1 (b) Rates used by the Joint Underwriting Association
2 shall be actuarially sound. To the extent applicable, the rate
3 standards set forth in s. 627.062 shall be considered by the
4 commission ~~department~~ in establishing rates to be used by the
5 joint underwriting plan. The initial rate level shall be
6 determined using the rates, rules, rating plans, and
7 classifications contained in the most current Insurance
8 Services Office (ISO) filing with the department or the filing
9 of other licensed rating organizations with an additional
10 increment of 25 percent of premium. For any type of coverage
11 or classification which lends itself to manual rating for
12 which the Insurance Services Office or another licensed rating
13 organization does not file or publish a rate, the Joint
14 Underwriting Association shall file and use an initial rate
15 based on the average current market rate. The initial rate
16 level for the rate plan shall also be subject to an experience
17 and schedule rating plan which may produce a maximum of 25
18 percent debits or credits. For any risk which does not lend
19 itself to manual rating and for which no rate has been
20 promulgated under the rate plan, the board shall develop and
21 file with the commissioner, subject to his or her approval,
22 appropriate criteria and factors for rating the individual
23 risk. Such criteria and factors shall include, but not be
24 limited to, loss rating plans, composite rating plans, and
25 unique and unusual risk rating plans. The initial rates
26 required under this paragraph shall be adjusted in conformity
27 with future filings by the Insurance Services Office with the
28 commission ~~department~~ and shall remain in effect until such
29 time as the Joint Underwriting Association has sufficient data
30 as to independently justify an actuarially sound change in
31 such rates.

1 (c)1. In the event an underwriting deficit exists for
2 any policy year the plan is in effect, any surplus which has
3 accrued from previous years and is not projected within
4 reasonable actuarial certainty to be needed for payment for
5 claims in the year the surplus arose shall be used to offset
6 the deficit to the extent available.
7 2. As to any remaining deficit, the board of governors
8 of the Joint Underwriting Association shall levy and collect
9 an assessment in an amount sufficient to offset such deficit.
10 Such assessment shall be levied against the insurers
11 participating in the plan during the year giving rise to the
12 assessment. Any assessments against insurers for the lines of
13 property and casualty insurance issued to commercial risks
14 shall be recovered from the participating insurers in the
15 proportion that the net direct premium of each insurer for
16 commercial risks written during the preceding calendar year
17 bears to the aggregate net direct premium written for
18 commercial risks by all members of the plan for the lines of
19 insurance included in the plan. Any assessments against
20 insurers for the lines of property and casualty insurance
21 issued to personal risks eligible under sub-subparagraph
22 (a)1.a. or sub-subparagraph (a)1.c. shall be recovered from
23 the participating insurers in the proportion that the net
24 direct premium of each insurer for personal risks written
25 during the preceding calendar year bears to the aggregate net
26 direct premium written for personal risks by all members of
27 the plan for the lines of insurance included in the plan.
28 3. The board shall take all reasonable and prudent
29 steps necessary to collect the amount of assessment due from
30 each participating insurer and policyholder, including, if
31 prudent, filing suit to collect such assessment. If the board

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1 is unable to collect an assessment from any insurer, the
2 uncollected assessments shall be levied as an additional
3 assessment against the participating insurers and any
4 participating insurer required to pay an additional assessment
5 as a result of such failure to pay shall have a cause of
6 action against such nonpaying insurer.
7 4. Any funds or entitlements that the state may be
8 eligible to receive by virtue of the Federal Government's
9 termination of the Federal Crime Insurance Program referenced
10 in sub-subparagraph (a)1.c. may be used under the plan to
11 offset any subsequent underwriting deficits that may occur
12 from risks previously insured with the Federal Crime Insurance
13 Program.
14 5. Assessments shall be included as an appropriate
15 factor in the making of rates as provided in s. 627.3512.
16 6.a. The Legislature finds that the potential for
17 unlimited assessments under this paragraph may induce insurers
18 to attempt to reduce their writings in the voluntary market,
19 and that such actions would worsen the availability problems
20 that the association was created to remedy. It is the intent
21 of the Legislature that insurers remain fully responsible for
22 covering any deficits of the association; however, it is also
23 the intent of the Legislature to provide a means by which
24 assessment liabilities may be amortized over a period of
25 years.
26 b. The total amount of deficit assessments under this
27 paragraph with respect to any year may not exceed 10 percent
28 of the statewide total gross written premium for all insurers
29 for the coverages referred to in the introductory language of
30 this subsection for the prior year, except that if the deficit
31 with respect to any plan year exceeds such amount and bonds

1 are issued under sub-subparagraph c. to defray the deficit,
2 the total amount of assessments with respect to such deficit
3 may not in any year exceed 10 percent of the deficit, or such
4 lesser percentage as is sufficient to retire the bonds as
5 determined by the board, and shall continue annually until the
6 bonds are retired.
7 c. The governing body of any unit of local government,
8 any residents or businesses of which are insured by the
9 association, may issue bonds as defined in s. 125.013 or s.
10 166.101 from time to time to fund an assistance program, in
11 conjunction with the association, for the purpose of defraying
12 deficits of the association. Revenue bonds may not be issued
13 until validated pursuant to chapter 75, unless a state of
14 emergency is declared by executive order or proclamation of
15 the Governor pursuant to s. 252.36 making such findings as are
16 necessary to determine that it is in the best interests of,
17 and necessary for, the protection of the public health,
18 safety, and general welfare of residents of this state and the
19 protection and preservation of the economic stability of
20 insurers operating in this state, and declaring it an
21 essential public purpose to permit certain municipalities or
22 counties to issue such bonds as will provide relief to
23 claimants and policyholders of the joint underwriting
24 association and insurers responsible for apportionment of
25 association losses. The unit of local government shall enter
26 into such contracts with the association as are necessary to
27 carry out this paragraph. Any bonds issued under this
28 sub-subparagraph shall be payable from and secured by moneys
29 received by the association from assessments under this
30 paragraph, and assigned and pledged to or on behalf of the
31 unit of local government for the benefit of the holders of

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1 such bonds. The funds, credit, property, and taxing power of
2 the state or of the unit of local government shall not be
3 pledged for the payment of such bonds. If any of the bonds
4 remain unsold 60 days after issuance, the department shall
5 require all insurers subject to assessment to purchase the
6 bonds, which shall be treated as admitted assets; each insurer
7 shall be required to purchase that percentage of the unsold
8 portion of the bond issue that equals the insurer's relative
9 share of assessment liability under this subsection. An
10 insurer shall not be required to purchase the bonds to the
11 extent that the department determines that the purchase would
12 endanger or impair the solvency of the insurer.
13 7. The plan shall provide for the deferment, in whole
14 or in part, of the assessment of an insurer if the department
15 finds that payment of the assessment would endanger or impair
16 the solvency of the insurer. In the event an assessment
17 against an insurer is deferred in whole or in part, the amount
18 by which such assessment is deferred may be assessed against
19 the other member insurers in a manner consistent with the
20 basis for assessments set forth in subparagraph 2.
21 (d) Upon adoption of the plan, all insurers authorized
22 in this state to underwrite property or casualty insurance
23 shall participate in the plan.
24 (e) A Risk Underwriting Committee of the Joint
25 Underwriting Association composed of three members experienced
26 in evaluating insurance risks is created to review risks
27 rejected by the voluntary market for which application is made
28 for insurance through the joint underwriting plan. The
29 committee shall consist of a representative of the market
30 assistance plan created under s. 627.3515, a member selected
31 by the insurers participating in the Joint Underwriting

Association, and a member named by the Insurance Commissioner. The Risk Underwriting Committee shall appoint such advisory committees as are provided for in the plan and are necessary to conduct its functions. The salaries and expenses of the members of the Risk Underwriting Committee and its advisory committees shall be paid by the joint underwriting plan. The plan approved by the department shall establish criteria and procedures for use by the Risk Underwriting Committee for determining whether an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following shall be considered:

1. Whether the likelihood of a loss for the individual risk is substantially higher than for other risks of the same class; and

2. Whether the uncertainty associated with the individual risk is such that an appropriate premium cannot be determined.

The acceptance or rejection of a risk by the underwriting committee shall be construed as the private placement of insurance, and the provisions of chapter 120 shall not apply.

(f) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Florida Property and Casualty Joint Underwriting Association or its agents or employees, members of the board of governors, or the department or its representatives for any action taken by them in the performance of their duties under this subsection. Such immunity does not apply to actions for breach of any contract

1 or agreement pertaining to insurance, or any other willful
2 tort.
3 (6) RESIDENTIAL PROPERTY AND CASUALTY JOINT
4 UNDERWRITING ASSOCIATION.--
5 (a) There is created a joint underwriting association
6 for equitable apportionment or sharing among insurers of
7 property and casualty insurance covering residential property,
8 for applicants who are in good faith entitled, but are unable,
9 to procure insurance through the voluntary market. The
10 association shall operate pursuant to a plan of operation
11 approved by order of the department. The plan is subject to
12 continuous review by the department. The department may, by
13 order, withdraw approval of all or part of a plan if the
14 department determines that conditions have changed since
15 approval was granted and that the purposes of the plan require
16 changes in the plan. For the purposes of this subsection,
17 residential coverage includes both personal lines residential
18 coverage, which consists of the type of coverage provided by
19 homeowner's, mobile home owner's, dwelling, tenant's,
20 condominium unit owner's, and similar policies, and commercial
21 lines residential coverage, which consists of the type of
22 coverage provided by condominium association, apartment
23 building, and similar policies.
24 (b)1. All insurers authorized to write subject lines
25 of business in this state, other than underwriting
26 associations or other entities created under this section,
27 must participate in and be members of the Residential Property
28 and Casualty Joint Underwriting Association. A member's
29 participation shall begin on the first day of the calendar
30 year following the year in which the member was issued a
31 certificate of authority to transact insurance for subject

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1 lines of business in this state and shall terminate 1 year
2 after the end of the first calendar year during which the
3 member no longer holds a certificate of authority to transact
4 insurance for subject lines of business in this state.
5 2. All revenues, assets, liabilities, losses, and
6 expenses of the association shall be divided into two separate
7 accounts, one of which is for personal lines residential
8 coverages and the other of which is for commercial lines
9 residential coverages. Revenues, assets, liabilities, losses,
10 and expenses not attributable to particular coverages shall be
11 prorated between the accounts.
12 3. With respect to a deficit in an account:
13 a. When the deficit incurred in a particular calendar
14 year is not greater than 10 percent of the aggregate statewide
15 direct written premium for the subject lines of business for
16 the prior calendar year for all member insurers, the entire
17 deficit shall be recovered through assessments of member
18 insurers under paragraph (g).
19 b. When the deficit incurred in a particular calendar
20 year exceeds 10 percent of the aggregate statewide direct
21 written premium for the subject lines of business for the
22 prior calendar year for all member insurers, the association
23 shall levy an assessment on member insurers in an amount equal
24 to the greater of 10 percent of the deficit or 10 percent of
25 the aggregate statewide direct written premium for the subject
26 lines of business for the prior calendar year for all member
27 insurers. Any remaining deficit shall be recovered through
28 emergency assessments under sub-subparagraph d.
29 c. Each member insurer's share of the total assessment
30 under sub-subparagraph a. or sub-subparagraph b. shall be in
31 the proportion that the member insurer's direct written

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1 premium for the subject lines of business for the year
2 preceding the assessment bears to the aggregate statewide
3 direct written premium for the subject lines of business for
4 that year for all member insurers.
5 d. Upon a determination by the board of governors that
6 a deficit in an account exceeds the amount that will be
7 recovered through regular assessments on member insurers under
8 sub-subparagraph a. or sub-subparagraph b., the board shall
9 levy, after verification by the department, emergency
10 assessments to be collected by member insurers and by
11 underwriting associations created under this section which
12 write subject lines of business upon issuance or renewal of
13 policies for subject lines of business, excluding National
14 Flood Insurance policies, in the year or years following levy
15 of the regular assessments. The amount of the emergency
16 assessment collected in a particular year shall be a uniform
17 percentage of that year's direct written premium for subject
18 lines of business for all member insurers and underwriting
19 associations, excluding National Flood Insurance Program
20 policy premiums, as annually determined by the board and
21 verified by the department. The department shall verify the
22 arithmetic calculations involved in the board's determination
23 within 30 days after receipt of the information on which the
24 determination was based. Notwithstanding any other provision
25 of law, each member insurer and each underwriting association
26 created under this section which writes subject lines of
27 business shall collect emergency assessments from its
28 policyholders without such obligation being affected by any
29 credit, limitation, exemption, or deferment. The emergency
30 assessments so collected shall be transferred directly to the
31 association on a periodic basis as determined by the

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1 association. The aggregate amount of emergency assessments
2 levied under this sub-subparagraph in any calendar year may
3 not exceed the greater of 10 percent of the amount needed to
4 cover the original deficit, plus interest, fees, commissions,
5 required reserves, and other costs associated with financing
6 of the original deficit, or 10 percent of the aggregate
7 statewide direct written premium for subject lines of business
8 written by member insurers and underwriting associations for
9 the prior year, plus interest, fees, commissions, required
10 reserves, and other costs associated with financing the
11 original deficit.
12 e. The board may pledge the proceeds of assessments,
13 projected recoveries from the Florida Hurricane Catastrophe
14 Fund, other insurance and reinsurance recoverables, market
15 equalization surcharges and other surcharges, and other funds
16 available to the association as the source of revenue for and
17 to secure bonds issued under paragraph (g), bonds or other
18 indebtedness issued under subparagraph (c)3., or lines of
19 credit or other financing mechanisms issued or created under
20 this subsection, or to retire any other debt incurred as a
21 result of deficits or events giving rise to deficits, or in
22 any other way that the board determines will efficiently
23 recover such deficits. The purpose of the lines of credit or
24 other financing mechanisms is to provide additional resources
25 to assist the association in covering claims and expenses
26 attributable to a catastrophe. As used in this subsection, the
27 term "assessments" includes regular assessments under
28 sub-subparagraph a., sub-subparagraph b., or subparagraph
29 (g)1. and emergency assessments under sub-subparagraph d.
30 Emergency assessments collected under sub-subparagraph d. are
31 not part of an insurer's rates, are not premium, and are not

1 subject to premium tax, fees, or commissions; however, failure
2 to pay the emergency assessment shall be treated as failure to
3 pay premium. The emergency assessments under sub-subparagraph
4 d. shall continue as long as any bonds issued or other
5 indebtedness incurred with respect to a deficit for which the
6 assessment was imposed remain outstanding, unless adequate
7 provision has been made for the payment of such bonds or other
8 indebtedness pursuant to the documents governing such bonds or
9 other indebtedness.
10 f. As used in this subsection, the term "subject lines
11 of business" means, with respect to the personal lines
12 account, any personal lines policy defined in s. 627.4025, and
13 means, with respect to the commercial lines account, all
14 commercial property and commercial fire insurance.
15 (c) The plan of operation of the association:
16 1. May provide for one or more designated insurers,
17 able and willing to provide policy and claims service, to act
18 on behalf of the association to provide such service. Each
19 licensed agent shall be entitled to indicate the order of
20 preference regarding who will service the business placed by
21 the agent. The association shall adhere to each agent's
22 preferences unless after consideration of other factors in
23 assigning agents, including, but not limited to, servicing
24 capacity and fee arrangements, the association has reason to
25 believe it is in the best interest of the association to make
26 a different assignment.
27 2. Must provide for adoption of residential property
28 and casualty insurance policy forms, which forms must be
29 approved by the department prior to use. The association
30 shall adopt the following policy forms:
31

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1 a. Standard personal lines policy forms including wind
2 coverage, which are multiperil policies providing what is
3 generally considered to be full coverage of a residential
4 property similar to the coverage provided under an HO-2, HO-3,
5 HO-4, or HO-6 policy.
6 b. Standard personal lines policy forms without wind
7 coverage, which are the same as the policies described in
8 sub-subparagraph a. except that they do not include wind
9 coverage.
10 c. Basic personal lines policy forms including wind
11 coverage, which are policies similar to an HO-8 policy or a
12 dwelling fire policy that provide coverage meeting the
13 requirements of the secondary mortgage market, but which
14 coverage is more limited than the coverage under a standard
15 policy.
16 d. Basic personal lines policy forms without wind
17 coverage, which are the same as the policies described in
18 sub-subparagraph c. except that they do not include wind
19 coverage.
20 e. Commercial lines residential policy forms including
21 wind coverage that are generally similar to the basic perils
22 of full coverage obtainable for commercial residential
23 structures in the admitted voluntary market.
24 f. Commercial lines residential policy forms without
25 wind coverage, which are the same as the policies described in
26 sub-subparagraph e. except that they do not include wind
27 coverage.
28 3. May provide that the association may employ or
29 otherwise contract with individuals or other entities to
30 provide administrative or professional services that may be
31 appropriate to effectuate the plan. The association shall

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1 have the power to borrow funds, by issuing bonds or by
2 incurring other indebtedness, and shall have other powers
3 reasonably necessary to effectuate the requirements of this
4 subsection. The association may issue bonds or incur other
5 indebtedness, or have bonds issued on its behalf by a unit of
6 local government pursuant to subparagraph (g)2., in the
7 absence of a hurricane or other weather-related event, upon a
8 determination by the association, subject to approval by the
9 department, that such action would enable it to efficiently
10 meet the financial obligations of the association and that
11 such financings are reasonably necessary to effectuate the
12 requirements of this subsection. The association is
13 authorized to take all actions needed to facilitate tax-free
14 status for any such bonds or indebtedness, including formation
15 of trusts or other affiliated entities. The association shall
16 have the authority to pledge assessments, projected recoveries
17 from the Florida Hurricane Catastrophe Fund, other reinsurance
18 recoverables, market equalization and other surcharges, and
19 other funds available to the association as security for bonds
20 or other indebtedness. In recognition of s. 10, Art. I of the
21 State Constitution, prohibiting the impairment of obligations
22 of contracts, it is the intent of the Legislature that no
23 action be taken whose purpose is to impair any bond indenture
24 or financing agreement or any revenue source committed by
25 contract to such bond or other indebtedness.
26 4. Must require that the association operate subject
27 to the supervision and approval of a board of governors
28 consisting of 13 individuals, including 1 who is elected as
29 chair. The board shall consist of:
30 a. The insurance consumer advocate appointed under s.
31 627.0613.

1 b. Five members designated by the insurance industry.
2 c. Five consumer representatives appointed by the
3 Insurance Commissioner. Two of the consumer representatives
4 must, at the time of appointment, be holders of policies
5 issued by the association, who are selected with consideration
6 given to reflecting the geographic balance of association
7 policyholders. Two of the consumer members must be individuals
8 who are minority persons as defined in s. 288.703(3). One of
9 the consumer members shall have expertise in the field of
10 mortgage lending.
11 d. Two representatives of the insurance industry
12 appointed by the Insurance Commissioner. Of the two insurance
13 industry representatives appointed by the Insurance
14 Commissioner, at least one must be an individual who is a
15 minority person as defined in s. 288.703(3).
16
17 Any board member may be disapproved or removed and replaced by
18 the commissioner at any time for cause. All board members,
19 including the chair, must be appointed to serve for 3-year
20 terms beginning annually on a date designated by the plan.
21 5. Must provide a procedure for determining the
22 eligibility of a risk for coverage, as follows:
23 a. With respect to personal lines residential risks,
24 if the risk is offered coverage from an authorized insurer at
25 the insurer's approved rate under either a standard policy
26 including wind coverage or, if consistent with the insurer's
27 underwriting rules as filed with the department, a basic
28 policy including wind coverage, the risk is not eligible for
29 any policy issued by the association. If the risk accepts an
30 offer of coverage through the market assistance plan or an
31 offer of coverage through a mechanism established by the

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1 association before a policy is issued to the risk by the
2 association or during the first 30 days of coverage by the
3 association, and the producing agent who submitted the
4 application to the plan or to the association is not currently
5 appointed by the insurer, the insurer shall either appoint the
6 agent to service the risk or, if the insurer places the
7 coverage through a new agent, require the new agent who then
8 writes the policy to pay not less than 50 percent of the first
9 year's commission to the producing agent who submitted the
10 application to the plan or the association, except that if the
11 new agent is an employee or exclusive agent of the insurer,
12 the new agent shall pay a policy fee of $50 to the producing
13 agent in lieu of splitting the commission. If the risk is not
14 able to obtain any such offer, the risk is eligible for either
15 a standard policy including wind coverage or a basic policy
16 including wind coverage issued by the association; however, if
17 the risk could not be insured under a standard policy
18 including wind coverage regardless of market conditions, the
19 risk shall be eligible for a basic policy including wind
20 coverage unless rejected under subparagraph 8. The association
21 shall determine the type of policy to be provided on the basis
22 of objective standards specified in the underwriting manual
23 and based on generally accepted underwriting practices.
24 b. With respect to commercial lines residential risks,
25 if the risk is offered coverage under a policy including wind
26 coverage from an authorized insurer at its approved rate, the
27 risk is not eligible for any policy issued by the association.
28 If the risk accepts an offer of coverage through the market
29 assistance plan or an offer of coverage through a mechanism
30 established by the association before a policy is issued to
31 the risk by the association, and the producing agent who

submitted the application to the plan or the association is not currently appointed by the insurer, the insurer shall either appoint the agent to service the risk or, if the insurer places the coverage through a new agent, require the new agent who then writes the policy to pay not less than 50 percent of the first year's commission to the producing agent who submitted the application to the plan, except that if the new agent is an employee or exclusive agent of the insurer, the new agent shall pay a policy fee of $50 to the producing agent in lieu of splitting the commission. If the risk is not able to obtain any such offer, the risk is eligible for a policy including wind coverage issued by the association.

c. This subparagraph does not require the association to provide wind coverage or hurricane coverage in any area in which such coverage is available through the Florida Windstorm Underwriting Association.

6. Must include rules for classifications of risks and rates therefor.

7. Must provide that if premium and investment income attributable to a particular plan year are in excess of projected losses and expenses of the plan attributable to that year, such excess shall be held in surplus. Such surplus shall be available to defray deficits as to future years and shall be used for that purpose prior to assessing member insurers as to any plan year.

8. Must provide objective criteria and procedures to be uniformly applied for all applicants in determining whether an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following shall be considered:

1 a. Whether the likelihood of a loss for the individual
2 risk is substantially higher than for other risks of the same
3 class; and
4 b. Whether the uncertainty associated with the
5 individual risk is such that an appropriate premium cannot be
6 determined.
7
8 The acceptance or rejection of a risk by the association shall
9 be construed as the private placement of insurance, and the
10 provisions of chapter 120 shall not apply.
11 9. Must provide that the association shall make its
12 best efforts to procure catastrophe reinsurance at reasonable
13 rates, as determined by the board of governors.
14 10. Must provide that in the event of regular deficit
15 assessments under sub-subparagraph (b)3.a. or sub-subparagraph
16 (b)3.b., or by the Florida Windstorm Underwriting Association
17 under sub-sub-subparagraph (2)(b)2.d.(I) or
18 sub-sub-subparagraph (2)(b)2.d.(II), the association shall
19 levy upon association policyholders in its next rate filing,
20 or by a separate rate filing solely for this purpose, a market
21 equalization surcharge in a percentage equal to the total
22 amount of such regular assessments divided by the aggregate
23 statewide direct written premium for subject lines of business
24 for member insurers for the prior calendar year. Market
25 equalization surcharges under this subparagraph are not
26 considered premium and are not subject to commissions, fees,
27 or premium taxes; however, failure to pay a market
28 equalization surcharge shall be treated as failure to pay
29 premium.
30 11. The policies issued by the association must
31 provide that, if the association or the market assistance plan

1 obtains an offer from an authorized insurer to cover the risk
2 at its approved rates under either a standard policy including
3 wind coverage or a basic policy including wind coverage, the
4 risk is no longer eligible for coverage through the
5 association. However, if the risk is located in an area in
6 which Florida Windstorm Underwriting Association coverage is
7 available, such an offer of a standard or basic policy
8 terminates eligibility regardless of whether or not the offer
9 includes wind coverage. Upon termination of eligibility, the
10 association shall provide written notice to the policyholder
11 and agent of record stating that the association policy shall
12 be canceled as of 60 days after the date of the notice because
13 of the offer of coverage from an authorized insurer. Other
14 provisions of the insurance code relating to cancellation and
15 notice of cancellation do not apply to actions under this
16 subparagraph.
17 12. Association policies and applications must include
18 a notice that the association policy could, under this section
19 or s. 627.3511, be replaced with a policy issued by an
20 admitted insurer that does not provide coverage identical to
21 the coverage provided by the association. The notice shall
22 also specify that acceptance of association coverage creates a
23 conclusive presumption that the applicant or policyholder is
24 aware of this potential.
25 13. May establish, subject to approval by the
26 department, different eligibility requirements and operational
27 procedures for any line or type of coverage for any specified
28 county or area if the board determines that such changes to
29 the eligibility requirements and operational procedures are
30 justified due to the voluntary market being sufficiently
31 stable and competitive in such area or for such line or type

1 of coverage and that consumers who, in good faith, are unable
2 to obtain insurance through the voluntary market through
3 ordinary methods would continue to have access to coverage
4 from the association. When coverage is sought in connection
5 with a real property transfer, such requirements and
6 procedures shall not provide for an effective date of coverage
7 later than the date of the closing of the transfer as
8 established by the transferor, the transferee, and, if
9 applicable, the lender.
10 (d)1. It is the intent of the Legislature that the
11 rates for coverage provided by the association be actuarially
12 sound and not competitive with approved rates charged in the
13 admitted voluntary market, so that the association functions
14 as a residual market mechanism to provide insurance only when
15 the insurance cannot be procured in the voluntary market.
16 Rates shall include an appropriate catastrophe loading factor
17 that reflects the actual catastrophic exposure of the
18 association and recognizes that the association has little or
19 no capital or surplus; and the association shall carefully
20 review each rate filing to assure that provider compensation
21 is not excessive.
22 2. For each county, the average rates of the
23 association for each line of business for personal lines
24 residential policies shall be no lower than the average rates
25 charged by the insurer that had the highest average rate in
26 that county among the 20 insurers with the greatest total
27 direct written premium in the state for that line of business
28 in the preceding year, except that with respect to mobile home
29 coverages, the average rates of the association shall be no
30 lower than the average rates charged by the insurer that had
31 the highest average rate in that county among the 5 insurers

with the greatest total written premium for mobile home owner's policies in the state in the preceding year.

3. Rates for commercial residential coverage shall not be subject to the requirements of subparagraph 2., but shall be subject to all other requirements of this paragraph and s. 627.062.

4. Nothing in this paragraph shall require or allow the association to adopt a rate that is inadequate under s. 627.062 or to reduce rates approved under s. 627.062.

5. ~~The association may require arbitration of a filing pursuant to s. 627.062(6).~~Rate filings of the association under this paragraph shall be made on a use and file basis under s. 627.062(2)(a)2. The association shall make a rate filing at least once a year, but no more often than quarterly.

(e) Coverage through the association is hereby activated effective upon approval of the plan, and shall remain activated until coverage is deactivated pursuant to paragraph (f). Thereafter, coverage through the association shall be reactivated by order of the department only under one of the following circumstances:

1. If the market assistance plan receives a minimum of 100 applications for coverage within a 3-month period, or 200 applications for coverage within a 1-year period or less for residential coverage, unless the market assistance plan provides a quotation from admitted carriers at their filed rates for at least 90 percent of such applicants. Any market assistance plan application that is rejected because an individual risk is so hazardous as to be uninsurable using the criteria specified in subparagraph (c)8. shall not be included in the minimum percentage calculation provided herein. In the event that there is a legal or administrative challenge to a

1 determination by the department that the conditions of this
2 subparagraph have been met for eligibility for coverage in the
3 association, any eligible risk may obtain coverage during the
4 pendency of such challenge.
5 2. In response to a state of emergency declared by the
6 Governor under s. 252.36, the department may activate coverage
7 by order for the period of the emergency upon a finding by the
8 department that the emergency significantly affects the
9 availability of residential property insurance.
10 (f) The activities of the association shall be
11 reviewed at least annually by the board and, upon
12 recommendation by the board or petition of any interested
13 party, coverage shall be deactivated if the department finds
14 that the conditions giving rise to its activation no longer
15 exist.
16 (g)1. The board shall certify to the department its
17 needs for annual assessments as to a particular calendar year,
18 and any startup or interim assessments that it deems to be
19 necessary to sustain operations as to a particular year
20 pending the receipt of annual assessments. Upon verification,
21 the department shall approve such certification, and the board
22 shall levy such annual, startup, or interim assessments. Such
23 assessments shall be prorated as provided in paragraph (b).
24 The board shall take all reasonable and prudent steps
25 necessary to collect the amount of assessment due from each
26 participating member insurer, including, if prudent, filing
27 suit to collect such assessment. If the board is unable to
28 collect an assessment from any member insurer, the uncollected
29 assessments shall be levied as an additional assessment
30 against the participating member insurers and any
31 participating member insurer required to pay an additional

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1 assessment as a result of such failure to pay shall have a
2 cause of action against such nonpaying member insurer.
3 Assessments shall be included as an appropriate factor in the
4 making of rates.
5 2. The governing body of any unit of local government,
6 any residents of which are insured by the association, may
7 issue bonds as defined in s. 125.013 or s. 166.101 from time
8 to time to fund an assistance program, in conjunction with the
9 association, for the purpose of defraying deficits of the
10 association. In order to avoid needless and indiscriminate
11 proliferation, duplication, and fragmentation of such
12 assistance programs, any unit of local government, any
13 residents of which are insured by the association, may provide
14 for the payment of losses, regardless of whether or not the
15 losses occurred within or outside of the territorial
16 jurisdiction of the local government. Revenue bonds may not be
17 issued until validated pursuant to chapter 75, unless a state
18 of emergency is declared by executive order or proclamation of
19 the Governor pursuant to s. 252.36 making such findings as are
20 necessary to determine that it is in the best interests of,
21 and necessary for, the protection of the public health,
22 safety, and general welfare of residents of this state and the
23 protection and preservation of the economic stability of
24 insurers operating in this state, and declaring it an
25 essential public purpose to permit certain municipalities or
26 counties to issue such bonds as will permit relief to
27 claimants and policyholders of the joint underwriting
28 association and insurers responsible for apportionment of
29 association losses. Any such unit of local government may
30 enter into such contracts with the association and with any
31 other entity created pursuant to this subsection as are

1 necessary to carry out this paragraph. Any bonds issued under
2 this subparagraph shall be payable from and secured by moneys
3 received by the association from emergency assessments under
4 sub-subparagraph (b)3.d., and assigned and pledged to or on
5 behalf of the unit of local government for the benefit of the
6 holders of such bonds. The funds, credit, property, and
7 taxing power of the state or of the unit of local government
8 shall not be pledged for the payment of such bonds. If any of
9 the bonds remain unsold 60 days after issuance, the department
10 shall require all insurers subject to assessment to purchase
11 the bonds, which shall be treated as admitted assets; each
12 insurer shall be required to purchase that percentage of the
13 unsold portion of the bond issue that equals the insurer's
14 relative share of assessment liability under this subsection.
15 An insurer shall not be required to purchase the bonds to the
16 extent that the department determines that the purchase would
17 endanger or impair the solvency of the insurer.
18 3.a. In addition to any credits, bonuses, or
19 exemptions provided under s. 627.3511, the board shall adopt a
20 program for the reduction of both new and renewal writings in
21 the association. The board may consider any prudent and not
22 unfairly discriminatory approach to reducing association
23 writings, but must adopt at least a credit against assessment
24 liability or other liability that provides an incentive for
25 insurers to take risks out of the association and to keep
26 risks out of the association by maintaining or increasing
27 voluntary writings in counties in which association risks are
28 highly concentrated and a program to provide a formula under
29 which an insurer voluntarily taking risks out of the
30 association by maintaining or increasing voluntary writings
31

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1 will be relieved wholly or partially from assessments under
2 sub-subparagraphs (b)3.a. and b.
3 b. Any credit or exemption from regular assessments
4 adopted under this subparagraph shall last no longer than the
5 3 years following the cancellation or expiration of the policy
6 by the association. With the approval of the department, the
7 board may extend such credits for an additional year if the
8 insurer guarantees an additional year of renewability for all
9 policies removed from the association, or for 2 additional
10 years if the insurer guarantees 2 additional years of
11 renewability for all policies so removed.
12 c. There shall be no credit, limitation, exemption, or
13 deferment from emergency assessments to be collected from
14 policyholders pursuant to sub-subparagraph (b)3.d.
15 4. The plan shall provide for the deferment, in whole
16 or in part, of the assessment of a member insurer, other than
17 an emergency assessment collected from policyholders pursuant
18 to sub-subparagraph (b)3.d., if the department finds that
19 payment of the assessment would endanger or impair the
20 solvency of the insurer. In the event an assessment against a
21 member insurer is deferred in whole or in part, the amount by
22 which such assessment is deferred may be assessed against the
23 other member insurers in a manner consistent with the basis
24 for assessments set forth in paragraph (b).
25 (h) Nothing in this subsection shall be construed to
26 preclude the issuance of residential property insurance
27 coverage pursuant to part VIII of chapter 626.
28 (i) There shall be no liability on the part of, and no
29 cause of action of any nature shall arise against, any member
30 insurer or its agents or employees, the association or its
31 agents or employees, members of the board of governors or

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1 their respective designees at a board meeting, association
2 committee members, or the department or its representatives,
3 for any action taken by them in the performance of their
4 duties or responsibilities under this subsection. Such
5 immunity does not apply to:
6 1. Any of the foregoing persons or entities for any
7 willful tort;
8 2. The association or its servicing or producing
9 agents for breach of any contract or agreement pertaining to
10 insurance coverage;
11 3. The association with respect to issuance or payment
12 of debt; or
13 4. Any member insurer with respect to any action to
14 enforce a member insurer's obligations to the association
15 under this subsection.
16 (j) The Residential Property and Casualty Joint
17 Underwriting Association is not a state agency, board, or
18 commission. However, for the purposes of s. 199.183(1), the
19 Residential Property and Casualty Joint Underwriting
20 Association shall be considered a political subdivision of the
21 state and shall be exempt from the corporate income tax.
22 (k) Upon a determination by the board of governors
23 that the conditions giving rise to the establishment and
24 activation of the association no longer exist, and upon the
25 consent thereto by order of the department, the association is
26 dissolved. Upon dissolution, the assets of the association
27 shall be applied first to pay all debts, liabilities, and
28 obligations of the association, including the establishment of
29 reasonable reserves for any contingent liabilities or
30 obligations, and all remaining assets of the association shall
31

1 become property of the state and deposited in the Florida
2 Hurricane Catastrophe Fund.
3 (l) All obligations, rights, assets, and liabilities
4 of the Florida Property and Casualty Joint Underwriting
5 Association created by subsection (5), which obligations,
6 rights, assets, or liabilities relate to the provision of
7 commercial lines residential property insurance coverage as
8 described in this section are hereby transferred to the
9 Residential Property and Casualty Joint Underwriting
10 Association. The Residential Property and Casualty Joint
11 Underwriting Association is not required to issue endorsements
12 or certificates of assumption to insureds during the remaining
13 term of in-force transferred policies.
14 (m) Notwithstanding any other provision of law:
15 1. The pledge or sale of, the lien upon, and the
16 security interest in any rights, revenues, or other assets of
17 the association created or purported to be created pursuant to
18 any financing documents to secure any bonds or other
19 indebtedness of the association shall be and remain valid and
20 enforceable, notwithstanding the commencement of and during
21 the continuation of, and after, any rehabilitation,
22 insolvency, liquidation, bankruptcy, receivership,
23 conservatorship, reorganization, or similar proceeding against
24 the association under the laws of this state.
25 2. No such proceeding shall relieve the association of
26 its obligation, or otherwise affect its ability to perform its
27 obligation, to continue to collect, or levy and collect,
28 assessments, market equalization or other surcharges under
29 subparagraph (c)10., or any other rights, revenues, or other
30 assets of the association pledged pursuant to any financing
31 documents.

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1 3. Each such pledge or sale of, lien upon, and
2 security interest in, including the priority of such pledge,
3 lien, or security interest, any such assessments, market
4 equalization or other surcharges, or other rights, revenues,
5 or other assets which are collected, or levied and collected,
6 after the commencement of and during the pendency of, or
7 after, any such proceeding shall continue unaffected by such
8 proceeding. As used in this subsection, the term "financing
9 documents" means any agreement or agreements, instrument or
10 instruments, or other document or documents now existing or
11 hereafter created evidencing any bonds or other indebtedness
12 of the association or pursuant to which any such bonds or
13 other indebtedness has been or may be issued and pursuant to
14 which any rights, revenues, or other assets of the association
15 are pledged or sold to secure the repayment of such bonds or
16 indebtedness, together with the payment of interest on such
17 bonds or such indebtedness, or the payment of any other
18 obligation of the association related to such bonds or
19 indebtedness.
20 4. Any such pledge or sale of assessments, revenues,
21 contract rights, or other rights or assets of the association
22 shall constitute a lien and security interest, or sale, as the
23 case may be, that is immediately effective and attaches to
24 such assessments, revenues, or contract rights or other rights
25 or assets, whether or not imposed or collected at the time the
26 pledge or sale is made. Any such pledge or sale is effective,
27 valid, binding, and enforceable against the association or
28 other entity making such pledge or sale, and valid and binding
29 against and superior to any competing claims or obligations
30 owed to any other person or entity, including policyholders in
31 this state, asserting rights in any such assessments,

1 revenues, or contract rights or other rights or assets to the
2 extent set forth in and in accordance with the terms of the
3 pledge or sale contained in the applicable financing
4 documents, whether or not any such person or entity has notice
5 of such pledge or sale and without the need for any physical
6 delivery, recordation, filing, or other action.
7 (n)1. The following records of the Residential
8 Property and Casualty Joint Underwriting Association are
9 confidential and exempt from the provisions of s. 119.07(1)
10 and s. 24(a), Art. I of the State Constitution:
11 a. Underwriting files, except that a policyholder or
12 an applicant shall have access to his or her own underwriting
13 files.
14 b. Claims files, until termination of all litigation
15 and settlement of all claims arising out of the same incident,
16 although portions of the claims files may remain exempt, as
17 otherwise provided by law. Confidential and exempt claims file
18 records may be released to other governmental agencies upon
19 written request and demonstration of need; such records held
20 by the receiving agency remain confidential and exempt as
21 provided for herein.
22 c. Records obtained or generated by an internal
23 auditor pursuant to a routine audit, until the audit is
24 completed, or if the audit is conducted as part of an
25 investigation, until the investigation is closed or ceases to
26 be active. An investigation is considered "active" while the
27 investigation is being conducted with a reasonable, good faith
28 belief that it could lead to the filing of administrative,
29 civil, or criminal proceedings.
30 d. Matters reasonably encompassed in privileged
31 attorney-client communications.

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1 e. Proprietary information licensed to the association
2 under contract and the contract provides for the
3 confidentiality of such proprietary information.
4 f. All information relating to the medical condition
5 or medical status of an association employee which is not
6 relevant to the employee's capacity to perform his or her
7 duties, except as otherwise provided in this paragraph.
8 Information which is exempt shall include, but is not limited
9 to, information relating to workers' compensation, insurance
10 benefits, and retirement or disability benefits.
11 g. Upon an employee's entrance into the employee
12 assistance program, a program to assist any employee who has a
13 behavioral or medical disorder, substance abuse problem, or
14 emotional difficulty which affects the employee's job
15 performance, all records relative to that participation shall
16 be confidential and exempt from the provisions of s. 119.07(1)
17 and s. 24(a), Art. I of the State Constitution, except as
18 otherwise provided in s. 112.0455(11).
19 h. Information relating to negotiations for financing,
20 reinsurance, depopulation, or contractual services, until the
21 conclusion of the negotiations.
22 i. Minutes of closed meetings regarding underwriting
23 files, and minutes of closed meetings regarding an open claims
24 file until termination of all litigation and settlement of all
25 claims with regard to that claim, except that information
26 otherwise confidential or exempt by law will be redacted.
27
28 When an authorized insurer is considering underwriting a risk
29 insured by the association, relevant underwriting files and
30 confidential claims files may be released to the insurer
31 provided the insurer agrees in writing, notarized and under

1 oath, to maintain the confidentiality of such files. When a
2 file is transferred to an insurer that file is no longer a
3 public record because it is not held by an agency subject to
4 the provisions of the public records law. Underwriting files
5 and confidential claims files may also be released to staff of
6 and the board of governors of the market assistance plan
7 established pursuant to s. 627.3515, who must retain the
8 confidentiality of such files, except such files may be
9 released to authorized insurers that are considering assuming
10 the risks to which the files apply, provided the insurer
11 agrees in writing, notarized and under oath, to maintain the
12 confidentiality of such files. Finally, the association or
13 the board or staff of the market assistance plan may make the
14 following information obtained from underwriting files and
15 confidential claims files available to licensed general lines
16 insurance agents: name, address, and telephone number of the
17 residential property owner or insured; location of the risk;
18 rating information; loss history; and policy type. The
19 receiving licensed general lines insurance agent must retain
20 the confidentiality of the information received.
21 2. Portions of meetings of the Residential Property
22 and Casualty Joint Underwriting Association are exempt from
23 the provisions of s. 286.011 and s. 24(b), Art. I of the State
24 Constitution wherein confidential underwriting files or
25 confidential open claims files are discussed. All portions of
26 association meetings which are closed to the public shall be
27 recorded by a court reporter. The court reporter shall record
28 the times of commencement and termination of the meeting, all
29 discussion and proceedings, the names of all persons present
30 at any time, and the names of all persons speaking. No
31 portion of any closed meeting shall be off the record.

Subject to the provisions hereof and s. 119.07(2)(a), the court reporter's notes of any closed meeting shall be retained by the association for a minimum of 5 years. A copy of the transcript, less any exempt matters, of any closed meeting wherein claims are discussed shall become public as to individual claims after settlement of the claim.

Section 61. Subsections (3) and (4) of section 627.3512, Florida Statutes, are amended to read:

627.3512 Recoupment of residual market deficit assessments.--

(3) The insurer or insurer group shall file with the commission ~~department~~ a statement setting forth the amount of the assessment factor and an explanation of how the factor will be applied, at least 15 days prior to the factor being applied to any policies. The statement shall include documentation of the assessment paid by the insurer or insurer group and the arithmetic calculations supporting the assessment factor. The commission ~~department~~ shall complete its review within 15 days after receipt of the filing and shall limit its review to verification of the arithmetic calculations. The insurer or insurer group may use the assessment factor at any time after the expiration of the 15-day period unless the commission ~~department~~ has notified the insurer or insurer group in writing that the arithmetic calculations are incorrect.

(4) The commission ~~department~~ may adopt rules to implement this section.

Section 62. Subsection (8) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

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1 (8) The expense factors associated with rates used by
2 a fund shall be filed with the commission ~~department~~ at least
3 30 days prior to use and may not be used until approved by the
4 commission ~~department~~. The commission ~~department~~ shall
5 disapprove the rates unless the filed expense factors
6 associated therewith are justified and reasonable for the
7 benefits and services provided.
8 Section 63. Section 627.361, Florida Statutes, is
9 amended to read:
10 627.361 False or misleading information.--No person
11 shall willfully withhold information from or knowingly give
12 false or misleading information to the department, commission,
13 any statistical agency designated by the department or
14 commission, any rating organization, or any insurer, which
15 will affect the rates or premiums chargeable under this part.
16 Section 64. Subsections (6), (7), and (8) of section
17 627.410, Florida Statutes, are amended to read:
18 627.410 Filing, approval of forms.--
19 (6)(a) An insurer shall not deliver or issue for
20 delivery or renew in this state any health insurance policy
21 form until it has filed with the commission ~~department~~ a copy
22 of every applicable rating manual, rating schedule, change in
23 rating manual, and change in rating schedule; if rating
24 manuals and rating schedules are not applicable, the insurer
25 must file with the commission ~~department~~ applicable premium
26 rates and any change in applicable premium rates.
27 (b) The commission ~~department~~ may establish by rule,
28 for each type of health insurance form, procedures to be used
29 in ascertaining the reasonableness of benefits in relation to
30 premium rates and may, by rule, exempt from any requirement of
31 paragraph (a) any health insurance policy form or type thereof

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1 (as specified in such rule) to which form or type such
2 requirements may not be practically applied or to which form
3 or type the application of such requirements is not desirable
4 or necessary for the protection of the public. With respect to
5 any health insurance policy form or type thereof which is
6 exempted by rule from any requirement of paragraph (a),
7 premium rates filed pursuant to ss. 627.640 and 627.662 shall
8 be for informational purposes.
9 (c) Every filing made pursuant to this subsection
10 shall be made within the same time period provided in, and
11 shall be deemed to be approved under the same conditions as
12 those provided in, subsection (2), except that such filings
13 shall be made with the commission, rather than the department.
14 (d) Every filing made pursuant to this subsection,
15 except disability income policies and accidental death
16 policies, shall be prohibited from applying the following
17 rating practices:
18 1. Select and ultimate premium schedules.
19 2. Premium class definitions which classify insured
20 based on year of issue or duration since issue.
21 3. Attained age premium structures on policy forms
22 under which more than 50 percent of the policies are issued to
23 persons age 65 or over.
24 (e) Except as provided in subparagraph 1., an insurer
25 shall continue to make available for purchase any individual
26 policy form issued on or after October 1, 1993. A policy form
27 shall not be considered to be available for purchase unless
28 the insurer has actively offered it for sale in the previous
29 12 months.
30 1. An insurer may discontinue the availability of a
31 policy form if the insurer provides to the department and

1 commission in writing its decision at least 30 days prior to
2 discontinuing the availability of the form of the policy or
3 certificate. After receipt of the notice by the department
4 and commission, the insurer shall no longer offer for sale the
5 policy form or certificate form in this state.
6 2. An insurer that discontinues the availability of a
7 policy form pursuant to subparagraph 1. shall not file for
8 approval a new policy form providing similar benefits as the
9 discontinued form for a period of 5 years after the insurer
10 provides notice to the department of the discontinuance. The
11 period of discontinuance may be reduced if the department or
12 commission determines that a shorter period is appropriate.
13 3. The experience of all policy forms providing
14 similar benefits shall be combined for all rating purposes.
15 (7)(a) Each insurer subject to the requirements of
16 subsection (6) shall make an annual filing with the commission
17 ~~department~~ no later than 12 months after its previous filing,
18 demonstrating the reasonableness of benefits in relation to
19 premium rates. The commission ~~department~~, after receiving a
20 request to be exempted from the provisions of this section,
21 may, for good cause due to insignificant numbers of policies
22 in force or insignificant premium volume, exempt a company, by
23 line of coverage, from filing rates or rate certification as
24 required by this section.
25 (b) The filing required by this subsection shall be
26 satisfied by one of the following methods:
27 1. A rate filing prepared by an actuary which contains
28 documentation demonstrating the reasonableness of benefits in
29 relation to premiums charged in accordance with the applicable
30 rating laws and rules adopted ~~promulgated~~ by the commission
31 ~~department~~.

1 2. If no rate change is proposed, a filing which
2 consists of a certification by an actuary that benefits are
3 reasonable in relation to premiums currently charged in
4 accordance with applicable laws and rules adopted ~~promulgated~~
5 by the commission ~~department~~.
6 (c) As used in this section, "actuary" means an
7 individual who is a member of the Society of Actuaries or the
8 American Academy of Actuaries. If an insurer does not employ
9 or otherwise retain the services of an actuary, the insurer's
10 certification shall be prepared by insurer personnel or
11 consultants with a minimum of 5 years' experience in insurance
12 ratemaking. The chief executive officer of the insurer shall
13 review and sign the certification indicating his or her
14 agreement with its conclusions.
15 (d) If at the time a filing is required under this
16 section an insurer is in the process of completing a rate
17 review, the insurer may apply to the commission ~~department~~ for
18 an extension of up to an additional 30 days in which to make
19 the filing. The request for extension must be received by the
20 commission ~~department~~ in its offices in Tallahassee no later
21 than the date the filing is due.
22 (e) If an insurer fails to meet the filing
23 requirements of this subsection and does not submit the filing
24 within 60 days following the date the filing is due, the
25 commission ~~department~~ may, in addition to any other penalty
26 authorized by law, order the insurer to discontinue the
27 issuance of policies for which the required filing was not
28 made, until ~~such time as~~ the commission ~~department~~ determines
29 that the required filing is properly submitted.
30 (8)(a) For the purposes of subsections (6) and (7),
31 benefits of an individual accident and health insurance policy

form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission ~~department~~, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the commission ~~department~~, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The commission ~~department~~ shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the commission ~~department~~ may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.

(b) The renewal premium rates shall be deemed to be approved upon filing with the commission ~~department~~ if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:

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1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.

2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.

3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the commission ~~department~~ no later than the end of such quarter. The commission ~~department~~ shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.

4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of

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1 the experience period, except that no refund need be made to a
2 policyholder in an amount less than $10. Refunds less than $10
3 shall be aggregated and paid pro rata to the policyholders
4 receiving refunds. The refund shall include interest at the
5 then-current variable loan interest rate for life insurance
6 policies established by the National Association of Insurance
7 Commissioners, from the end of the experience period until the
8 date of payment. Payments shall be made during the third
9 calendar quarter of the year following the experience period
10 for which a refund is determined to be due. However, no
11 refunds shall be made until 60 days after the filing of the
12 audit report in order that the commission ~~department~~ has
13 adequate time to review the report.
14 5. A guarantee that if the applicable loss ratio
15 exceeds the durational target loss ratio for that experience
16 period by more than 20 percent, provided there are at least
17 2,000 policyholders on the form nationwide or, if not, then
18 accumulated each calendar year until 2,000 policyholder years
19 is reached, the insurer, if directed by the commission
20 ~~department~~, shall withdraw the policy form for the purposes of
21 issuing new policies.
22 (c) As used in this subsection:
23 1. "Loss ratio" means the ratio of incurred claims to
24 earned premium.
25 2. "Applicable loss ratio" means the loss ratio
26 attributable solely to this state if there are 2,000 or more
27 policyholders in the state. If there are 500 or more
28 policyholders in this state but less than 2,000, it is the
29 linear interpolation of the nationwide loss ratio and the loss
30 ratio for this state. If there are less than 500
31 policyholders in this state, it is the nationwide loss ratio.

3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

Section 65. Section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.--

(1) The department shall disapprove any form filed under s. 627.410(1)-(5)~~s. 627.410~~, or withdraw any previous approval thereof, only if the form:

(a) Is in any respect in violation of, or does not comply with, this code.

(b) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(c) Has any title, heading, or other indication of its provisions which is misleading.

(d) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(e) Is for health insurance~~,~~and ~~provides benefits which are unreasonable in relation to the premium charged,~~ contains provisions that ~~which~~ are unfair or inequitable or contrary to the public policy of this state or that ~~which~~ encourage misrepresentation~~, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices~~.

(f) Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or

1 conditions of such contract, for human immunodeficiency virus
2 infection or acquired immune deficiency syndrome which are
3 different than those which apply to any other sickness or
4 medical condition.
5 (2) The commission shall disapprove any health
6 insurance rate filing under s. 627.410(6), (7), or (8) or
7 withdraw any previous approval thereof only if the benefits
8 are unreasonable in relation to the premium charged or the
9 filing applies rating practices that result in premium
10 escalations that are not viable for the policyholder market or
11 result in unfair discrimination in sales practices. In
12 determining whether the benefits are reasonable in relation to
13 the premium charged, the commission ~~department~~, in accordance
14 with reasonable actuarial techniques, shall consider:
15 (a) Past loss experience and prospective loss
16 experience within and without this state.
17 (b) Allocation of expenses.
18 (c) Risk and contingency margins, along with
19 justification of such margins.
20 (d) Acquisition costs.
21 Section 66. Paragraph (c) of subsection (7) of section
22 627.6475, Florida Statutes, is amended to read:
23 627.6475 Individual reinsurance pool.--
24 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
25 (c)1. The board, as part of the plan of operation,
26 shall establish a methodology for determining premium rates to
27 be charged by the program for reinsuring eligible individuals
28 pursuant to this section. The methodology must include a
29 system for classifying individuals which reflects the types of
30 case characteristics commonly used by carriers in this state.
31 The methodology must provide for the development of basic

reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the commission ~~department~~, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. An eligible individual may be reinsured for a rate that is five times the rate established by the board.

2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the commission ~~department~~.

Section 67. Paragraph (a) of subsection (4) of section 627.6498, Florida Statutes, is amended to read:

627.6498 Minimum benefits coverage; exclusions; premiums; deductibles.--

(4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--

(a) The plan shall provide for annual deductibles for major medical expense coverage in the amount of $1,000 or any higher amounts proposed by the board and approved by the commission ~~department~~, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the association. With regard to any preferred provider arrangement used ~~utilized~~ by the association, the deductibles

1 provided in this paragraph shall be the minimum deductibles
2 applicable to the preferred providers and higher deductibles,
3 as approved by the department, may be applied to providers who
4 are not preferred providers.
5 1. Separate schedules of premium rates based on age
6 may apply for individual risks.
7 2. Rates are subject to approval by the commission
8 ~~department~~.
9 3. Standard risk rates for coverages issued by the
10 association shall be established by the commission ~~department~~,
11 pursuant to s. 627.6675(3).
12 4. The board shall establish separate premium
13 schedules for low-risk individuals, medium-risk individuals,
14 and high-risk individuals and shall revise premium schedules
15 annually beginning January 1999. No rate shall exceed 200
16 percent of the standard risk rate for low-risk individuals,
17 225 percent of the standard risk rate for medium-risk
18 individuals, or 250 percent of the standard risk rate for
19 high-risk individuals. For the purpose of determining what
20 constitutes a low-risk individual, medium-risk individual, or
21 high-risk individual, the board shall consider the anticipated
22 claims payment for individuals based upon an individual's
23 health condition.
24 Section 68. Section 627.6675, Florida Statutes, is
25 amended to read:
26 627.6675 Conversion on termination of
27 eligibility.--Subject to all of the provisions of this
28 section, a group policy delivered or issued for delivery in
29 this state by an insurer or nonprofit health care services
30 plan that provides, on an expense-incurred basis, hospital,
31 surgical, or major medical expense insurance, or any

1 combination of these coverages, shall provide that an employee
2 or member whose insurance under the group policy has been
3 terminated for any reason, including discontinuance of the
4 group policy in its entirety or with respect to an insured
5 class, and who has been continuously insured under the group
6 policy, and under any group policy providing similar benefits
7 that the terminated group policy replaced, for at least 3
8 months immediately prior to termination, shall be entitled to
9 have issued to him or her by the insurer a policy or
10 certificate of health insurance, referred to in this section
11 as a "converted policy." A group insurer may meet the
12 requirements of this section by contracting with another
13 insurer, authorized in this state, to issue an individual
14 converted policy, which policy has been approved by the
15 department under s. 627.410. An employee or member shall not
16 be entitled to a converted policy if termination of his or her
17 insurance under the group policy occurred because he or she
18 failed to pay any required contribution, or because any
19 discontinued group coverage was replaced by similar group
20 coverage within 31 days after discontinuance.
21 (1) TIME LIMIT.--Written application for the converted
22 policy shall be made and the first premium must be paid to the
23 insurer, not later than 63 days after termination of the group
24 policy. However, if termination was the result of failure to
25 pay any required premium or contribution and such nonpayment
26 of premium was due to acts of an employer or policyholder
27 other than the employee or certificateholder, written
28 application for the converted policy must be made and the
29 first premium must be paid to the insurer not later than 63
30 days after notice of termination is mailed by the insurer or
31 the employer, whichever is earlier, to the employee's or

certificateholder's last address as shown by the record of the insurer or the employer, whichever is applicable. In such case of termination due to nonpayment of premium by the employer or policyholder, the premium for the converted policy may not exceed the rate for the prior group coverage for the period of coverage under the converted policy prior to the date notice of termination is mailed to the employee or certificateholder. For the period of coverage after such date, the premium for the converted policy is subject to the requirements of subsection (3).

(2) EVIDENCE OF INSURABILITY.--The converted policy shall be issued without evidence of insurability.

(3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR GROUP COVERAGE.--

(a) The premium for the converted policy shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. However, the premium for the converted policy may not exceed 200 percent of the standard risk rate as established by the commission ~~department~~, pursuant to this subsection.

(b) Actual or expected experience under converted policies may be combined with such experience under group policies for the purposes of determining premium and loss experience and establishing premium rate levels for group coverage.

(c) The commission ~~department~~ shall annually determine standard risk rates, using reasonable actuarial techniques and standards adopted by the commission ~~department~~ by rule. The standard risk rates must be determined as follows:

1. Standard risk rates for individual coverage must be determined separately for indemnity policies, preferred provider/exclusive provider policies, and health maintenance organization contracts.

2. The commission ~~department~~ shall survey insurers and health maintenance organizations representing at least an 80 percent market share, based on premiums earned in the state for the most recent calendar year, for each of the categories specified in subparagraph 1.

3. Standard risk rate schedules must be determined, computed as the average rates charged by the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.

4. The rate schedule shall be determined from analysis of the one county with the largest market share in the state of all such carriers.

5. The rate for other counties must be determined by using the weighted average of each carrier's county factor relationship to the county determined in subparagraph 4.

6. The rate schedule must be determined for different age brackets and family size brackets.

(4) EFFECTIVE DATE OF COVERAGE.--The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) SCOPE OF COVERAGE.--The converted policy shall cover the employee or member and his or her dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) OPTIONAL COVERAGE.--The insurer shall not be required to issue a converted policy covering any person who

1 is or could be covered by Medicare. The insurer shall not be
2 required to issue a converted policy covering a person if
3 paragraphs (a) and (b) apply to the person:
4 (a) If any of the following apply to the person:
5 1. The person is covered for similar benefits by
6 another hospital, surgical, medical, or major medical expense
7 insurance policy or hospital or medical service subscriber
8 contract or medical practice or other prepayment plan, or by
9 any other plan or program.
10 2. The person is eligible for similar benefits,
11 whether or not actually provided coverage, under any
12 arrangement of coverage for individuals in a group, whether on
13 an insured or uninsured basis.
14 3. Similar benefits are provided for or are available
15 to the person under any state or federal law.
16 (b) If the benefits provided under the sources
17 referred to in subparagraph (a)1. or the benefits provided or
18 available under the sources referred to in subparagraphs (a)2.
19 and 3., together with the benefits provided by the converted
20 policy, would result in overinsurance according to the
21 insurer's standards. The insurer's standards must bear some
22 reasonable relationship to actual health care costs in the
23 area in which the insured lives at the time of conversion and
24 must be filed with the department prior to their use in
25 denying coverage.
26 (7) INFORMATION REQUESTED BY INSURER.--
27 (a) A converted policy may include a provision under
28 which the insurer may request information, in advance of any
29 premium due date, of any person covered thereunder as to
30 whether:
31

1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.

2. The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

3. Similar benefits are provided for or are available to the person under any state or federal law.

(b) The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person only for one or more of the following reasons:

1. Either the benefits provided under the sources referred to in subparagraphs (a)1. and 2. for the person or the benefits provided or available under the sources referred to in subparagraph (a)3. for the person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the department.

2. The converted policyholder fails to provide the information requested pursuant to paragraph (a).

3. Fraud or intentional misrepresentation in applying for any benefits under the converted policy.

4. Other reasons approved by the department.

(8) BENEFITS OFFERED.--

(a) An insurer shall not be required to issue a converted policy that provides benefits in excess of those provided under the group policy from which conversion is made.

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1 (b) An insurer shall offer the benefits specified in
2 s. 627.668 and the benefits specified in s. 627.669 if those
3 benefits were provided in the group plan.
4 (c) An insurer shall offer maternity benefits and
5 dental benefits if those benefits were provided in the group
6 plan.
7 (9) PREEXISTING CONDITION PROVISION.--The converted
8 policy shall not exclude a preexisting condition not excluded
9 by the group policy. However, the converted policy may provide
10 that any hospital, surgical, or medical benefits payable under
11 the converted policy may be reduced by the amount of any such
12 benefits payable under the group policy after the termination
13 of covered under the group policy. The converted policy may
14 also provide that during the first policy year the benefits
15 payable under the converted policy, together with the benefits
16 payable under the group policy, shall not exceed those that
17 would have been payable had the individual's insurance under
18 the group policy remained in force.
19 (10) REQUIRED OPTION FOR MAJOR MEDICAL
20 COVERAGE.--Subject to the provisions and conditions of this
21 part, the employee or member shall be entitled to obtain a
22 converted policy providing major medical coverage under a plan
23 meeting the following requirements:
24 (a) A maximum benefit equal to the lesser of the
25 policy limit of the group policy from which the individual
26 converted or $500,000 per covered person for all covered
27 medical expenses incurred during the covered person's
28 lifetime.
29 (b) Payment of benefits at the rate of 80 percent of
30 covered medical expenses which are in excess of the
31 deductible, until 20 percent of such expenses in a benefit

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1 period reaches $2,000, after which benefits will be paid at
2 the rate of 90 percent during the remainder of the contract
3 year unless the insured is in the insurer's case management
4 program, in which case benefits shall be paid at the rate of
5 100 percent during the remainder of the contract year. For
6 the purposes of this paragraph, "case management program"
7 means the specific supervision and management of the medical
8 care provided or prescribed for a specific individual, which
9 may include the use of health care providers designated by the
10 insurer. Payment of benefits for outpatient treatment of
11 mental illness, if provided in the converted policy, may be at
12 a lesser rate but not less than 50 percent.
13 (c) A deductible for each calendar year that must be
14 $500, $1,000, or $2,000, at the option of the policyholder.
15 (d) The term "covered medical expenses," as used in
16 this subsection, shall be consistent with those customarily
17 offered by the insurer under group or individual health
18 insurance policies but is not required to be identical to the
19 covered medical expenses provided in the group policy from
20 which the individual converted.
21 (11) ALTERNATIVE PLANS.--The insurer shall, in
22 addition to the option required by subsection (10), offer the
23 standard health benefit plan, as established pursuant to s.
24 627.6699(12). The insurer may, at its option, also offer
25 alternative plans for group health conversion in addition to
26 the plans required by this section.
27 (12) RETIREMENT COVERAGE.--If coverage would be
28 continued under the group policy on an employee following the
29 employee's retirement prior to the time he or she is or could
30 be covered by Medicare, the employee may elect, instead of
31 such continuation of group insurance, to have the same

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1 conversion rights as would apply had his or her insurance
2 terminated at retirement by reason or termination of
3 employment or membership.
4 (13) REDUCTION OF COVERAGE DUE TO MEDICARE.--The
5 converted policy may provide for reduction of coverage on any
6 person upon his or her eligibility for coverage under Medicare
7 or under any other state or federal law providing for benefits
8 similar to those provided by the converted policy.
9 (14) CONVERSION PRIVILEGE ALLOWED.--The conversion
10 privilege shall also be available to any of the following:
11 (a) The surviving spouse, if any, at the death of the
12 employee or member, with respect to the spouse and the
13 children whose coverages under the group policy terminate by
14 reason of the death, otherwise to each surviving child whose
15 coverage under the group policy terminates by reason of such
16 death, or, if the group policy provides for continuation of
17 dependents' coverages following the employee's or member's
18 death, at the end of such continuation.
19 (b) The former spouse whose coverage would otherwise
20 terminate because of annulment or dissolution of marriage, if
21 the former spouse is dependent for financial support.
22 (c) The spouse of the employee or member upon
23 termination of coverage of the spouse, while the employee or
24 member remains insured under the group policy, by reason of
25 ceasing to be a qualified family member under the group
26 policy, with respect to the spouse and the children whose
27 coverages under the group policy terminate at the same time.
28 (d) A child solely with respect to himself or herself
29 upon termination of his or her coverage by reason of ceasing
30 to be a qualified family member under the group policy, if a
31

1 conversion privilege is not otherwise provided in this
2 subsection with respect to such termination.
3 (15) BENEFIT LEVELS.--If the benefit levels required
4 in subsection (10) exceed the benefit levels provided under
5 the group policy, the conversion policy may offer benefits
6 which are substantially similar to those provided under the
7 group policy in lieu of those required in subsection (10).
8 (16) GROUP COVERAGE INSTEAD OF INDIVIDUAL
9 COVERAGE.--The insurer may elect to provide group insurance
10 coverage instead of issuing a converted individual policy.
11 (17) NOTIFICATION.--A notification of the conversion
12 privilege shall be included in each certificate of coverage.
13 The insurer shall mail an election and premium notice form,
14 including an outline of coverage, on a form approved by the
15 department, within 14 days after an individual who is eligible
16 for a converted policy gives notice to the insurer that the
17 individual is considering applying for the converted policy or
18 otherwise requests such information. The outline of coverage
19 must contain a description of the principal benefits and
20 coverage provided by the policy and its principal exclusions
21 and limitations, including, but not limited to, deductibles
22 and coinsurance.
23 (18) OUTSIDE CONVERSIONS.--A converted policy that is
24 delivered outside of this state must be on a form that could
25 be delivered in the other jurisdiction as a converted policy
26 had the group policy been issued in that jurisdiction.
27 (19) APPLICABILITY.--This section does not require
28 conversion on termination of eligibility for a policy or
29 contract that provides benefits for specified diseases, or for
30 accidental injuries only, disability income, Medicare
31

1 supplement, hospital indemnity, limited benefit,
2 nonconventional, or excess policies.
3 (20) Nothing in this section or in the incorporation
4 of it into insurance policies shall be construed to require
5 insurers to provide benefits equal to those provided in the
6 group policy from which the individual converted; provided,
7 however, that comprehensive benefits are offered which shall
8 be subject to approval by the Insurance Commissioner.
9 Section 69. Subsections (3), (6), (8), (11), (12), and
10 (16) of section 627.6699, Florida Statutes, are amended to
11 read:
12 627.6699 Employee Health Care Access Act.--
13 (3) DEFINITIONS.--As used in this section, the term:
14 (a) "Actuarial certification" means a written
15 statement, by a member of the American Academy of Actuaries or
16 another person acceptable to the commission ~~department~~, that a
17 small employer carrier is in compliance with subsection (6),
18 based upon the person's examination, including a review of the
19 appropriate records and of the actuarial assumptions and
20 methods used by the carrier in establishing premium rates for
21 applicable health benefit plans.
22 (b) "Basic health benefit plan" and "standard health
23 benefit plan" mean low-cost health care plans developed
24 pursuant to subsection (12).
25 (c) "Board" means the board of directors of the
26 program.
27 (d) "Carrier" means a person who provides health
28 benefit plans in this state, including an authorized insurer,
29 a health maintenance organization, a multiple-employer welfare
30 arrangement, or any other person providing a health benefit
31 plan that is subject to insurance regulation in this state.

1 However, the term does not include a multiple-employer welfare
2 arrangement, which multiple-employer welfare arrangement
3 operates solely for the benefit of the members or the members
4 and the employees of such members, and was in existence on
5 January 1, 1992.
6 (e) "Case management program" means the specific
7 supervision and management of the medical care provided or
8 prescribed for a specific individual, which may include the
9 use of health care providers designated by the carrier.
10 (f) "Creditable coverage" has the same meaning
11 ascribed in s. 627.6561.
12 (g) "Dependent" means the spouse or child of an
13 eligible employee, subject to the applicable terms of the
14 health benefit plan covering that employee.
15 (h) "Eligible employee" means an employee who works
16 full time, having a normal workweek of 25 or more hours, and
17 who has met any applicable waiting-period requirements or
18 other requirements of this act. The term includes a
19 self-employed individual, a sole proprietor, a partner of a
20 partnership, or an independent contractor, if the sole
21 proprietor, partner, or independent contractor is included as
22 an employee under a health benefit plan of a small employer,
23 but does not include a part-time, temporary, or substitute
24 employee.
25 (i) "Established geographic area" means the county or
26 counties, or any portion of a county or counties, within which
27 the carrier provides or arranges for health care services to
28 be available to its insureds, members, or subscribers.
29 (j) "Guaranteed-issue basis" means an insurance policy
30 that must be offered to an employer, employee, or dependent of
31

1 the employee, regardless of health status, preexisting
2 conditions, or claims history.
3 (k) "Health benefit plan" means any hospital or
4 medical policy or certificate, hospital or medical service
5 plan contract, or health maintenance organization subscriber
6 contract. The term does not include accident-only, specified
7 disease, individual hospital indemnity, credit, dental-only,
8 vision-only, Medicare supplement, long-term care, or
9 disability income insurance; similar supplemental plans
10 provided under a separate policy, certificate, or contract of
11 insurance, which cannot duplicate coverage under an underlying
12 health plan and are specifically designed to fill gaps in the
13 underlying health plan, coinsurance, or deductibles; coverage
14 issued as a supplement to liability insurance; workers'
15 compensation or similar insurance; or automobile
16 medical-payment insurance.
17 (l) "Late enrollee" means an eligible employee or
18 dependent as defined under s. 627.6561(1)(b).
19 (m) "Limited benefit policy or contract" means a
20 policy or contract that provides coverage for each person
21 insured under the policy for a specifically named disease or
22 diseases, a specifically named accident, or a specifically
23 named limited market that fulfills an experimental or
24 reasonable need, such as the small group market.
25 (n) "Modified community rating" means a method used to
26 develop carrier premiums which spreads financial risk across a
27 large population and allows adjustments for age, gender,
28 family composition, tobacco usage, and geographic area as
29 determined under paragraph (5)(j).
30
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1 (o) "Participating carrier" means any carrier that
2 issues health benefit plans in this state except a small
3 employer carrier that elects to be a risk-assuming carrier.
4 (p) "Plan of operation" means the plan of operation of
5 the program, including articles, bylaws, and operating rules,
6 adopted by the board under subsection (11).
7 (q) "Program" means the Florida Small Employer Carrier
8 Reinsurance Program created under subsection (11).
9 (r) "Rating period" means the calendar period for
10 which premium rates established by a small employer carrier
11 are assumed to be in effect.
12 (s) "Reinsuring carrier" means a small employer
13 carrier that elects to comply with the requirements set forth
14 in subsection (11).
15 (t) "Risk-assuming carrier" means a small employer
16 carrier that elects to comply with the requirements set forth
17 in subsection (10).
18 (u) "Self-employed individual" means an individual or
19 sole proprietor who derives his or her income from a trade or
20 business carried on by the individual or sole proprietor which
21 results in taxable income as indicated on IRS Form 1040,
22 schedule C or F, and which generated taxable income in one of
23 the 2 previous years.
24 (v) "Small employer" means, in connection with a
25 health benefit plan with respect to a calendar year and a plan
26 year, any person, sole proprietor, self-employed individual,
27 independent contractor, firm, corporation, partnership, or
28 association that is actively engaged in business, has its
29 principal place of business in this state, employed an average
30 of at least 1 but not more than 50 eligible employees on
31 business days during the preceding calendar year, and employs

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1 at least 1 employee on the first day of the plan year. For
2 purposes of this section, a sole proprietor, an independent
3 contractor, or a self-employed individual is considered a
4 small employer only if all of the conditions and criteria
5 established in this section are met.
6 (w) "Small employer carrier" means a carrier that
7 offers health benefit plans covering eligible employees of one
8 or more small employers.
9 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
10 (a) The commission ~~department~~ may, by rule, establish
11 regulations to administer this subsection ~~section~~ and to
12 assure that rating practices used by small employer carriers
13 are consistent with the purpose of this section, including
14 assuring that differences in rates charged for health benefit
15 plans by small employer carriers are reasonable and reflect
16 objective differences in plan design, not including
17 differences due to the nature of the groups assumed to select
18 particular health benefit plans.
19 (b) For all small employer health benefit plans that
20 are subject to this section and are issued by small employer
21 carriers on or after January 1, 1994, premium rates for health
22 benefit plans subject to this section are subject to the
23 following:
24 1. Small employer carriers must use a modified
25 community rating methodology in which the premium for each
26 small employer must be determined solely on the basis of the
27 eligible employee's and eligible dependent's gender, age,
28 family composition, tobacco use, or geographic area as
29 determined under paragraph (5)(j).
30 2. Rating factors related to age, gender, family
31 composition, tobacco use, or geographic location may be

1 developed by each carrier to reflect the carrier's experience.
2 The factors used by carriers are subject to commission
3 ~~department~~ review and approval.
4 3. Small employer carriers may not modify the rate for
5 a small employer for 12 months from the initial issue date or
6 renewal date, unless the composition of the group changes or
7 benefits are changed.
8 4. Carriers participating in the alliance program, in
9 accordance with ss. 408.70-408.706, may apply a different
10 community rate to business written in that program.
11 (c) For all small employer health benefit plans that
12 are subject to this section, that are issued by small employer
13 carriers before January 1, 1994, and that are renewed on or
14 after January 1, 1995, renewal rates must be based on the same
15 modified community rating standard applied to new business.
16 (d) Notwithstanding s. 627.401(2), this section and
17 ss. 627.410 and 627.411 apply to any health benefit plan
18 provided by a small employer carrier that provides coverage to
19 one or more employees of a small employer regardless of where
20 the policy, certificate, or contract is issued or delivered,
21 if the health benefit plan covers employees or their covered
22 dependents who are residents of this state.
23 (8) MAINTENANCE OF RECORDS.--
24 (a) Each small employer carrier must maintain at its
25 principal place of business a complete and detailed
26 description of its rating practices and renewal practices,
27 including information and documentation that demonstrate that
28 its rating methods and practices are based upon commonly
29 accepted actuarial assumptions and are in accordance with
30 sound actuarial principles.
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(b) Each small employer carrier must file with the commission ~~department~~ on or before March 15 of each year an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. The certification must be in a form and manner and contain the information prescribed by the commission ~~department~~. The carrier must retain a copy of the certification at its principal place of business.

(c) A small employer carrier must make the information and documentation described in paragraph (a) available to the commission and the department upon request. The information constitutes proprietary and trade secret information and may not be disclosed by the commission or the department to persons outside the commission or department, except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(d) Each small employer carrier must file with the department quarterly an enrollment report as directed by the department. Such report shall not constitute proprietary or trade secret information.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."

(b)1. The program shall operate subject to the supervision and control of the board.

2. Effective upon this act becoming a law, the board shall consist of the commissioner or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the commissioner and serve as follows:

1 a. The commissioner shall include representatives of
2 small employer carriers subject to assessment under this
3 subsection. If two or more carriers elect to be risk-assuming
4 carriers, the membership must include at least two
5 representatives of risk-assuming carriers; if one carrier is
6 risk-assuming, one member must be a representative of such
7 carrier. At least one member must be a carrier who is subject
8 to the assessments, but is not a small employer carrier.
9 Subject to such restrictions, at least five members shall be
10 selected from individuals recommended by small employer
11 carriers pursuant to procedures provided by rule of the
12 department. Three members shall be selected from a list of
13 health insurance carriers that issue individual health
14 insurance policies. At least two of the three members selected
15 must be reinsuring carriers. Two members shall be selected
16 from a list of insurance agents who are actively engaged in
17 the sale of health insurance.
18 b. A member appointed under this subparagraph shall
19 serve a term of 4 years and shall continue in office until the
20 member's successor takes office, except that, in order to
21 provide for staggered terms, the commissioner shall designate
22 two of the initial appointees under this subparagraph to serve
23 terms of 2 years and shall designate three of the initial
24 appointees under this subparagraph to serve terms of 3 years.
25 3. The commissioner may remove a member for cause.
26 4. Vacancies on the board shall be filled in the same
27 manner as the original appointment for the unexpired portion
28 of the term.
29 5. The commissioner may require an entity that
30 recommends persons for appointment to submit additional lists
31 of recommended appointees.

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1 (c)1.
2 a. No later than August 15, 1992, the board shall
3 submit to the department a plan of operation to assure the
4 fair, reasonable, and equitable administration of the program.
5 The board may at any time submit to the department any
6 amendments to the plan that the board finds to be necessary or
7 suitable.
8 b. No later than September 15, 1992, the department
9 shall, after notice and hearing, approve the plan of operation
10 if it determines that the plan submitted by the board is
11 suitable to assure the fair, reasonable, and equitable
12 administration of the program and provides for the sharing of
13 program gains and losses equitably and proportionately in
14 accordance with paragraph (j).
15 c. The plan of operation, or any amendment thereto,
16 becomes effective upon written approval of the department.
17 2. If the board fails to submit a suitable plan of
18 operation by August 15, 1992, the department shall, after
19 notice and hearing, adopt a temporary plan of operation by
20 September 15, 1992. The department shall amend or rescind the
21 temporary plan of operation, as appropriate, after it approves
22 a suitable plan of operation submitted by the board.
23 (d) The plan of operation must, among other things:
24 1. Establish procedures for handling and accounting
25 for program assets and moneys and for an annual fiscal
26 reporting to the department.
27 2. Establish procedures for selecting an administering
28 carrier and set forth the powers and duties of the
29 administering carrier.
30 3. Establish procedures for reinsuring risks.
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1 4. Establish procedures for collecting assessments
2 from participating carriers to provide for claims reinsured by
3 the program and for administrative expenses, other than
4 amounts payable to the administrative carrier, incurred or
5 estimated to be incurred during the period for which the
6 assessment is made.
7 5. Provide for any additional matters at the
8 discretion of the board.
9 (e) The board shall:
10 1. Recommend to the department market conduct
11 requirements and other requirements for carriers and agents,
12 including requirements relating to:
13 a. Registration by each carrier with the department of
14 its intention to be a small employer carrier under this
15 section;
16 b. Publication by the department of a list of all
17 small employer carriers, including a requirement applicable to
18 agents and carriers that a health benefit plan may not be sold
19 by a carrier that is not identified as a small employer
20 carrier;
21 c. The availability of a broadly publicized, toll-free
22 telephone number for access by small employers to information
23 concerning this section;
24 d. Periodic reports by carriers and agents concerning
25 health benefit plans issued; and
26 e. Methods concerning periodic demonstration by small
27 employer carriers and agents that they are marketing or
28 issuing health benefit plans to small employers.
29 2. By January 1, 1995, the board shall conduct a study
30 of the effectiveness of this section and may recommend, to the
31 department, improvements to achieve greater rate stability,

1 accessibility, and affordability in the small employer
2 marketplace.
3 (f) The program has the general powers and authority
4 granted under the laws of this state to insurance companies
5 and health maintenance organizations licensed to transact
6 business, except the power to issue health benefit plans
7 directly to groups or individuals. In addition thereto, the
8 program has specific authority to:
9 1. Enter into contracts as necessary or proper to
10 carry out the provisions and purposes of this act, including
11 the authority to enter into contracts with similar programs of
12 other states for the joint performance of common functions or
13 with persons or other organizations for the performance of
14 administrative functions.
15 2. Sue or be sued, including taking any legal action
16 necessary or proper for recovering any assessments and
17 penalties for, on behalf of, or against the program or any
18 carrier.
19 3. Take any legal action necessary to avoid the
20 payment of improper claims against the program.
21 4. Issue reinsurance policies, in accordance with the
22 requirements of this act.
23 5. Establish rules, conditions, and procedures for
24 reinsurance risks under the program participation.
25 6. Establish actuarial functions as appropriate for
26 the operation of the program.
27 7. Assess participating carriers in accordance with
28 paragraph (j), and make advance interim assessments as may be
29 reasonable and necessary for organizational and interim
30 operating expenses. Interim assessments shall be credited as
31

1 offsets against any regular assessments due following the
2 close of the calendar year.
3 8. Appoint appropriate legal, actuarial, and other
4 committees as necessary to provide technical assistance in the
5 operation of the program, and in any other function within the
6 authority of the program.
7 9. Borrow money to effect the purposes of the program.
8 Any notes or other evidences of indebtedness of the program
9 which are not in default constitute legal investments for
10 carriers and may be carried as admitted assets.
11 10. To the extent necessary, increase the $5,000
12 deductible reinsurance requirement to adjust for the effects
13 of inflation.
14 (g) A reinsuring carrier may reinsure with the program
15 coverage of an eligible employee of a small employer, or any
16 dependent of such an employee, subject to each of the
17 following provisions:
18 1. With respect to a standard and basic health care
19 plan, the program must reinsure the level of coverage
20 provided; and, with respect to any other plan, the program
21 must reinsure the coverage up to, but not exceeding, the level
22 of coverage provided under the standard and basic health care
23 plan.
24 2. Except in the case of a late enrollee, a reinsuring
25 carrier may reinsure an eligible employee or dependent within
26 60 days after the commencement of the coverage of the small
27 employer. A newly employed eligible employee or dependent of a
28 small employer may be reinsured within 60 days after the
29 commencement of his or her coverage.
30 3. A small employer carrier may reinsure an entire
31 employer group within 60 days after the commencement of the

1 group's coverage under the plan. The carrier may choose to
2 reinsure newly eligible employees and dependents of the
3 reinsured group pursuant to subparagraph 1.
4 4. The program may not reimburse a participating
5 carrier with respect to the claims of a reinsured employee or
6 dependent until the carrier has paid incurred claims of at
7 least $5,000 in a calendar year for benefits covered by the
8 program. In addition, the reinsuring carrier shall be
9 responsible for 10 percent of the next $50,000 and 5 percent
10 of the next $100,000 of incurred claims during a calendar year
11 and the program shall reinsure the remainder.
12 5. The board annually shall adjust the initial level
13 of claims and the maximum limit to be retained by the carrier
14 to reflect increases in costs and utilization within the
15 standard market for health benefit plans within the state. The
16 adjustment shall not be less than the annual change in the
17 medical component of the "Consumer Price Index for All Urban
18 Consumers" of the Bureau of Labor Statistics of the Department
19 of Labor, unless the board proposes and the department
20 approves a lower adjustment factor.
21 6. A small employer carrier may terminate reinsurance
22 for all reinsured employees or dependents on any plan
23 anniversary.
24 7. The premium rate charged for reinsurance by the
25 program to a health maintenance organization that is approved
26 by the Secretary of Health and Human Services as a federally
27 qualified health maintenance organization pursuant to 42
28 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
29 requirements that limit the amount of risk that may be ceded
30 to the program, which requirements are more restrictive than
31 subparagraph 4., shall be reduced by an amount equal to that

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1 portion of the risk, if any, which exceeds the amount set
2 forth in subparagraph 4. which may not be ceded to the
3 program.
4 8. The board may consider adjustments to the premium
5 rates charged for reinsurance by the program for carriers that
6 use effective cost containment measures, including high-cost
7 case management, as defined by the board.
8 9. A reinsuring carrier shall apply its
9 case-management and claims-handling techniques, including, but
10 not limited to, utilization review, individual case
11 management, preferred provider provisions, other managed care
12 provisions or methods of operation, consistently with both
13 reinsured business and nonreinsured business.
14 (h)1. The board, as part of the plan of operation,
15 shall establish a methodology for determining premium rates to
16 be charged by the program for reinsuring small employers and
17 individuals pursuant to this section. The methodology shall
18 include a system for classification of small employers that
19 reflects the types of case characteristics commonly used by
20 small employer carriers in the state. The methodology shall
21 provide for the development of basic reinsurance premium
22 rates, which shall be multiplied by the factors set for them
23 in this paragraph to determine the premium rates for the
24 program. The basic reinsurance premium rates shall be
25 established by the board, subject to the approval of the
26 <u>commission</u> ~~department~~, and shall be set at levels which
27 reasonably approximate gross premiums charged to small
28 employers by small employer carriers for health benefit plans
29 with benefits similar to the standard and basic health benefit
30 plan. The premium rates set by the board may vary by
31 geographical area, as determined under this section, to

1 reflect differences in cost. The multiplying factors must be
2 established as follows:
3 a. The entire group may be reinsured for a rate that
4 is 1.5 times the rate established by the board.
5 b. An eligible employee or dependent may be reinsured
6 for a rate that is 5 times the rate established by the board.
7 2. The board periodically shall review the methodology
8 established, including the system of classification and any
9 rating factors, to assure that it reasonably reflects the
10 claims experience of the program. The board may propose
11 changes to the rates which shall be subject to the approval of
12 the commission ~~department~~.
13 (i) If a health benefit plan for a small employer
14 issued in accordance with this subsection is entirely or
15 partially reinsured with the program, the premium charged to
16 the small employer for any rating period for the coverage
17 issued must be consistent with the requirements relating to
18 premium rates set forth in s. 627.4106.
19 (j)1. Before March 1 of each calendar year, the board
20 shall determine and report to the department the program net
21 loss for the previous year, including administrative expenses
22 for that year, and the incurred losses for the year, taking
23 into account investment income and other appropriate gains and
24 losses.
25 2. Any net loss for the year shall be recouped by
26 assessment of the carriers, as follows:
27 a. The operating losses of the program shall be
28 assessed in the following order subject to the specified
29 limitations. The first tier of assessments shall be made
30 against reinsuring carriers in an amount which shall not
31 exceed 5 percent of each reinsuring carrier's premiums from

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1 health benefit plans covering small employers. If such
2 assessments have been collected and additional moneys are
3 needed, the board shall make a second tier of assessments in
4 an amount which shall not exceed 0.5 percent of each carrier's
5 health benefit plan premiums. Except as provided in paragraph
6 (n), risk-assuming carriers are exempt from all assessments
7 authorized pursuant to this section. The amount paid by a
8 reinsuring carrier for the first tier of assessments shall be
9 credited against any additional assessments made.
10 b. The board shall equitably assess carriers for
11 operating losses of the plan based on market share. The board
12 shall annually assess each carrier a portion of the operating
13 losses of the plan. The first tier of assessments shall be
14 determined by multiplying the operating losses by a fraction,
15 the numerator of which equals the reinsuring carrier's earned
16 premium pertaining to direct writings of small employer health
17 benefit plans in the state during the calendar year for which
18 the assessment is levied, and the denominator of which equals
19 the total of all such premiums earned by reinsuring carriers
20 in the state during that calendar year. The second tier of
21 assessments shall be based on the premiums that all carriers,
22 except risk-assuming carriers, earned on all health benefit
23 plans written in this state. The board may levy interim
24 assessments against carriers to ensure the financial ability
25 of the plan to cover claims expenses and administrative
26 expenses paid or estimated to be paid in the operation of the
27 plan for the calendar year prior to the association's
28 anticipated receipt of annual assessments for that calendar
29 year. Any interim assessment is due and payable within 30
30 days after receipt by a carrier of the interim assessment
31 notice. Interim assessment payments shall be credited against

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the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the department, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before March 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 90 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the department within 90 days following the end of the applicable calendar year, the department may evaluate the operations of the program and implement such amendments to the

1 plan of operation the department deems necessary to reduce
2 future losses and assessments.
3 5. If assessments exceed the amount of the actual
4 losses and administrative expenses of the program, the excess
5 shall be held as interest and used by the board to offset
6 future losses or to reduce program premiums. As used in this
7 paragraph, the term "future losses" includes reserves for
8 incurred but not reported claims.
9 6. Each carrier's proportion of the assessment shall
10 be determined annually by the board, based on annual
11 statements and other reports considered necessary by the board
12 and filed by the carriers with the board.
13 7. Provision shall be made in the plan of operation
14 for the imposition of an interest penalty for late payment of
15 an assessment.
16 8. A carrier may seek, from the commissioner, a
17 deferment, in whole or in part, from any assessment made by
18 the board. The department may defer, in whole or in part, the
19 assessment of a carrier if, in the opinion of the department,
20 the payment of the assessment would place the carrier in a
21 financially impaired condition. If an assessment against a
22 carrier is deferred, in whole or in part, the amount by which
23 the assessment is deferred may be assessed against the other
24 carriers in a manner consistent with the basis for assessment
25 set forth in this section. The carrier receiving such
26 deferment remains liable to the program for the amount
27 deferred and is prohibited from reinsuring any individuals or
28 groups in the program if it fails to pay assessments.
29 (k) Neither the participation in the program as
30 reinsuring carriers, the establishment of rates, forms, or
31 procedures, nor any other joint or collective action required

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1 by this act, may be the basis of any legal action, criminal or
2 civil liability, or penalty against the program or any of its
3 carriers either jointly or separately.
4 (l) The board, as part of the plan of operation, shall
5 develop standards setting forth the manner and levels of
6 compensation to be paid to agents for the sale of basic and
7 standard health benefit plans. In establishing such
8 standards, the board shall take into consideration the need to
9 assure the broad availability of coverages, the objectives of
10 the program, the time and effort expended in placing the
11 coverage, the need to provide ongoing service to the small
12 employer, the levels of compensation currently used in the
13 industry, and the overall costs of coverage to small employers
14 selecting these plans.
15 (m) The board shall monitor compliance with this
16 section, including the market conduct of small employer
17 carriers, and shall report to the department any unfair trade
18 practices and misleading or unfair conduct by a small employer
19 carrier that has been reported to the board by agents,
20 consumers, or any other person. The department shall
21 investigate all reports and, upon a finding of noncompliance
22 with this section or of unfair or misleading practices, shall
23 take action against the small employer carrier as permitted
24 under the insurance code or chapter 641. The board is not
25 given investigatory or regulatory powers, but must forward all
26 reports of cases or abuse or misrepresentation to the
27 department.
28 (n) Notwithstanding paragraph (j), the administrative
29 expenses of the program shall be recouped by assessment of
30 risk-assuming carriers and reinsuring carriers and such
31 amounts shall not be considered part of the operating losses

1 of the plan for the purposes of this paragraph. Each
2 carrier's portion of such administrative expenses shall be
3 determined by multiplying the total of such administrative
4 expenses by a fraction, the numerator of which equals the
5 carrier's earned premium pertaining to direct writing of small
6 employer health benefit plans in the state during the calendar
7 year for which the assessment is levied, and the denominator
8 of which equals the total of such premiums earned by all
9 carriers in the state during such calendar year.
10 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
11 PLANS.--
12 (a)1. By May 15, 1993, the commissioner shall appoint
13 a health benefit plan committee composed of four
14 representatives of carriers which shall include at least two
15 representatives of HMOs, at least one of which is a staff
16 model HMO, two representatives of agents, four representatives
17 of small employers, and one employee of a small employer. The
18 carrier members shall be selected from a list of individuals
19 recommended by the board. The commissioner may require the
20 board to submit additional recommendations of individuals for
21 appointment. As alliances are established under s. 408.702,
22 each alliance shall also appoint an additional member to the
23 committee.
24 2. The committee shall develop changes to the form and
25 level of coverages for the standard health benefit plan and
26 the basic health benefit plan, and shall submit the forms, and
27 levels of coverages to the department by September 30, 1993.
28 The department must approve such forms and levels of coverages
29 by November 30, 1993, and may return the submissions to the
30 committee for modification on a schedule that allows the
31 department to grant final approval by November 30, 1993.

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1 3. The plans shall comply with all of the requirements
2 of this subsection.
3 4. The plans must be filed with and approved by the
4 department prior to issuance or delivery by any small employer
5 carrier.
6 5. After approval of the revised health benefit plans,
7 if the department determines that modifications to a plan
8 might be appropriate, the commissioner shall appoint a new
9 health benefit plan committee in the manner provided in
10 subparagraph 1. to submit recommended modifications to the
11 department for approval.
12 (b)1. Each small employer carrier issuing new health
13 benefit plans shall offer to any small employer, upon request,
14 a standard health benefit plan and a basic health benefit plan
15 that meets the criteria set forth in this section.
16 2. For purposes of this subsection, the terms
17 "standard health benefit plan" and "basic health benefit plan"
18 mean policies or contracts that a small employer carrier
19 offers to eligible small employers that contain:
20 a. An exclusion for services that are not medically
21 necessary or that are not covered preventive health services;
22 and
23 b. A procedure for preauthorization by the small
24 employer carrier, or its designees.
25 3. A small employer carrier may include the following
26 managed care provisions in the policy or contract to control
27 costs:
28 a. A preferred provider arrangement or exclusive
29 provider organization or any combination thereof, in which a
30 small employer carrier enters into a written agreement with
31 the provider to provide services at specified levels of

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1 reimbursement or to provide reimbursement to specified
2 providers. Any such written agreement between a provider and a
3 small employer carrier must contain a provision under which
4 the parties agree that the insured individual or covered
5 member has no obligation to make payment for any medical
6 service rendered by the provider which is determined not to be
7 medically necessary. A carrier may use preferred provider
8 arrangements or exclusive provider arrangements to the same
9 extent as allowed in group products that are not issued to
10 small employers.
11 b. A procedure for utilization review by the small
12 employer carrier or its designees.
13
14 This subparagraph does not prohibit a small employer carrier
15 from including in its policy or contract additional managed
16 care and cost containment provisions, subject to the approval
17 of the department, which have potential for controlling costs
18 in a manner that does not result in inequitable treatment of
19 insureds or subscribers. The carrier may use such provisions
20 to the same extent as authorized for group products that are
21 not issued to small employers.
22 4. The standard health benefit plan shall include:
23 a. Coverage for inpatient hospitalization;
24 b. Coverage for outpatient services;
25 c. Coverage for newborn children pursuant to s.
26 627.6575;
27 d. Coverage for child care supervision services
28 pursuant to s. 627.6579;
29 e. Coverage for adopted children upon placement in the
30 residence pursuant to s. 627.6578;
31 f. Coverage for mammograms pursuant to s. 627.6613;

1 g. Coverage for handicapped children pursuant to s.
2 627.6615;
3 h. Emergency or urgent care out of the geographic
4 service area; and
5 i. Coverage for services provided by a hospice
6 licensed under s. 400.602 in cases where such coverage would
7 be the most appropriate and the most cost-effective method for
8 treating a covered illness.
9 5. The standard health benefit plan and the basic
10 health benefit plan may include a schedule of benefit
11 limitations for specified services and procedures. If the
12 committee develops such a schedule of benefits limitation for
13 the standard health benefit plan or the basic health benefit
14 plan, a small employer carrier offering the plan must offer
15 the employer an option for increasing the benefit schedule
16 amounts by 4 percent annually.
17 6. The basic health benefit plan shall include all of
18 the benefits specified in subparagraph 4.; however, the basic
19 health benefit plan shall place additional restrictions on the
20 benefits and utilization and may also impose additional cost
21 containment measures.
22 7. Sections 627.419(2), (3), and (4), 627.6574,
23 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668,
24 and 627.66911 apply to the standard health benefit plan and to
25 the basic health benefit plan. However, notwithstanding said
26 provisions, the plans may specify limits on the number of
27 authorized treatments, if such limits are reasonable and do
28 not discriminate against any type of provider.
29 8. Each small employer carrier that provides for
30 inpatient and outpatient services by allopathic hospitals may
31 provide as an option of the insured similar inpatient and

1 outpatient services by hospitals accredited by the American
2 Osteopathic Association when such services are available and
3 the osteopathic hospital agrees to provide the service.
4 (c) If a small employer rejects, in writing, the
5 standard health benefit plan and the basic health benefit
6 plan, the small employer carrier may offer the small employer
7 a limited benefit policy or contract.
8 (d)1. Upon offering coverage under a standard health
9 benefit plan, a basic health benefit plan, or a limited
10 benefit policy or contract for any small employer, the small
11 employer carrier shall provide such employer group with a
12 written statement that contains, at a minimum:
13 a. An explanation of those mandated benefits and
14 providers that are not covered by the policy or contract;
15 b. An explanation of the managed care and cost control
16 features of the policy or contract, along with all appropriate
17 mailing addresses and telephone numbers to be used by insureds
18 in seeking information or authorization; and
19 c. An explanation of the primary and preventive care
20 features of the policy or contract.
21
22 Such disclosure statement must be presented in a clear and
23 understandable form and format and must be separate from the
24 policy or certificate or evidence of coverage provided to the
25 employer group.
26 2. Before a small employer carrier issues a standard
27 health benefit plan, a basic health benefit plan, or a limited
28 benefit policy or contract, it must obtain from the
29 prospective policyholder a signed written statement in which
30 the prospective policyholder:
31

1 a. Certifies as to eligibility for coverage under the
2 standard health benefit plan, basic health benefit plan, or
3 limited benefit policy or contract;
4 b. Acknowledges the limited nature of the coverage and
5 an understanding of the managed care and cost control features
6 of the policy or contract;
7 c. Acknowledges that if misrepresentations are made
8 regarding eligibility for coverage under a standard health
9 benefit plan, a basic health benefit plan, or a limited
10 benefit policy or contract, the person making such
11 misrepresentations forfeits coverage provided by the policy or
12 contract; and
13 d. If a limited plan is requested, acknowledges that
14 the prospective policyholder had been offered, at the time of
15 application for the insurance policy or contract, the
16 opportunity to purchase any health benefit plan offered by the
17 carrier and that the prospective policyholder had rejected
18 that coverage.
19
20 A copy of such written statement shall be provided to the
21 prospective policyholder no later than at the time of delivery
22 of the policy or contract, and the original of such written
23 statement shall be retained in the files of the small employer
24 carrier for the period of time that the policy or contract
25 remains in effect or for 5 years, whichever period is longer.
26 3. Any material statement made by an applicant for
27 coverage under a health benefit plan which falsely certifies
28 as to the applicant's eligibility for coverage serves as the
29 basis for terminating coverage under the policy or contract.
30 4. Each marketing communication that is intended to be
31 used in the marketing of a health benefit plan in this state

must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

(e)1. A small employer carrier may not use any policy, contract, or form~~, or rate~~ under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the carrier insurer has filed it with the department and the department has approved it under ss. 627.410, ~~627.4106,~~and 627.411.

2. A small employer carrier may not use any rate until the carrier has filed it with the commission and the commission has approved it under ss. 627.410 and 627.411.~~A small employer carrier must file with the department by December 1, 1993, the standard and basic health benefit plan that it intends to initially use to comply with this subsection during calendar year 1994, together with the rates therefor, and the department must approve the submissions by January 1, 1994.~~

(16) RULEMAKING AUTHORITY.--The department may adopt rules to administer this section, including rules governing compliance by small employer carriers and small employers, except for rules related to rates. The commission may adopt rules to administer this section related to rates.

Section 70. Subsections (2), (4), and (7) of section 627.6745, Florida Statutes, are amended to read:

627.6745 Loss ratio standards; public rate hearings.--

(2) Each entity providing Medicare supplement policies or certificates in this state shall file annually its rates, rating schedules, and supporting documentation with the commission demonstrating that it is in compliance with the applicable loss ratio standards of this code. The filing of

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1 rates and rating schedules shall demonstrate that the actual
2 and expected losses in relation to premiums comply with the
3 requirements of this section.
4 (4) Each insurer providing Medicare supplement
5 insurance to residents of this state shall annually submit to
6 the commission ~~department~~ information on actual loss ratios on
7 forms prescribed by the National Association of Insurance
8 Commissioners pursuant to the Omnibus Budget Reconciliation
9 Act of 1990 (Pub. L. No. 101-508).
10 (7) The commission ~~department~~ shall adopt a written
11 policy statement regarding the holding of public hearings
12 prior to approval of any premium increases for Medicare
13 supplement insurance policies.
14 Section 71. Section 627.678, Florida Statutes, is
15 amended to read:
16 627.678 Rules.--
17 (1) For the effective protection of the public
18 interest, the department shall have full power and authority
19 to adopt, promulgate, and enforce separate rules pertaining to
20 issuance and use of each type of credit insurance defined in
21 s. 627.677, except for matters related to rates. The
22 commission may adopt rules related to rates for credit life
23 and disability insurance consistent with the provisions of
24 this part.
25 (2) Rules made pursuant to this section shall be
26 principally designed, and shall be promulgated with the
27 purpose of protecting the borrower from excessive charges by
28 or collected through the lender for insurance in relation to
29 the amount of the loan, to avoid duplication or overlapping of
30 insurance coverage and to avoid loss of the borrower's funds
31 by short-rate cancellation or termination of such insurance.

1 However, nothing in such rules shall be construed to authorize
2 the department to prohibit operation of normal dividend
3 distributions under participating insurance contracts.
4 Section 72. Section 627.6785, Florida Statutes, is
5 amended to read:
6 627.6785 Filing of rates with department.--
7 (1) Credit disability and credit life insurers shall
8 file with the commission ~~department~~ a copy of all rates and
9 any rate changes used in this state, subject to the procedures
10 specified in s. 627.410.
11 (2) No credit disability rate and no credit life rate
12 shall exceed the maximum allowable rate promulgated by the
13 commission ~~department~~.
14 (3) No credit life rate or credit disability rate
15 shall be deemed to comply with the allowable rate criteria
16 contained in this part if the benefits provided are not
17 reasonable in relation to the premium charged or if the rate
18 ~~it~~ contains age restrictions which make ineligible for credit
19 life those debtors or lessors 70 years of age or under, or for
20 credit disability those debtors or lessors 65 years of age or
21 under, at the time the indebtedness is incurred. However, for
22 credit life, the coverage shall be provided, at a minimum,
23 until the earlier of the maturity date of the loan or the loan
24 anniversary at age 71, and, for credit disability, the
25 coverage shall be provided, at a minimum, until the earlier of
26 the maturity date of the loan or the loan anniversary at age
27 66.
28 Section 73. Section 627.682, Florida Statutes, is
29 amended to read:
30 627.682 Filing, approval of forms.--All forms of
31 policies, certificates of insurance, statements of insurance,

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applications for insurance, binders, endorsements, and riders of credit life or disability insurance delivered or issued for delivery in this state shall be filed with and approved by the department before use as provided in ss. 627.410 and 627.411. In addition to grounds as specified in s. 627.411, the department, upon compliance with the procedures set forth in s. 627.410, shall disapprove any such form and may withdraw any previous approval thereof ~~if the benefits provided therein are not reasonable in relation to the premiums charged, or~~ if it contains provisions that ~~which~~ are unjust, unfair, inequitable, misleading, or deceptive or that ~~which~~ encourage misrepresentation of such policy.

Section 74. Subsection (9) of section 627.727, Florida Statutes, is amended to read:

627.727 Motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.--

(9) Insurers may offer policies of uninsured motorist coverage containing policy provisions, in language approved by the department, establishing that if the insured accepts this offer:

(a) The coverage provided as to two or more motor vehicles shall not be added together to determine the limit of insurance coverage available to an injured person for any one accident, except as provided in paragraph (c).

(b) If at the time of the accident the injured person is occupying a motor vehicle, the uninsured motorist coverage available to her or him is the coverage available as to that motor vehicle.

(c) If the injured person is occupying a motor vehicle which is not owned by her or him or by a family member residing with her or him, the injured person is entitled to

1 the highest limits of uninsured motorist coverage afforded for
2 any one vehicle as to which she or he is a named insured or
3 insured family member. Such coverage shall be excess over the
4 coverage on the vehicle the injured person is occupying.
5 (d) The uninsured motorist coverage provided by the
6 policy does not apply to the named insured or family members
7 residing in her or his household who are injured while
8 occupying any vehicle owned by such insureds for which
9 uninsured motorist coverage was not purchased.
10 (e) If, at the time of the accident the injured person
11 is not occupying a motor vehicle, she or he is entitled to
12 select any one limit of uninsured motorist coverage for any
13 one vehicle afforded by a policy under which she or he is
14 insured as a named insured or as an insured resident of the
15 named insured's household.
16
17 In connection with the offer authorized by this subsection,
18 insurers shall inform the named insured, applicant, or lessee,
19 on a form approved by the department, of the limitations
20 imposed under this subsection and that such coverage is an
21 alternative to coverage without such limitations. If this
22 form is signed by a named insured, applicant, or lessee, it
23 shall be conclusively presumed that there was an informed,
24 knowing acceptance of such limitations. When the named
25 insured, applicant, or lessee has initially accepted such
26 limitations, such acceptance shall apply to any policy which
27 renews, extends, changes, supersedes, or replaces an existing
28 policy unless the named insured requests deletion of such
29 limitations and pays the appropriate premium for such
30 coverage. Any insurer who provides coverage which includes
31 the limitations provided in this subsection shall file revised

premium rates with the commission ~~department~~ for such uninsured motorist coverage to take effect prior to initially providing such coverage. The revised rates shall reflect the anticipated reduction in loss costs attributable to such limitations but shall in any event reflect a reduction in the uninsured motorist coverage premium of at least 20 percent for policies with such limitations. Such filing shall not increase the rates for coverage which does not contain the limitations authorized by this subsection, and such rates shall remain in effect until the insurer demonstrates the need for a change in uninsured motorist rates pursuant to s. 627.0651.

Section 75. Subsection (1) of section 627.780, Florida Statutes, is amended to read:

627.780 Illegal dealings in risk premium.--

(1) A person may not knowingly quote, charge, accept, collect, or receive a premium for title insurance other than the premium adopted by the commission ~~department~~.

Section 76. Section 627.782, Florida Statutes, is amended to read:

627.782 Adoption of rates.--

(1) Subject to the rating provisions of this code, the commission ~~department~~ must adopt a rule specifying the premium to be charged in this state by title insurers for the respective types of title insurance contracts and, for policies issued through agents or agencies, the percentage of such premium required to be retained by the title insurer which shall not be less than 30 percent. However, in a transaction subject to the Real Estate Settlement Procedures Act of 1974, 12 U.S.C. ss. 2601 et seq., as amended, no portion of the premium attributable to providing a primary

1 title service shall be paid to or retained by any person who
2 does not actually perform or is not liable for the performance
3 of such service. The commission ~~department~~ may, by rule,
4 establish limitations on related title services charges made
5 in addition to the premium based upon the expenses associated
6 with the services rendered and other relevant factors.
7 (2) In adopting premium rates, the commission
8 ~~department~~ must give due consideration to the following:
9 (a) The title insurers' loss experience and
10 prospective loss experience under closing protection letters
11 and policy liabilities.
12 (b) A reasonable margin for underwriting profit and
13 contingencies, including contingent liability under s.
14 627.7865, sufficient to allow title insurers, agents, and
15 agencies to earn a rate of return on their capital that will
16 attract and retain adequate capital investment in the title
17 insurance business and maintain an efficient title insurance
18 delivery system.
19 (c) Past expenses and prospective expenses for
20 administration and handling of risks.
21 (d) Liability for defalcation.
22 (e) Other relevant factors.
23 (3) Rates may be grouped by classification or schedule
24 and may differ as to class of risk assumed.
25 (4) Rates may not be excessive, inadequate, or
26 unfairly discriminatory.
27 (5) The premium applies to each $100 of insurance
28 issued to an insured.
29 (6) The premium rates apply throughout this state.
30 (7) The commission ~~department~~ shall, in accordance
31 with the standards provided in subsection (2), review the

premium as needed, but not less frequently than once every 3 years, and shall, based upon the review required by this subsection, revise the premium if the results of the review so warrant.

(8) The commission ~~department~~ may, by rule, require licensees under this part to annually submit statistical information, including loss and expense data, as the department determines to be necessary to analyze premium rates, retention rates, and the condition of the title insurance industry.

Section 77. Section 627.7825, Florida Statutes, is amended to read:

627.7825 Alternative rate adoption.--Notwithstanding s. 627.782(1) and (7), the premium rates to be charged by title insurers in this state from July 1, 1999, through June 30, 2002, for title insurance contracts shall be as set forth in this section. The rules related to premium rates for title insurance, including endorsements, adopted by the department and in effect on April 1, 1999, that do not conflict with the provisions of this section shall remain in effect until June 30, 2002. The commission ~~department~~ shall not grant a rate deviation pursuant to s. 627.783 for the premium rates established in this section and in department rules in effect on April 1, 1999, which ~~that~~ do not conflict with this section.

(1) ORIGINAL TITLE INSURANCE RATES.--

(a) For owner and leasehold title insurance:

1. The premium for the original owner's or for leasehold insurance shall be:

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	Per Thousand	Minimum Insurer Retention
From $0 to $100,000 of liability written	$5.75	30%
From $100,000 to $1 million, add	$5.00	30%
Over $1 million and up to $5 million, add	$2.50	35%
Over $5 million and up to $10 million, add	$2.25	40%
Over $10 million, add	$2.00	40%

The minimum premium for all conveyances except multiple conveyances shall be $100. The minimum premium for multiple conveyances on the same property shall be $60.

2. In all cases, the owner's policy shall be issued for the full insurable value of the premises.

(b) For mortgage title insurance:

1. The premium for the original mortgage title insurance shall be:

	Per Thousand	Minimum Insurer Retention
From $0 to $100,000 of liability written	$5.75	30%
From $100,000 to $1 million, add	$5.00	30%
Over $1 million and up to $5 million, add	$2.50	35%
Over $5 million and up to $10 million, add	$2.25	40%
Over $10 million, add	$2.00	40%

The minimum premium for all conveyances except multiple conveyances shall be $100. The minimum premium for multiple conveyances on the same property shall be $60.

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2. A mortgage title insurance policy shall not be issued for an amount less than the full principal debt. A policy may, however, be issued for an amount up to 25 percent in excess of the principal debt to cover interest and foreclosure costs.

(2) REISSUE RATES.--

(a) The reissue premium charge for owner's, mortgage, and leasehold title insurance policies shall be:

	Per Thousand
Up to $100,000 of liability written	$3.30
Over $100,000 and up to $1 million, add	$3.00
Over $1 million and up to $10 million, add	$2.00
Over $10 million, add	$1.50

The minimum premium shall be $100.

(b) Provided a previous owner's policy was issued insuring the seller or the mortgagor in the current transaction and that both the reissuing agent and the reissuing underwriter retain for their respective files copies of the prior owner's policy or policies, the reissue premium rates in paragraph (a) shall apply to:

1. Policies on real property which is unimproved except for roads, bridges, drainage facilities, and utilities if the current owner's title has been insured prior to the application for a new policy;

2. Policies issued with an effective date of less than 3 years after the effective date of the policy insuring the seller or mortgagor in the current transaction; or

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1 3. Mortgage policies issued on refinancing of property
2 insured by an original owner's policy which insured the title
3 of the current mortgagor.
4 (c) Any amount of new insurance, in the aggregate, in
5 excess of the amount under the previous policy shall be
6 computed at the original owner's or leasehold rates, as
7 provided in subsection (1).
8 (3) NEW HOME PURCHASE DISCOUNT.--Provided the seller
9 has not leased or occupied the premises, the original premium
10 for a policy on the first sale of residential property with a
11 one to four family improvement that is granted a certificate
12 of occupancy shall be discounted by the amount of premium paid
13 for any prior loan policies insuring the lien of a mortgage
14 executed by the seller on the premises. In the case of prior
15 loan policies insuring the lien of a mortgage on multiple
16 units or parcels, the discount shall be prorated by dividing
17 the amount of the premium paid for the prior loan policies by
18 the total number of units or parcels without regard to varying
19 unit or parcel value. The minimum new home purchase premium
20 shall be $200. The new home purchase discount may not be
21 combined with any other reduction from original premium rates
22 provided for in this section. The insurer shall reserve for
23 unearned premiums only on the excess amount of the policy over
24 the amount of the actual or prorated amount of the prior loan
25 policy.
26 (4) SUBSTITUTION LOANS RATES.--
27 (a) When the same borrower and the same lender make a
28 substitution loan on the same property, the title to which was
29 insured by an insurer in connection with the previous loan,
30 the following premium rates for substitution loans shall
31 apply:

Age of Previous Loan	Premium Rates
3 years or under	30 percent of the original rates
From 3 to 4 years	40 percent of the original rates
From 4 to 5 years	50 percent of the original rates
From 5 to 10 years	60 percent of the original rates
Over 10 years	100 percent of original rates

The minimum premium for substitution loan rates shall be $100.

(b) At the time a substitution loan is made, the unpaid principal balance of the previous loan will be considered the amount of insurance in force on which the foregoing premium rates shall be calculated. To these rates shall be added the original rates in the applicable schedules for any new insurance, including any difference between the unpaid principal balance of the previous loan and the amount of the new loan.

(c) In the case of a substitution loan of $250,000 or more, when the same borrower and any lender make a substitution loan on the same property, the title to which was insured by an insurer in connection with the previous loan, the premium for such substitution loans shall be the rates as set forth in paragraphs (a) and (b).

Section 78. Section 627.783, Florida Statutes, is amended to read:

627.783 Rate deviation.--

(1) A title insurer may petition the <u>commission</u> ~~department~~ for an order authorizing a specific deviation from the adopted premium, and a title insurer or title insurance agent may petition the <u>commission</u> ~~department~~ for an order authorizing and permitting a specific deviation above the

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reasonable charge for related title services rendered specified in s. 627.782(1). The petition shall be in writing and sworn to and shall set forth allegations of fact upon which the petitioner will rely, including the petitioner's reasons for requesting the deviation. Any authorized title insurer, agent, or agency may join in the petition for like authority to deviate or may file a separate petition praying for like authority or opposing the deviation. The commission ~~department~~ shall rule on all such petitions simultaneously.

(2) If, in the judgment of the commission ~~department~~, the requested deviation is not justified, the commission ~~department~~ may enter an order denying the petition. An order granting a petition constitutes an amendment to the adopted premium as to the petitioners named in the order, and is subject to s. 627.782.

Section 79. Section 627.793, Florida Statutes, is amended to read:

627.793 Rulemaking authority.--The department may ~~is authorized to~~ adopt rules implementing the provisions of this part, except for those provisions related to rates. The commission may adopt rules implementing the provisions of this part relating to rates.

Section 80. Subsection (6) of section 627.9407, Florida Statutes, is amended to read:

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.--

(6) LOSS RATIO AND RESERVE STANDARDS.--

(a) The department shall adopt rules establishing ~~loss ratio and~~ reserve standards for long-term-care ~~long-term care~~ insurance policies. The rules must contain a specific reference to long-term-care ~~long-term care~~ insurance policies.

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Such ~~loss ratio and~~ reserve standards shall be established at levels ~~at which benefits are reasonable in relation to premiums and~~ that provide for adequate reserving of the long-term-care ~~long-term care~~ insurance risk.

(b) The commission shall adopt rules establishing loss-ratio standards for long-term-care policies. The rules must contain a specific reference to long-term-care insurance policies. Such loss-ratio standards shall be established at levels at which benefits are reasonable in relation to premiums.

Section 81. Section 636.017, Florida Statutes, is amended to read:

636.017 Rates and charges.--

(1) The rates charged by any prepaid limited health service organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The commission ~~department~~ may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this section.

(2) In determining whether a rate is in compliance with subsection (1), the commission ~~department~~ must take into consideration the limited services provided, the method in which the services are provided, and the method of provider payment. This section may not be construed as authorizing the commission ~~department~~ to establish by rule minimum loss ratios for prepaid limited health service organizations' rates.

Section 82. Present subsections (4) through (21) of section 641.19, Florida Statutes, are redesignated as subsections (5) through (22), respectively, and a new subsection (4) is added to that section to read:

641.19 Definitions.--As used in this part, the term:

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1 (4) "Commission" means the Insurance Rating
2 Commission.
3 Section 83. Subsections (2), (3), and (38) of section
4 641.31, Florida Statutes, are amended to read:
5 641.31 Health maintenance contracts.--
6 (2) The rates charged by any health maintenance
7 organization to its subscribers shall not be excessive,
8 inadequate, or unfairly discriminatory or follow a rating
9 methodology that is inconsistent, indeterminate, or ambiguous
10 or encourages misrepresentation or misunderstanding. The
11 commission ~~department~~, in accordance with generally accepted
12 actuarial practice as applied to health maintenance
13 organizations, may define by rule what constitutes excessive,
14 inadequate, or unfairly discriminatory rates and may require
15 whatever information it deems necessary to determine that a
16 rate or proposed rate meets the requirements of this
17 subsection.
18 (3)(a) If a health maintenance organization desires to
19 amend any contract with its subscribers or any certificate or
20 member handbook, or desires to change any basic health
21 maintenance contract, certificate, grievance procedure, or
22 member handbook form, or application form where written
23 application is required and is to be made a part of the
24 contract, or printed amendment, addendum, rider, or
25 endorsement form or form of renewal certificate, it may do so,
26 upon filing with the department the proposed change or
27 amendment. Any proposed change shall be effective
28 immediately, subject to disapproval by the department.
29 Following receipt of notice of such disapproval or withdrawal
30 of approval, no health maintenance organization shall issue or
31

1 use any form disapproved by the department or as to which the
2 department has withdrawn approval.
3 (b) Any change in the rate is subject to paragraph (d)
4 and requires at least 30 days' advance written notice to the
5 subscriber. In the case of a group member, there may be a
6 contractual agreement with the health maintenance organization
7 to have the employer provide the required notice to the
8 individual members of the group.
9 (c) The department shall disapprove any form filed
10 under this subsection, or withdraw any previous approval
11 thereof, if the form:
12 1. Is in any respect in violation of, or does not
13 comply with, any provision of this part or rule adopted
14 thereunder.
15 2. Contains or incorporates by reference, where such
16 incorporation is otherwise permissible, any inconsistent,
17 ambiguous, or misleading clauses or exceptions and conditions
18 which deceptively affect the risk purported to be assumed in
19 the general coverage of the contract.
20 3. Has any title, heading, or other indication of its
21 provisions which is misleading.
22 4. Is printed or otherwise reproduced in such a manner
23 as to render any material provision of the form substantially
24 illegible.
25 5. Contains provisions which are unfair, inequitable,
26 or contrary to the public policy of this state or which
27 encourage misrepresentation.
28 6. Excludes coverage for human immunodeficiency virus
29 infection or acquired immune deficiency syndrome or contains
30 limitations in the benefits payable, or in the terms or
31 conditions of such contract, for human immunodeficiency virus

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infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(d) Any change in rates charged for the contract must be filed with the commission ~~department~~ not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the commission ~~department~~. The approval of the filing by the commission ~~department~~ constitutes a waiver of any unexpired portion of such waiting period. The commission ~~department~~ may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved.

(e) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(38)(a) Notwithstanding any other provision of this part, a health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health maintenance organization may choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization

1 provider contract. The rider may not require a referral from
2 the health maintenance organization for the point-of-service
3 benefits.
4 (b) A health maintenance organization offering a
5 point-of-service rider under this subsection must have a valid
6 certificate of authority issued under the provisions of the
7 chapter, must have been licensed under this chapter for a
8 minimum of 3 years, and must at all times that it has riders
9 in effect maintain a minimum surplus of $5 million.
10 (c) Premiums paid in for the point-of-service riders
11 may not exceed 15 percent of total premiums for all health
12 plan products sold by the health maintenance organization
13 offering the rider. If the premiums paid for point-of-service
14 riders exceed 15 percent, the health maintenance organization
15 must notify the department and the commission and, once this
16 fact is known, must immediately cease offering such a rider
17 until it is in compliance with the rider premium cap.
18 (d) Notwithstanding the limitations of deductibles and
19 copayment provisions in this part, a point-of-service rider
20 may require the subscriber to pay a reasonable copayment for
21 each visit for services provided by a noncontracted provider
22 chosen at the time of the service. The copayment by the
23 subscriber may either be a specific dollar amount or a
24 percentage of the reimbursable provider charges covered by the
25 contract and must be paid by the subscriber to the
26 noncontracted provider upon receipt of covered services. The
27 point-of-service rider may require that a reasonable annual
28 deductible for the expenses associated with the
29 point-of-service rider be met and may include a lifetime
30 maximum benefit amount. The rider must include the language
31 required by s. 627.6044 and must comply with copayment limits

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1 described in s. 627.6471. Section 641.315(2) and (3) does not
2 apply to a point-of-service rider authorized under this
3 subsection.
4 (e) The term "point of service" may not be used by a
5 health maintenance organization except with riders permitted
6 under this section or with forms approved by the department in
7 which a point-of-service product is offered with an indemnity
8 carrier.
9 (f) A point-of-service rider must be filed and
10 approved under ss. 627.410 and 627.411.
11 Section 84. Paragraph (b) of subsection (10) of
12 section 641.3903, Florida Statutes, is amended to read:
13 641.3903 Unfair methods of competition and unfair or
14 deceptive acts or practices defined.--The following are
15 defined as unfair methods of competition and unfair or
16 deceptive acts or practices:
17 (10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED
18 CHARGES FOR HEALTH MAINTENANCE COVERAGE.--
19 (b) Knowingly collecting as a premium or charge for
20 health maintenance coverage any sum in excess of or less than
21 the premium or charge applicable to health maintenance
22 coverage, in accordance with the applicable classifications
23 and rates as filed with the commission ~~department~~, and as
24 specified in the health maintenance contract.
25 Section 85. Subsection (3) of section 641.3922,
26 Florida Statutes, is amended to read:
27 641.3922 Conversion contracts; conditions.--Issuance
28 of a converted contract shall be subject to the following
29 conditions:
30 (3) CONVERSION PREMIUM.--The premium for the converted
31 contract shall be determined in accordance with premium rates

applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the standard risk rate, as established by the commission ~~department~~ under s. 627.6675(3). The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

Section 86. Present subsections (2) through (11) of section 641.402, Florida Statutes, are redesignated as subsections (3) through (12), respectively, and a new subsection (2) is added to that section to read:

641.402 Definitions.--As used in this part, the term:

(2) "Commission" means the Insurance Rating Commission.

Section 87. Subsection (2) and (7) of section 641.42, Florida Statutes, are amended to read:

641.42 Prepaid health clinic contracts.--

(2) The rates charged by any clinic to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The commission ~~department~~, in accordance with generally accepted actuarial practice, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information the commission ~~department~~ deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(7)(a) If a clinic desires to amend any contract with any of its subscribers or desires to change any rate charged for the contract, the clinic may do so, upon filing with the

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1 department the proposed amendment <u>to the contract</u> or <u>upon</u>
2 <u>filing with the commission the proposed</u> change in rates.
3 (b) No prepaid health clinic contract form or
4 application form when written application is required and is
5 to be made a part of the policy or contract, or no printed
6 amendment, addendum, rider, or endorsement form or form of
7 renewal certificate, shall be delivered or issued for delivery
8 in this state, unless the form has been filed with the
9 department at its offices in Tallahassee by or in behalf of
10 the clinic which proposes to use such form and has been
11 approved by the department. Every such filing shall be made
12 not less than 30 days in advance of any such use or delivery.
13 At the expiration of such 30 days, the form so filed shall be
14 deemed approved unless prior to the end of the 30 days the
15 form has been affirmatively approved or disapproved by the
16 department. The approval of any such form by the department
17 constitutes a waiver of any unexpired portion of such waiting
18 period. The department may extend by not more than an
19 additional 15 days the period within which the department may
20 so affirmatively approve or disapprove any such form, by
21 giving notice of such extension before the expiration of the
22 initial 30-day period. At the expiration of any such period
23 as so extended, and in the absence of such prior affirmative
24 approval or disapproval, such form shall be deemed approved.
25 The department may, for cause, withdraw a previous approval.
26 No clinic shall issue or use any form which has been
27 disapproved by the department or any form for which the
28 department has withdrawn approval.
29 (c) The department shall disapprove any form filed
30 under this subsection, or withdraw any previous approval of
31 the form, only if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted under this part.

2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

3. Has a misleading title, misleading heading, or other indication of the provisions of the form which is misleading.

4. Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(8) No rate or rate change shall be used unless the rate has been filed with and approved by the commission pursuant to the same procedures as provided in subsection (7). The commission shall disapprove any such rate, or withdraw any previous approval, only if the rate

~~5.~~ provides benefits that ~~which~~ are unreasonable in relation to the rate charged or contains provisions that ~~which~~ are unfair, inequitable, or contrary to the public policy of this state or encourage misrepresentation.

~~(d)~~ In determining whether the benefits are reasonable in relation to the rate charged, the commission ~~department~~, in accordance with reasonable actuarial techniques, shall consider:

(a)~~1.~~ Past loss experience and prospective loss experience.

(b)~~2.~~ Allocation of expenses.

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(c)~~3.~~ Risk and contingency margins, along with justification of such margins.

(d)~~4.~~ Acquisition costs.

(e)~~5.~~ Other factors deemed appropriate by the commission ~~department~~, based on sound actuarial techniques.

Section 88. Section 642.027, Florida Statutes, is amended to read:

642.027 Premium rates.--No policy of legal expense insurance may be issued in this state unless the premium rates for the insurance have been filed with and approved by the commission ~~department~~. Premium rates shall be established and justified in accordance with generally accepted insurance principles, including, but not limited to, the experience or judgment of the insurer making the rate filing or actuarial computations. The commission ~~department~~ may disapprove rates that are excessive, inadequate, or unfairly discriminatory. Rates are not unfairly discriminatory because they are averaged broadly among persons insured under group, blanket, or franchise policies. The commission ~~department~~ may require the submission of any other information reasonably necessary in determining whether to approve or disapprove a filing made under this section or s. 642.025.

Section 89. Subsection (2) of section 648.33, Florida Statutes, is amended to read:

648.33 Bail bond rates.--

(2) It is unlawful for a bail bond agent to execute a bail bond without charging a premium therefor, and the premium rate may not exceed or be less than the premium rate as filed with and approved by the commission ~~department~~.

Section 90. Effective upon this act becoming law, the Governor may make appointments to the Insurance Rating

1 Commission pursuant to section 624.371, Florida Statutes, as
2 created by this act, for terms of office beginning on January
3 1, 2001.
4 Section 91. Effective January 1, 2001, all activities
5 and functions of the Department of Insurance related to
6 reviewing, approving, or establishing rates for insurers and
7 other entities regulated by the department are transferred to
8 the Insurance Rating Commission pursuant to a type two
9 transfer as defined in section 20.06, Florida Statutes.
10 Effective upon this act becoming law, the Department of
11 Insurance and the Executive Office of the Governor shall
12 jointly prepare a budget amendment pursuant to chapter 216,
13 Florida Statutes, to implement the plan, in consultation with
14 the legislative committees having jurisdiction over the
15 Department of Insurance.
16 Section 92. By January 31, 2001, the Division of
17 Statutory Revision of the Office of Legislative Services shall
18 prepare and submit to the President of the Senate and the
19 Speaker of the House of Representatives draft substantive
20 legislation to conform the Florida Statutes to the provisions
21 of this act. The legislation shall not be drafted as a
22 reviser's bill. The draft shall include provisions:
23 (1) Changing the term "Comptroller" or "Treasurer" to
24 "Chief Financial Officer" with respect to functions of the
25 Chief Financial Officer where appropriate;
26 (2) Changing references to the "Department of Banking
27 and Finance" or the "Department of Insurance" to the
28 "Department of Financial Services" where appropriate; and
29 (3) Otherwise conforming the statutes to the abolition
30 of the offices of Comptroller and Treasurer, the creation of
31 the Office of the Chief Financial Officer, the abolition of

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1 the Department of Banking and Finance and the Department of
2 Insurance, and the creation of the Department of Financial
3 Services.
4 Section 93. (1) The Financial Services Transition
5 Task Force is established. All members of the task force shall
6 be appointed prior to September 1, 2000. The task force shall
7 be composed of:
8 (a) One consumer a representative appointed by the
9 Governor;
10 (b) Two members appointed by the President of the
11 Senate;
12 (c) Two members appointed by the Speaker of the House
13 of Representatives;
14 (d) Two members appointed by the Comptroller; and
15 (e) Two members appointed by the Insurance
16 Commissioner and Treasurer.
17 (2) The organizational meeting of the task force must
18 be held by October 1, 2000. The members of the task force
19 shall elect a chair by majority vote. Members of the task
20 force shall serve without compensation, but shall be
21 reimbursed for per diem and travel expenses as provided in
22 section 112.061, Florida Statutes.
23 (3) The purpose of the task force is to review the
24 Florida Statutes and rules and:
25 (a) Recommend amendments to statutes and rules made
26 necessary by the changes made by this act;
27 (b) Identify any organizational problems involving,
28 without limitation, communication among divisions, technical
29 assistance, and other services, and recommend solutions to the
30 identified problems;
31

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1 (c) Identify any issues related to technology,
2 including the coordination or incompatibility of technology
3 systems, and suggest solutions to the identified problems;
4 (d) Recommend methods to improve departmental
5 accountability, including, but not limited to, modification of
6 performance measures.
7 (4) The task force may procure information and
8 assistance from any officer or agency of the state or any
9 subdivision thereof. All such officials and agencies shall
10 give the task force all relevant information and assistance
11 with respect to any matter within their knowledge or control.
12 (5) The task force shall submit an initial report to
13 the Governor, the President of the Senate, and the Speaker of
14 the House of Representatives by January 1, 2001.
15 (6) The task force shall submit a final report to the
16 Governor, the President of the Senate, and the Speaker of the
17 House of Representatives by January 1, 2002.
18 (7) The task force terminates upon submission of its
19 final report.
20 Section 94. Effective July 1, 2000, section 442.0011,
21 Florida Statutes, is created to read:
22 442.0011 Exclusion from chapter.--This chapter is not
23 applicable to any firefighter employee, and firefighter
24 employer, or any place of firefighter employment covered by
25 ss. 633-801 through 633.830.
26 Section 95. Effective July 1, 2000, section 633.801,
27 Florida Statutes, is created to read:
28 633.801 Short title.--Sections 633.801 through 633.830
29 may be cited as the "Florida Firefighters Occupational Safety
30 and Health Act."
31

1 Section 96. Effective July 1, 2000, section 633.802,
2 Florida Statutes, is created to read:
3 633.802 Definitions.--Unless the context clearly
4 requires otherwise, the following definitions apply to ss.
5 633.801 through 633.830:
6 (1) "Department" means the Department of Insurance.
7 (2) "Division" means the Division of State Fire
8 Marshal of the Department of Insurance.
9 (3) "Firefighter employee" means any person engaged in
10 any employment, public or private, as a firefighter under any
11 appointment or contract of hire or apprenticeship, express or
12 implied, oral or written, whether lawfully or unlawfully
13 employed, and includes all volunteer firefighters responding
14 to or assisting with fire or medical emergencies whether or
15 not the firefighter is on duty.
16 (4) "Firefighter employer" means the state and all
17 political subdivisions thereof, all public and quasi-public
18 corporations therein, and every person carrying on any
19 employment thereof, which employs firefighters or which uses
20 volunteer firefighters.
21 (5) "Firefighter employment" or "employment" means any
22 service performed by a firefighter employee for the
23 firefighter employer, and includes the use of all volunteer
24 firefighters.
25 (6) "Firefighter place of employment" or "place of
26 employment" means the physical location at which the
27 firefighter is employed.
28 Section 97. Effective July 1, 2000, section 633.803,
29 Florida Statutes, is created to read:
30 633.803 Legislative intent.--It is the intent of the
31 Legislature to enhance firefighter occupational safety and

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1 health in this state through the implementation and
2 maintenance of policies, procedures, practices, rules, and
3 standards that reduce the incidence of firefighter employee
4 accidents, firefighter occupational diseases, and firefighter
5 fatalities compensable under chapter 440 or otherwise. The
6 Legislature further intends that the division develop a means
7 by which it can identify individual firefighter employers with
8 a high frequency or severity of work-related injuries; conduct
9 safety inspections of those firefighter employers; and assist
10 those firefighter employers in the development and
11 implemention of firefighter employee safety and health
12 programs. In addition, it is the intent of the Legislature
13 that the division administer the provisions of ss. 633.801
14 through 633.830; provide assistance to firefighter employers,
15 firefighter employees, and insurers; and enforce the policies,
16 rules, and standards set forth in ss. 633.801 through 633.830.
17 Section 98. Effective July 1, 2000, section 633.804,
18 Florida Statutes, is created to read:
19 633.804 Safety inspections, consultations; rules.--The
20 division shall adopt rules governing the manner, means, and
21 frequency of firefighter employer and firefighter employee
22 safety inspections and consultations by all insurers and
23 self-insurers.
24 Section 99. Effective July 1, 2000, section 633.805,
25 Florida Statutes, is created to read:
26 633.805 Division to make study of firefighter
27 occupational diseases, etc.--The division shall make a
28 continuous study of firefighter occupational diseases and the
29 ways and means for their control and prevention and shall make
30 and enforce necessary regulations for such control. For this
31 purpose, the division is authorized to cooperate with

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1 firefighter employers, firefighter employees, and insurers and
2 with the Department of Health.
3 Section 100. Effective July 1, 2000, section 633.806,
4 Florida Statutes, is created to read:
5 633.806 Investigations by the division; refusal to
6 admit; penalty.--
7 (1) The division shall make studies and investigations
8 with respect to safety provisions and the causes of
9 firefighter injuries in firefighter places of employment, and
10 shall make to the Legislature and firefighter employers and
11 insurers such recommendations as it considers proper as to the
12 best means of preventing firefighter injuries. In making such
13 studies and investigations, the division may:
14 (a) Cooperate with any agency of the United States
15 charged with the duty of enforcing any law securing safety
16 against injury in any place of firefighter employment covered
17 by ss. 633.801 through 633.830, or any agency or department of
18 the state engaged in enforcing any law to assure safety for
19 firefighter employees.
20 (b) Allow any such agency or department to have access
21 to the records of the division.
22 (2) The division and its authorized representatives
23 may enter and inspect any place of firefighter employment at
24 any reasonable time for the purpose of investigating
25 compliance with ss. 633.801 through 633.830 and making
26 inspections for the proper enforcement of ss. 633.801 through
27 633.830. Any firefighter employer who refuses to admit any
28 member of the division or its authorized representative to any
29 place of firefighter employment or to allow investigation and
30 inspection pursuant to this subsection is guilty of a
31

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1 misdemeanor of the second degree, punishable as provided in s.
2 775.082 or s. 775.083.
3 (3) The division by rule may adopt procedures for
4 conducting investigations of firefighter employers under ss.
5 633.801 through 633.830.
6 Section 101. Effective July 1, 2000, section 633.807,
7 Florida Statutes, is created to read:
8 633.807 Safety; firefighter employer
9 responsibilities.--Every firefighter employer shall furnish to
10 firefighters employment that is safe for the firefighter
11 employees, furnish and use safety devices and safeguards,
12 adopt and use methods and processes reasonably adequate to
13 render such an employment and place of employment safe, and do
14 every other thing reasonably necessary to protect the lives,
15 health, and safety of such firefighter employees. As used in
16 this section, the terms "safe" and "safety" as applied to any
17 employment or place of firefighter employment mean such
18 freedom from danger as is reasonably necessary for the
19 protection of the lives, health, and safety of firefighter
20 employees, including conditions and methods of sanitation and
21 hygiene. Safety devices and safeguards required to be
22 furnished by the firefighter employer by this section or by
23 the division under authority of this section shall not include
24 personal apparel and protective devices that replace personal
25 apparel normally worn by firefighter employees during regular
26 working hours.
27 Section 102. Effective July 1, 2000, section 633.808,
28 Florida Statutes, is created to read:
29 633.808 Division authority.--The division shall:
30 (1) Investigate and prescribe by rule what safety
31 devices, safeguards, or other means of protection must be

1 adopted for the prevention of accidents in every firefighter
2 place of employment or at any fire scene; determine what
3 suitable devices, safeguards, or other means of protection for
4 the prevention of occupational diseases must be adopted or
5 followed in any or all such firefighter places of employment
6 or at any fire scene; and adopt reasonable rules for the
7 prevention of accidents, the safety, protection, and security
8 of firefighters engaged in interior firefighting, and the
9 prevention of occupational diseases.
10 (2) Ascertain, fix, and order such reasonable
11 standards and rules for the construction, repair, and
12 maintenance of firefighter places of employment as shall
13 render them safe. Such rules and standards must be adopted in
14 accordance with chapter 120.
15 (3) Assist firefighter employers in the development
16 and implementation of firefighter employee safety training
17 programs by contracting with professional safety
18 organizations.
19 (4) Adopt rules prescribing recordkeeping
20 responsibilities for firefighter employers, which may include
21 rules for maintaining a log and summary of occupational
22 injuries, diseases, and illnesses and for producing on request
23 a notice of injury and firefighter employee accident
24 investigation records, and rules prescribing a retention
25 schedule for such records.
26 Section 103. Effective July 1, 2000, section 633.809,
27 Florida Statutes, is created to read:
28 633.809 Right of entry.--The division and its
29 authorized representatives may enter at any reasonable time
30 any firefighter place of employment for the purpose of
31 examining any tool, appliance, or machinery used in such

1 employment and may make inspections for the proper enforcement
2 of ss. 633.801 through 633.830. A firefighter employer or
3 owner may not refuse to admit any member of the division or
4 its authorized representatives to any firefighter place of
5 employment.
6 Section 104. Effective July 1, 2000, section 633.810,
7 Florida Statutes, is created to read:
8 633.810 Firefighter employers whose firefighter
9 employees have a high frequency of work-related injuries.--The
10 division shall develop a means by which it can identify
11 individual firefighter employers whose firefighter employees
12 have a high frequency or severity of work-related injuries.
13 The division shall carry out safety inspections of the
14 facilities and operations of these firefighter employers in
15 order to assist them in reducing the frequency and severity of
16 work-related injuries. The division shall develop safety and
17 health programs for those firefighter employers. Insurers
18 shall distribute these safety and health programs to the
19 firefighter employers so identified by the division. Those
20 firefighter employers identified by the division as having a
21 high frequency or severity of work-related injuries shall
22 implement a division-developed safety and health program. The
23 division shall carry out safety inspections of those
24 firefighter employers so identified to ensure compliance with
25 the safety and health program and to assist such firefighter
26 employers in reducing the number of work-related injuries. The
27 division may not assess penalties as the result of such
28 inspections, except as provided by s. 633.813. Copies of any
29 report made as the result of such an inspection must be
30 provided to the firefighter employer and its insurer.
31 Firefighter employers may submit their own safety and health

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1 programs to the division for approval in lieu of using the
2 division-developed safety and health program. The division
3 must promptly review the program submitted and approve or
4 disapprove it. Upon approval by the division, the program must
5 be implemented by the firefighter employer. If the program is
6 not approved or if a program is not submitted, the firefighter
7 employer must implement the division-developed program. The
8 division shall adopt rules setting forth the criteria for
9 safety and health programs.
10 Section 105. Effective July 1, 2000, section 633.811,
11 Florida Statutes, is created to read:
12 633.811 Insurer consultations.--Each insurer writing
13 workers' compensation insurance in this state, each
14 firefighter employer qualifying as an individual self-insurer
15 under s. 440.38, each self-insurance fund under s. 624.461,
16 and each assessable mutual insurer under s. 628.6011 must
17 provide safety consultations to each of its policyholders who
18 requests such consultations. Each such insurer or self-insurer
19 must inform its policyholders of the availability of such
20 consultations. The division is responsible for approving all
21 safety and health programs. The division shall aid all
22 insurers and self insurers in establishing their safety and
23 health programs by setting out criteria in an appropriate
24 format.
25 Section 106. Effective July 1, 2000, section 633.812,
26 Florida Statutes, is created to read:
27 633.812 Workplace safety committees and safety
28 coordinators.--
29 (1) In order to promote health and safety in places of
30 firefighter employment in this state:
31

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1 (a) Each firefighter employer of 20 or more
2 firefighter employees shall establish and administer a
3 workplace safety committee in accordance with rules adopted
4 under this section.
5 (b) Each firefighter employer of fewer than 20
6 firefighter employees which is identified by the division as
7 having high frequency or severity of work-related injuries
8 shall establish and administer a workplace safety committee or
9 designate a workplace safety coordinator who shall establish
10 and administer workplace safety activities in accordance with
11 rules adopted under this section.
12 (2) The division shall adopt rules:
13 (a) Prescribing the membership of the workplace safety
14 committees so as to ensure an equal number of firefighter
15 employee representatives, who are volunteers or are elected by
16 their peers, and of firefighter employer representatives, and
17 specifying the frequency of meetings.
18 (b) Requiring firefighter employers to make adequate
19 records of each meeting and to file and to maintain the
20 records subject to inspection by the division.
21 (c) Prescribing the duties and functions of the
22 workplace safety committee and workplace safety coordinator,
23 which include, but are not limited to:
24 1. Establishing procedures for workplace safety
25 inspections by the committee.
26 2. Establishing procedures investigating all workplace
27 accidents, safety-related incidents, illnesses, and deaths.
28 3. Evaluating accident-prevention and
29 illness-prevention programs.
30 4. Prescribing guidelines for the training of safety
31 committee members.

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1 (3) The composition, selection, and function of safety
2 committees shall be a mandatory topic of negotiations with any
3 certified collective bargaining agent for firefighter
4 employers that operate under a collective bargaining
5 agreement. Firefighter employers that operate under a
6 collective bargaining agreement that contains provisions
7 regulating the formation and operation of workplace safety
8 committees that meet or exceed the minimum requirements
9 contained in this section, or firefighter employers who
10 otherwise have existing workplace safety committees that meet
11 or exceed the minimum requirements established by this section
12 are in compliance with this section.
13 (4) Firefighter employees must be compensated their
14 regular hourly wage while engaged in workplace safety
15 committee or workplace safety coordinator training, meetings,
16 or other duties prescribed under this section.
17 Section 107. Effective July 1, 2000, section 633.813,
18 Florida Statutes, is created to read:
19 633.813 Firefighter employer penalties.--If any
20 firefighter employer violates or fails or refuses to comply
21 with ss. 633.801 through 633.830, or with any rule adopted by
22 the division, in accordance with chapter 120, for the
23 prevention of injuries, accidents, or occupational diseases or
24 with any lawful order of the division in connection with ss.
25 633.801 through 633.830, or fails or refuses to furnish or
26 adopt any safety device, safeguard, or other means of
27 protection prescribed by the division under ss. 633.801
28 through 633.830 for the prevention of accidents or
29 occupational diseases, the division may assess against the
30 firefighter employer a civil penalty of not less than $100 nor
31 more than $5,000 for each day the violation, omission,

1 failure, or refusal continues after the firefighter employer
2 has been given notice thereof in writing. The total penalty
3 for each violation may not exceed $50,000. The division shall
4 adopt rules requiring penalties commensurate with the
5 frequency or severity, or both, of safety violations. A
6 hearing must be held in the county where the violation,
7 omission, failure, or refusal is alleged to have occurred,
8 unless otherwise agreed to by the firefighter employer and
9 authorized by the division. All penalties assessed and
10 collected under this section shall be deposited in the
11 Insurance Commissioner's Regulatory Trust Fund.
12 Section 108. Effective July 1, 2000, section 633.814,
13 Florida Statutes, is created to read:
14 633.814 Division cooperation with Federal Government;
15 exemption from division requirements.--
16 (1) The division shall cooperate with the Federal
17 Government so that duplicate inspections will be avoided yet
18 assure safe places of firefighter employment for the citizens
19 of this state.
20 (2) Except as provided in this section, a private
21 firefighter employer is not subject to the requirements of the
22 division if:
23 (a) The private firefighter employer is subject to the
24 federal regulations in 29 C.F.R. ss. 1910 and 1926;
25 (b) The private firefighter employer has adopted and
26 implemented a written safety program that conforms to the
27 requirements of 29 C.F.R. ss. 1910 and 1926;
28 (c) A private firefighter employer with 20 or more
29 full-time firefighter employees shall include provisions for a
30 safety committee in the safety program. The safety committee
31 must include firefighter employee representation and must meet

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1 at least once each calendar quarter. The private firefighter
2 employer must make adequate records of each meeting and
3 maintain the records subject to inspections under subsection
4 (3). The safety committee shall, if appropriate, make
5 recommendations regarding improvements to the safety program
6 and corrections of hazards affecting workplace safety; and
7 (d) The private firefighter employer provides the
8 division with a written statement that certifies compliance
9 with this subsection.
10 (3) The division may enter at any reasonable time any
11 place of firefighter employment for the purposes of verifying
12 the accuracy of the written certification. If the division
13 determines that the firefighter employer has not complied with
14 the requirements of subsection (2), the firefighter employer
15 shall be subject to the rules of the division until the
16 firefighter employer complies with subsection (2) and
17 recertifies that fact to the division.
18 (4) This section shall not restrict the division from
19 performing any duties pursuant to a written contract between
20 the division and the Federal Occupational Safety and Health
21 Administration (OSHA).
22 Section 109. Effective July 1, 2000, section 633.815,
23 Florida Statutes, is created to read:
24 633.815 Failure to implement a safety and health
25 program; cancellations.--If a firefighter employer that is
26 found by the division to have a high frequency or severity of
27 work-related injuries fails to implement a safety and health
28 program, the insurer or self-insurer's fund that is providing
29 coverage fo r the firefighter employer may cancel the contract
30 for insurance with the firefighter employer. In the
31 alternative, the insurer or fund may terminate any discount or

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1 deviation granted to the firefighter employer for the
2 remainder of the term of the policy. If the contract is
3 canceled or the discount or deviation is terminated, the
4 insurer must make such reports as are required by law.
5 Section 110. Effective July 1, 2000, section 633.816,
6 Florida Statutes, is created to read:
7 633.816 Expenses of administration.--The amounts that
8 are needed to administer ss. 633.801 through 633.830 shall be
9 disbursed from the Insurance Commissioner's Regulatory Trust
10 Fund.
11 Section 111. Effective July 1, 2000, section 633.817,
12 Florida Statutes, is created to read:
13 633.817 Refusal to admit; penalty.--The division and
14 its authorized representatives may enter and inspect any place
15 of firefighter employment at any reasonable time for the
16 purpose of investigating compliance with ss. 633.801 through
17 633.830 and conducting inspections for the proper enforcement
18 of ss. 633.801 through 633.830. A firefighter employer who
19 refuses to admit any member of the division or its authorized
20 representative to any place of employment or to allow
21 investigation and inspection pursuant to this section commits
22 a misdemeanor of the second degree, punishable as provided in
23 s. 775.082 or s. 775.083.
24 Section 112. Effective July 1, 2000, section 633.818,
25 Florida Statutes, is created to read:
26 633.818 Firefighter employee rights and
27 responsibilities.--
28 (1) Each firefighter employee of a firefighter
29 employer covered under ss. 633.801 through 633.830 shall
30 comply with rules adopted by the division and with reasonable
31 workplace safety and health standards, rules, policies,

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1 procedures, and work practices established by the firefighter
2 employer and the workplace safety committee. A firefighter
3 employee who knowingly fails to comply with this subsection
4 maybe disciplined or discharged by the firefighter employer.
5 (2) A firefighter employer may not discharge, threaten
6 to discharge, cause to be discharged, intimidate, coerce,
7 otherwise discipline, or in any manner discriminate against a
8 firefighter employee for any of the following reasons:
9 (a) The firefighter employee has testified or is about
10 to testify, on her or his own behalf, or on behalf of others,
11 in any proceeding instituted under ss. 633.801 through
12 633.830;
13 (b) The firefighter employee has exercised any other
14 right afforded under ss. 633.801 through 633.830; or
15 (c) The firefighter employee is engaged in activities
16 relating to the workplace safety committee.
17 (3) Neither pay, position, seniority, nor other
18 benefit may be lost for exercising any right under, or for
19 seeking compliance with, any requirement of ss. 633.801
20 through 633.830.
21 Section 113. Effective July 1, 2000, section 633.819,
22 Florida Statutes, is created to read:
23 633.819 Compliance.--Failure of a firefighter employer
24 or an insurer to comply with ss. 633.801 through 633.830, or
25 with any rules adopted under s.. 633.801 through 633.830,
26 constitutes grounds for the division to seek remedies,
27 including injunctive relief, for compliance by making
28 appropriate filings with the Circuit Court of Leon County.
29 Section 114. Effective July 1, 2000, section 633.820,
30 Florida Statutes, is created to read:
31

1 633.820 False statements to insurers.--A firefighter
2 employer who knowingly and willfully falsifies or conceals a
3 material fact, makes a false, fictitious, or fraudulent
4 statement or representation; or makes or uses any false
5 document knowing the document to contain any false fictitious,
6 or fraudulent entry or statement to an insurer of workers'
7 compensation insurance under ss. 633.801 through 633.830 is
8 guilty of a misdemeanor of the second degree, punishable as
9 provided in s. 775.082 or s. 775.083.
10 Section 115. Effective July 1, 2000, section 633.821,
11 Florida Statutes, is created to read:
12 633.821 Insurer penalties.--If any insurer violates,
13 or fails or refuses to comply with, ss. 633.801 through
14 633.830 or with any rule adopted or order issued under ss.
15 633.801 through 633.830, the division, after notice and
16 hearing in accordance with chapter 120, may assess against the
17 insurer a civil penalty of not less than $100 nor more than
18 $5,000 each day the violation, failure, or refusal continues
19 after the insurer has been given written notice thereof. The
20 total penalty for each violation, failure, or refusal may not
21 exceed $50,000. The division shall adopt rules providing for
22 penalties for noncompliance with ss. 633.801 through 633.830
23 by insurers. All penalties assessed and collected under this
24 section shall be deposited in the Insurance Commissioner's
25 Regulatory Trust Fund.
26 Section 116. Effective July 1, 2000, section 633.823,
27 Florida Statutes, is created to read:
28 633.823 Matters within jurisdiction of the division;
29 false, fictitious, or fraudulent acts, statements, and
30 representations prohibited; penalty; statute of
31 limitations.--A person may not, in any matter within the

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1 jurisdiction of the division, knowingly and willfully falsify
2 or conceal a material fact; make any false, fictitious, or
3 fraudulent statement or representation; or make or use any
4 false document, knowing the same to contain any false,
5 fictitious, or fraudulent statement or entry. A person who
6 violates this section commits a misdemeanor of the second
7 degree, punishable as provided in s. 775.082 or s. 775.083.
8 The statute of limitations for prosecution of an act committed
9 in violation of this section is 5 years after the date the act
10 was committed or, if not discovered within 30 days after the
11 act was committed, 5 years after the date the act was
12 discovered.
13 Section 117. Effective July 1, 2000, section 633.825,
14 Florida Statutes, is created to read:
15 633.825 Workplace safety.--
16 (1) The division shall assist in making the workplace
17 a safer place to work and decreasing the frequency and
18 severity of on-the-job injuries.
19 (2) The division shall have the authority to adopt
20 rules for the purpose of assuring safe working conditions for
21 all firefighter employees by authorizing the enforcement of
22 effective standards, assisting and encouraging firefighter
23 employers to maintain safe working conditions, and by
24 providing for education and training in the field of safety.
25 For firefighter employers, the division may by rule adopt
26 subparts C through T and subpart Z of 29 C.F.R. part 1910;
27 subparts C through Z of 29 C.F.R. part 1926; subparts A
28 through D, subpart I, and subpart M of 29 C.F.R. part 1928;
29 subparts A through G of 29 C.F.R. part 1917; subparts A
30 through L and subpart Z of 29 C.F.R. part 1915; subparts A
31 through J of 29 C.F.R. part 1918, latest revision, provided

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1 that 29 C.F.R. s. 1910.156 applies to volunteer firefighters
2 and fire departments operated by the state or political
3 subdivisions; the National Fire Protection Association, Inc.,
4 Standard 1500, paragraph 5-7 (Personal Alert Safety System)
5 (1992 edition); and ANSI A 10.4-1990.
6 (3) The provisions of chapter 440 which pertain to
7 workplace safety shall be applicable to the division.
8 (4) The division shall have authority to adopt any
9 rule necessary to implement, interpret, and make specific any
10 matter pertaining to any subject or reference contained in
11 this section, including all of the provisions referred to in
12 subsection (2), as they relate to firefighter employees,
13 firefighter employers, and firefighter places of employment.
14 Section 118. Except as otherwise provided in this act,
15 this act shall take effect January 1, 2001.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
SB 1682

Creates the Department of Financial Services and designates the Chief Financial Officer as the department head January 7, 2003.

Transfers the Department of Banking and Finance and the Department of Insurance to the new Department of Financial Services.

Establishes four offices in the department, each headed by a commissioner.

Provides final order authority to the Commissioner of Financial Institutions and the Commissioner of Securities and Finance.

Transfers the Division of Accountancy and its related board to the department and places the Division in the Office of the Commissioner of Securities and Finance.

Creates an Insurance Rating Commission effective January 1, 2001, and transfers all ratemaking authority currently housed in the Department of Insurance to the commission.

Establishes the manner in which commissioners are appointed and confirmed, as well as provides for qualifications.

Provides that the Public Counsel is to represent the public before the commission.

Creates the Florida Firefighters Occupational Safety and Health Act, and delegates authority to implement the act to the Division of State Fire Marshal effective July 1, 2000.

Creates the Financial Services Transition Task Force.