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; amending ss. 175.141, 185.12, 408.701,
13 651.018, F.S.; conforming references; amending
14 s. 624.19, F.S.; authorizing the use of forms;
15 amending s. 624.321, F.S.; conforming
16 provisions to include the Insurance Rating
17 Commission; amending s. 624.322, F.S.;
18 conforming provisions to include the Insurance
19 Rating Commission; amending s. 626.9541, F.S.;
20 conforming provisions to substitute the
21 Insurance Rating Commission for the Department
22 of Insurance; amending s. 626.9926, F.S.;
23 conforming provisions to include the Insurance
24 Rating Commission; amending s. 627.031, F.S.;
25 substituting the Insurance Rating Commission
26 for the Department of Insurance; amending s.
27 627.0612, F.S.; conforming provisions to
28 include the commission; amending s. 627.0613,
29 F.S.; removing authority of the consumer
30 advocate; amending s. 627.062, F.S.; conforming
31 provisions to substitute the commission for the

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

1 powers, duties, and responsibilities of chapter
2 442, excluding ss. 442.101 through 442.127,
3 which relate to firefighter employers,
4 firefighter employees, and firefighter places
5 of employment, from the Division of Safety,
6 Department of Labor and Employment Security;
7 providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Effective January 7, 2003, section 17.001,
12 Florida Statutes, is created to read:
13 17.001 Financial Officer.--As provided in s. 4(c),
14 Art. IV of the State Constitution, the Chief Financial Officer
15 is the chief fiscal officer of the state and is responsible
16 for settling and approving accounts against the state and
17 keeping all state funds and securities.
18 Section 2. Effective January 7, 2003, section 20.121,
19 Florida Statutes, is created to read:
20 20.121 Department of Financial Services.--There is
21 created a Department of Financial Services.
22 (1) The head of the Department of Financial Services
23 is the Chief Financial Officer.
24 (2)(a) The Division of Administration is created
25 within the Office of the Chief Financial Officer. The division
26 is headed by a director who is appointed by and serves at the
27 pleasure of the Chief Financial Officer. A Bureau of Financial
28 and Support Services is created within the division.
29 (b) The Division of Financial Investigations is
30 created within the Office of the Chief Financial Officer. Its
31 responsibilities include, but are not limited to, conducting

1 investigations of insurance fraud. The division is headed by a
2 director who is appointed by and serves at the pleasure of the
3 Chief Financial Officer.
4 (3) Notwithstanding the requirements of s. 20.04 and
5 except as otherwise provided in this section, the principal
6 policy and program development unit of the department is the
7 "office." Each office is headed by a commissioner who is
8 appointed by and serves at the pleasure of the Chief Financial
9 Officer. Each commissioner shall perform such duties as are
10 specified in this section and such other duties as are
11 assigned by the Chief Financial Officer. The principal unit of
12 each office is the "division." Each division is headed by a
13 "director."
14 (4)(a) The Office of the Commissioner of Insurance is
15 established in the Department of Financial Services. The
16 office shall be headed by the Commissioner of Insurance. Prior
17 to appointment as commissioner, the Commissioner of Insurance
18 must have had, within the previous 10 years, at least 5 years
19 of experience as a senior officer of an insurer, as defined in
20 s. 624.03, or insurance agency, as defined in s. 626.094, or
21 as an examiner or other senior employee of a state or federal
22 agency having regulatory responsibility over insurers or
23 insurance agencies.
24 (b) The Office of the Commissioner of Insurance shall
25 consist of the following divisions:
26 1. Division of Insurance Agents and Agencies;
27 2. Division of Insurance Consumer Services;
28 3. Division of Insurer Services;
29 4. Division of Rehabilitation and Liquidation;
30 5. Division of Risk Management; and
31 6. Division of State Fire Marshal.

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

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

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

(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.

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1 10. Board of Landscape Architecture, created under
2 part II of chapter 481.
3 11. Board of Pilot Commissioners, created under
4 chapter 310.
5 12. Board of Professional Engineers, created under
6 chapter 471.
7 13. Board of Professional Geologists, created under
8 chapter 492.
9 14. Board of Professional Surveyors and Mappers,
10 created under chapter 472.
11 15. Board of Veterinary Medicine, created under
12 chapter 474.
13 (b) The following board and commission are established
14 within the Division of Real Estate:
15 1. Florida Real Estate Appraisal Board, created under
16 part II of chapter 475.
17 2. Florida Real Estate Commission, created under part
18 I of chapter 475.
19 ~~(c) The following board is established within the~~
20 ~~Division of Certified Public Accounting:~~
21 ~~1. Board of Accountancy, created under chapter 473.~~
22 Section 8. <u>Effective January 7, 2003, the Division of</u>
23 <u>Certified Public Accounting and the Board of Accountancy</u>
24 <u>created under chapter 473, Florida Statutes, are transferred</u>
25 <u>to the Department of Financial Services by a type two</u>
26 <u>transfer, as defined in section 20.06, Florida Statutes.</u>
27 Section 9. Subsection (1) of section 350.061, Florida
28 Statutes, is amended to read:
29 350.061 Public Counsel; appointment; oath;
30 restrictions on Public Counsel and his or her employees.--
31

(1) The Joint Legislative Auditing Committee shall appoint a Public Counsel by majority vote of the members of the committee to represent the ~~general~~ public ~~of Florida~~ before the Florida Public Service Commission and the Insurance Rating Commission. The Public Counsel shall be an attorney admitted to practice before the Florida Supreme Court and shall serve at the pleasure of the Joint Legislative Auditing Committee, subject to annual reconfirmation by the committee. Vacancies in the office shall be filled in the same manner as the original appointment.

Section 10. Section 350.0611, Florida Statutes, is amended to read:

350.0611 Public Counsel; duties and powers.--It shall be the duty of the Public Counsel to provide legal representation for the people of the state in proceedings before the Public Service Commission and the Insurance Rating Commission. As used in this section, the term "commission" includes both such commissions. The Public Counsel shall have such powers as are necessary to carry out the duties of his or her office, including, but not limited to, the following specific powers:

(1) To recommend to the commission, by petition, the commencement of any proceeding or action or to appear, in the name of the state or its citizens, in any proceeding or action before the commission and urge therein any position which he or she deems to be in the public interest, whether consistent or inconsistent with positions previously adopted by the commission, and utilize therein all forms of discovery available to attorneys in civil actions generally, subject to protective orders of the commission which shall be reviewable by summary procedure in the circuit courts of this state;

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

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

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

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

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

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

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1 (d) A commissioner, while in office, may not serve as
2 the representative of any political party or on any executive
3 committee or other governing body of a political party; serve
4 as an executive officer or employee of any political party,
5 committee, organization, or association; receive remuneration
6 for activities on behalf of any candidate for public office;
7 engage on behalf of any candidate for public office in the
8 solicitation of votes or other activities on behalf of such
9 candidacy; or become a candidate for election to any public
10 office.
11 (e) A commissioner, during his or her term of office,
12 may not make any public comment regarding the merits of any
13 proceeding under ss. 120.569 and 120.57 which is pending
14 before the commission.
15 (f) A commissioner may not conduct himself or herself
16 in an unprofessional manner at any time during the performance
17 of his or her duties.
18 (3) The Commission on Ethics shall accept and
19 investigate any alleged violations of this section pursuant to
20 the procedures contained in ss. 112.322-112.3241. The
21 Commission on Ethics shall provide the Governor with a report
22 of its findings and recommendations. The Governor may enforce
23 the findings and recommendations of the Commission on Ethics,
24 pursuant to part III of chapter 112. An insurance rating
25 commissioner may request an advisory opinion from the
26 Commission on Ethics, pursuant to s. 112.322(3)(a), regarding
27 the standards of conduct or prohibitions set forth in this
28 section and in ss. 624.372 and 624.377.
29 624.375 Enforcement and interpretation.--Any violation
30 of s. 624.372, s. 624.373, or s. 624.377 by a commissioner,
31 former commissioner, or former employee is punishable as

1 provided in ss. 112.317 and 112.324. The Commission on Ethics
2 may investigate complaints of violation of such sections in
3 the manner provided in part III of chapter 112. A commissioner
4 may request an advisory opinion from the Commission of Ethics
5 as provided by s. 112.322(3)(a).
6 624.376 Place of meeting; expenditures; employment of
7 personnel.--
8 (1) The offices of the commission must be located in
9 the vicinity of Tallahassee, but the commissioners may hold
10 sessions or hearings anywhere in the state at their
11 discretion.
12 (2) The commission constitutes a separate budget
13 entity to be funded by appropriations from the Insurance
14 Commissioner's Regulatory Trust Fund.
15 (3) The commission may employ clerical, technical, and
16 professional personnel reasonably necessary for the
17 performance of its duties.
18 (4) The commission may employ actuaries, who shall be
19 at-will employees and who shall serve at the pleasure of the
20 commission. Actuaries employed under this subsection must be
21 members of the Society of Actuaries or the Casualty Actuarial
22 Society and are exempt from the Career Service System
23 established under chapter 110. The commission shall set the
24 salaries of the actuaries employed under this subsection in
25 accordance with s. 216.251(2)(a)5. at levels that are
26 commensurate with salary levels paid to actuaries by the
27 insurance industry.
28 624.377 Former commissioners and employees;
29 representation of clients before commission.--
30 (1) Any former commissioner of the Insurance Rating
31 Commission is prohibited, for a period of 2 years following

1 termination of service on the commission, from representing
2 before the commission any client regulated by the commission.
3 (2) Any former employee of the commission is
4 prohibited from representing before the commission any client
5 regulated by the commission on any matter that was pending at
6 the time of the employee's termination and in which such
7 former employee had participated.
8 (3) For a period of 2 years following termination of
9 service on the commission, a former member may not accept
10 employment by or compensation from a business entity that,
11 directly or indirectly, owns or controls a person or entity
12 regulated by the commission, from a person or entity regulated
13 by the commission, from a business entity that, directly or
14 indirectly, is an affiliate or subsidiary of a person or
15 entity regulated by the commission, or from a business entity
16 or trade association that has been a party to a commission
17 proceeding that was pending within the 2 years preceding the
18 member's termination of service on the commission.
19 Section 15. Section 175.141, Florida Statutes, is
20 amended to read:
21 175.141 Payment of excise tax credit on similar state
22 excise or license tax.--The tax herein authorized to be
23 imposed by each municipality and each special fire control
24 district shall in nowise be in addition to any similar state
25 excise or license tax imposed by part V ~~IV~~ of chapter 624, but
26 the payor of the tax hereby authorized shall receive credit
27 therefor on his or her said state excise or license tax and
28 the balance of said state excise or license tax shall be paid
29 to the Department of Revenue as provided by law.
30 Section 16. Section 185.12, Florida Statutes, is
31 amended to read:

185.12 Payment of excise tax credit on similar state excise or license tax.--The tax herein authorized shall in nowise be additional to the similar state excise or license tax imposed by part V ~~IV~~, chapter 624, but the payor of the tax hereby authorized shall receive credit therefor on his or her state excise or license tax and the balance of said state excise or license tax shall be paid to the Department of Revenue as provided by law.

Section 17. Subsection (14) of section 408.701, Florida Statutes, is amended to read:

408.701 Community health purchasing; definitions.--As used in ss. 408.70-408.706, the term:

(14) "Health insurer" or "insurer" means an organization licensed by the department under part IV ~~III~~ of chapter 624 or part I of chapter 641.

Section 18. Section 651.018, Florida Statutes, is amended to read:

651.018 Administrative supervision.--The department may place a facility in administrative supervision pursuant to part VII ~~VI~~ of chapter 624.

Section 19. Section 624.19, Florida Statutes, is amended to read:

624.19 Existing forms and filings.--Every form of 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. 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 production of books, papers, records, files, correspondence, documents, or other evidence which is relevant to the inquiry.

Section 21. Section 624.322, Florida Statutes, is amended to read:

624.322 Testimony compelled; immunity from prosecution.--

(1) If any natural person asks to be excused from attending or testifying or from producing any books, papers, records, contracts, documents, or other evidence in connection with any examination, hearing, or investigation being conducted by the department or the commission or the examiners of either ~~its examiner~~, on the ground that the testimony or evidence required of her or him may tend to incriminate the person or subject her or him to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, the person must, if so directed by the department or commission and the Department of Legal Affairs, nonetheless comply with such direction; but she or he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which she or he may have so testified or produced evidence; and no testimony so given or evidence produced shall be received against the person upon any

1 criminal action, investigation, or proceeding. However, no
2 such person so testifying shall be exempt from prosecution or
3 punishment for any perjury committed by her or him in such
4 testimony, and the testimony or evidence so given or produced
5 shall be admissible against her or him upon any criminal
6 action, investigation, or proceeding concerning such perjury.
7 No license or permit conferred or to be conferred to such
8 person shall be refused, suspended, or revoked based upon the
9 use of such testimony.
10 (2) Any such individual may execute, acknowledge, and
11 file in the office of the Department of Insurance or
12 commission, whichever is applicable, a statement expressly
13 waiving such immunity or privilege in respect to any
14 transaction, matter, or thing specified in such statement; and
15 thereupon the testimony of such individual or such evidence in
16 relation to such transaction, matter, or thing may be received
17 or produced before any judge or justice, court, tribunal,
18 grand jury, or otherwise; and, if so received or produced,
19 such individual shall not be entitled to any immunity or
20 privileges on account of any testimony she or he may so give
21 or evidence so produced.
22 Section 22. Paragraph (o) of subsection (1) of section
23 626.9541, Florida Statutes, is amended to read:
24 626.9541 Unfair methods of competition and unfair or
25 deceptive acts or practices defined.--
26 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR
27 DECEPTIVE ACTS.--The following are defined as unfair methods
28 of competition and unfair or deceptive acts or practices:
29 (o) Illegal dealings in premiums; excess or reduced
30 charges for insurance.--
31

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the commission ~~department~~, and as specified in the policy; or, in cases when classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges in excess of or less than those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph shall not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance or any combination thereof or refusing to renew the policy solely

1 because the insured was involved in a motor vehicle accident
2 unless the insurer's file contains information from which the
3 insurer in good faith determines that the insured was
4 substantially at fault in the accident.
5 b. An insurer which imposes and collects such a
6 surcharge or which refuses to renew such policy shall, in
7 conjunction with the notice of premium due or notice of
8 nonrenewal, notify the named insured that he or she is
9 entitled to reimbursement of such amount or renewal of the
10 policy under the conditions listed below and will subsequently
11 reimburse him or her or renew the policy, if the named insured
12 demonstrates that the operator involved in the accident was:
13 (I) Lawfully parked;
14 (II) Reimbursed by, or on behalf of, a person
15 responsible for the accident or has a judgment against such
16 person;
17 (III) Struck in the rear by another vehicle headed in
18 the same direction and was not convicted of a moving traffic
19 violation in connection with the accident;
20 (IV) Hit by a "hit-and-run" driver, if the accident
21 was reported to the proper authorities within 24 hours after
22 discovering the accident;
23 (V) Not convicted of a moving traffic violation in
24 connection with the accident, but the operator of the other
25 automobile involved in such accident was convicted of a moving
26 traffic violation;
27 (VI) Finally adjudicated not to be liable by a court
28 of competent jurisdiction;
29 (VII) In receipt of a traffic citation which was
30 dismissed or nolle prossed; or
31

1 (VIII) Not at fault as evidenced by a written
2 statement from the insured establishing facts demonstrating
3 lack of fault which are not rebutted by information in the
4 insurer's file from which the insurer in good faith determines
5 that the insured was substantially at fault.
6 c. In addition to the other provisions of this
7 subparagraph, an insurer may not fail to renew a policy if the
8 insured has had only one accident in which he or she was at
9 fault within the current 3-year period. However, an insurer
10 may nonrenew a policy for reasons other than accidents in
11 accordance with s. 627.728. This subparagraph does not
12 prohibit nonrenewal of a policy under which the insured has
13 had three or more accidents, regardless of fault, during the
14 most recent 3-year period.
15 4. Imposing or requesting an additional premium for,
16 or refusing to renew, a policy for motor vehicle insurance
17 solely because the insured committed a noncriminal traffic
18 infraction as described in s. 318.14 unless the infraction is:
19 a. A second infraction committed within an 18-month
20 period, or a third or subsequent infraction committed within a
21 36-month period.
22 b. A violation of s. 316.183, when such violation is a
23 result of exceeding the lawful speed limit by more than 15
24 miles per hour.
25 5. Upon the request of the insured, the insurer and
26 licensed agent shall supply to the insured the complete proof
27 of fault or other criteria which justifies the additional
28 charge or cancellation.
29 6. No insurer shall impose or request an additional
30 premium for motor vehicle insurance, cancel or refuse to issue
31 a policy, or refuse to renew a policy because the insured or

1 the applicant is a handicapped or physically disabled person,
2 so long as such handicap or physical disability does not
3 substantially impair such person's mechanically assisted
4 driving ability.
5 7. No insurer may cancel or otherwise terminate any
6 insurance contract or coverage, or require execution of a
7 consent to rate endorsement, during the stated policy term for
8 the purpose of offering to issue, or issuing, a similar or
9 identical contract or coverage to the same insured with the
10 same exposure at a higher premium rate or continuing an
11 existing contract or coverage with the same exposure at an
12 increased premium.
13 8. No insurer may issue a nonrenewal notice on any
14 insurance contract or coverage, or require execution of a
15 consent to rate endorsement, for the purpose of offering to
16 issue, or issuing, a similar or identical contract or coverage
17 to the same insured at a higher premium rate or continuing an
18 existing contract or coverage at an increased premium without
19 meeting any applicable notice requirements.
20 9. No insurer shall, with respect to premiums charged
21 for motor vehicle insurance, unfairly discriminate solely on
22 the basis of age, sex, marital status, or scholastic
23 achievement.
24 10. Imposing or requesting an additional premium for
25 motor vehicle comprehensive or uninsured motorist coverage
26 solely because the insured was involved in a motor vehicle
27 accident or was convicted of a moving traffic violation.
28 11. No insurer shall cancel or issue a nonrenewal
29 notice on any insurance policy or contract without complying
30 with any applicable cancellation or nonrenewal provision
31 required under the Florida Insurance Code.

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12. No insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

Section 23. Section 626.9926, Florida Statutes, is amended to read:

626.9926 Rate regulation not authorized.--Nothing in this act shall be construed to authorize the department or commission to directly or indirectly regulate the amount paid as consideration for entry into a viatical settlement contract or viatical settlement purchase agreement.

Section 24. Subsection (2) of section 627.031, Florida Statutes, is amended to read:

627.031 Purposes of this part; interpretation.--

(2) It is the purpose of this part to protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory insurance rates, and to authorize the commission ~~department~~ to regulate such rates. If at any time the commission ~~department~~ has reason to believe any such rate is excessive, inadequate, or unfairly discriminatory under the law, it is directed to take the necessary action to cause such rate to comply with the laws of this state.

Section 25. Section 627.0612, Florida Statutes, is amended to read:

627.0612 Administrative proceedings in rating determinations.--In any proceeding to determine whether rates,

rating plans, or other matters governed by this part comply with the law, the appellate court shall set aside a final order of the department or commission if the department or commission has violated s. 120.57(1)(k) by substituting its findings of fact for findings of an administrative law judge which were supported by competent substantial evidence.

Section 26. Subsection (3) of section 627.0613, 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 27. 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

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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 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

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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.

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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.

1 (e) After consideration of the rate factors provided
2 in paragraphs (b), (c), and (d), a rate may be found by the
3 commission ~~department~~ to be excessive, inadequate, or unfairly
4 discriminatory based upon the following standards:
5 1. Rates shall be deemed excessive if they are likely
6 to produce a profit from Florida business that is unreasonably
7 high in relation to the risk involved in the class of business
8 or if expenses are unreasonably high in relation to services
9 rendered.
10 2. Rates shall be deemed excessive if, among other
11 things, the rate structure established by a stock insurance
12 company provides for replenishment of surpluses from premiums,
13 when the replenishment is attributable to investment losses.
14 3. Rates shall be deemed inadequate if they are
15 clearly insufficient, together with the investment income
16 attributable to them, to sustain projected losses and expenses
17 in the class of business to which they apply.
18 4. A rating plan, including discounts, credits, or
19 surcharges, shall be deemed unfairly discriminatory if it
20 fails to clearly and equitably reflect consideration of the
21 policyholder's participation in a risk management program
22 adopted pursuant to s. 627.0625.
23 5. A rate shall be deemed inadequate as to the premium
24 charged to a risk or group of risks if discounts or credits
25 are allowed which exceed a reasonable reflection of expense
26 savings and reasonably expected loss experience from the risk
27 or group of risks.
28 6. A rate shall be deemed unfairly discriminatory as
29 to a risk or group of risks if the application of premium
30 discounts, credits, or surcharges among such risks does not
31

bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the commission ~~department~~ may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The commission ~~department~~ may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the commission ~~department~~ finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the commission ~~department~~ shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the commission ~~department~~ may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the commission ~~department~~ finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the commission ~~department~~ all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The commission ~~department~~ shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show

1 that the rate is not excessive, inadequate, or unfairly
2 discriminatory. After the commission ~~department~~ notifies an
3 insurer that a rate may be excessive, inadequate, or unfairly
4 discriminatory, unless the commission ~~department~~ withdraws the
5 notification, the insurer shall not alter the rate except to
6 conform with the commission's ~~department's~~ notice until the
7 earlier of 120 days after the date the notification was
8 provided or 180 days after the date of the implementation of
9 the rate. The commission ~~department~~ may, subject to chapter
10 120, disapprove without the 60-day notification any rate
11 increase filed by an insurer within the prohibited time period
12 or during the time that the legality of the increased rate is
13 being contested.
14 (h) In the event the commission ~~department~~ finds that
15 a rate or rate change is excessive, inadequate, or unfairly
16 discriminatory, the commission ~~department~~ shall issue an order
17 of disapproval specifying that a new rate or rate schedule
18 which responds to the findings of the commission ~~department~~ be
19 filed by the insurer. The commission ~~department~~ shall further
20 order, for any "use and file" filing made in accordance with
21 subparagraph (a)2., that premiums charged each policyholder
22 constituting the portion of the rate above that which was
23 actuarially justified be returned to such policyholder in the
24 form of a credit or refund. If the commission ~~department~~ finds
25 that an insurer's rate or rate change is inadequate, the new
26 rate or rate schedule filed with the commission ~~department~~ in
27 response to such a finding shall be applicable only to new or
28 renewal business of the insurer written on or after the
29 effective date of the responsive filing.
30 (i) Except as otherwise specifically provided in this
31 chapter, the commission ~~department~~ shall not prohibit any

1 insurer, including any residual market plan or joint
2 underwriting association, from paying acquisition costs based
3 on the full amount of premium, as defined in s. 627.403,
4 applicable to any policy, or prohibit any such insurer from
5 including the full amount of acquisition costs in a rate
6 filing.
7
8 The provisions of this subsection shall not apply to workers'
9 compensation and employer's liability insurance and to motor
10 vehicle insurance.
11 (3)(a) For individual risks that are not rated in
12 accordance with the insurer's rates, rating schedules, rating
13 manuals, and underwriting rules filed with the commission
14 ~~department~~ and which have been submitted to the insurer for
15 individual rating, the insurer must maintain documentation on
16 each risk subject to individual risk rating. The
17 documentation must identify the named insured and specify the
18 characteristics and classification of the risk supporting the
19 reason for the risk being individually risk rated, including
20 any modifications to existing approved forms to be used on the
21 risk. The insurer must maintain these records for a period of
22 at least 5 years after the effective date of the policy.
23 (b) Individual risk rates and modifications to
24 existing approved forms are not subject to this part or part
25 II, except for paragraph (a) and ss. 627.402, 627.403,
26 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085,
27 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417,
28 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but
29 are subject to all other applicable provisions of this code
30 and rules adopted thereunder.
31

1 (c) This subsection does not apply to private
2 passenger motor vehicle insurance.
3 ~~(6)(a) After any action with respect to a rate filing~~
4 ~~that constitutes agency action for purposes of the~~
5 ~~Administrative Procedure Act, an insurer may, in lieu of~~
6 ~~demanding a hearing under s. 120.57, require arbitration of~~
7 ~~the rate filing. Arbitration shall be conducted by a board of~~
8 ~~arbitrators consisting of an arbitrator selected by the~~
9 ~~department, an arbitrator selected by the insurer, and an~~
10 ~~arbitrator selected jointly by the other two arbitrators. Each~~
11 ~~arbitrator must be certified by the American Arbitration~~
12 ~~Association. A decision is valid only upon the affirmative~~
13 ~~vote of at least two of the arbitrators. No arbitrator may be~~
14 ~~an employee of any insurance regulator or regulatory body or~~
15 ~~of any insurer, regardless of whether or not the employing~~
16 ~~insurer does business in this state. The department and the~~
17 ~~insurer must treat the decision of the arbitrators as the~~
18 ~~final approval of a rate filing. Costs of arbitration shall be~~
19 ~~paid by the insurer.~~
20 ~~(b) Arbitration under this subsection shall be~~
21 ~~conducted pursuant to the procedures specified in ss.~~
22 ~~682.06-682.10. Either party may apply to the circuit court to~~
23 ~~vacate or modify the decision pursuant to s. 682.13 or s.~~
24 ~~682.14. The department shall adopt rules for arbitration under~~
25 ~~this subsection, which rules may not be inconsistent with the~~
26 ~~arbitration rules of the American Arbitration Association as~~
27 ~~of January 1, 1996.~~
28 ~~(c) Upon initiation of the arbitration process, the~~
29 ~~insurer waives all rights to challenge the action of the~~
30 ~~department under the Administrative Procedure Act or any other~~
31 ~~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 28. 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.

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1 (e) Members of the commission shall serve without
2 compensation, but shall be reimbursed for per diem and travel
3 expenses pursuant to s. 112.061.
4 (f) The State Board of Administration shall, as a cost
5 of administration of the Florida Hurricane Catastrophe Fund,
6 provide for travel, expenses, and staff support for the
7 commission.
8 (g) There shall be no liability on the part of, and no
9 cause of action of any nature shall arise against, any member
10 of the commission, any member of the State Board of
11 Administration, or any employee of the State Board of
12 Administration for any action taken in the performance of
13 their duties under this section. In addition, the commission
14 may, in writing, waive any potential cause of action for
15 negligence of a consultant, contractor, or contract employee
16 engaged to assist the commission.
17 (3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.--
18 (a) The commission shall consider any actuarial
19 methods, principles, standards, models, or output ranges that
20 have the potential for improving the accuracy of or
21 reliability of the hurricane loss projections used in
22 residential property insurance rate filings. The commission
23 shall, from time to time, adopt findings as to the accuracy or
24 reliability of particular methods, principles, standards,
25 models, or output ranges.
26 (b) In establishing reimbursement premiums for the
27 Florida Hurricane Catastrophe Fund, the State Board of
28 Administration must, to the extent feasible, employ actuarial
29 methods, principles, standards, models, or output ranges found
30 by the commission to be accurate or reliable.
31

(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, models, or output ranges at least annually thereafter. ~~As soon as possible, but no later than July 1, 1996,~~The commission shall adopt revised actuarial methods, principles, standards, models, or output ranges which include specification of acceptable computer models or output ranges derived from computer models.

Section 29. Persons who are members of the Florida Commission on Hurricane Loss Projection Methodology on December 31, 2000, shall remain members of the commission until new members are appointed pursuant to section 627.0628, Florida Statutes, as amended by this act, except that the Public Counsel or his or her designee from the Office of the Public Counsel shall become a member effective January 1, 2001, and the Insurance Consumer Advocate shall cease to be a member on that date.

Section 30. Subsections (1), (2), (3), (6), (7), and (9) of section 627.0645, Florida Statutes, are amended to read:

627.0645 Annual filings.--

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line and commercial motor vehicle,

shall make an annual base rate filing for each such line with the commission ~~department~~ no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The commission ~~department~~, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(3) The filing requirements of this section shall be satisfied by one of the following methods:

(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission ~~department~~.

(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing

rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.

(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the commission ~~department~~ for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the commission ~~department~~ no later than the date the filing is due.

(7) Nothing in this section limits the commission's ~~department's~~ authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.

(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the commission ~~department~~ may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until ~~such time as~~ the commission ~~department~~ determines that the required filing is properly submitted.

Section 31. Subsection (1) of section 627.06501, Florida Statutes, is amended to read:

627.06501 Insurance discounts for certain persons completing driver improvement course.--

(1) Any rate, rating schedule, or rating manual for the liability, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the commission ~~department~~ may provide for an appropriate reduction in premium charges as to such coverages when the principal

operator on the covered vehicle has successfully completed a driver improvement course approved and certified by the Department of Highway Safety and Motor Vehicles which is effective in reducing crash or violation rates, or both, as determined pursuant to s. 318.1451(5). Any discount, not to exceed 10 percent, used by an insurer is presumed to be appropriate unless credible data demonstrates otherwise.

Section 32. Subsections (1), (2), (5), (9), (10), (11), and (13) of section 627.0651, Florida Statutes, are amended to read:

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

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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).

(2) Upon receiving notice of a rate filing or rate change, the commission ~~department~~ shall review the rate or rate change to determine if the 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:

(a) Past and prospective loss experience within and outside this state.

(b) The past and prospective expenses.

(c) The degree of competition among insurers for the risk insured.

(d) 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. Such investment income shall not include income from invested surplus. The commission ~~department~~ may adopt ~~promulgate~~ rules using ~~utilizing~~ reasonable techniques of actuarial science and economics to specify the manner in

1 which insurers shall calculate investment income attributable
2 to motor vehicle insurance policies written in this state and
3 the manner in which such investment income is used in the
4 calculation of insurance rates. Such manner shall contemplate
5 the use of a positive underwriting profit allowance in the
6 rates that will be compatible with a reasonable rate of return
7 plus provisions for contingencies. The total of the profit and
8 contingency factor as specified in the filing shall be
9 utilized in computing excess profits in conjunction with s.
10 627.066. In adopting ~~promulgating~~ such rules, the commission
11 ~~department~~ shall in all instances adhere to and implement the
12 provisions of this paragraph.
13 (e) The reasonableness of the judgment reflected in
14 the filing.
15 (f) Dividends, savings, or unabsorbed premium deposits
16 allowed or returned to Florida policyholders, members, or
17 subscribers.
18 (g) The cost of repairs to motor vehicles.
19 (h) The cost of medical services, if applicable.
20 (i) The adequacy of loss reserves.
21 (j) The cost of reinsurance.
22 (k) Trend factors, including trends in actual losses
23 per insured unit for the insurer making the filing.
24 (l) Other relevant factors which impact upon the
25 frequency or severity of claims or upon expenses.
26 (5)(a) Rates shall be deemed inadequate if they are
27 clearly insufficient, together with the investment income
28 attributable to them, to sustain projected losses and expenses
29 in the class of business to which they apply.
30 (b) The commission ~~Insurance Commissioner~~ shall have
31 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 department shall impose an administrative fine pursuant to s. 624.4211.

(9) In reviewing the rate or rate change filed, the commission ~~department~~ may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated herein.

(10) The commission ~~department~~ may, at any time, review a rate or rate change, the pertinent records of the insurer, and market conditions; and, if the commission ~~department~~ finds on a preliminary basis that the rate or rate change may be excessive, inadequate, or unfairly discriminatory, the commission ~~department~~ shall so notify the insurer. However, the commission ~~department~~ may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the commission ~~department~~ finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the commission

~~department~~ all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the commission ~~department~~ notifies an insurer that a rate may be excessive, inadequate, or unfairly 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

1 the commission ~~department~~ in response to such a finding shall
2 be applicable only to new or renewal business of the insurer
3 written on or after the effective date of the responsive
4 filing.
5 (13)(a) Underwriting rules not contained in rating
6 manuals shall be filed for private passenger automobile
7 insurance and homeowners' insurance.
8 (b) The submission of rates, rating schedules, and
9 rating manuals to the commission ~~department~~ by a licensed
10 rating organization of which an insurer is a member or
11 subscriber will be sufficient compliance with this subsection
12 for any insurer maintaining membership or subscribership in
13 such organization, to the extent that the insurer uses the
14 rates, rating schedules, and rating manuals of such
15 organization. All such information shall be available for
16 public inspection, upon receipt by the commission ~~department~~,
17 during usual business hours.
18 Section 33. Section 627.0653, Florida Statutes, is
19 amended to read:
20 627.0653 Insurance discounts for specified motor
21 vehicle equipment.--
22 (1) Any rates, rating schedules, or rating manuals for
23 the liability, personal injury protection, and collision
24 coverages of a motor vehicle insurance policy filed with the
25 commission ~~department~~ shall provide a premium discount if the
26 insured vehicle is equipped with factory-installed, four-wheel
27 antilock brakes.
28 (2) Each insurer writing motor vehicle comprehensive
29 coverage in this state shall include in its rating manual
30 discount provisions for comprehensive coverage which
31 specifically relate to an antitheft device or vehicle recovery

system utilized in the insured vehicle which are factory installed or approved by the commission ~~department~~. The commission ~~department~~ shall adopt, by rule, procedures under which manufacturers, distributors, or sellers may apply to the commission ~~department~~ for approval of non-factory-installed devices under this subsection. The rules must include, at a minimum, the test results that must accompany the application and the standards for approval.

(3) Any rates, rating schedules, or rating manuals for personal injury protection coverage and medical payments coverage, if offered, of a motor vehicle insurance policy filed with the commission ~~department~~ shall provide a premium discount if the insured vehicle is equipped with one or more air bags which are factory installed.

(4) The removal of a discount or credit does not constitute the imposition of, or request for, additional premium or a surcharge if the basis for the discount or credit no longer exists or is substantially eliminated.

(5) Each insurer writing motor vehicle comprehensive coverage in this state may provide a premium discount for this coverage if the insured vehicle has the complete manufacturer's vehicle identification number permanently etched on the windshield and all windows of the vehicle. The etching must be by a tool or process that does not destroy the integrity of the glass or visibility for the operator of the motor vehicle. The identification numbers and letters must be at least 1/4 inch in height. A sticker may identify the presence of this identification system. The commission ~~department~~ may, by rule, set forth appropriate guidelines to implement this subsection.

Section 34. Section 627.06535, Florida Statutes, is amended to read:

627.06535 Electric vehicles; restrictions on imposing surcharges.--An insurer may not impose a surcharge on the premium for motor vehicle insurance written on an electric vehicle, as defined in s. 320.01, if the surcharge is based on a factor such as new technology, passenger payload, weight-to-horsepower ratio, or types of materials, including composite materials or aluminum, used to manufacture the vehicle, unless the commission ~~Department of Insurance~~ determines from actuarial data submitted to it that the surcharge is justified.

Section 35. 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 36. 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.

(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~~

1 ~~hereinafter. Prior to July 1, 1982, the data required by this~~
2 ~~section shall be submitted to the department for the years~~
3 ~~1979, 1980, and 1981. Excessive profits shall be calculated~~
4 ~~in accordance with the provisions of this section. However,~~
5 ~~only the excessive profits realized by the insurer group in~~
6 ~~1981 shall be refunded to policyholders, and such refunds~~
7 ~~shall be made in accordance with this section. Prior to July~~
8 ~~1, 1983, the data required by this section shall be submitted~~
9 ~~to the department for the years 1980, 1981, and 1982.~~
10 ~~Excessive profits shall be calculated in accordance with this~~
11 ~~section; however, refunds shall only be made for excessive~~
12 ~~profits realized in the years 1981 and 1982. Thereafter,~~
13 ~~excessive profits shall be calculated and refunded on the~~
14 ~~basis of 3 years as set forth in this section.~~
15 Section 37. Subsection (4) of section 627.072, Florida
16 Statutes, is amended to read:
17 627.072 Making and use of rates.--
18 (4)(a) In the case of workers' compensation and
19 employer's liability insurance, the <u>commission</u> ~~department~~
20 shall consider <u>using</u> ~~utilizing~~ the following methodology in
21 rate determinations: Premiums, expenses, and expected claim
22 costs would be discounted to a common point of time, such as
23 the initial point of a policy year, in the determination of
24 rates; the cash-flow pattern of premiums, expenses, and claim
25 costs would be determined initially by using data from 8 to 10
26 of the largest insurers writing workers' compensation
27 insurance in the state; such insurers may be selected for
28 their statistical ability to report the data on an
29 accident-year basis and in accordance with subparagraphs
30 (b)1., 2., and 3., for at least 2 1/2 years; such a cash-flow
31 pattern would be modified when necessary in accordance with

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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;

2. Each insurer shall submit financial reports to the rating bureau and the commission ~~department~~ which shall include total incurred claim amounts and paid-claim amounts by policy year and by injury types as of December 31 of each calendar year; and

3. Each insurer shall submit to the rating bureau and the commission ~~department~~ paid-premium data on an individual risk basis in which risks are to be subdivided by premium size as follows:

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:	

4. Each insurer which does not have the capability of reporting in accordance with subparagraphs 1., 2., and 3.

1 shall be required to commence such reporting procedures as of
2 January 1, 1980.
3 ~~(c) The Insurance Commissioner is directed to consider~~
4 ~~using the methodology specified in paragraph (a) prior to~~
5 ~~March 31, 1980; and, in the event the Insurance Commissioner~~
6 ~~decides not to use this methodology, she or he shall report~~
7 ~~such decision and the reasons therefor to the committees of~~
8 ~~substance in the area of insurance in each house of the~~
9 ~~Legislature by March 31, 1980.~~
10 Section 38. Subsections (1), (5), and (6) of section
11 627.091, Florida Statutes, are amended to read:
12 627.091 Rate filings; workers' compensation and
13 employer's liability insurances.--
14 (1) As to workers' compensation and employer's
15 liability insurances, every insurer shall file with the
16 commission ~~department~~ every manual of classifications, rules,
17 and rates, every rating plan, and every modification of any of
18 the foregoing which it proposes to use. Every insurer is
19 authorized to include deductible provisions in its manual of
20 classifications, rules, and rates. Such deductibles shall in
21 all cases be in a form and manner which is consistent with the
22 underlying purpose of chapter 440.
23 (5) Pursuant to the provisions of s. 624.3161, the
24 commission ~~department~~ may examine the underlying statistical
25 data used in such filings.
26 (6) Whenever the committee of a recognized rating
27 organization with responsibility for workers' compensation and
28 employer's liability insurance rates in this state meets to
29 discuss the necessity for, or a request for, Florida rate
30 increases or decreases, the determination of Florida rates,
31 the rates to be requested, and any other matters pertaining

1 specifically and directly to such Florida rates, such meetings
2 shall be held in this state and shall be subject to s.
3 286.011. The committee of such a rating organization shall
4 provide at least 3 weeks' prior notice of such meetings to the
5 commission ~~department~~ and shall provide at least 14 days'
6 prior notice of such meetings to the public by publication in
7 the Florida Administrative Weekly.
8 Section 39. Section 627.0915, Florida Statutes, is
9 amended to read:
10 627.0915 Rate filings; workers' compensation,
11 drug-free workplace, and safe employers.--The commission
12 ~~Department of Insurance~~ shall approve rating plans for
13 workers' compensation insurance that give specific
14 identifiable consideration in the setting of rates to
15 employers that either implement a drug-free workplace program
16 pursuant to rules adopted by the Division of Workers'
17 Compensation of the Department of Labor and Employment
18 Security or implement a safety program approved by the
19 Division of Safety pursuant to rules adopted by the Division
20 of Safety of the Department of Labor and Employment Security
21 or implement both a drug-free workplace program and a safety
22 program. The Division of Safety may by rule require that the
23 client of a help supply services company comply with the
24 essential requirements of a workplace safety program as a
25 condition for receiving a premium credit. The plans must take
26 effect January 1, 1994, must be actuarially sound, and must
27 state the savings anticipated to result from such drug-testing
28 and safety programs.
29 Section 40. Section 627.0916, Florida Statutes, is
30 amended to read:
31

627.0916 Agricultural horse farms.--Notwithstanding any other provision of this chapter to the contrary, any rates, rating schedules, or rating manuals for workers' compensation and employer's liability insurance filed with the commission ~~Department of Insurance~~ shall provide for the rates of an agricultural horse farm engaged in breeding or training to be separated into the following three rate classifications and the premium paid shall be applied proportionately according to payroll: breeding activity involving stallions; breeding activity not involving stallions, including but not limited to boarding and foaling; and training.

Section 41. 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 42. Section 627.101, Florida Statutes, is amended to read:

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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~~

1 approves a filing, it shall give prompt notice thereof to the
2 insurer or rating organization that made the filing, and in
3 which case the filing shall become effective upon such
4 approval or upon such subsequent date as may be satisfactory
5 to the commission ~~department~~ and the insurer or rating
6 organization that made the filing.
7 Section 43. Section 627.111, Florida Statutes, is
8 amended to read:
9 627.111 Effective date of filing.--
10 (1) If, pursuant to s. 627.101(2), the commission
11 ~~department~~ determines to hold a public hearing as to a filing,
12 or it holds such a public hearing pursuant to request therefor
13 under s. 627.101(3), it shall give written notice thereof to
14 the rating organization or insurer that made the filing and
15 shall hold such hearing within 30 days, and not less than 10
16 days prior to the date of the hearing, it shall give written
17 notice of the hearing to the insurer or rating organization
18 that made the filing. The commission ~~department~~ may also, in
19 its discretion, give advance public notice of such hearing by
20 publication of notice in one or more daily newspapers of
21 general circulation in this state.
22 (2) If the order of the commission ~~department~~
23 disapproves the filing, the filing shall not become effective
24 during the effectiveness of such order. If the order of the
25 commission ~~department~~ approves the filing, the filing shall
26 become effective upon the date of the order or upon such
27 subsequent date as may be satisfactory to the insurer or
28 rating organization that made the filing.
29 Section 44. Section 627.141, Florida Statutes, is
30 amended to read:
31

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627.141 Subsequent disapproval of filing; workers' compensation and employer's liability insurances.--If at any time after a filing has been approved by it or has otherwise become effective the commission ~~department~~ finds that the filing no longer meets the requirements of this chapter, it shall issue an order specifying in what respects it finds that such filing fails to meet such requirements and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. The order shall not affect any insurance contract or policy made or issued prior to the expiration of the period set forth in the order.

Section 45. Subsection (1) of section 627.151, Florida Statutes, is amended to read:

627.151 Basis of approval or disapproval of workers' compensation or employer's liability insurance filing; scope of disapproval power.--

(1) In determining at any time whether to approve or disapprove a filing as to workers' compensation or employer's liability insurance, or to permit the filing otherwise to become effective, the commission ~~department~~ shall give consideration only to the applicable standards and factors referred to in ss. 627.062 and 627.072.

Section 46. Paragraph (f) of subsection (2) of section 627.192, Florida Statutes, is amended to read:

627.192 Workers' compensation insurance; employee leasing arrangements.--

(2) For purposes of the Florida Insurance Code:

(f) "Premium subject to dispute" means that the insured has provided a written notice of dispute to the insurer or service carrier, has initiated any applicable proceeding for resolving such disputes as prescribed by law or

rating organization procedures approved by the commission ~~department~~, or has initiated litigation regarding the premium dispute. The insured must have detailed the specific areas of dispute and provided an estimate of the premium the insured believes to be correct. The insured must have paid any undisputed portion of the bill.

Section 47. Section 627.211, Florida Statutes, is amended to read:

627.211 Deviations; workers' compensation and employer's liability insurances.--

(1) Every member or subscriber to a rating organization shall, as to workers' compensation or employer's liability insurance, adhere to the filings made on its behalf by such organization; except that any such insurer may make written application to the commission ~~department~~ for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance, for a class of insurance which is found by the commission ~~department~~ to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of workers' compensation or employer's liability insurance:

(a) Comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(b) For which separate expense provisions are included in the filings of the rating organization.

Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant

1 relies. A copy of the application and data shall be sent
2 simultaneously to the rating organization.
3 (2) Every member or subscriber to a rating
4 organization may, as to workers' compensation and employer's
5 liability insurance, file a plan or plans to use deviations
6 that vary according to factors present in each insured's
7 individual risk. The insurer that files for the deviations
8 provided in this subsection shall file the qualifications for
9 the plans, schedules of rating factors, and the maximum
10 deviation factors which shall be subject to the approval of
11 the commission ~~department~~ pursuant to s. 627.091. The actual
12 deviation which shall be used for each insured that qualifies
13 under this subsection may not exceed the maximum filed
14 deviation under that plan and shall be based on the merits of
15 each insured's individual risk as determined by using
16 schedules of rating factors which shall be applied uniformly.
17 Insurers shall maintain statistical data in accordance with
18 the schedule of rating factors. Such data shall be available
19 to support the continued use of such varying deviations.
20 (3) In considering an application for the deviation,
21 the commission ~~department~~ shall give consideration to the
22 applicable principles for ratemaking as set forth in ss.
23 627.062 and 627.072, the financial condition of the insurer,
24 and the impact of the deviation on the current market
25 conditions including the composition of the market, the
26 stability of rates, and the level of competition in the
27 market. In evaluating the financial condition of the insurer,
28 the commission ~~department~~ may consider:~~(1)~~the insurer's
29 audited financial statements and whether the statements
30 provide unqualified opinions or contain significant
31 qualifications or "subject to" provisions;~~(2)~~any independent

or other actuarial certification of loss reserves;~~(3)~~whether workers' compensation and employer's liability reserves are above the midpoint or best estimate of the actuary's reserve range estimate;~~(4)~~the adequacy of the proposed rate;~~(5)~~ historical experience demonstrating the profitability of the insurer;~~(6)~~the existence of excess or other reinsurance that contains a sufficiently low attachment point and maximums that provide adequate protection to the insurer; and~~(7)~~other 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.~~

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(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. 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 48. 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 49. 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 s. 627.0625, commercial umbrella liability insurance as defined in s. 627.0625, or commercial casualty insurance as defined in s. 627.0625 shall file with the commission ~~department~~ prior to July 1 of each year, on a form prescribed by the commission ~~department~~, the following data for the component types of such insurance as provided in the form:

1. Calendar-year earned premium.

2. Accident-year incurred losses and loss adjustment expenses.

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

4. Policyholder dividends applicable to the calendar year.

Nothing herein is intended to prohibit an insurer from filing on a calendar-year basis.

(b) The data filed for the group shall be a consolidation of the data of the individual insurers of the group. However, an insurer may elect to either consolidate commercial umbrella liability insurance data with commercial casualty insurance data or to separately file data for

1 commercial umbrella liability insurance. Each insurer shall
2 elect its method of filing commercial umbrella liability
3 insurance at the time of filing data for accident year 1987
4 and shall thereafter continue filing under the same method. In
5 the case of commercial umbrella liability insurance data
6 reported separately, a separate excessive profits test shall
7 be applied and the test period shall be 10 years. ~~In the case~~
8 ~~of workers' compensation and employer's liability insurance,~~
9 ~~the final report for the test period including accident years~~
10 ~~1984, 1985, and 1986 must be filed prior to July 1, 1988. In~~
11 ~~the case of commercial property and commercial casualty~~
12 ~~insurance, the final report for the test period including~~
13 ~~accident years 1987, 1988, and 1989 must be filed prior to~~
14 ~~July 1, 1991.~~
15 (9) If the insurer group has realized an excessive
16 profit, the department shall order a return of the excessive
17 amounts after affording the insurer group an opportunity for
18 hearing and otherwise complying with the requirements of
19 chapter 120. Such excessive amounts shall be refunded in all
20 instances unless the insurer group affirmatively demonstrates
21 to the commission ~~department~~ that the refund of the excessive
22 amounts will render a member of the insurer group financially
23 impaired or will render it insolvent under the provisions of
24 the Florida Insurance Code.
25 (12)(a) Refunds shall be completed in one of the
26 following ways:
27 1. If the insurer group elects to make a cash refund,
28 the refund shall be completed within 60 days of entry of a
29 final order indicating that excessive profits have been
30 realized.
31

1 2. If the insurer group elects to make refunds in the
2 form of a credit to renewal policies, such credits shall be
3 applied to policy renewal premium notices which are forwarded
4 to insureds more than 60 calendar days after entry of a final
5 order indicating that excessive profits have been realized.
6 If an insurer group has made this election but an insured
7 thereafter cancels her or his policy or otherwise allows the
8 policy to terminate, the insurer group shall make a cash
9 refund not later than 60 days after termination of such
10 coverage.
11 (b) Upon completion of the renewal credits or refund
12 payments, the insurer group shall immediately certify to the
13 <u>commission</u> ~~department~~ that the refunds have been made.
14 Section 50. Subsection (1) of section 627.221, Florida
15 Statutes, is amended to read:
16 627.221 Rating organizations; licensing; fee.--
17 (1) A person, whether located within or outside this
18 state, may make application to the <u>commission</u> ~~department~~ for a
19 license as a rating organization. As to property or inland
20 marine insurance, the application shall be for such kinds of
21 insurance or subdivisions thereof or classes of risk or a part
22 or combination thereof as are specified in the application.
23 As to casualty and surety insurances, the application shall be
24 for such kinds of insurance or subdivisions thereof as are
25 specified in the application. The applicant shall file with
26 its application:
27 (a) A copy of its constitution, its articles of
28 agreement or association or its certificate of incorporation,
29 and of its bylaws, rules, and regulations governing the
30 conduct of its business;
31 (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 its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, it shall issue a license specifying (in the case of a casualty or surety rating organization) the kinds of insurance or subdivisions thereof, or (in the case of a property insurance rating organization) the kinds of insurance or subdivisions thereof or classes of risk or a part or combination thereof, for which the applicant is authorized to act as a rating organization.

Section 51. Section 627.231, Florida Statutes, is amended to read:

627.231 Subscribers to rating organizations.--

(1) Subject to rules and regulations which have been approved by the commission ~~department~~ as reasonable, each rating organization shall permit any insurer, not a member, to subscribe to its rating services. As to property and marine rating organizations, an insurer shall be so permitted to subscribe to rating services for any kind of insurance, subdivision thereof, or class of risk or a part or combination thereof for which the rating organization is authorized so to act. As to casualty and surety rating organizations, an

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insurer shall be so permitted to subscribe to rating services for any kind of insurance or subdivision thereof for which the rating organization is authorized so to act. The rating organization shall give notice to subscribers of proposed changes in such rules and regulations.

(2) The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the commission ~~department~~. If the commission ~~department~~ 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 52. 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 (1) Its constitution, its articles of agreement or
2 association, or its certificate of incorporation, and its
3 bylaws, rules and regulations governing the conduct of its
4 business;
5 (2) Its list of members and subscribers; and
6 (3) The name and address of the resident of this state
7 designated by it upon whom notices or orders of the department
8 or process affecting such rating organization may be served.
9 Section 53. Section 627.281, Florida Statutes, is
10 amended to read:
11 627.281 Appeal from rating organization; workers'
12 compensation and employer's liability insurance filings.--
13 (1) Any member or subscriber to a rating organization
14 may appeal to the commission ~~department~~ from the action or
15 decision of such rating organization in approving or rejecting
16 any proposed change in or addition to the workers'
17 compensation or employer's liability insurance filings of such
18 rating organization, and the commission ~~department~~ shall issue
19 an order approving the decision of such rating organization or
20 directing it to give further consideration to such proposal.
21 If such appeal is from the action or decision of the rating
22 organization in rejecting a proposed addition to its filings,
23 the commission ~~department~~ may, if ~~in the event that~~ it finds
24 that such action or decision was unreasonable, issue an order
25 directing the rating organization to make an addition to its
26 filings, on behalf of its members and subscribers, in a manner
27 consistent with its findings, within a reasonable time after
28 the issuance of such order.
29 (2) If such appeal is based upon the failure of the
30 rating organization to make a filing on behalf of such member
31 or subscriber which is based on a system of expense provisions

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which differs, in accordance with the right granted in s. 627.072(2), from the system of expense provisions included in a filing made by the rating organization, the commission ~~department~~ shall, if it grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal, the commission ~~department~~ shall apply the applicable standards set forth in ss. 627.062 and 627.072.

Section 54. Subsection (2) of section 627.291, Florida Statutes, is amended to read:

627.291 Information to be furnished insureds; appeal by insureds; workers' compensation and employer's liability insurances.--

(2) As to workers' compensation and employer's liability insurances, every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on his or her written request to review the manner in which such rating system has been applied in connection with the insurance afforded him or her. If the rating organization or insurer fails to grant or rejects such request within 30 days after it is made, the applicant may proceed in the same manner as if his or her application had been rejected. Any party affected by the action of such rating organization or insurer on such request may, within 30 days after written notice of such action, appeal to the commission ~~department~~, which may affirm or reverse such action.

Section 55. Section 627.301, Florida Statutes, is amended to read:

627.301 Advisory organizations.--

(1) No advisory organization shall conduct its operations in this state unless and until it has filed with the commission ~~department~~:

(a) A copy of its constitution, articles of incorporation, articles of agreement or of association, and bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals thereof;

(b) A list of its members and subscribers; and

(c) The name and address of a resident of this state upon whom notices or orders of the department or process may be served.

(2) Every such advisory organization shall notify the commission ~~department~~ promptly of every change in:

(a) Its constitution;

(b) Its articles of incorporation, agreement, or association;

(c) Its bylaws, rules and regulations governing the conduct of its business;

(d) The list of members and subscribers; and

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

(3) No such advisory organization shall engage in any unfair or unreasonable practice with respect to such activities.

Section 56. Subsection (4) of section 627.311, Florida Statutes, is amended to read:

627.311 Joint underwriters and joint reinsurers.--

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1 (4)(a) ~~Effective upon this act becoming a law,~~The
2 department shall, after consultation with insurers, approve a
3 joint underwriting plan of insurers which shall operate as a
4 nonprofit entity. For the purposes of this subsection, the
5 term "insurer" includes group self-insurance funds authorized
6 by s. 624.4621, commercial self-insurance funds authorized by
7 s. 624.462, assessable mutual insurers authorized under s.
8 628.6011, and insurers licensed to write workers' compensation
9 and employer's liability insurance in this state. The purpose
10 of the plan is to provide workers' compensation and employer's
11 liability insurance to applicants who are required by law to
12 maintain workers' compensation and employer's liability
13 insurance and who are in good faith entitled to but who are
14 unable to purchase such insurance through the voluntary
15 market. The joint underwriting plan shall issue policies
16 beginning January 1, 1994. The plan must have actuarially
17 sound rates that assure that the plan is self-supporting.
18 (b) The operation of the plan is subject to the
19 supervision of a 13-member board of governors. The board of
20 governors shall be comprised of:
21 1. Five of the 20 domestic insurers, as defined in s.
22 624.06(1), having the largest voluntary direct premiums
23 written in this state for workers' compensation and employer's
24 liability insurance, which shall be elected by those 20
25 domestic insurers;
26 2. Five of the 20 foreign insurers as defined in s.
27 624.06(2) having the largest voluntary direct premiums written
28 in this state for workers' compensation and employer's
29 liability insurance, which shall be elected by those 20
30 foreign insurers;
31

1 3. One person, who shall serve as the chair, appointed
2 by the Insurance Commissioner;
3 4. One person appointed by the largest property and
4 casualty insurance agents' association in this state; and
5 5. The consumer advocate appointed under s. 627.0613
6 or the consumer advocate's designee.
7
8 Each board member shall serve a 4-year term and may serve
9 consecutive terms. No board member shall be an insurer which
10 provides service to the plan or which has an affiliate which
11 provides services to the plan or which is serviced by a
12 service company or third-party administrator which provides
13 services to the plan or which has an affiliate which provides
14 services to the plan. The minutes, audits, and procedures of
15 the board of governors are subject to chapter 119.
16 (c) The operation of the plan shall be governed by a
17 plan of operation that is prepared at the direction of the
18 board of governors. The plan of operation may be changed at
19 any time by the board of governors or upon request of the
20 department or commission. The plan of operation and all
21 changes thereto are subject to the approval of the department,
22 except that all changes related to rates are subject to
23 approval of the commission. The plan of operation shall:
24 1. Authorize the board to engage in the activities
25 necessary to implement this subsection, including, but not
26 limited to, borrowing money.
27 2. Develop criteria for eligibility for coverage by
28 the plan, including, but not limited to, documented rejection
29 by at least two insurers which reasonably assures that
30 insureds covered under the plan are unable to acquire coverage
31 in the voluntary market. Any insured may voluntarily elect to

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1 accept coverage from an insurer for a premium equal to or
2 greater than the plan premium if the insurer writing the
3 coverage adheres to the provisions of s. 627.171.
4 3. Require notice from the agent to the insured at the
5 time of the application for coverage that the application is
6 for coverage with the plan and that coverage may be available
7 through an insurer, group self-insurers' fund, commercial
8 self-insurance fund, or assessable mutual insurer through
9 another agent at a lower cost.
10 4. Establish programs to encourage insurers to provide
11 coverage to applicants of the plan in the voluntary market and
12 to insureds of the plan, including, but not limited to:
13 a. Establishing procedures for an insurer to use in
14 notifying the plan of the insurer's desire to provide coverage
15 to applicants to the plan or existing insureds of the plan and
16 in describing the types of risks in which the insurer is
17 interested. The description of the desired risks must be on a
18 form developed by the plan.
19 b. Developing forms and procedures that provide an
20 insurer with the information necessary to determine whether
21 the insurer wants to write particular applicants to the plan
22 or insureds of the plan.
23 c. Developing procedures for notice to the plan and
24 the applicant to the plan or insured of the plan that an
25 insurer will insure the applicant or the insured of the plan,
26 and notice of the cost of the coverage offered; and developing
27 procedures for the selection of an insuring entity by the
28 applicant or insured of the plan.
29 d. Provide for a market-assistance plan to assist in
30 the placement of employers. All applications for coverage in
31 the plan received 45 days before the effective date for

1 coverage shall be processed through the market-assistance
2 plan. A market-assistance plan specifically designed to serve
3 the needs of small good policyholders as defined by the board
4 must be finalized by January 1, 1994.
5 5. Provide for policy and claims services to the
6 insureds of the plan of the nature and quality provided for
7 insureds in the voluntary market.
8 6. Provide for the review of applications for coverage
9 with the plan for reasonableness and accuracy, using any
10 available historic information regarding the insured.
11 7. Provide for procedures for auditing insureds of the
12 plan which are based on reasonable business judgment and are
13 designed to maximize the likelihood that the plan will collect
14 the appropriate premiums.
15 8. Authorize the plan to terminate the coverage of and
16 refuse future coverage for any insured that submits a
17 fraudulent application to the plan or provides fraudulent or
18 grossly erroneous records to the plan or to any service
19 provider of the plan in conjunction with the activities of the
20 plan.
21 9. Establish service standards for agents who submit
22 business to the plan.
23 10. Establish criteria and procedures to prohibit any
24 agent who does not adhere to the established service standards
25 from placing business with the plan or receiving, directly or
26 indirectly, any commissions for business placed with the plan.
27 11. Provide for the establishment of reasonable safety
28 programs for all insureds in the plan.
29 12. Authorize the plan to terminate the coverage of
30 and refuse future coverage to any insured who fails to pay
31 premiums or surcharges when due; who, at the time of

1 application, is delinquent in payments of workers'
2 compensation or employer's liability insurance premiums or
3 surcharges owed to an insurer, group self-insurers' fund,
4 commercial self-insurance fund, or assessable mutual insurer
5 licensed to write such coverage in this state; or who refuses
6 to substantially comply with any safety programs recommended
7 by the plan.
8 13. Authorize the board of governors to provide the
9 services required by the plan through staff employed by the
10 plan, through reasonably compensated service providers who
11 contract with the plan to provide services as specified by the
12 board of governors, or through a combination of employees and
13 service providers.
14 14. Provide for service standards for service
15 providers, methods of determining adherence to those service
16 standards, incentives and disincentives for service, and
17 procedures for terminating contracts for service providers
18 that fail to adhere to service standards.
19 15. Provide procedures for selecting service providers
20 and standards for qualification as a service provider that
21 reasonably assure that any service provider selected will
22 continue to operate as an ongoing concern and is capable of
23 providing the specified services in the manner required.
24 16. Provide for reasonable accounting and
25 data-reporting practices.
26 17. Provide for annual review of costs associated with
27 the administration and servicing of the policies issued by the
28 plan to determine alternatives by which costs can be reduced.
29 18. Authorize the acquisition of such excess insurance
30 or reinsurance as is consistent with the purposes of the plan.
31

1 19. Provide for an annual report to the department on
2 a date specified by the department and containing such
3 information as the department reasonably requires.
4 20. Establish multiple rating plans for various
5 classifications of risk which reflect risk of loss, hazard
6 grade, actual losses, size of premium, and compliance with
7 loss control. At least one of such plans must be a
8 preferred-rating plan to accommodate small-premium
9 policyholders with good experience as defined in
10 sub-subparagraph 22.a.
11 21. Establish agent commission schedules.
12 22. Establish three subplans as follows:
13 a. Subplan "A" must include those insureds whose
14 annual premium does not exceed $2,500 and who have neither
15 incurred any lost-time claims nor incurred medical-only claims
16 exceeding 50 percent of their premium for the immediate 2
17 years.
18 b. Subplan "B" must include insureds that are
19 employers identified by the board of governors as high-risk
20 employers due solely to the nature of the operations being
21 performed by those insureds and for whom no market exists in
22 the voluntary market, and whose experience modifications are
23 less than 1.00.
24 c. Subplan "C" must include all other insureds within
25 the plan.
26 (d) The plan must be funded through actuarially sound
27 premiums charged to insureds of the plan. The plan may issue
28 assessable policies only to those insureds in subplan "C."
29 Those assessable policies must be clearly identified as
30 assessable by containing, in contrasting color and in not less
31 than 10-point type, the following statements: "This is an

assessable policy. If the plan is unable to pay its obligations, policyholders will be required to contribute on a pro rata earned premium basis the money necessary to meet any assessment levied." The plan may issue assessable policies with differing terms and conditions to different groups within the plan when a reasonable basis exists for the differentiation. The plan may offer rating, dividend plans, 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.

(g) Whenever a deficit exists, the plan shall, within 90 days, provide the department and the commission with a program to eliminate the deficit within a reasonable time. The deficit may be funded both through increased premiums charged to insureds of the plan for subsequent years and through assessments on insureds in the plan if the plan uses assessable policies.

(h) Any premium or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds of the plan in conjunction with loss prevention or dividend programs shall be retained by the plan for future use.

(i) The decisions of the board of governors do not constitute final agency action and are not subject to chapter 120.

(j) Policies for insureds shall be issued by the plan.

(k) The plan created under this subsection is liable only for payment for losses arising under policies issued by the plan with dates of accidents occurring on or after January 1, 1994.

(l) Plan losses are the sole and exclusive responsibility of the plan, and payment for such losses must be funded in accordance with this subsection and must not

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1 come, directly or indirectly, from insurers or any guaranty
2 association for such insurers.
3 (m) Each joint underwriting plan or association
4 created under this section is not a state agency, board, or
5 commission. However, for the purposes of s. 199.183(1) only,
6 the joint underwriting plan is a political subdivision of the
7 state and is exempt from the corporate income tax.
8 (n) Each joint underwriting plan or association may
9 elect to pay premium taxes on the premiums received on its
10 behalf or may elect to have the member insurers to whom the
11 premiums are allocated pay the premium taxes if the member
12 insurer had written the policy. The joint underwriting plan or
13 association shall notify the member insurers and the
14 Department of Revenue by January 15 of each year of its
15 election for the same year. As used in this paragraph, the
16 term "premiums received" means the consideration for
17 insurance, by whatever name called, but does not include any
18 policy assessment or surcharge received by the joint
19 underwriting association as a result of apportioning losses or
20 deficits of the association pursuant to this section.
21 (o) Effective midnight, December 31, 1993, the Florida
22 Workers' Compensation Insurance Plan, administered by the
23 National Council on Compensation Insurance, shall terminate,
24 except with respect to workers' compensation policies issued
25 pursuant to such Florida Workers' Compensation Insurance Plan
26 with inception dates on or before December 31, 1993.
27 (p) Neither the plan nor any member of the board of
28 governors is liable for monetary damages to any person for any
29 statement, vote, decision, or failure to act, regarding the
30 management or policies of the plan, unless:
31

1 1. The member breached or failed to perform her or his
2 duties as a member; and
3 2. The member's breach of, or failure to perform,
4 duties constitutes:
5 a. A violation of the criminal law, unless the member
6 had reasonable cause to believe her or his conduct was
7 unlawful. A judgment or other final adjudication against a
8 member in any criminal proceeding for violation of the
9 criminal law estops that member from contesting the fact that
10 her or his breach, or failure to perform, constitutes a
11 violation of the criminal law; but does not estop the member
12 from establishing that she or he had reasonable cause to
13 believe that her or his conduct was lawful or had no
14 reasonable cause to believe that her or his conduct was
15 unlawful;
16 b. A transaction from which the member derived an
17 improper personal benefit, either directly or indirectly; or
18 c. Recklessness or any act or omission that was
19 committed in bad faith or with malicious purpose or in a
20 manner exhibiting wanton and willful disregard of human
21 rights, safety, or property. For purposes of this
22 sub-subparagraph, the term "recklessness" means the acting, or
23 omission to act, in conscious disregard of a risk:
24 (I) Known, or so obvious that it should have been
25 known, to the member; and
26 (II) Known to the member, or so obvious that it should
27 have been known, to be so great as to make it highly probable
28 that harm would follow from such act or omission.
29 (q) No insurer shall provide workers' compensation and
30 employer's liability insurance to any person who is delinquent
31

in the payment of premiums, assessments, penalties, or surcharges owed to the plan.

(5) As used in this section and ss. 215.555 and 627.351, the term "collateral protection insurance" means commercial property insurance of which a creditor is the primary beneficiary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation 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 57. 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 58. 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.

(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 59. 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

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1 surety insurers with respect to the equitable apportionment
2 among them of insurance which may be afforded applicants who
3 are in good faith entitled to, but are unable to, procure such
4 insurance through ordinary methods, and such insurers may
5 agree among themselves on the use of reasonable rate
6 modifications for such insurance. Such agreements and rate
7 modifications shall be subject to the approval of the
8 department. The department shall, after consultation with the
9 insurers licensed to write automobile liability insurance in
10 this state, adopt a reasonable plan or plans for the equitable
11 apportionment among such insurers of applicants for such
12 insurance who are in good faith entitled to, but are unable
13 to, procure such insurance through ordinary methods, and, when
14 such plan has been adopted, all such insurers shall subscribe
15 thereto and shall participate therein. Such plan or plans
16 shall include rules for classification of risks and rates
17 therefor. The plan or plans shall make available
18 noncancelable coverage as provided in s. 627.7275(2). Any
19 insured placed with the plan shall be notified of the fact
20 that insurance coverage is being afforded through the plan and
21 not through the private market, and such notification shall be
22 given in writing within 10 days of such placement. To assure
23 that plan rates are made adequate to pay claims and expenses,
24 insurers shall develop a means of obtaining loss and expense
25 experience at least annually, and the plan shall file such
26 experience, when available, with the commission ~~department~~ in
27 sufficient detail to make a determination of rate adequacy.
28 Prior to the filing of such experience with the commission
29 ~~department~~, the plan shall poll each member insurer as to the
30 need for an actuary who is a member of the Casualty Actuarial
31 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 the filing. Notification to the plan by the commission ~~department~~ of its preliminary findings, which include a point of entry to the plan pursuant to chapter 120, 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 plan of its preliminary findings within 60 days of the filing. In addition to provisions for claims and expenses, the ratemaking formula shall include a factor for projected claims trending and 5 percent for contingencies. In no instance shall the formula include a renewal discount for plan insureds. However, the plan shall reunderwrite each insured on an annual basis, based upon all applicable rating factors approved by the department. Trend factors shall not be found to be inappropriate if not in excess of trend factors normally used in the development of residual market rates by the appropriate licensed rating organization. Each application for coverage in the plan shall include, in boldfaced 12-point type immediately preceding the applicant's signature, the following statement:

1 "THIS INSURANCE IS BEING AFFORDED THROUGH THE
2 FLORIDA JOINT UNDERWRITING ASSOCIATION AND NOT
3 THROUGH THE PRIVATE MARKET. PLEASE BE ADVISED
4 THAT COVERAGE WITH A PRIVATE INSURER MAY BE
5 AVAILABLE FROM ANOTHER AGENT AT A LOWER COST.
6 AGENT AND COMPANY LISTINGS ARE AVAILABLE IN THE
7 LOCAL YELLOW PAGES."
8
9 The plan shall annually report to the commission
10 ~~department~~ the number and percentage of plan insureds
11 who are not surcharged due to their driving record.
12 (2) WINDSTORM INSURANCE RISK APPORTIONMENT.--
13 (a) Agreements may be made among property insurers
14 with respect to the equitable apportionment among them of
15 insurance which may be afforded applicants who are in good
16 faith entitled to, but are unable to procure, such insurance
17 through ordinary methods; and such insurers may agree among
18 themselves on the use of reasonable rate modifications for
19 such insurance. Such agreements and rate modifications shall
20 be subject to the applicable provisions of this chapter.
21 (b) The department shall require all insurers holding
22 a certificate of authority to transact property insurance on a
23 direct basis in this state, other than joint underwriting
24 associations and other entities formed pursuant to this
25 section, to provide windstorm coverage to applicants from
26 areas determined to be eligible pursuant to paragraph (c) who
27 in good faith are entitled to, but are unable to procure, such
28 coverage through ordinary means; or it shall adopt a
29 reasonable plan or plans for the equitable apportionment or
30 sharing among such insurers of windstorm coverage, which may
31 include formation of an association for this purpose. As used

1 in this subsection, the term "property insurance" means
2 insurance on real or personal property, as defined in s.
3 624.604, including insurance for fire, industrial fire, allied
4 lines, farmowners multiperil, homeowners' multiperil,
5 commercial multiperil, and mobile homes, and including
6 liability coverages on all such insurance, but excluding
7 inland marine as defined in s. 624.607(3) and excluding
8 vehicle insurance as defined in s. 624.605(1)(a) other than
9 insurance on mobile homes used as permanent dwellings. The
10 department shall adopt rules that provide a formula for the
11 recovery and repayment of any deferred assessments.
12 1. For the purpose of this section, properties
13 eligible for such windstorm coverage are defined as dwellings,
14 buildings, and other structures, including mobile homes which
15 are used as dwellings and which are tied down in compliance
16 with mobile home tie-down requirements prescribed by the
17 Department of Highway Safety and Motor Vehicles pursuant to s.
18 320.8325, and the contents of all such properties. An
19 applicant or policyholder is eligible for coverage only if an
20 offer of coverage cannot be obtained by or for the applicant
21 or policyholder from an admitted insurer at approved rates.
22 2.a.(I) All insurers required to be members of such
23 association shall participate in its writings, expenses, and
24 losses. Surplus of the association shall be retained for the
25 payment of claims and shall not be distributed to the member
26 insurers. Such participation by member insurers shall be in
27 the proportion that the net direct premiums of each member
28 insurer written for property insurance in this state during
29 the preceding calendar year bear to the aggregate net direct
30 premiums for property insurance of all member insurers, as
31 reduced by any credits for voluntary writings, in this state

1 during the preceding calendar year. For the purposes of this
2 subsection, the term "net direct premiums" means direct
3 written premiums for property insurance, reduced by premium
4 for liability coverage and for the following if included in
5 allied lines: rain and hail on growing crops; livestock;
6 association direct premiums booked; National Flood Insurance
7 Program direct premiums; and similar deductions specifically
8 authorized by the plan of operation and approved by the
9 department. A member's participation shall begin on the first
10 day of the calendar year following the year in which it is
11 issued a certificate of authority to transact property
12 insurance in the state and shall terminate 1 year after the
13 end of the calendar year during which it no longer holds a
14 certificate of authority to transact property insurance in the
15 state. The commissioner, after review of annual statements,
16 other reports, and any other statistics that the commissioner
17 deems necessary, shall certify to the association the
18 aggregate direct premiums written for property insurance in
19 this state by all member insurers.
20 (II) The plan of operation shall provide for a board
21 of directors consisting of the Insurance Consumer Advocate
22 appointed under s. 627.0613, 1 consumer representative
23 appointed by the Insurance Commissioner, 1 consumer
24 representative appointed by the Governor, and 12 additional
25 members appointed as specified in the plan of operation. One
26 of the 12 additional members shall be elected by the domestic
27 companies of this state on the basis of cumulative weighted
28 voting based on the net direct premiums of domestic companies
29 in this state. Nothing in the 1997 amendments to this
30 paragraph terminates the existing board or the terms of any
31 members of the board.

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

1 of 100,000 Residential Property and Casualty Joint
2 Underwriting Association policies or 15 percent of the total
3 number of Residential Property and Casualty Joint Underwriting
4 Association policies, provided the governing board of the
5 Residential Property and Casualty Joint Underwriting
6 Association certifies that the take-out plan will materially
7 reduce the Residential Property and Casualty Joint
8 Underwriting Association's 100-year probable maximum loss from
9 hurricanes. With the approval of the department, the board
10 may extend such credits for an additional year if the insurer
11 guarantees an additional year of renewability for all policies
12 removed from the Residential Property and Casualty Joint
13 Underwriting Association, or for 2 additional years if the
14 insurer guarantees 2 additional years of renewability for all
15 policies removed from the Residential Property and Casualty
16 Joint Underwriting Association.
17 b. Assessments to pay deficits in the association
18 under this subparagraph shall be included as an appropriate
19 factor in the making of rates as provided in s. 627.3512.
20 c. The Legislature finds that the potential for
21 unlimited deficit assessments under this subparagraph may
22 induce insurers to attempt to reduce their writings in the
23 voluntary market, and that such actions would worsen the
24 availability problems that the association was created to
25 remedy. It is the intent of the Legislature that insurers
26 remain fully responsible for paying regular assessments and
27 collecting emergency assessments for any deficits of the
28 association; however, it is also the intent of the Legislature
29 to provide a means by which assessment liabilities may be
30 amortized over a period of years.
31

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1 d.(I) When the deficit incurred in a particular
2 calendar year is 10 percent or less of the aggregate statewide
3 direct written premium for property insurance for the prior
4 calendar year for all member insurers, the association shall
5 levy an assessment on member insurers in an amount equal to
6 the deficit.
7 (II) When the deficit incurred in a particular
8 calendar year exceeds 10 percent of the aggregate statewide
9 direct written premium for property insurance for the prior
10 calendar year for all member insurers, the association shall
11 levy an assessment on member insurers in an amount equal to
12 the greater of 10 percent of the deficit or 10 percent of the
13 aggregate statewide direct written premium for property
14 insurance for the prior calendar year for member insurers. Any
15 remaining deficit shall be recovered through emergency
16 assessments under sub-sub-subparagraph (III).
17 (III) Upon a determination by the board of directors
18 that a deficit exceeds the amount that will be recovered
19 through regular assessments on member insurers, pursuant to
20 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
21 board shall levy, after verification by the department,
22 emergency assessments to be collected by member insurers and
23 by underwriting associations created pursuant to this section
24 which write property insurance, upon issuance or renewal of
25 property insurance policies other than National Flood
26 Insurance policies in the year or years following levy of the
27 regular assessments. The amount of the emergency assessment
28 collected in a particular year shall be a uniform percentage
29 of that year's direct written premium for property insurance
30 for all member insurers and underwriting associations,
31 excluding National Flood Insurance policy premiums, as

1 annually determined by the board and verified by the
2 department. The department shall verify the arithmetic
3 calculations involved in the board's determination within 30
4 days after receipt of the information on which the
5 determination was based. Notwithstanding any other provision
6 of law, each member insurer and each underwriting association
7 created pursuant to this section shall collect emergency
8 assessments from its policyholders without such obligation
9 being affected by any credit, limitation, exemption, or
10 deferment. The emergency assessments so collected shall be
11 transferred directly to the association on a periodic basis as
12 determined by the association. The aggregate amount of
13 emergency assessments levied under this sub-sub-subparagraph
14 in any calendar year may not exceed the greater of 10 percent
15 of the amount needed to cover the original deficit, plus
16 interest, fees, commissions, required reserves, and other
17 costs associated with financing of the original deficit, or 10
18 percent of the aggregate statewide direct written premium for
19 property insurance written by member insurers and underwriting
20 associations for the prior year, plus interest, fees,
21 commissions, required reserves, and other costs associated
22 with financing the original deficit. The board may pledge the
23 proceeds of the emergency assessments under this
24 sub-sub-subparagraph as the source of revenue for bonds, to
25 retire any other debt incurred as a result of the deficit or
26 events giving rise to the deficit, or in any other way that
27 the board determines will efficiently recover the deficit. The
28 emergency assessments under this sub-sub-subparagraph shall
29 continue as long as any bonds issued or other indebtedness
30 incurred with respect to a deficit for which the assessment
31 was imposed remain outstanding, unless adequate provision has

1 been made for the payment of such bonds or other indebtedness
2 pursuant to the document governing such bonds or other
3 indebtedness. Emergency assessments collected under this
4 sub-sub-subparagraph are not part of an insurer's rates, are
5 not premium, and are not subject to premium tax, fees, or
6 commissions; however, failure to pay the emergency assessment
7 shall be treated as failure to pay premium.
8 (IV) Each member insurer's share of the total regular
9 assessments under sub-sub-subparagraph (I) or
10 sub-sub-subparagraph (II) shall be in the proportion that the
11 insurer's net direct premium for property insurance in this
12 state, for the year preceding the assessment bears to the
13 aggregate statewide net direct premium for property insurance
14 of all member insurers, as reduced by any credits for
15 voluntary writings for that year.
16 (V) If regular deficit assessments are made under
17 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), or by
18 the Residential Property and Casualty Joint Underwriting
19 Association under sub-subparagraph (6)(b)3.a. or
20 sub-subparagraph (6)(b)3.b., the association shall levy upon
21 the association's policyholders, as part of its next rate
22 filing, or by a separate rate filing solely for this purpose,
23 a market equalization surcharge in a percentage equal to the
24 total amount of such regular assessments divided by the
25 aggregate statewide direct written premium for property
26 insurance for member insurers for the prior calendar year.
27 Market equalization surcharges under this sub-sub-subparagraph
28 are not considered premium and are not subject to commissions,
29 fees, or premium taxes; however, failure to pay a market
30 equalization surcharge shall be treated as failure to pay
31 premium.

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

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. The authority
13 granted by this sub-subparagraph is additional to any bonding
14 authority granted by subparagraph 6.
15 3. The plan shall also provide that any member with a
16 surplus as to policyholders of $20 million or less writing 25
17 percent or more of its total countrywide property insurance
18 premiums in this state may petition the department, within the
19 first 90 days of each calendar year, to qualify as a limited
20 apportionment company. The apportionment of such a member
21 company in any calendar year for which it is qualified shall
22 not exceed its gross participation, which shall not be
23 affected by the formula for voluntary writings. In no event
24 shall a limited apportionment company be required to
25 participate in any apportionment of losses pursuant to
26 sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II)
27 in the aggregate which exceeds $50 million after payment of
28 available plan funds in any calendar year. However, a limited
29 apportionment company shall collect from its policyholders any
30 emergency assessment imposed under sub-sub-subparagraph
31 2.d.(III). The plan shall provide that, if the department

determines that any regular assessment will result in an impairment of the surplus of a limited apportionment company, the department may direct that all or part of such assessment be deferred. However, there shall be no limitation or deferment of an emergency assessment to be collected from policyholders under sub-sub-subparagraph 2.d.(III).

4. The plan shall provide for the deferment, in whole or in part, of a regular assessment of a member insurer under sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II), but not for an emergency assessment collected from policyholders under sub-sub-subparagraph 2.d.(III), if, in the opinion of the commissioner, payment of such regular assessment would endanger or impair the solvency of the member insurer. In the event a regular assessment against a member insurer is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II).

5.a. The plan of operation may include deductibles and rules for classification of risks and rate modifications consistent with the objective of providing and maintaining funds sufficient to pay catastrophe losses.

b. ~~The association may require arbitration of a rate filing under s. 627.062(6).~~It is the intent of the Legislature that the rates for coverage provided by the association be actuarially sound and not competitive with approved rates charged in the admitted voluntary market such that the association functions as a residual market mechanism to provide insurance only when the insurance cannot be procured in the voluntary market. The plan of operation shall

1 provide a mechanism to assure that, beginning no later than
2 January 1, 1999, the rates charged by the association for each
3 line of business are reflective of approved rates in the
4 voluntary market for hurricane coverage for each line of
5 business in the various areas eligible for association
6 coverage.
7 c. The association shall provide for windstorm
8 coverage on residential properties in limits up to $10 million
9 for commercial lines residential risks and up to $1 million
10 for personal lines residential risks. If coverage with the
11 association is sought for a residential risk valued in excess
12 of these limits, coverage shall be available to the risk up to
13 the replacement cost or actual cash value of the property, at
14 the option of the insured, if coverage for the risk cannot be
15 located in the authorized market. The association must accept
16 a commercial lines residential risk with limits above $10
17 million or a personal lines residential risk with limits above
18 $1 million if coverage is not available in the authorized
19 market. The association may write coverage above the limits
20 specified in this subparagraph with or without facultative or
21 other reinsurance coverage, as the association determines
22 appropriate.
23 d. The plan of operation must provide objective
24 criteria and procedures, approved by the department, to be
25 uniformly applied for all applicants in determining whether an
26 individual risk is so hazardous as to be uninsurable. In
27 making this determination and in establishing the criteria and
28 procedures, the following shall be considered:
29 (I) Whether the likelihood of a loss for the
30 individual risk is substantially higher than for other risks
31 of the same class; and

1 (II) Whether the uncertainty associated with the
2 individual risk is such that an appropriate premium cannot be
3 determined.
4
5 The acceptance or rejection of a risk by the association
6 pursuant to such criteria and procedures must be construed as
7 the private placement of insurance, and the provisions of
8 chapter 120 do not apply.
9 e. The policies issued by the association must provide
10 that if the association obtains an offer from an authorized
11 insurer to cover the risk at its approved rates under either a
12 standard policy including wind coverage or, if consistent with
13 the insurer's underwriting rules as filed with the department,
14 a basic policy including wind coverage, the risk is no longer
15 eligible for coverage through the association. Upon
16 termination of eligibility, the association shall provide
17 written notice to the policyholder and agent of record stating
18 that the association policy must be canceled as of 60 days
19 after the date of the notice because of the offer of coverage
20 from an authorized insurer. Other provisions of the insurance
21 code relating to cancellation and notice of cancellation do
22 not apply to actions under this sub-subparagraph.
23 f. Association policies and applications must include
24 a notice that the association policy could, under this
25 section, be replaced with a policy issued by an authorized
26 insurer that does not provide coverage identical to the
27 coverage provided by the association. The notice shall also
28 specify that acceptance of association coverage creates a
29 conclusive presumption that the applicant or policyholder is
30 aware of this potential.
31

1 6.a. The plan of operation may authorize the formation
2 of a private nonprofit corporation, a private nonprofit
3 unincorporated association, a partnership, a trust, a limited
4 liability company, or a nonprofit mutual company which may be
5 empowered, among other things, to borrow money by issuing
6 bonds or by incurring other indebtedness and to accumulate
7 reserves or funds to be used for the payment of insured
8 catastrophe losses. The plan may authorize all actions
9 necessary to facilitate the issuance of bonds, including the
10 pledging of assessments or other revenues.
11 b. Any entity created under this subsection, or any
12 entity formed for the purposes of this subsection, may sue and
13 be sued, may borrow money; issue bonds, notes, or debt
14 instruments; pledge or sell assessments, market equalization
15 surcharges and other surcharges, rights, premiums, contractual
16 rights, projected recoveries from the Florida Hurricane
17 Catastrophe Fund, other reinsurance recoverables, and other
18 assets as security for such bonds, notes, or debt instruments;
19 enter into any contracts or agreements necessary or proper to
20 accomplish such borrowings; and take other actions necessary
21 to carry out the purposes of this subsection. The association
22 may issue bonds or incur other indebtedness, or have bonds
23 issued on its behalf by a unit of local government pursuant to
24 subparagraph (g)2., in the absence of a hurricane or other
25 weather-related event, upon a determination by the association
26 subject to approval by the department that such action would
27 enable it to efficiently meet the financial obligations of the
28 association and that such financings are reasonably necessary
29 to effectuate the requirements of this subsection. Any such
30 entity may accumulate reserves and retain surpluses as of the
31 end of any association year to provide for the payment of

1 losses incurred by the association during that year or any
2 future year. The association shall incorporate and continue
3 the plan of operation and articles of agreement in effect on
4 the effective date of chapter 76-96, Laws of Florida, to the
5 extent that it is not inconsistent with chapter 76-96, and as
6 subsequently modified consistent with chapter 76-96. The board
7 of directors and officers currently serving shall continue to
8 serve until their successors are duly qualified as provided
9 under the plan. The assets and obligations of the plan in
10 effect immediately prior to the effective date of chapter
11 76-96 shall be construed to be the assets and obligations of
12 the successor plan created herein.
13 c. In recognition of s. 10, Art. I of the State
14 Constitution, prohibiting the impairment of obligations of
15 contracts, it is the intent of the Legislature that no action
16 be taken whose purpose is to impair any bond indenture or
17 financing agreement or any revenue source committed by
18 contract to such bond or other indebtedness issued or incurred
19 by the association or any other entity created under this
20 subsection.
21 7. On such coverage, an agent's remuneration shall be
22 that amount of money payable to the agent by the terms of his
23 or her contract with the company with which the business is
24 placed. However, no commission will be paid on that portion of
25 the premium which is in excess of the standard premium of that
26 company.
27 8. Subject to approval by the department, the
28 association may establish different eligibility requirements
29 and operational procedures for any line or type of coverage
30 for any specified eligible area or portion of an eligible area
31 if the board determines that such changes to the eligibility

1 requirements and operational procedures are justified due to
2 the voluntary market being sufficiently stable and competitive
3 in such area or for such line or type of coverage and that
4 consumers who, in good faith, are unable to obtain insurance
5 through the voluntary market through ordinary methods would
6 continue to have access to coverage from the association. When
7 coverage is sought in connection with a real property
8 transfer, such requirements and procedures shall not provide
9 for an effective date of coverage later than the date of the
10 closing of the transfer as established by the transferor, the
11 transferee, and, if applicable, the lender.
12 9. Notwithstanding any other provision of law:
13 a. The pledge or sale of, the lien upon, and the
14 security interest in any rights, revenues, or other assets of
15 the association created or purported to be created pursuant to
16 any financing documents to secure any bonds or other
17 indebtedness of the association shall be and remain valid and
18 enforceable, notwithstanding the commencement of and during
19 the continuation of, and after, any rehabilitation,
20 insolvency, liquidation, bankruptcy, receivership,
21 conservatorship, reorganization, or similar proceeding against
22 the association under the laws of this state or any other
23 applicable laws.
24 b. No such proceeding shall relieve the association of
25 its obligation, or otherwise affect its ability to perform its
26 obligation, to continue to collect, or levy and collect,
27 assessments, market equalization or other surcharges,
28 projected recoveries from the Florida Hurricane Catastrophe
29 Fund, reinsurance recoverables, or any other rights, revenues,
30 or other assets of the association pledged.
31

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

1 owed to any other person or entity, including policyholders in
2 this state, asserting rights in any such assessments,
3 revenues, contract, or other rights or assets to the extent
4 set forth in and in accordance with the terms of the pledge or
5 sale contained in the applicable financing documents, whether
6 or not any such person or entity has notice of such pledge or
7 sale and without the need for any physical delivery,
8 recordation, filing, or other action.
9 f. There shall be no liability on the part of, and no
10 cause of action of any nature shall arise against, any member
11 insurer or its agents or employees, agents or employees of the
12 association, members of the board of directors of the
13 association, or the department or its representatives, for any
14 action taken by them in the performance of their duties or
15 responsibilities under this subsection. Such immunity does not
16 apply to actions for breach of any contract or agreement
17 pertaining to insurance, or any willful tort.
18 (c) The provisions of paragraph (b) are applicable
19 only with respect to:
20 1. Those areas that were eligible for coverage under
21 this subsection on April 9, 1993; or
22 2. Any county or area as to which the department,
23 after public hearing, finds that the following criteria exist:
24 a. Due to the lack of windstorm insurance coverage in
25 the county or area so affected, economic growth and
26 development is being deterred or otherwise stifled in such
27 county or area, mortgages are in default, and financial
28 institutions are unable to make loans;
29 b. The county or area so affected has adopted and is
30 enforcing the structural requirements of the State Minimum
31 Building Codes, as defined in s. 553.73, for new construction

1 and has included adequate minimum floor elevation requirements
2 for structures in areas subject to inundation; and
3 c. Extending windstorm insurance coverage to such
4 county or area is consistent with and will implement and
5 further the policies and objectives set forth in applicable
6 state laws, rules, and regulations governing coastal
7 management, coastal construction, comprehensive planning,
8 beach and shore preservation, barrier island preservation,
9 coastal zone protection, and the Coastal Zone Protection Act
10 of 1985.
11
12 Any time after the department has determined that the criteria
13 referred to in this subparagraph do not exist with respect to
14 any county or area of the state, it may, after a subsequent
15 public hearing, declare that such county or area is no longer
16 eligible for windstorm coverage through the plan.
17 (d) For the purpose of evaluating whether the criteria
18 of paragraph (c) are met, such criteria shall be applied as
19 the situation would exist if policies had not been written by
20 the Florida Residential Property and Casualty Joint
21 Underwriting Association and property insurance for such
22 policyholders was not available.
23 (e) Notwithstanding the provisions of subparagraph
24 (c)2. or paragraph (d), eligibility shall not be extended to
25 any area that was not eligible on March 1, 1997, except that
26 the department may act with respect to any petition on which a
27 hearing was held prior to May 9, 1997.
28 (4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
29 (a) The department shall, after consultation with
30 insurers as set forth in paragraph (b), adopt a joint
31 underwriting plan as set forth in paragraph (d).

1 (b) Entities licensed to issue casualty insurance as
2 defined in s. 624.605(1)(b), (k), and (q) and self-insurers
3 authorized to issue medical malpractice insurance under s.
4 627.357 shall participate in the plan and shall be members of
5 the Joint Underwriting Association.
6 (c) The Joint Underwriting Association shall operate
7 subject to the supervision and approval of a board of
8 governors consisting of representatives of five of the
9 insurers participating in the Joint Underwriting Association,
10 an attorney to be named by The Florida Bar, a physician to be
11 named by the Florida Medical Association, a dentist to be
12 named by the Florida Dental Association, and a hospital
13 representative to be named by the Florida Hospital
14 Association. The board of governors shall choose, during the
15 first meeting of the board after June 30 of each year, one of
16 its members to serve as chair of the board and another member
17 to serve as vice chair of the board. There shall be no
18 liability on the part of, and no cause of action of any nature
19 shall arise against, any member insurer, self-insurer, or its
20 agents or employees, the Joint Underwriting Association or its
21 agents or employees, members of the board of governors, or the
22 department or its representatives for any action taken by them
23 in the performance of their powers and duties under this
24 subsection.
25 (d) The plan shall provide coverage for claims arising
26 out of the rendering of, or failure to render, medical care or
27 services and, in the case of health care facilities, coverage
28 for bodily injury or property damage to the person or property
29 of any patient arising out of the insured's activities, in
30 appropriate policy forms for all health care providers as
31

defined in paragraph (h). The plan shall include, but shall not be limited to:

1. Classifications of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas. To assure that plan rates are adequate to pay claims and expenses, the Joint Underwriting Association shall develop a means of obtaining loss and expense experience; and the plan shall file such experience, when available, with the commission ~~department~~ in sufficient detail to make a determination of rate adequacy. Within 60 days after a rate filing, the commission ~~department~~ shall approve such rates or rate revisions as are fully supported by the filing. In addition to provisions for claims and expenses, the ratemaking formula may include a factor for projected claims trending and a margin for contingencies. The use of trend factors shall not be found to be inappropriate.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for:

a. Insureds who are retired or semiretired.

b. The estates of deceased insureds.

c. Part-time professionals.

4. Protection in an amount not to exceed $250,000 per claim, $750,000 annual aggregate for health care providers other than hospitals and in an amount not to exceed $1.5 million per claim, $5 million annual aggregate for hospitals. Such coverage for health care providers other than hospitals shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and the total limits of $250,000 per claim, $750,000 annual aggregate.

1 The plan shall also provide tail coverage in these amounts to
2 insureds whose claims-made coverage with another insurer or
3 trust has or will be terminated. Such tail coverage shall
4 provide coverage for incidents that occurred during the
5 claims-made policy period for which a claim is made after the
6 policy period.
7 5. A risk management program for insureds of the
8 association. This program shall include, but not be limited
9 to: investigation and analysis of frequency, severity, and
10 causes of adverse or untoward medical injuries; development of
11 measures to control these injuries; systematic reporting of
12 medical incidents; investigation and analysis of patient
13 complaints; and auditing of association members to assure
14 implementation of this program. The plan may refuse to insure
15 any insured who refuses or fails to comply with the risk
16 management program implemented by the association. Prior to
17 cancellation or refusal to renew an insured, the association
18 shall provide the insured 60 days' notice of intent to cancel
19 or nonrenew and shall further notify the insured of any action
20 which must be taken to be in compliance with the risk
21 management program.
22 (e) In the event an underwriting deficit exists for
23 any policy year the plan is in effect, any surplus which has
24 accrued from previous years and is not projected within
25 reasonable actuarial certainty to be needed for payment of
26 claims in the year the surplus arose shall be used to offset
27 the deficit to the extent available.
28 1. As to remaining deficit, except those relating to
29 deficit assessment coverage, each policyholder shall pay to
30 the association a premium contingency assessment not to exceed
31 one-third of the premium payment paid by such policyholder to

1 the association for that policy year. The association shall
2 pay no further claims on any policy for the policyholder who
3 fails to pay the premium contingency assessment.
4 2. If there is any remaining deficit under the plan
5 after maximum collection of the premium contingency
6 assessment, such deficit shall be recovered from the companies
7 participating in the plan in the proportion that the net
8 direct premiums of each such member written during the
9 calendar year immediately preceding the end of the policy year
10 for which there is a deficit assessment bear to the aggregate
11 net direct premiums written in this state by all members of
12 the association. The term "premiums" as used herein means
13 premiums for the lines of insurance defined in s.
14 624.605(1)(b), (k), and (q), including premiums for such
15 coverage issued under package policies.
16 (f) The plan shall provide for one or more insurers
17 able and willing to provide policy service through licensed
18 resident agents and claims service on behalf of all other
19 insurers participating in the plan. In the event no insurer
20 is able and willing to provide such services, the Joint
21 Underwriting Association is authorized to perform any and all
22 such services.
23 (g) All books, records, documents, or audits relating
24 to the Joint Underwriting Association or its operation shall
25 be open to public inspection, except that a claim file in the
26 possession of the Joint Underwriting Association is
27 confidential and exempt from the provisions of s. 119.07(1)
28 during the processing of that claim. Any information
29 contained in these files that identifies an injured person is
30 confidential and exempt from the provisions of s. 119.07(1).
31 (h) As used in this subsection:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 1. "Health care provider" means hospitals licensed
2 under chapter 395; physicians licensed under chapter 458;
3 osteopathic physicians licensed under chapter 459; podiatric
4 physicians licensed under chapter 461; dentists licensed under
5 chapter 466; chiropractic physicians licensed under chapter
6 460; naturopaths licensed under chapter 462; nurses licensed
7 under chapter 464; midwives licensed under chapter 467;
8 clinical laboratories registered under chapter 483; physician
9 assistants licensed under chapter 458 or chapter 459; physical
10 therapists and physical therapist assistants licensed under
11 chapter 486; health maintenance organizations certificated
12 under part I of chapter 641; ambulatory surgical centers
13 licensed under chapter 395; other medical facilities as
14 defined in subparagraph 2.; blood banks, plasma centers,
15 industrial clinics, and renal dialysis facilities; or
16 professional associations, partnerships, corporations, joint
17 ventures, or other associations for professional activity by
18 health care providers.
19 2. "Other medical facility" means a facility the
20 primary purpose of which is to provide human medical
21 diagnostic services or a facility providing nonsurgical human
22 medical treatment, to which facility the patient is admitted
23 and from which facility the patient is discharged within the
24 same working day, and which facility is not part of a
25 hospital. However, a facility existing for the primary
26 purpose of performing terminations of pregnancy or an office
27 maintained by a physician or dentist for the practice of
28 medicine shall not be construed to be an "other medical
29 facility."
30 3. "Health care facility" means any hospital licensed
31 under chapter 395, health maintenance organization

1 certificated under part I of chapter 641, ambulatory surgical
2 center licensed under chapter 395, or other medical facility
3 as defined in subparagraph 2.
4 (i) The manager of the plan or the manager's assistant
5 is the agent for service of process for the plan.
6 (5) PROPERTY AND CASUALTY INSURANCE RISK
7 APPORTIONMENT.--The department shall adopt by rule a joint
8 underwriting plan to equitably apportion among insurers
9 authorized in this state to write property insurance as
10 defined in s. 624.604 or casualty insurance as defined in s.
11 624.605, the underwriting of one or more classes of property
12 insurance or casualty insurance, except for the types of
13 insurance that are included within property insurance or
14 casualty insurance for which an equitable apportionment plan,
15 assigned risk plan, or joint underwriting plan is authorized
16 under s. 627.311 or subsection (1), subsection (2), subsection
17 (3), subsection (4), or subsection (6) and except for risks
18 eligible for flood insurance written through the federal flood
19 insurance program to persons with risks eligible under
20 subparagraph (a)1. and who are in good faith entitled to, but
21 are unable to, obtain such property or casualty insurance
22 coverage, including excess coverage, through the voluntary
23 market. For purposes of this subsection, an adequate level of
24 coverage means that coverage which is required by state law or
25 by responsible or prudent business practices. The Joint
26 Underwriting Association shall not be required to provide
27 coverage for any type of risk for which there are no insurers
28 providing similar coverage in this state. The department may
29 designate one or more participating insurers who agree to
30 provide policyholder and claims service, including the
31 issuance of policies, on behalf of the participating insurers.

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

1 assistance plan provides a quotation for at least 80 percent
2 of such applicants, such classification shall immediately be
3 eligible for coverage in the Joint Underwriting Association.
4 (II) Any market assistance plan application which is
5 rejected because an individual risk is so hazardous as to be
6 practically uninsurable, considering whether the likelihood of
7 a loss for such a risk is substantially higher than for other
8 risks of the same class due to individual risk
9 characteristics, prior loss experience, unwillingness to
10 cooperate with a prior insurer, physical characteristics and
11 physical location shall not be included in the minimum
12 percentage calculation provided above. In the event that there
13 is any legal or administrative challenge to a determination by
14 the department that the conditions of this subparagraph have
15 been met for eligibility for coverage in the Joint
16 Underwriting Association for a given classification, any
17 eligible risk may obtain coverage during the pendency of any
18 such challenge.
19 e. In order to qualify as a quotation for the purpose
20 of meeting the minimum percentage calculation in this
21 subparagraph, the quoted premium must meet the following
22 criteria:
23 (I) In the case of an admitted carrier, the quoted
24 premium must not exceed the premium available for a given
25 classification currently in use by the Joint Underwriting
26 Association or the premium developed by using the rates and
27 rating plans on file with the department by the quoting
28 insurer, whichever is greater.
29 (II) In the case of an authorized surplus lines
30 insurer, the quoted premium must not exceed the premium
31 available for a given classification currently in use by the

1 Joint Underwriting Association by more than 25 percent, after
2 consideration of any individual risk surcharge or credit.
3 f. Any agent who falsely certifies the unavailability
4 of coverage as provided by sub-subparagraphs a. and b., is
5 subject to the penalties provided in s. 626.611.
6 2. A means for the equitable apportionment of profits
7 or losses and expenses among participating insurers.
8 3. Rules for the classification of risks and rates
9 which reflect the past and prospective loss experience.
10 4. A rating plan which reasonably reflects the prior
11 claims experience of the insureds. Such rating plan shall
12 include at least two levels of rates for risks that have
13 favorable loss experience and risks that have unfavorable loss
14 experience, as established by the plan.
15 5. Reasonable limits to available amounts of
16 insurance. Such limits may not be less than the amounts of
17 insurance required of eligible risks by Florida law.
18 6. Risk management requirements for insurance where
19 such requirements are reasonable and are expected to reduce
20 losses.
21 7. Deductibles as may be necessary to meet the needs
22 of insureds.
23 8. Policy forms which are consistent with the forms in
24 use by the majority of the insurers providing coverage in the
25 voluntary market for the coverage requested by the applicant.
26 9. A means to remove risks from the plan once such
27 risks no longer meet the eligibility requirements of this
28 paragraph. For this purpose, the plan shall include the
29 following requirements: At each 6-month interval after the
30 activation of any class of insureds, the board of governors or
31 its designated committee shall review the number of

1 applications to the market assistance plan for that class. If,
2 based on these latest numbers, at least 90 percent of such
3 applications have been provided a quotation, the Joint
4 Underwriting Association shall cease underwriting new
5 applications for such class within 30 days, and notification
6 of this decision shall be sent to the Insurance Commissioner,
7 the major agents' associations, and the board of directors of
8 the market assistance plan. A quotation for the purpose of
9 this subparagraph shall meet the same criteria for a quotation
10 as provided in sub-subparagraph d. All policies which were
11 previously written for that class shall continue in force
12 until their normal expiration date, at which time, subject to
13 the required timely notification of nonrenewal by the Joint
14 Underwriting Association, the insured may then elect to
15 reapply to the Joint Underwriting Association according to the
16 requirements of eligibility. If, upon reapplication, those
17 previously insured Joint Underwriting Association risks meet
18 the eligibility requirements, the Joint Underwriting
19 Association shall provide the coverage requested.
20 10. A means for providing credits to insurers against
21 any deficit assessment levied pursuant to paragraph (c), for
22 risks voluntarily written through the market assistance plan
23 by such insurers.
24 11. That the Joint Underwriting Association shall
25 operate subject to the supervision and approval of a board of
26 governors consisting of 13 individuals appointed by the
27 Insurance Commissioner, and shall have an executive or
28 underwriting committee. At least four of the members shall be
29 representatives of insurance trade associations as follows:
30 one member from the American Insurance Association, one member
31 from the Alliance of American Insurers, one member from the

1 National Association of Independent Insurers, and one member
2 from an unaffiliated insurer writing coverage on a national
3 basis. Two representatives shall be from two of the statewide
4 agents' associations. Each board member shall be appointed to
5 serve for 2-year terms beginning on a date designated by the
6 plan and shall serve at the pleasure of the commissioner.
7 Members may be reappointed for subsequent terms.
8 (b) Rates used by the Joint Underwriting Association
9 shall be actuarially sound. To the extent applicable, the rate
10 standards set forth in s. 627.062 shall be considered by the
11 commission ~~department~~ in establishing rates to be used by the
12 joint underwriting plan. The initial rate level shall be
13 determined using the rates, rules, rating plans, and
14 classifications contained in the most current Insurance
15 Services Office (ISO) filing with the department or the filing
16 of other licensed rating organizations with an additional
17 increment of 25 percent of premium. For any type of coverage
18 or classification which lends itself to manual rating for
19 which the Insurance Services Office or another licensed rating
20 organization does not file or publish a rate, the Joint
21 Underwriting Association shall file and use an initial rate
22 based on the average current market rate. The initial rate
23 level for the rate plan shall also be subject to an experience
24 and schedule rating plan which may produce a maximum of 25
25 percent debits or credits. For any risk which does not lend
26 itself to manual rating and for which no rate has been
27 promulgated under the rate plan, the board shall develop and
28 file with the commissioner, subject to his or her approval,
29 appropriate criteria and factors for rating the individual
30 risk. Such criteria and factors shall include, but not be
31 limited to, loss rating plans, composite rating plans, and

1 unique and unusual risk rating plans. The initial rates
2 required under this paragraph shall be adjusted in conformity
3 with future filings by the Insurance Services Office with the
4 commission ~~department~~ and shall remain in effect until such
5 time as the Joint Underwriting Association has sufficient data
6 as to independently justify an actuarially sound change in
7 such rates.
8 (c)1. In the event an underwriting deficit exists for
9 any policy year the plan is in effect, any surplus which has
10 accrued from previous years and is not projected within
11 reasonable actuarial certainty to be needed for payment for
12 claims in the year the surplus arose shall be used to offset
13 the deficit to the extent available.
14 2. As to any remaining deficit, the board of governors
15 of the Joint Underwriting Association shall levy and collect
16 an assessment in an amount sufficient to offset such deficit.
17 Such assessment shall be levied against the insurers
18 participating in the plan during the year giving rise to the
19 assessment. Any assessments against insurers for the lines of
20 property and casualty insurance issued to commercial risks
21 shall be recovered from the participating insurers in the
22 proportion that the net direct premium of each insurer for
23 commercial risks written during the preceding calendar year
24 bears to the aggregate net direct premium written for
25 commercial risks by all members of the plan for the lines of
26 insurance included in the plan. Any assessments against
27 insurers for the lines of property and casualty insurance
28 issued to personal risks eligible under sub-subparagraph
29 (a)1.a. or sub-subparagraph (a)1.c. shall be recovered from
30 the participating insurers in the proportion that the net
31 direct premium of each insurer for personal risks written

1 during the preceding calendar year bears to the aggregate net
2 direct premium written for personal risks by all members of
3 the plan for the lines of insurance included in the plan.
4 3. The board shall take all reasonable and prudent
5 steps necessary to collect the amount of assessment due from
6 each participating insurer and policyholder, including, if
7 prudent, filing suit to collect such assessment. If the board
8 is unable to collect an assessment from any insurer, the
9 uncollected assessments shall be levied as an additional
10 assessment against the participating insurers and any
11 participating insurer required to pay an additional assessment
12 as a result of such failure to pay shall have a cause of
13 action against such nonpaying insurer.
14 4. Any funds or entitlements that the state may be
15 eligible to receive by virtue of the Federal Government's
16 termination of the Federal Crime Insurance Program referenced
17 in sub-subparagraph (a)1.c. may be used under the plan to
18 offset any subsequent underwriting deficits that may occur
19 from risks previously insured with the Federal Crime Insurance
20 Program.
21 5. Assessments shall be included as an appropriate
22 factor in the making of rates as provided in s. 627.3512.
23 6.a. The Legislature finds that the potential for
24 unlimited assessments under this paragraph may induce insurers
25 to attempt to reduce their writings in the voluntary market,
26 and that such actions would worsen the availability problems
27 that the association was created to remedy. It is the intent
28 of the Legislature that insurers remain fully responsible for
29 covering any deficits of the association; however, it is also
30 the intent of the Legislature to provide a means by which
31

1 assessment liabilities may be amortized over a period of
2 years.
3 b. The total amount of deficit assessments under this
4 paragraph with respect to any year may not exceed 10 percent
5 of the statewide total gross written premium for all insurers
6 for the coverages referred to in the introductory language of
7 this subsection for the prior year, except that if the deficit
8 with respect to any plan year exceeds such amount and bonds
9 are issued under sub-subparagraph c. to defray the deficit,
10 the total amount of assessments with respect to such deficit
11 may not in any year exceed 10 percent of the deficit, or such
12 lesser percentage as is sufficient to retire the bonds as
13 determined by the board, and shall continue annually until the
14 bonds are retired.
15 c. The governing body of any unit of local government,
16 any residents or businesses of which are insured by the
17 association, may issue bonds as defined in s. 125.013 or s.
18 166.101 from time to time to fund an assistance program, in
19 conjunction with the association, for the purpose of defraying
20 deficits of the association. Revenue bonds may not be issued
21 until validated pursuant to chapter 75, unless a state of
22 emergency is declared by executive order or proclamation of
23 the Governor pursuant to s. 252.36 making such findings as are
24 necessary to determine that it is in the best interests of,
25 and necessary for, the protection of the public health,
26 safety, and general welfare of residents of this state and the
27 protection and preservation of the economic stability of
28 insurers operating in this state, and declaring it an
29 essential public purpose to permit certain municipalities or
30 counties to issue such bonds as will provide relief to
31 claimants and policyholders of the joint underwriting

1 association and insurers responsible for apportionment of
2 association losses. The unit of local government shall enter
3 into such contracts with the association as are necessary to
4 carry out this paragraph. Any bonds issued under this
5 sub-subparagraph shall be payable from and secured by moneys
6 received by the association from assessments under this
7 paragraph, and assigned and pledged to or on behalf of the
8 unit of local government for the benefit of the holders of
9 such bonds. The funds, credit, property, and taxing power of
10 the state or of the unit of local government shall not be
11 pledged for the payment of such bonds. If any of the bonds
12 remain unsold 60 days after issuance, the department shall
13 require all insurers subject to assessment to purchase the
14 bonds, which shall be treated as admitted assets; each insurer
15 shall be required to purchase that percentage of the unsold
16 portion of the bond issue that equals the insurer's relative
17 share of assessment liability under this subsection. An
18 insurer shall not be required to purchase the bonds to the
19 extent that the department determines that the purchase would
20 endanger or impair the solvency of the insurer.
21 7. The plan shall provide for the deferment, in whole
22 or in part, of the assessment of an insurer if the department
23 finds that payment of the assessment would endanger or impair
24 the solvency of the insurer. In the event an assessment
25 against an insurer is deferred in whole or in part, the amount
26 by which such assessment is deferred may be assessed against
27 the other member insurers in a manner consistent with the
28 basis for assessments set forth in subparagraph 2.
29 (d) Upon adoption of the plan, all insurers authorized
30 in this state to underwrite property or casualty insurance
31 shall participate in the plan.

1 (e) A Risk Underwriting Committee of the Joint
2 Underwriting Association composed of three members experienced
3 in evaluating insurance risks is created to review risks
4 rejected by the voluntary market for which application is made
5 for insurance through the joint underwriting plan. The
6 committee shall consist of a representative of the market
7 assistance plan created under s. 627.3515, a member selected
8 by the insurers participating in the Joint Underwriting
9 Association, and a member named by the Insurance Commissioner.
10 The Risk Underwriting Committee shall appoint such advisory
11 committees as are provided for in the plan and are necessary
12 to conduct its functions. The salaries and expenses of the
13 members of the Risk Underwriting Committee and its advisory
14 committees shall be paid by the joint underwriting plan. The
15 plan approved by the department shall establish criteria and
16 procedures for use by the Risk Underwriting Committee for
17 determining whether an individual risk is so hazardous as to
18 be uninsurable. In making this determination and in
19 establishing the criteria and procedures, the following shall
20 be considered:
21 1. Whether the likelihood of a loss for the individual
22 risk is substantially higher than for other risks of the same
23 class; and
24 2. Whether the uncertainty associated with the
25 individual risk is such that an appropriate premium cannot be
26 determined.
27
28 The acceptance or rejection of a risk by the underwriting
29 committee shall be construed as the private placement of
30 insurance, and the provisions of chapter 120 shall not apply.
31

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, the Florida Property and
4 Casualty Joint Underwriting Association or its agents or
5 employees, members of the board of governors, or the
6 department or its representatives for any action taken by them
7 in the performance of their duties under this subsection. Such
8 immunity does not apply to actions for breach of any contract
9 or agreement pertaining to insurance, or any other willful
10 tort.
11 (6) RESIDENTIAL PROPERTY AND CASUALTY JOINT
12 UNDERWRITING ASSOCIATION.--
13 (a) There is created a joint underwriting association
14 for equitable apportionment or sharing among insurers of
15 property and casualty insurance covering residential property,
16 for applicants who are in good faith entitled, but are unable,
17 to procure insurance through the voluntary market. The
18 association shall operate pursuant to a plan of operation
19 approved by order of the department. The plan is subject to
20 continuous review by the department. The department may, by
21 order, withdraw approval of all or part of a plan if the
22 department determines that conditions have changed since
23 approval was granted and that the purposes of the plan require
24 changes in the plan. For the purposes of this subsection,
25 residential coverage includes both personal lines residential
26 coverage, which consists of the type of coverage provided by
27 homeowner's, mobile home owner's, dwelling, tenant's,
28 condominium unit owner's, and similar policies, and commercial
29 lines residential coverage, which consists of the type of
30 coverage provided by condominium association, apartment
31 building, and similar policies.

1 (b)1. All insurers authorized to write subject lines
2 of business in this state, other than underwriting
3 associations or other entities created under this section,
4 must participate in and be members of the Residential Property
5 and Casualty Joint Underwriting Association. A member's
6 participation shall begin on the first day of the calendar
7 year following the year in which the member was issued a
8 certificate of authority to transact insurance for subject
9 lines of business in this state and shall terminate 1 year
10 after the end of the first calendar year during which the
11 member no longer holds a certificate of authority to transact
12 insurance for subject lines of business in this state.
13 2. All revenues, assets, liabilities, losses, and
14 expenses of the association shall be divided into two separate
15 accounts, one of which is for personal lines residential
16 coverages and the other of which is for commercial lines
17 residential coverages. Revenues, assets, liabilities, losses,
18 and expenses not attributable to particular coverages shall be
19 prorated between the accounts.
20 3. With respect to a deficit in an account:
21 a. When the deficit incurred in a particular calendar
22 year is not greater than 10 percent of the aggregate statewide
23 direct written premium for the subject lines of business for
24 the prior calendar year for all member insurers, the entire
25 deficit shall be recovered through assessments of member
26 insurers under paragraph (g).
27 b. When the deficit incurred in a particular calendar
28 year exceeds 10 percent of the aggregate statewide direct
29 written premium for the subject lines of business for the
30 prior calendar year for all member insurers, the association
31 shall levy an assessment on member insurers in an amount equal

1 to the greater of 10 percent of the deficit or 10 percent of
2 the aggregate statewide direct written premium for the subject
3 lines of business for the prior calendar year for all member
4 insurers. Any remaining deficit shall be recovered through
5 emergency assessments under sub-subparagraph d.
6 c. Each member insurer's share of the total assessment
7 under sub-subparagraph a. or sub-subparagraph b. shall be in
8 the proportion that the member insurer's direct written
9 premium for the subject lines of business for the year
10 preceding the assessment bears to the aggregate statewide
11 direct written premium for the subject lines of business for
12 that year for all member insurers.
13 d. Upon a determination by the board of governors that
14 a deficit in an account exceeds the amount that will be
15 recovered through regular assessments on member insurers under
16 sub-subparagraph a. or sub-subparagraph b., the board shall
17 levy, after verification by the department, emergency
18 assessments to be collected by member insurers and by
19 underwriting associations created under this section which
20 write subject lines of business upon issuance or renewal of
21 policies for subject lines of business, excluding National
22 Flood Insurance policies, in the year or years following levy
23 of the regular assessments. The amount of the emergency
24 assessment collected in a particular year shall be a uniform
25 percentage of that year's direct written premium for subject
26 lines of business for all member insurers and underwriting
27 associations, excluding National Flood Insurance Program
28 policy premiums, as annually determined by the board and
29 verified by the department. The department shall verify the
30 arithmetic calculations involved in the board's determination
31 within 30 days after receipt of the information on which the

1 determination was based. Notwithstanding any other provision
2 of law, each member insurer and each underwriting association
3 created under this section which writes subject lines of
4 business shall collect emergency assessments from its
5 policyholders without such obligation being affected by any
6 credit, limitation, exemption, or deferment. The emergency
7 assessments so collected shall be transferred directly to the
8 association on a periodic basis as determined by the
9 association. The aggregate amount of emergency assessments
10 levied under this sub-subparagraph in any calendar year may
11 not exceed the greater of 10 percent of the amount needed to
12 cover the original deficit, plus interest, fees, commissions,
13 required reserves, and other costs associated with financing
14 of the original deficit, or 10 percent of the aggregate
15 statewide direct written premium for subject lines of business
16 written by member insurers and underwriting associations for
17 the prior year, plus interest, fees, commissions, required
18 reserves, and other costs associated with financing the
19 original deficit.
20 e. The board may pledge the proceeds of assessments,
21 projected recoveries from the Florida Hurricane Catastrophe
22 Fund, other insurance and reinsurance recoverables, market
23 equalization surcharges and other surcharges, and other funds
24 available to the association as the source of revenue for and
25 to secure bonds issued under paragraph (g), bonds or other
26 indebtedness issued under subparagraph (c)3., or lines of
27 credit or other financing mechanisms issued or created under
28 this subsection, or to retire any other debt incurred as a
29 result of deficits or events giving rise to deficits, or in
30 any other way that the board determines will efficiently
31 recover such deficits. The purpose of the lines of credit or

1 other financing mechanisms is to provide additional resources
2 to assist the association in covering claims and expenses
3 attributable to a catastrophe. As used in this subsection, the
4 term "assessments" includes regular assessments under
5 sub-subparagraph a., sub-subparagraph b., or subparagraph
6 (g)1. and emergency assessments under sub-subparagraph d.
7 Emergency assessments collected under sub-subparagraph d. are
8 not part of an insurer's rates, are not premium, and are not
9 subject to premium tax, fees, or commissions; however, failure
10 to pay the emergency assessment shall be treated as failure to
11 pay premium. The emergency assessments under sub-subparagraph
12 d. shall continue as long as any bonds issued or other
13 indebtedness incurred with respect to a deficit for which the
14 assessment was imposed remain outstanding, unless adequate
15 provision has been made for the payment of such bonds or other
16 indebtedness pursuant to the documents governing such bonds or
17 other indebtedness.
18 f. As used in this subsection, the term "subject lines
19 of business" means, with respect to the personal lines
20 account, any personal lines policy defined in s. 627.4025, and
21 means, with respect to the commercial lines account, all
22 commercial property and commercial fire insurance.
23 (c) The plan of operation of the association:
24 1. May provide for one or more designated insurers,
25 able and willing to provide policy and claims service, to act
26 on behalf of the association to provide such service. Each
27 licensed agent shall be entitled to indicate the order of
28 preference regarding who will service the business placed by
29 the agent. The association shall adhere to each agent's
30 preferences unless after consideration of other factors in
31 assigning agents, including, but not limited to, servicing

1 capacity and fee arrangements, the association has reason to
2 believe it is in the best interest of the association to make
3 a different assignment.
4 2. Must provide for adoption of residential property
5 and casualty insurance policy forms, which forms must be
6 approved by the department prior to use. The association
7 shall adopt the following policy forms:
8 a. Standard personal lines policy forms including wind
9 coverage, which are multiperil policies providing what is
10 generally considered to be full coverage of a residential
11 property similar to the coverage provided under an HO-2, HO-3,
12 HO-4, or HO-6 policy.
13 b. Standard personal lines policy forms without wind
14 coverage, which are the same as the policies described in
15 sub-subparagraph a. except that they do not include wind
16 coverage.
17 c. Basic personal lines policy forms including wind
18 coverage, which are policies similar to an HO-8 policy or a
19 dwelling fire policy that provide coverage meeting the
20 requirements of the secondary mortgage market, but which
21 coverage is more limited than the coverage under a standard
22 policy.
23 d. Basic personal lines policy forms without wind
24 coverage, which are the same as the policies described in
25 sub-subparagraph c. except that they do not include wind
26 coverage.
27 e. Commercial lines residential policy forms including
28 wind coverage that are generally similar to the basic perils
29 of full coverage obtainable for commercial residential
30 structures in the admitted voluntary market.
31

1 f. Commercial lines residential policy forms without
2 wind coverage, which are the same as the policies described in
3 sub-subparagraph e. except that they do not include wind
4 coverage.
5 3. May provide that the association may employ or
6 otherwise contract with individuals or other entities to
7 provide administrative or professional services that may be
8 appropriate to effectuate the plan. The association shall
9 have the power to borrow funds, by issuing bonds or by
10 incurring other indebtedness, and shall have other powers
11 reasonably necessary to effectuate the requirements of this
12 subsection. The association may issue bonds or incur other
13 indebtedness, or have bonds issued on its behalf by a unit of
14 local government pursuant to subparagraph (g)2., in the
15 absence of a hurricane or other weather-related event, upon a
16 determination by the association, subject to approval by the
17 department, that such action would enable it to efficiently
18 meet the financial obligations of the association and that
19 such financings are reasonably necessary to effectuate the
20 requirements of this subsection. The association is
21 authorized to take all actions needed to facilitate tax-free
22 status for any such bonds or indebtedness, including formation
23 of trusts or other affiliated entities. The association shall
24 have the authority to pledge assessments, projected recoveries
25 from the Florida Hurricane Catastrophe Fund, other reinsurance
26 recoverables, market equalization and other surcharges, and
27 other funds available to the association as security for bonds
28 or other indebtedness. In recognition of s. 10, Art. I of the
29 State Constitution, prohibiting the impairment of obligations
30 of contracts, it is the intent of the Legislature that no
31 action be taken whose purpose is to impair any bond indenture

1 or financing agreement or any revenue source committed by
2 contract to such bond or other indebtedness.
3 4. Must require that the association operate subject
4 to the supervision and approval of a board of governors
5 consisting of 13 individuals, including 1 who is elected as
6 chair. The board shall consist of:
7 a. The insurance consumer advocate appointed under s.
8 627.0613.
9 b. Five members designated by the insurance industry.
10 c. Five consumer representatives appointed by the
11 Insurance Commissioner. Two of the consumer representatives
12 must, at the time of appointment, be holders of policies
13 issued by the association, who are selected with consideration
14 given to reflecting the geographic balance of association
15 policyholders. Two of the consumer members must be individuals
16 who are minority persons as defined in s. 288.703(3). One of
17 the consumer members shall have expertise in the field of
18 mortgage lending.
19 d. Two representatives of the insurance industry
20 appointed by the Insurance Commissioner. Of the two insurance
21 industry representatives appointed by the Insurance
22 Commissioner, at least one must be an individual who is a
23 minority person as defined in s. 288.703(3).
24
25 Any board member may be disapproved or removed and replaced by
26 the commissioner at any time for cause. All board members,
27 including the chair, must be appointed to serve for 3-year
28 terms beginning annually on a date designated by the plan.
29 5. Must provide a procedure for determining the
30 eligibility of a risk for coverage, as follows:
31

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

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1 of objective standards specified in the underwriting manual
2 and based on generally accepted underwriting practices.
3 b. With respect to commercial lines residential risks,
4 if the risk is offered coverage under a policy including wind
5 coverage from an authorized insurer at its approved rate, the
6 risk is not eligible for any policy issued by the association.
7 If the risk accepts an offer of coverage through the market
8 assistance plan or an offer of coverage through a mechanism
9 established by the association before a policy is issued to
10 the risk by the association, and the producing agent who
11 submitted the application to the plan or the association is
12 not currently appointed by the insurer, the insurer shall
13 either appoint the agent to service the risk or, if the
14 insurer places the coverage through a new agent, require the
15 new agent who then writes the policy to pay not less than 50
16 percent of the first year's commission to the producing agent
17 who submitted the application to the plan, except that if the
18 new agent is an employee or exclusive agent of the insurer,
19 the new agent shall pay a policy fee of $50 to the producing
20 agent in lieu of splitting the commission. If the risk is not
21 able to obtain any such offer, the risk is eligible for a
22 policy including wind coverage issued by the association.
23 c. This subparagraph does not require the association
24 to provide wind coverage or hurricane coverage in any area in
25 which such coverage is available through the Florida Windstorm
26 Underwriting Association.
27 6. Must include rules for classifications of risks and
28 rates therefor.
29 7. Must provide that if premium and investment income
30 attributable to a particular plan year are in excess of
31 projected losses and expenses of the plan attributable to that

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1 year, such excess shall be held in surplus. Such surplus shall
2 be available to defray deficits as to future years and shall
3 be used for that purpose prior to assessing member insurers as
4 to any plan year.
5 8. Must provide objective criteria and procedures to
6 be uniformly applied for all applicants in determining whether
7 an individual risk is so hazardous as to be uninsurable. In
8 making this determination and in establishing the criteria and
9 procedures, the following shall be considered:
10 a. Whether the likelihood of a loss for the individual
11 risk is substantially higher than for other risks of the same
12 class; and
13 b. Whether the uncertainty associated with the
14 individual risk is such that an appropriate premium cannot be
15 determined.
16
17 The acceptance or rejection of a risk by the association shall
18 be construed as the private placement of insurance, and the
19 provisions of chapter 120 shall not apply.
20 9. Must provide that the association shall make its
21 best efforts to procure catastrophe reinsurance at reasonable
22 rates, as determined by the board of governors.
23 10. Must provide that in the event of regular deficit
24 assessments under sub-subparagraph (b)3.a. or sub-subparagraph
25 (b)3.b., or by the Florida Windstorm Underwriting Association
26 under sub-sub-subparagraph (2)(b)2.d.(I) or
27 sub-sub-subparagraph (2)(b)2.d.(II), the association shall
28 levy upon association policyholders in its next rate filing,
29 or by a separate rate filing solely for this purpose, a market
30 equalization surcharge in a percentage equal to the total
31 amount of such regular assessments divided by the aggregate

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1 statewide direct written premium for subject lines of business
2 for member insurers for the prior calendar year. Market
3 equalization surcharges under this subparagraph are not
4 considered premium and are not subject to commissions, fees,
5 or premium taxes; however, failure to pay a market
6 equalization surcharge shall be treated as failure to pay
7 premium.
8 11. The policies issued by the association must
9 provide that, if the association or the market assistance plan
10 obtains an offer from an authorized insurer to cover the risk
11 at its approved rates under either a standard policy including
12 wind coverage or a basic policy including wind coverage, the
13 risk is no longer eligible for coverage through the
14 association. However, if the risk is located in an area in
15 which Florida Windstorm Underwriting Association coverage is
16 available, such an offer of a standard or basic policy
17 terminates eligibility regardless of whether or not the offer
18 includes wind coverage. Upon termination of eligibility, the
19 association shall provide written notice to the policyholder
20 and agent of record stating that the association policy shall
21 be canceled as of 60 days after the date of the notice because
22 of the offer of coverage from an authorized insurer. Other
23 provisions of the insurance code relating to cancellation and
24 notice of cancellation do not apply to actions under this
25 subparagraph.
26 12. Association policies and applications must include
27 a notice that the association policy could, under this section
28 or s. 627.3511, be replaced with a policy issued by an
29 admitted insurer that does not provide coverage identical to
30 the coverage provided by the association. The notice shall
31 also specify that acceptance of association coverage creates a

1 conclusive presumption that the applicant or policyholder is
2 aware of this potential.
3 13. May establish, subject to approval by the
4 department, different eligibility requirements and operational
5 procedures for any line or type of coverage for any specified
6 county or area if the board determines that such changes to
7 the eligibility requirements and operational procedures are
8 justified due to the voluntary market being sufficiently
9 stable and competitive in such area or for such line or type
10 of coverage and that consumers who, in good faith, are unable
11 to obtain insurance through the voluntary market through
12 ordinary methods would continue to have access to coverage
13 from the association. When coverage is sought in connection
14 with a real property transfer, such requirements and
15 procedures shall not provide for an effective date of coverage
16 later than the date of the closing of the transfer as
17 established by the transferor, the transferee, and, if
18 applicable, the lender.
19 (d)1. It is the intent of the Legislature that the
20 rates for coverage provided by the association be actuarially
21 sound and not competitive with approved rates charged in the
22 admitted voluntary market, so that the association functions
23 as a residual market mechanism to provide insurance only when
24 the insurance cannot be procured in the voluntary market.
25 Rates shall include an appropriate catastrophe loading factor
26 that reflects the actual catastrophic exposure of the
27 association and recognizes that the association has little or
28 no capital or surplus; and the association shall carefully
29 review each rate filing to assure that provider compensation
30 is not excessive.
31

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1 2. For each county, the average rates of the
2 association for each line of business for personal lines
3 residential policies shall be no lower than the average rates
4 charged by the insurer that had the highest average rate in
5 that county among the 20 insurers with the greatest total
6 direct written premium in the state for that line of business
7 in the preceding year, except that with respect to mobile home
8 coverages, the average rates of the association shall be no
9 lower than the average rates charged by the insurer that had
10 the highest average rate in that county among the 5 insurers
11 with the greatest total written premium for mobile home
12 owner's policies in the state in the preceding year.
13 3. Rates for commercial residential coverage shall not
14 be subject to the requirements of subparagraph 2., but shall
15 be subject to all other requirements of this paragraph and s.
16 627.062.
17 4. Nothing in this paragraph shall require or allow
18 the association to adopt a rate that is inadequate under s.
19 627.062 or to reduce rates approved under s. 627.062.
20 5. ~~The association may require arbitration of a filing~~
21 ~~pursuant to s. 627.062(6).~~Rate filings of the association
22 under this paragraph shall be made on a use and file basis
23 under s. 627.062(2)(a)2. The association shall make a rate
24 filing at least once a year, but no more often than quarterly.
25 (e) Coverage through the association is hereby
26 activated effective upon approval of the plan, and shall
27 remain activated until coverage is deactivated pursuant to
28 paragraph (f). Thereafter, coverage through the association
29 shall be reactivated by order of the department only under one
30 of the following circumstances:
31

1 1. If the market assistance plan receives a minimum of
2 100 applications for coverage within a 3-month period, or 200
3 applications for coverage within a 1-year period or less for
4 residential coverage, unless the market assistance plan
5 provides a quotation from admitted carriers at their filed
6 rates for at least 90 percent of such applicants. Any market
7 assistance plan application that is rejected because an
8 individual risk is so hazardous as to be uninsurable using the
9 criteria specified in subparagraph (c)8. shall not be included
10 in the minimum percentage calculation provided herein. In the
11 event that there is a legal or administrative challenge to a
12 determination by the department that the conditions of this
13 subparagraph have been met for eligibility for coverage in the
14 association, any eligible risk may obtain coverage during the
15 pendency of such challenge.
16 2. In response to a state of emergency declared by the
17 Governor under s. 252.36, the department may activate coverage
18 by order for the period of the emergency upon a finding by the
19 department that the emergency significantly affects the
20 availability of residential property insurance.
21 (f) The activities of the association shall be
22 reviewed at least annually by the board and, upon
23 recommendation by the board or petition of any interested
24 party, coverage shall be deactivated if the department finds
25 that the conditions giving rise to its activation no longer
26 exist.
27 (g)1. The board shall certify to the department its
28 needs for annual assessments as to a particular calendar year,
29 and any startup or interim assessments that it deems to be
30 necessary to sustain operations as to a particular year
31 pending the receipt of annual assessments. Upon verification,

1 the department shall approve such certification, and the board
2 shall levy such annual, startup, or interim assessments. Such
3 assessments shall be prorated as provided in paragraph (b).
4 The board shall take all reasonable and prudent steps
5 necessary to collect the amount of assessment due from each
6 participating member insurer, including, if prudent, filing
7 suit to collect such assessment. If the board is unable to
8 collect an assessment from any member insurer, the uncollected
9 assessments shall be levied as an additional assessment
10 against the participating member insurers and any
11 participating member insurer required to pay an additional
12 assessment as a result of such failure to pay shall have a
13 cause of action against such nonpaying member insurer.
14 Assessments shall be included as an appropriate factor in the
15 making of rates.
16 2. The governing body of any unit of local government,
17 any residents of which are insured by the association, may
18 issue bonds as defined in s. 125.013 or s. 166.101 from time
19 to time to fund an assistance program, in conjunction with the
20 association, for the purpose of defraying deficits of the
21 association. In order to avoid needless and indiscriminate
22 proliferation, duplication, and fragmentation of such
23 assistance programs, any unit of local government, any
24 residents of which are insured by the association, may provide
25 for the payment of losses, regardless of whether or not the
26 losses occurred within or outside of the territorial
27 jurisdiction of the local government. Revenue bonds may not be
28 issued until validated pursuant to chapter 75, unless a state
29 of emergency is declared by executive order or proclamation of
30 the Governor pursuant to s. 252.36 making such findings as are
31 necessary to determine that it is in the best interests of,

1 and necessary for, the protection of the public health,
2 safety, and general welfare of residents of this state and the
3 protection and preservation of the economic stability of
4 insurers operating in this state, and declaring it an
5 essential public purpose to permit certain municipalities or
6 counties to issue such bonds as will permit relief to
7 claimants and policyholders of the joint underwriting
8 association and insurers responsible for apportionment of
9 association losses. Any such unit of local government may
10 enter into such contracts with the association and with any
11 other entity created pursuant to this subsection as are
12 necessary to carry out this paragraph. Any bonds issued under
13 this subparagraph shall be payable from and secured by moneys
14 received by the association from emergency assessments under
15 sub-subparagraph (b)3.d., and assigned and pledged to or on
16 behalf of the unit of local government for the benefit of the
17 holders of such bonds. The funds, credit, property, and
18 taxing power of the state or of the unit of local government
19 shall not be pledged for the payment of such bonds. If any of
20 the bonds remain unsold 60 days after issuance, the department
21 shall require all insurers subject to assessment to purchase
22 the bonds, which shall be treated as admitted assets; each
23 insurer shall be required to purchase that percentage of the
24 unsold portion of the bond issue that equals the insurer's
25 relative share of assessment liability under this subsection.
26 An insurer shall not be required to purchase the bonds to the
27 extent that the department determines that the purchase would
28 endanger or impair the solvency of the insurer.
29 3.a. In addition to any credits, bonuses, or
30 exemptions provided under s. 627.3511, the board shall adopt a
31 program for the reduction of both new and renewal writings in

1 the association. The board may consider any prudent and not
2 unfairly discriminatory approach to reducing association
3 writings, but must adopt at least a credit against assessment
4 liability or other liability that provides an incentive for
5 insurers to take risks out of the association and to keep
6 risks out of the association by maintaining or increasing
7 voluntary writings in counties in which association risks are
8 highly concentrated and a program to provide a formula under
9 which an insurer voluntarily taking risks out of the
10 association by maintaining or increasing voluntary writings
11 will be relieved wholly or partially from assessments under
12 sub-subparagraphs (b)3.a. and b.
13 b. Any credit or exemption from regular assessments
14 adopted under this subparagraph shall last no longer than the
15 3 years following the cancellation or expiration of the policy
16 by the association. With the approval of the department, the
17 board may extend such credits for an additional year if the
18 insurer guarantees an additional year of renewability for all
19 policies removed from the association, or for 2 additional
20 years if the insurer guarantees 2 additional years of
21 renewability for all policies so removed.
22 c. There shall be no credit, limitation, exemption, or
23 deferment from emergency assessments to be collected from
24 policyholders pursuant to sub-subparagraph (b)3.d.
25 4. The plan shall provide for the deferment, in whole
26 or in part, of the assessment of a member insurer, other than
27 an emergency assessment collected from policyholders pursuant
28 to sub-subparagraph (b)3.d., if the department finds that
29 payment of the assessment would endanger or impair the
30 solvency of the insurer. In the event an assessment against a
31 member insurer is deferred in whole or in part, the amount by

1 which such assessment is deferred may be assessed against the
2 other member insurers in a manner consistent with the basis
3 for assessments set forth in paragraph (b).
4 (h) Nothing in this subsection shall be construed to
5 preclude the issuance of residential property insurance
6 coverage pursuant to part VIII of chapter 626.
7 (i) There shall be no liability on the part of, and no
8 cause of action of any nature shall arise against, any member
9 insurer or its agents or employees, the association or its
10 agents or employees, members of the board of governors or
11 their respective designees at a board meeting, association
12 committee members, or the department or its representatives,
13 for any action taken by them in the performance of their
14 duties or responsibilities under this subsection. Such
15 immunity does not apply to:
16 1. Any of the foregoing persons or entities for any
17 willful tort;
18 2. The association or its servicing or producing
19 agents for breach of any contract or agreement pertaining to
20 insurance coverage;
21 3. The association with respect to issuance or payment
22 of debt; or
23 4. Any member insurer with respect to any action to
24 enforce a member insurer's obligations to the association
25 under this subsection.
26 (j) The Residential Property and Casualty Joint
27 Underwriting Association is not a state agency, board, or
28 commission. However, for the purposes of s. 199.183(1), the
29 Residential Property and Casualty Joint Underwriting
30 Association shall be considered a political subdivision of the
31 state and shall be exempt from the corporate income tax.

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1 (k) Upon a determination by the board of governors
2 that the conditions giving rise to the establishment and
3 activation of the association no longer exist, and upon the
4 consent thereto by order of the department, the association is
5 dissolved. Upon dissolution, the assets of the association
6 shall be applied first to pay all debts, liabilities, and
7 obligations of the association, including the establishment of
8 reasonable reserves for any contingent liabilities or
9 obligations, and all remaining assets of the association shall
10 become property of the state and deposited in the Florida
11 Hurricane Catastrophe Fund.
12 (l) All obligations, rights, assets, and liabilities
13 of the Florida Property and Casualty Joint Underwriting
14 Association created by subsection (5), which obligations,
15 rights, assets, or liabilities relate to the provision of
16 commercial lines residential property insurance coverage as
17 described in this section are hereby transferred to the
18 Residential Property and Casualty Joint Underwriting
19 Association. The Residential Property and Casualty Joint
20 Underwriting Association is not required to issue endorsements
21 or certificates of assumption to insureds during the remaining
22 term of in-force transferred policies.
23 (m) Notwithstanding any other provision of law:
24 1. The pledge or sale of, the lien upon, and the
25 security interest in any rights, revenues, or other assets of
26 the association created or purported to be created pursuant to
27 any financing documents to secure any bonds or other
28 indebtedness of the association shall be and remain valid and
29 enforceable, notwithstanding the commencement of and during
30 the continuation of, and after, any rehabilitation,
31 insolvency, liquidation, bankruptcy, receivership,

1 conservatorship, reorganization, or similar proceeding against
2 the association under the laws of this state.
3 2. No such proceeding shall relieve the association of
4 its obligation, or otherwise affect its ability to perform its
5 obligation, to continue to collect, or levy and collect,
6 assessments, market equalization or other surcharges under
7 subparagraph (c)10., or any other rights, revenues, or other
8 assets of the association pledged pursuant to any financing
9 documents.
10 3. Each such pledge or sale of, lien upon, and
11 security interest in, including the priority of such pledge,
12 lien, or security interest, any such assessments, market
13 equalization or other surcharges, or other rights, revenues,
14 or other assets which are collected, or levied and collected,
15 after the commencement of and during the pendency of, or
16 after, any such proceeding shall continue unaffected by such
17 proceeding. As used in this subsection, the term "financing
18 documents" means any agreement or agreements, instrument or
19 instruments, or other document or documents now existing or
20 hereafter created evidencing any bonds or other indebtedness
21 of the association or pursuant to which any such bonds or
22 other indebtedness has been or may be issued and pursuant to
23 which any rights, revenues, or other assets of the association
24 are pledged or sold to secure the repayment of such bonds or
25 indebtedness, together with the payment of interest on such
26 bonds or such indebtedness, or the payment of any other
27 obligation of the association related to such bonds or
28 indebtedness.
29 4. Any such pledge or sale of assessments, revenues,
30 contract rights, or other rights or assets of the association
31 shall constitute a lien and security interest, or sale, as the

1 case may be, that is immediately effective and attaches to
2 such assessments, revenues, or contract rights or other rights
3 or assets, whether or not imposed or collected at the time the
4 pledge or sale is made. Any such pledge or sale is effective,
5 valid, binding, and enforceable against the association or
6 other entity making such pledge or sale, and valid and binding
7 against and superior to any competing claims or obligations
8 owed to any other person or entity, including policyholders in
9 this state, asserting rights in any such assessments,
10 revenues, or contract rights or other rights or assets to the
11 extent set forth in and in accordance with the terms of the
12 pledge or sale contained in the applicable financing
13 documents, whether or not any such person or entity has notice
14 of such pledge or sale and without the need for any physical
15 delivery, recordation, filing, or other action.
16 (n)1. The following records of the Residential
17 Property and Casualty Joint Underwriting Association are
18 confidential and exempt from the provisions of s. 119.07(1)
19 and s. 24(a), Art. I of the State Constitution:
20 a. Underwriting files, except that a policyholder or
21 an applicant shall have access to his or her own underwriting
22 files.
23 b. Claims files, until termination of all litigation
24 and settlement of all claims arising out of the same incident,
25 although portions of the claims files may remain exempt, as
26 otherwise provided by law. Confidential and exempt claims file
27 records may be released to other governmental agencies upon
28 written request and demonstration of need; such records held
29 by the receiving agency remain confidential and exempt as
30 provided for herein.
31

1 c. Records obtained or generated by an internal
2 auditor pursuant to a routine audit, until the audit is
3 completed, or if the audit is conducted as part of an
4 investigation, until the investigation is closed or ceases to
5 be active. An investigation is considered "active" while the
6 investigation is being conducted with a reasonable, good faith
7 belief that it could lead to the filing of administrative,
8 civil, or criminal proceedings.
9 d. Matters reasonably encompassed in privileged
10 attorney-client communications.
11 e. Proprietary information licensed to the association
12 under contract and the contract provides for the
13 confidentiality of such proprietary information.
14 f. All information relating to the medical condition
15 or medical status of an association employee which is not
16 relevant to the employee's capacity to perform his or her
17 duties, except as otherwise provided in this paragraph.
18 Information which is exempt shall include, but is not limited
19 to, information relating to workers' compensation, insurance
20 benefits, and retirement or disability benefits.
21 g. Upon an employee's entrance into the employee
22 assistance program, a program to assist any employee who has a
23 behavioral or medical disorder, substance abuse problem, or
24 emotional difficulty which affects the employee's job
25 performance, all records relative to that participation shall
26 be confidential and exempt from the provisions of s. 119.07(1)
27 and s. 24(a), Art. I of the State Constitution, except as
28 otherwise provided in s. 112.0455(11).
29 h. Information relating to negotiations for financing,
30 reinsurance, depopulation, or contractual services, until the
31 conclusion of the negotiations.

1 i. Minutes of closed meetings regarding underwriting
2 files, and minutes of closed meetings regarding an open claims
3 file until termination of all litigation and settlement of all
4 claims with regard to that claim, except that information
5 otherwise confidential or exempt by law will be redacted.
6
7 When an authorized insurer is considering underwriting a risk
8 insured by the association, relevant underwriting files and
9 confidential claims files may be released to the insurer
10 provided the insurer agrees in writing, notarized and under
11 oath, to maintain the confidentiality of such files. When a
12 file is transferred to an insurer that file is no longer a
13 public record because it is not held by an agency subject to
14 the provisions of the public records law. Underwriting files
15 and confidential claims files may also be released to staff of
16 and the board of governors of the market assistance plan
17 established pursuant to s. 627.3515, who must retain the
18 confidentiality of such files, except such files may be
19 released to authorized insurers that are considering assuming
20 the risks to which the files apply, provided the insurer
21 agrees in writing, notarized and under oath, to maintain the
22 confidentiality of such files. Finally, the association or
23 the board or staff of the market assistance plan may make the
24 following information obtained from underwriting files and
25 confidential claims files available to licensed general lines
26 insurance agents: name, address, and telephone number of the
27 residential property owner or insured; location of the risk;
28 rating information; loss history; and policy type. The
29 receiving licensed general lines insurance agent must retain
30 the confidentiality of the information received.
31

2. Portions of meetings of the Residential Property and Casualty Joint Underwriting Association are exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution wherein confidential underwriting files or confidential open claims files are discussed. All portions of association meetings which are closed to the public shall be recorded by a court reporter. The court reporter shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No 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 60. 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

1 calculations. The insurer or insurer group may use the
2 assessment factor at any time after the expiration of the
3 15-day period unless the commission ~~department~~ has notified
4 the insurer or insurer group in writing that the arithmetic
5 calculations are incorrect.
6 (4) The commission ~~department~~ may adopt rules to
7 implement this section.
8 Section 61. Subsection (8) of section 627.357, Florida
9 Statutes, is amended to read:
10 627.357 Medical malpractice self-insurance.--
11 (8) The expense factors associated with rates used by
12 a fund shall be filed with the commission ~~department~~ at least
13 30 days prior to use and may not be used until approved by the
14 commission ~~department~~. The commission ~~department~~ shall
15 disapprove the rates unless the filed expense factors
16 associated therewith are justified and reasonable for the
17 benefits and services provided.
18 Section 62. Section 627.361, Florida Statutes, is
19 amended to read:
20 627.361 False or misleading information.--No person
21 shall willfully withhold information from or knowingly give
22 false or misleading information to the department, commission,
23 any statistical agency designated by the department or
24 commission, any rating organization, or any insurer, which
25 will affect the rates or premiums chargeable under this part.
26 Section 63. Subsections (6), (7), and (8) of section
27 627.410, Florida Statutes, are amended to read:
28 627.410 Filing, approval of forms.--
29 (6)(a) An insurer shall not deliver or issue for
30 delivery or renew in this state any health insurance policy
31 form until it has filed with the commission ~~department~~ a copy

1 of every applicable rating manual, rating schedule, change in
2 rating manual, and change in rating schedule; if rating
3 manuals and rating schedules are not applicable, the insurer
4 must file with the commission ~~department~~ applicable premium
5 rates and any change in applicable premium rates.
6 (b) The commission ~~department~~ may establish by rule,
7 for each type of health insurance form, procedures to be used
8 in ascertaining the reasonableness of benefits in relation to
9 premium rates and may, by rule, exempt from any requirement of
10 paragraph (a) any health insurance policy form or type thereof
11 (as specified in such rule) to which form or type such
12 requirements may not be practically applied or to which form
13 or type the application of such requirements is not desirable
14 or necessary for the protection of the public. With respect to
15 any health insurance policy form or type thereof which is
16 exempted by rule from any requirement of paragraph (a),
17 premium rates filed pursuant to ss. 627.640 and 627.662 shall
18 be for informational purposes.
19 (c) Every filing made pursuant to this subsection
20 shall be made within the same time period provided in, and
21 shall be deemed to be approved under the same conditions as
22 those provided in, subsection (2), except that such filings
23 shall be made with the commission, rather than the department.
24 (d) Every filing made pursuant to this subsection,
25 except disability income policies and accidental death
26 policies, shall be prohibited from applying the following
27 rating practices:
28 1. Select and ultimate premium schedules.
29 2. Premium class definitions which classify insured
30 based on year of issue or duration since issue.
31

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the department and commission in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the department and commission, the insurer shall no longer offer for sale the policy form or certificate form in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the department of the discontinuance. The period of discontinuance may be reduced if the department or commission determines that a shorter period is appropriate.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the commission ~~department~~ no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. The commission ~~department~~, after receiving a request to be exempted from the provisions of this section,

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may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(b) The filing required by this subsection shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted ~~promulgated~~ by the commission ~~department~~.

2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules adopted ~~promulgated~~ by the commission ~~department~~.

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the commission ~~department~~ for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the

commission ~~department~~ in its offices in Tallahassee no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the commission ~~department~~ may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until ~~such time as~~ the commission ~~department~~ determines that the required filing is properly submitted.

(8)(a) For the purposes of subsections (6) and (7), 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

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1 the filing is not in compliance with ss. 627.671-627.675 or
2 the currently expected lifetime loss ratio is less than the
3 filed lifetime loss ratio as certified by an actuary in the
4 initial guaranteed loss ratio filing. If this section
5 conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall
6 control.
7 (b) The renewal premium rates shall be deemed to be
8 approved upon filing with the commission ~~department~~ if the
9 filing is accompanied by the most current approved loss ratio
10 guarantee. The loss ratio guarantee shall be in writing, shall
11 be signed by an officer of the insurer, and shall contain at
12 least:
13 1. A recitation of the anticipated lifetime and
14 durational target loss ratios contained in the actuarial
15 memorandum filed with the policy form when it was originally
16 approved. The durational target loss ratios shall be
17 calculated for 1-year experience periods. If statutory
18 changes have rendered any portion of such actuarial memorandum
19 obsolete, the loss ratio guarantee shall also include an
20 amendment to the actuarial memorandum reflecting current law
21 and containing new lifetime and durational loss ratio targets.
22 2. A guarantee that the applicable loss ratios for the
23 experience period in which the new rates will take effect, and
24 for each experience period thereafter until new rates are
25 filed, will meet the loss ratios referred to in subparagraph
26 1.
27 3. A guarantee that the applicable loss ratio results
28 for the experience period will be independently audited at the
29 insurer's expense. The audit shall be performed in the second
30 calendar quarter of the year following the end of the
31 experience period, and the audited results shall be reported

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1 to the commission ~~department~~ no later than the end of such
2 quarter. The commission ~~department~~ shall establish by rule
3 the minimum information reasonably necessary to be included in
4 the report. The audit shall be done in accordance with
5 accepted accounting and actuarial principles.
6 4. A guarantee that affected policyholders in this
7 state shall be issued a proportional refund, based on the
8 premium earned, of the amount necessary to bring the
9 applicable experience period loss ratio up to the durational
10 target loss ratio referred to in subparagraph 1. The refund
11 shall be made to all policyholders in this state who are
12 insured under the applicable policy form as of the last day of
13 the experience period, except that no refund need be made to a
14 policyholder in an amount less than $10. Refunds less than $10
15 shall be aggregated and paid pro rata to the policyholders
16 receiving refunds. The refund shall include interest at the
17 then-current variable loan interest rate for life insurance
18 policies established by the National Association of Insurance
19 Commissioners, from the end of the experience period until the
20 date of payment. Payments shall be made during the third
21 calendar quarter of the year following the experience period
22 for which a refund is determined to be due. However, no
23 refunds shall be made until 60 days after the filing of the
24 audit report in order that the commission ~~department~~ has
25 adequate time to review the report.
26 5. A guarantee that if the applicable loss ratio
27 exceeds the durational target loss ratio for that experience
28 period by more than 20 percent, provided there are at least
29 2,000 policyholders on the form nationwide or, if not, then
30 accumulated each calendar year until 2,000 policyholder years
31 is reached, the insurer, if directed by the commission

~~department~~, shall withdraw the policy form for the purposes of issuing new policies.

(c) As used in this subsection:

1. "Loss ratio" means the ratio of incurred claims to earned premium.

2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 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 64. 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 conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(2) The commission shall disapprove any health insurance rate filing under s. 627.410(6), (7), or (8) or withdraw any previous approval thereof only if the benefits are unreasonable in relation to the premium charged or the filing applies rating practices that result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices.In determining whether the benefits are reasonable in relation to the premium charged, the commission ~~department~~, in accordance with reasonable actuarial techniques, shall consider:

(a) Past loss experience and prospective loss experience within and without this state.

(b) Allocation of expenses.

1 (c) Risk and contingency margins, along with
2 justification of such margins.
3 (d) Acquisition costs.
4 Section 65. Paragraph (c) of subsection (7) of section
5 627.6475, Florida Statutes, is amended to read:
6 627.6475 Individual reinsurance pool.--
7 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
8 (c)1. The board, as part of the plan of operation,
9 shall establish a methodology for determining premium rates to
10 be charged by the program for reinsuring eligible individuals
11 pursuant to this section. The methodology must include a
12 system for classifying individuals which reflects the types of
13 case characteristics commonly used by carriers in this state.
14 The methodology must provide for the development of basic
15 reinsurance premium rates, which shall be multiplied by the
16 factors set for them in this paragraph to determine the
17 premium rates for the program. The basic reinsurance premium
18 rates shall be established by the board, subject to the
19 approval of the commission ~~department~~, and shall be set at
20 levels that reasonably approximate gross premiums charged to
21 eligible individuals for individual health insurance by health
22 insurance issuers. The premium rates set by the board may vary
23 by geographical area, as determined under this section, to
24 reflect differences in cost. An eligible individual may be
25 reinsured for a rate that is five times the rate established
26 by the board.
27 2. The board shall periodically review the methodology
28 established, including the system of classification and any
29 rating factors, to ensure that it reasonably reflects the
30 claims experience of the program. The board may propose
31

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1 changes to the rates that are subject to the approval of the
2 commission ~~department~~.
3 Section 66. Paragraph (a) of subsection (4) of section
4 627.6498, Florida Statutes, is amended to read:
5 627.6498 Minimum benefits coverage; exclusions;
6 premiums; deductibles.--
7 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--
8 (a) The plan shall provide for annual deductibles for
9 major medical expense coverage in the amount of $1,000 or any
10 higher amounts proposed by the board and approved by the
11 commission ~~department~~, plus the benefits payable under any
12 other type of insurance coverage or workers' compensation.
13 The schedule of premiums and deductibles shall be established
14 by the association. With regard to any preferred provider
15 arrangement used ~~utilized~~ by the association, the deductibles
16 provided in this paragraph shall be the minimum deductibles
17 applicable to the preferred providers and higher deductibles,
18 as approved by the department, may be applied to providers who
19 are not preferred providers.
20 1. Separate schedules of premium rates based on age
21 may apply for individual risks.
22 2. Rates are subject to approval by the commission
23 ~~department~~.
24 3. Standard risk rates for coverages issued by the
25 association shall be established by the commission ~~department~~,
26 pursuant to s. 627.6675(3).
27 4. The board shall establish separate premium
28 schedules for low-risk individuals, medium-risk individuals,
29 and high-risk individuals and shall revise premium schedules
30 annually beginning January 1999. No rate shall exceed 200
31 percent of the standard risk rate for low-risk individuals,

1 225 percent of the standard risk rate for medium-risk
2 individuals, or 250 percent of the standard risk rate for
3 high-risk individuals. For the purpose of determining what
4 constitutes a low-risk individual, medium-risk individual, or
5 high-risk individual, the board shall consider the anticipated
6 claims payment for individuals based upon an individual's
7 health condition.
8 Section 67. Section 627.6675, Florida Statutes, is
9 amended to read:
10 627.6675 Conversion on termination of
11 eligibility.--Subject to all of the provisions of this
12 section, a group policy delivered or issued for delivery in
13 this state by an insurer or nonprofit health care services
14 plan that provides, on an expense-incurred basis, hospital,
15 surgical, or major medical expense insurance, or any
16 combination of these coverages, shall provide that an employee
17 or member whose insurance under the group policy has been
18 terminated for any reason, including discontinuance of the
19 group policy in its entirety or with respect to an insured
20 class, and who has been continuously insured under the group
21 policy, and under any group policy providing similar benefits
22 that the terminated group policy replaced, for at least 3
23 months immediately prior to termination, shall be entitled to
24 have issued to him or her by the insurer a policy or
25 certificate of health insurance, referred to in this section
26 as a "converted policy." A group insurer may meet the
27 requirements of this section by contracting with another
28 insurer, authorized in this state, to issue an individual
29 converted policy, which policy has been approved by the
30 department under s. 627.410. An employee or member shall not
31 be entitled to a converted policy if termination of his or her

1 insurance under the group policy occurred because he or she
2 failed to pay any required contribution, or because any
3 discontinued group coverage was replaced by similar group
4 coverage within 31 days after discontinuance.
5 (1) TIME LIMIT.--Written application for the converted
6 policy shall be made and the first premium must be paid to the
7 insurer, not later than 63 days after termination of the group
8 policy. However, if termination was the result of failure to
9 pay any required premium or contribution and such nonpayment
10 of premium was due to acts of an employer or policyholder
11 other than the employee or certificateholder, written
12 application for the converted policy must be made and the
13 first premium must be paid to the insurer not later than 63
14 days after notice of termination is mailed by the insurer or
15 the employer, whichever is earlier, to the employee's or
16 certificateholder's last address as shown by the record of the
17 insurer or the employer, whichever is applicable. In such case
18 of termination due to nonpayment of premium by the employer or
19 policyholder, the premium for the converted policy may not
20 exceed the rate for the prior group coverage for the period of
21 coverage under the converted policy prior to the date notice
22 of termination is mailed to the employee or certificateholder.
23 For the period of coverage after such date, the premium for
24 the converted policy is subject to the requirements of
25 subsection (3).
26 (2) EVIDENCE OF INSURABILITY.--The converted policy
27 shall be issued without evidence of insurability.
28 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR
29 GROUP COVERAGE.--
30 (a) The premium for the converted policy shall be
31 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.

1 5. The rate for other counties must be determined by
2 using the weighted average of each carrier's county factor
3 relationship to the county determined in subparagraph 4.
4 6. The rate schedule must be determined for different
5 age brackets and family size brackets.
6 (4) EFFECTIVE DATE OF COVERAGE.--The effective date of
7 the converted policy shall be the day following the
8 termination of insurance under the group policy.
9 (5) SCOPE OF COVERAGE.--The converted policy shall
10 cover the employee or member and his or her dependents who
11 were covered by the group policy on the date of termination of
12 insurance. At the option of the insurer, a separate converted
13 policy may be issued to cover any dependent.
14 (6) OPTIONAL COVERAGE.--The insurer shall not be
15 required to issue a converted policy covering any person who
16 is or could be covered by Medicare. The insurer shall not be
17 required to issue a converted policy covering a person if
18 paragraphs (a) and (b) apply to the person:
19 (a) If any of the following apply to the person:
20 1. The person is covered for similar benefits by
21 another hospital, surgical, medical, or major medical expense
22 insurance policy or hospital or medical service subscriber
23 contract or medical practice or other prepayment plan, or by
24 any other plan or program.
25 2. The person is eligible for similar benefits,
26 whether or not actually provided coverage, under any
27 arrangement of coverage for individuals in a group, whether on
28 an insured or uninsured basis.
29 3. Similar benefits are provided for or are available
30 to the person under any state or federal law.
31

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1 (b) If the benefits provided under the sources
2 referred to in subparagraph (a)1. or the benefits provided or
3 available under the sources referred to in subparagraphs (a)2.
4 and 3., together with the benefits provided by the converted
5 policy, would result in overinsurance according to the
6 insurer's standards. The insurer's standards must bear some
7 reasonable relationship to actual health care costs in the
8 area in which the insured lives at the time of conversion and
9 must be filed with the department prior to their use in
10 denying coverage.
11 (7) INFORMATION REQUESTED BY INSURER.--
12 (a) A converted policy may include a provision under
13 which the insurer may request information, in advance of any
14 premium due date, of any person covered thereunder as to
15 whether:
16 1. The person is covered for similar benefits by
17 another hospital, surgical, medical, or major medical expense
18 insurance policy or hospital or medical service subscriber
19 contract or medical practice or other prepayment plan or by
20 any other plan or program.
21 2. The person is covered for similar benefits under
22 any arrangement of coverage for individuals in a group,
23 whether on an insured or uninsured basis.
24 3. Similar benefits are provided for or are available
25 to the person under any state or federal law.
26 (b) The converted policy may provide that the insurer
27 may refuse to renew the policy or the coverage of any person
28 only for one or more of the following reasons:
29 1. Either the benefits provided under the sources
30 referred to in subparagraphs (a)1. and 2. for the person or
31 the benefits provided or available under the sources referred

1 to in subparagraph (a)3. for the person, together with the
2 benefits provided by the converted policy, would result in
3 overinsurance according to the insurer's standards on file
4 with the department.
5 2. The converted policyholder fails to provide the
6 information requested pursuant to paragraph (a).
7 3. Fraud or intentional misrepresentation in applying
8 for any benefits under the converted policy.
9 4. Other reasons approved by the department.
10 (8) BENEFITS OFFERED.--
11 (a) An insurer shall not be required to issue a
12 converted policy that provides benefits in excess of those
13 provided under the group policy from which conversion is made.
14 (b) An insurer shall offer the benefits specified in
15 s. 627.668 and the benefits specified in s. 627.669 if those
16 benefits were provided in the group plan.
17 (c) An insurer shall offer maternity benefits and
18 dental benefits if those benefits were provided in the group
19 plan.
20 (9) PREEXISTING CONDITION PROVISION.--The converted
21 policy shall not exclude a preexisting condition not excluded
22 by the group policy. However, the converted policy may provide
23 that any hospital, surgical, or medical benefits payable under
24 the converted policy may be reduced by the amount of any such
25 benefits payable under the group policy after the termination
26 of covered under the group policy. The converted policy may
27 also provide that during the first policy year the benefits
28 payable under the converted policy, together with the benefits
29 payable under the group policy, shall not exceed those that
30 would have been payable had the individual's insurance under
31 the group policy remained in force.

1 (10) REQUIRED OPTION FOR MAJOR MEDICAL
2 COVERAGE.--Subject to the provisions and conditions of this
3 part, the employee or member shall be entitled to obtain a
4 converted policy providing major medical coverage under a plan
5 meeting the following requirements:
6 (a) A maximum benefit equal to the lesser of the
7 policy limit of the group policy from which the individual
8 converted or $500,000 per covered person for all covered
9 medical expenses incurred during the covered person's
10 lifetime.
11 (b) Payment of benefits at the rate of 80 percent of
12 covered medical expenses which are in excess of the
13 deductible, until 20 percent of such expenses in a benefit
14 period reaches $2,000, after which benefits will be paid at
15 the rate of 90 percent during the remainder of the contract
16 year unless the insured is in the insurer's case management
17 program, in which case benefits shall be paid at the rate of
18 100 percent during the remainder of the contract year. For
19 the purposes of this paragraph, "case management program"
20 means the specific supervision and management of the medical
21 care provided or prescribed for a specific individual, which
22 may include the use of health care providers designated by the
23 insurer. Payment of benefits for outpatient treatment of
24 mental illness, if provided in the converted policy, may be at
25 a lesser rate but not less than 50 percent.
26 (c) A deductible for each calendar year that must be
27 $500, $1,000, or $2,000, at the option of the policyholder.
28 (d) The term "covered medical expenses," as used in
29 this subsection, shall be consistent with those customarily
30 offered by the insurer under group or individual health
31 insurance policies but is not required to be identical to the

1 covered medical expenses provided in the group policy from
2 which the individual converted.
3 (11) ALTERNATIVE PLANS.--The insurer shall, in
4 addition to the option required by subsection (10), offer the
5 standard health benefit plan, as established pursuant to s.
6 627.6699(12). The insurer may, at its option, also offer
7 alternative plans for group health conversion in addition to
8 the plans required by this section.
9 (12) RETIREMENT COVERAGE.--If coverage would be
10 continued under the group policy on an employee following the
11 employee's retirement prior to the time he or she is or could
12 be covered by Medicare, the employee may elect, instead of
13 such continuation of group insurance, to have the same
14 conversion rights as would apply had his or her insurance
15 terminated at retirement by reason or termination of
16 employment or membership.
17 (13) REDUCTION OF COVERAGE DUE TO MEDICARE.--The
18 converted policy may provide for reduction of coverage on any
19 person upon his or her eligibility for coverage under Medicare
20 or under any other state or federal law providing for benefits
21 similar to those provided by the converted policy.
22 (14) CONVERSION PRIVILEGE ALLOWED.--The conversion
23 privilege shall also be available to any of the following:
24 (a) The surviving spouse, if any, at the death of the
25 employee or member, with respect to the spouse and the
26 children whose coverages under the group policy terminate by
27 reason of the death, otherwise to each surviving child whose
28 coverage under the group policy terminates by reason of such
29 death, or, if the group policy provides for continuation of
30 dependents' coverages following the employee's or member's
31 death, at the end of such continuation.

1 (b) The former spouse whose coverage would otherwise
2 terminate because of annulment or dissolution of marriage, if
3 the former spouse is dependent for financial support.
4 (c) The spouse of the employee or member upon
5 termination of coverage of the spouse, while the employee or
6 member remains insured under the group policy, by reason of
7 ceasing to be a qualified family member under the group
8 policy, with respect to the spouse and the children whose
9 coverages under the group policy terminate at the same time.
10 (d) A child solely with respect to himself or herself
11 upon termination of his or her coverage by reason of ceasing
12 to be a qualified family member under the group policy, if a
13 conversion privilege is not otherwise provided in this
14 subsection with respect to such termination.
15 (15) BENEFIT LEVELS.--If the benefit levels required
16 in subsection (10) exceed the benefit levels provided under
17 the group policy, the conversion policy may offer benefits
18 which are substantially similar to those provided under the
19 group policy in lieu of those required in subsection (10).
20 (16) GROUP COVERAGE INSTEAD OF INDIVIDUAL
21 COVERAGE.--The insurer may elect to provide group insurance
22 coverage instead of issuing a converted individual policy.
23 (17) NOTIFICATION.--A notification of the conversion
24 privilege shall be included in each certificate of coverage.
25 The insurer shall mail an election and premium notice form,
26 including an outline of coverage, on a form approved by the
27 department, within 14 days after an individual who is eligible
28 for a converted policy gives notice to the insurer that the
29 individual is considering applying for the converted policy or
30 otherwise requests such information. The outline of coverage
31 must contain a description of the principal benefits and

1 coverage provided by the policy and its principal exclusions
2 and limitations, including, but not limited to, deductibles
3 and coinsurance.
4 (18) OUTSIDE CONVERSIONS.--A converted policy that is
5 delivered outside of this state must be on a form that could
6 be delivered in the other jurisdiction as a converted policy
7 had the group policy been issued in that jurisdiction.
8 (19) APPLICABILITY.--This section does not require
9 conversion on termination of eligibility for a policy or
10 contract that provides benefits for specified diseases, or for
11 accidental injuries only, disability income, Medicare
12 supplement, hospital indemnity, limited benefit,
13 nonconventional, or excess policies.
14 (20) Nothing in this section or in the incorporation
15 of it into insurance policies shall be construed to require
16 insurers to provide benefits equal to those provided in the
17 group policy from which the individual converted; provided,
18 however, that comprehensive benefits are offered which shall
19 be subject to approval by the Insurance Commissioner.
20 Section 68. Subsections (3), (6), (8), (11), (12), and
21 (16) of section 627.6699, Florida Statutes, are amended to
22 read:
23 627.6699 Employee Health Care Access Act.--
24 (3) DEFINITIONS.--As used in this section, the term:
25 (a) "Actuarial certification" means a written
26 statement, by a member of the American Academy of Actuaries or
27 another person acceptable to the commission department, that a
28 small employer carrier is in compliance with subsection (6),
29 based upon the person's examination, including a review of the
30 appropriate records and of the actuarial assumptions and
31

1 methods used by the carrier in establishing premium rates for
2 applicable health benefit plans.
3 (b) "Basic health benefit plan" and "standard health
4 benefit plan" mean low-cost health care plans developed
5 pursuant to subsection (12).
6 (c) "Board" means the board of directors of the
7 program.
8 (d) "Carrier" means a person who provides health
9 benefit plans in this state, including an authorized insurer,
10 a health maintenance organization, a multiple-employer welfare
11 arrangement, or any other person providing a health benefit
12 plan that is subject to insurance regulation in this state.
13 However, the term does not include a multiple-employer welfare
14 arrangement, which multiple-employer welfare arrangement
15 operates solely for the benefit of the members or the members
16 and the employees of such members, and was in existence on
17 January 1, 1992.
18 (e) "Case management program" means the specific
19 supervision and management of the medical care provided or
20 prescribed for a specific individual, which may include the
21 use of health care providers designated by the carrier.
22 (f) "Creditable coverage" has the same meaning
23 ascribed in s. 627.6561.
24 (g) "Dependent" means the spouse or child of an
25 eligible employee, subject to the applicable terms of the
26 health benefit plan covering that employee.
27 (h) "Eligible employee" means an employee who works
28 full time, having a normal workweek of 25 or more hours, and
29 who has met any applicable waiting-period requirements or
30 other requirements of this act. The term includes a
31 self-employed individual, a sole proprietor, a partner of a

1 partnership, or an independent contractor, if the sole
2 proprietor, partner, or independent contractor is included as
3 an employee under a health benefit plan of a small employer,
4 but does not include a part-time, temporary, or substitute
5 employee.
6 (i) "Established geographic area" means the county or
7 counties, or any portion of a county or counties, within which
8 the carrier provides or arranges for health care services to
9 be available to its insureds, members, or subscribers.
10 (j) "Guaranteed-issue basis" means an insurance policy
11 that must be offered to an employer, employee, or dependent of
12 the employee, regardless of health status, preexisting
13 conditions, or claims history.
14 (k) "Health benefit plan" means any hospital or
15 medical policy or certificate, hospital or medical service
16 plan contract, or health maintenance organization subscriber
17 contract. The term does not include accident-only, specified
18 disease, individual hospital indemnity, credit, dental-only,
19 vision-only, Medicare supplement, long-term care, or
20 disability income insurance; similar supplemental plans
21 provided under a separate policy, certificate, or contract of
22 insurance, which cannot duplicate coverage under an underlying
23 health plan and are specifically designed to fill gaps in the
24 underlying health plan, coinsurance, or deductibles; coverage
25 issued as a supplement to liability insurance; workers'
26 compensation or similar insurance; or automobile
27 medical-payment insurance.
28 (l) "Late enrollee" means an eligible employee or
29 dependent as defined under s. 627.6561(1)(b).
30 (m) "Limited benefit policy or contract" means a
31 policy or contract that provides coverage for each person

1 insured under the policy for a specifically named disease or
2 diseases, a specifically named accident, or a specifically
3 named limited market that fulfills an experimental or
4 reasonable need, such as the small group market.
5 (n) "Modified community rating" means a method used to
6 develop carrier premiums which spreads financial risk across a
7 large population and allows adjustments for age, gender,
8 family composition, tobacco usage, and geographic area as
9 determined under paragraph (5)(j).
10 (o) "Participating carrier" means any carrier that
11 issues health benefit plans in this state except a small
12 employer carrier that elects to be a risk-assuming carrier.
13 (p) "Plan of operation" means the plan of operation of
14 the program, including articles, bylaws, and operating rules,
15 adopted by the board under subsection (11).
16 (q) "Program" means the Florida Small Employer Carrier
17 Reinsurance Program created under subsection (11).
18 (r) "Rating period" means the calendar period for
19 which premium rates established by a small employer carrier
20 are assumed to be in effect.
21 (s) "Reinsuring carrier" means a small employer
22 carrier that elects to comply with the requirements set forth
23 in subsection (11).
24 (t) "Risk-assuming carrier" means a small employer
25 carrier that elects to comply with the requirements set forth
26 in subsection (10).
27 (u) "Self-employed individual" means an individual or
28 sole proprietor who derives his or her income from a trade or
29 business carried on by the individual or sole proprietor which
30 results in taxable income as indicated on IRS Form 1040,
31

1 schedule C or F, and which generated taxable income in one of
2 the 2 previous years.
3 (v) "Small employer" means, in connection with a
4 health benefit plan with respect to a calendar year and a plan
5 year, any person, sole proprietor, self-employed individual,
6 independent contractor, firm, corporation, partnership, or
7 association that is actively engaged in business, has its
8 principal place of business in this state, employed an average
9 of at least 1 but not more than 50 eligible employees on
10 business days during the preceding calendar year, and employs
11 at least 1 employee on the first day of the plan year. For
12 purposes of this section, a sole proprietor, an independent
13 contractor, or a self-employed individual is considered a
14 small employer only if all of the conditions and criteria
15 established in this section are met.
16 (w) "Small employer carrier" means a carrier that
17 offers health benefit plans covering eligible employees of one
18 or more small employers.
19 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
20 (a) The <u>commission</u> ~~department~~ may, by rule, establish
21 regulations to administer this <u>subsection</u> ~~section~~ and to
22 assure that rating practices used by small employer carriers
23 are consistent with the purpose of this section, including
24 assuring that differences in rates charged for health benefit
25 plans by small employer carriers are reasonable and reflect
26 objective differences in plan design, not including
27 differences due to the nature of the groups assumed to select
28 particular health benefit plans.
29 (b) For all small employer health benefit plans that
30 are subject to this section and are issued by small employer
31 carriers on or after January 1, 1994, premium rates for health

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1 benefit plans subject to this section are subject to the
2 following:
3 1. Small employer carriers must use a modified
4 community rating methodology in which the premium for each
5 small employer must be determined solely on the basis of the
6 eligible employee's and eligible dependent's gender, age,
7 family composition, tobacco use, or geographic area as
8 determined under paragraph (5)(j).
9 2. Rating factors related to age, gender, family
10 composition, tobacco use, or geographic location may be
11 developed by each carrier to reflect the carrier's experience.
12 The factors used by carriers are subject to commission
13 ~~department~~ review and approval.
14 3. Small employer carriers may not modify the rate for
15 a small employer for 12 months from the initial issue date or
16 renewal date, unless the composition of the group changes or
17 benefits are changed.
18 4. Carriers participating in the alliance program, in
19 accordance with ss. 408.70-408.706, may apply a different
20 community rate to business written in that program.
21 (c) For all small employer health benefit plans that
22 are subject to this section, that are issued by small employer
23 carriers before January 1, 1994, and that are renewed on or
24 after January 1, 1995, renewal rates must be based on the same
25 modified community rating standard applied to new business.
26 (d) Notwithstanding s. 627.401(2), this section and
27 ss. 627.410 and 627.411 apply to any health benefit plan
28 provided by a small employer carrier that provides coverage to
29 one or more employees of a small employer regardless of where
30 the policy, certificate, or contract is issued or delivered,
31

if the health benefit plan covers employees or their covered dependents who are residents of this state.

(8) MAINTENANCE OF RECORDS.--

(a) Each small employer carrier must maintain at its principal place of business a complete and detailed description of its rating practices and renewal practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(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.--

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1 (a) There is created a nonprofit entity to be known as
2 the "Florida Small Employer Health Reinsurance Program."
3 (b)1. The program shall operate subject to the
4 supervision and control of the board.
5 2. Effective upon this act becoming a law, the board
6 shall consist of the commissioner or his or her designee, who
7 shall serve as the chairperson, and 13 additional members who
8 are representatives of carriers and insurance agents and are
9 appointed by the commissioner and serve as follows:
10 a. The commissioner shall include representatives of
11 small employer carriers subject to assessment under this
12 subsection. If two or more carriers elect to be risk-assuming
13 carriers, the membership must include at least two
14 representatives of risk-assuming carriers; if one carrier is
15 risk-assuming, one member must be a representative of such
16 carrier. At least one member must be a carrier who is subject
17 to the assessments, but is not a small employer carrier.
18 Subject to such restrictions, at least five members shall be
19 selected from individuals recommended by small employer
20 carriers pursuant to procedures provided by rule of the
21 department. Three members shall be selected from a list of
22 health insurance carriers that issue individual health
23 insurance policies. At least two of the three members selected
24 must be reinsuring carriers. Two members shall be selected
25 from a list of insurance agents who are actively engaged in
26 the sale of health insurance.
27 b. A member appointed under this subparagraph shall
28 serve a term of 4 years and shall continue in office until the
29 member's successor takes office, except that, in order to
30 provide for staggered terms, the commissioner shall designate
31 two of the initial appointees under this subparagraph to serve

1 terms of 2 years and shall designate three of the initial
2 appointees under this subparagraph to serve terms of 3 years.
3 3. The commissioner may remove a member for cause.
4 4. Vacancies on the board shall be filled in the same
5 manner as the original appointment for the unexpired portion
6 of the term.
7 5. The commissioner may require an entity that
8 recommends persons for appointment to submit additional lists
9 of recommended appointees.
10 (c)1.
11 a. No later than August 15, 1992, the board shall
12 submit to the department a plan of operation to assure the
13 fair, reasonable, and equitable administration of the program.
14 The board may at any time submit to the department any
15 amendments to the plan that the board finds to be necessary or
16 suitable.
17 b. No later than September 15, 1992, the department
18 shall, after notice and hearing, approve the plan of operation
19 if it determines that the plan submitted by the board is
20 suitable to assure the fair, reasonable, and equitable
21 administration of the program and provides for the sharing of
22 program gains and losses equitably and proportionately in
23 accordance with paragraph (j).
24 c. The plan of operation, or any amendment thereto,
25 becomes effective upon written approval of the department.
26 2. If the board fails to submit a suitable plan of
27 operation by August 15, 1992, the department shall, after
28 notice and hearing, adopt a temporary plan of operation by
29 September 15, 1992. The department shall amend or rescind the
30 temporary plan of operation, as appropriate, after it approves
31 a suitable plan of operation submitted by the board.

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1 (d) The plan of operation must, among other things:
2 1. Establish procedures for handling and accounting
3 for program assets and moneys and for an annual fiscal
4 reporting to the department.
5 2. Establish procedures for selecting an administering
6 carrier and set forth the powers and duties of the
7 administering carrier.
8 3. Establish procedures for reinsuring risks.
9 4. Establish procedures for collecting assessments
10 from participating carriers to provide for claims reinsured by
11 the program and for administrative expenses, other than
12 amounts payable to the administrative carrier, incurred or
13 estimated to be incurred during the period for which the
14 assessment is made.
15 5. Provide for any additional matters at the
16 discretion of the board.
17 (e) The board shall:
18 1. Recommend to the department market conduct
19 requirements and other requirements for carriers and agents,
20 including requirements relating to:
21 a. Registration by each carrier with the department of
22 its intention to be a small employer carrier under this
23 section;
24 b. Publication by the department of a list of all
25 small employer carriers, including a requirement applicable to
26 agents and carriers that a health benefit plan may not be sold
27 by a carrier that is not identified as a small employer
28 carrier;
29 c. The availability of a broadly publicized, toll-free
30 telephone number for access by small employers to information
31 concerning this section;

1 d. Periodic reports by carriers and agents concerning
2 health benefit plans issued; and
3 e. Methods concerning periodic demonstration by small
4 employer carriers and agents that they are marketing or
5 issuing health benefit plans to small employers.
6 2. By January 1, 1995, the board shall conduct a study
7 of the effectiveness of this section and may recommend, to the
8 department, improvements to achieve greater rate stability,
9 accessibility, and affordability in the small employer
10 marketplace.
11 (f) The program has the general powers and authority
12 granted under the laws of this state to insurance companies
13 and health maintenance organizations licensed to transact
14 business, except the power to issue health benefit plans
15 directly to groups or individuals. In addition thereto, the
16 program has specific authority to:
17 1. Enter into contracts as necessary or proper to
18 carry out the provisions and purposes of this act, including
19 the authority to enter into contracts with similar programs of
20 other states for the joint performance of common functions or
21 with persons or other organizations for the performance of
22 administrative functions.
23 2. Sue or be sued, including taking any legal action
24 necessary or proper for recovering any assessments and
25 penalties for, on behalf of, or against the program or any
26 carrier.
27 3. Take any legal action necessary to avoid the
28 payment of improper claims against the program.
29 4. Issue reinsurance policies, in accordance with the
30 requirements of this act.
31

1 5. Establish rules, conditions, and procedures for
2 reinsurance risks under the program participation.
3 6. Establish actuarial functions as appropriate for
4 the operation of the program.
5 7. Assess participating carriers in accordance with
6 paragraph (j), and make advance interim assessments as may be
7 reasonable and necessary for organizational and interim
8 operating expenses. Interim assessments shall be credited as
9 offsets against any regular assessments due following the
10 close of the calendar year.
11 8. Appoint appropriate legal, actuarial, and other
12 committees as necessary to provide technical assistance in the
13 operation of the program, and in any other function within the
14 authority of the program.
15 9. Borrow money to effect the purposes of the program.
16 Any notes or other evidences of indebtedness of the program
17 which are not in default constitute legal investments for
18 carriers and may be carried as admitted assets.
19 10. To the extent necessary, increase the $5,000
20 deductible reinsurance requirement to adjust for the effects
21 of inflation.
22 (g) A reinsuring carrier may reinsure with the program
23 coverage of an eligible employee of a small employer, or any
24 dependent of such an employee, subject to each of the
25 following provisions:
26 1. With respect to a standard and basic health care
27 plan, the program must reinsure the level of coverage
28 provided; and, with respect to any other plan, the program
29 must reinsure the coverage up to, but not exceeding, the level
30 of coverage provided under the standard and basic health care
31 plan.

1 2. Except in the case of a late enrollee, a reinsuring
2 carrier may reinsure an eligible employee or dependent within
3 60 days after the commencement of the coverage of the small
4 employer. A newly employed eligible employee or dependent of a
5 small employer may be reinsured within 60 days after the
6 commencement of his or her coverage.
7 3. A small employer carrier may reinsure an entire
8 employer group within 60 days after the commencement of the
9 group's coverage under the plan. The carrier may choose to
10 reinsure newly eligible employees and dependents of the
11 reinsured group pursuant to subparagraph 1.
12 4. The program may not reimburse a participating
13 carrier with respect to the claims of a reinsured employee or
14 dependent until the carrier has paid incurred claims of at
15 least $5,000 in a calendar year for benefits covered by the
16 program. In addition, the reinsuring carrier shall be
17 responsible for 10 percent of the next $50,000 and 5 percent
18 of the next $100,000 of incurred claims during a calendar year
19 and the program shall reinsure the remainder.
20 5. The board annually shall adjust the initial level
21 of claims and the maximum limit to be retained by the carrier
22 to reflect increases in costs and utilization within the
23 standard market for health benefit plans within the state. The
24 adjustment shall not be less than the annual change in the
25 medical component of the "Consumer Price Index for All Urban
26 Consumers" of the Bureau of Labor Statistics of the Department
27 of Labor, unless the board proposes and the department
28 approves a lower adjustment factor.
29 6. A small employer carrier may terminate reinsurance
30 for all reinsured employees or dependents on any plan
31 anniversary.

1 7. The premium rate charged for reinsurance by the
2 program to a health maintenance organization that is approved
3 by the Secretary of Health and Human Services as a federally
4 qualified health maintenance organization pursuant to 42
5 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
6 requirements that limit the amount of risk that may be ceded
7 to the program, which requirements are more restrictive than
8 subparagraph 4., shall be reduced by an amount equal to that
9 portion of the risk, if any, which exceeds the amount set
10 forth in subparagraph 4. which may not be ceded to the
11 program.
12 8. The board may consider adjustments to the premium
13 rates charged for reinsurance by the program for carriers that
14 use effective cost containment measures, including high-cost
15 case management, as defined by the board.
16 9. A reinsuring carrier shall apply its
17 case-management and claims-handling techniques, including, but
18 not limited to, utilization review, individual case
19 management, preferred provider provisions, other managed care
20 provisions or methods of operation, consistently with both
21 reinsured business and nonreinsured business.
22 (h)1. The board, as part of the plan of operation,
23 shall establish a methodology for determining premium rates to
24 be charged by the program for reinsuring small employers and
25 individuals pursuant to this section. The methodology shall
26 include a system for classification of small employers that
27 reflects the types of case characteristics commonly used by
28 small employer carriers in the state. The methodology shall
29 provide for the development of basic reinsurance premium
30 rates, which shall be multiplied by the factors set for them
31 in this paragraph to determine the premium rates for the

1 program. The basic reinsurance premium rates shall be
2 established by the board, subject to the approval of the
3 <u>commission</u> ~~department~~, and shall be set at levels which
4 reasonably approximate gross premiums charged to small
5 employers by small employer carriers for health benefit plans
6 with benefits similar to the standard and basic health benefit
7 plan. The premium rates set by the board may vary by
8 geographical area, as determined under this section, to
9 reflect differences in cost. The multiplying factors must be
10 established as follows:
11 a. The entire group may be reinsured for a rate that
12 is 1.5 times the rate established by the board.
13 b. An eligible employee or dependent may be reinsured
14 for a rate that is 5 times the rate established by the board.
15 2. The board periodically shall review the methodology
16 established, including the system of classification and any
17 rating factors, to assure that it reasonably reflects the
18 claims experience of the program. The board may propose
19 changes to the rates which shall be subject to the approval of
20 the <u>commission</u> ~~department~~.
21 (i) If a health benefit plan for a small employer
22 issued in accordance with this subsection is entirely or
23 partially reinsured with the program, the premium charged to
24 the small employer for any rating period for the coverage
25 issued must be consistent with the requirements relating to
26 premium rates set forth in s. 627.4106.
27 (j)1. Before March 1 of each calendar year, the board
28 shall determine and report to the department the program net
29 loss for the previous year, including administrative expenses
30 for that year, and the incurred losses for the year, taking
31

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1 into account investment income and other appropriate gains and
2 losses.
3 2. Any net loss for the year shall be recouped by
4 assessment of the carriers, as follows:
5 a. The operating losses of the program shall be
6 assessed in the following order subject to the specified
7 limitations. The first tier of assessments shall be made
8 against reinsuring carriers in an amount which shall not
9 exceed 5 percent of each reinsuring carrier's premiums from
10 health benefit plans covering small employers. If such
11 assessments have been collected and additional moneys are
12 needed, the board shall make a second tier of assessments in
13 an amount which shall not exceed 0.5 percent of each carrier's
14 health benefit plan premiums. Except as provided in paragraph
15 (n), risk-assuming carriers are exempt from all assessments
16 authorized pursuant to this section. The amount paid by a
17 reinsuring carrier for the first tier of assessments shall be
18 credited against any additional assessments made.
19 b. The board shall equitably assess carriers for
20 operating losses of the plan based on market share. The board
21 shall annually assess each carrier a portion of the operating
22 losses of the plan. The first tier of assessments shall be
23 determined by multiplying the operating losses by a fraction,
24 the numerator of which equals the reinsuring carrier's earned
25 premium pertaining to direct writings of small employer health
26 benefit plans in the state during the calendar year for which
27 the assessment is levied, and the denominator of which equals
28 the total of all such premiums earned by reinsuring carriers
29 in the state during that calendar year. The second tier of
30 assessments shall be based on the premiums that all carriers,
31 except risk-assuming carriers, earned on all health benefit

plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against 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

1 were incurred. The evaluation shall include an estimate of
2 future assessments, the administrative costs of the program,
3 the appropriateness of the premiums charged and the level of
4 carrier retention under the program, and the costs of coverage
5 for small employers. If the board fails to file a report with
6 the department within 90 days following the end of the
7 applicable calendar year, the department may evaluate the
8 operations of the program and implement such amendments to the
9 plan of operation the department deems necessary to reduce
10 future losses and assessments.
11 5. If assessments exceed the amount of the actual
12 losses and administrative expenses of the program, the excess
13 shall be held as interest and used by the board to offset
14 future losses or to reduce program premiums. As used in this
15 paragraph, the term "future losses" includes reserves for
16 incurred but not reported claims.
17 6. Each carrier's proportion of the assessment shall
18 be determined annually by the board, based on annual
19 statements and other reports considered necessary by the board
20 and filed by the carriers with the board.
21 7. Provision shall be made in the plan of operation
22 for the imposition of an interest penalty for late payment of
23 an assessment.
24 8. A carrier may seek, from the commissioner, a
25 deferment, in whole or in part, from any assessment made by
26 the board. The department may defer, in whole or in part, the
27 assessment of a carrier if, in the opinion of the department,
28 the payment of the assessment would place the carrier in a
29 financially impaired condition. If an assessment against a
30 carrier is deferred, in whole or in part, the amount by which
31 the assessment is deferred may be assessed against the other

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1 carriers in a manner consistent with the basis for assessment
2 set forth in this section. The carrier receiving such
3 deferment remains liable to the program for the amount
4 deferred and is prohibited from reinsuring any individuals or
5 groups in the program if it fails to pay assessments.
6 (k) Neither the participation in the program as
7 reinsuring carriers, the establishment of rates, forms, or
8 procedures, nor any other joint or collective action required
9 by this act, may be the basis of any legal action, criminal or
10 civil liability, or penalty against the program or any of its
11 carriers either jointly or separately.
12 (l) The board, as part of the plan of operation, shall
13 develop standards setting forth the manner and levels of
14 compensation to be paid to agents for the sale of basic and
15 standard health benefit plans. In establishing such
16 standards, the board shall take into consideration the need to
17 assure the broad availability of coverages, the objectives of
18 the program, the time and effort expended in placing the
19 coverage, the need to provide ongoing service to the small
20 employer, the levels of compensation currently used in the
21 industry, and the overall costs of coverage to small employers
22 selecting these plans.
23 (m) The board shall monitor compliance with this
24 section, including the market conduct of small employer
25 carriers, and shall report to the department any unfair trade
26 practices and misleading or unfair conduct by a small employer
27 carrier that has been reported to the board by agents,
28 consumers, or any other person. The department shall
29 investigate all reports and, upon a finding of noncompliance
30 with this section or of unfair or misleading practices, shall
31 take action against the small employer carrier as permitted

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1 under the insurance code or chapter 641. The board is not
2 given investigatory or regulatory powers, but must forward all
3 reports of cases or abuse or misrepresentation to the
4 department.
5 (n) Notwithstanding paragraph (j), the administrative
6 expenses of the program shall be recouped by assessment of
7 risk-assuming carriers and reinsuring carriers and such
8 amounts shall not be considered part of the operating losses
9 of the plan for the purposes of this paragraph. Each
10 carrier's portion of such administrative expenses shall be
11 determined by multiplying the total of such administrative
12 expenses by a fraction, the numerator of which equals the
13 carrier's earned premium pertaining to direct writing of small
14 employer health benefit plans in the state during the calendar
15 year for which the assessment is levied, and the denominator
16 of which equals the total of such premiums earned by all
17 carriers in the state during such calendar year.
18 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
19 PLANS.--
20 (a)1. By May 15, 1993, the commissioner shall appoint
21 a health benefit plan committee composed of four
22 representatives of carriers which shall include at least two
23 representatives of HMOs, at least one of which is a staff
24 model HMO, two representatives of agents, four representatives
25 of small employers, and one employee of a small employer. The
26 carrier members shall be selected from a list of individuals
27 recommended by the board. The commissioner may require the
28 board to submit additional recommendations of individuals for
29 appointment. As alliances are established under s. 408.702,
30 each alliance shall also appoint an additional member to the
31 committee.

1 2. The committee shall develop changes to the form and
2 level of coverages for the standard health benefit plan and
3 the basic health benefit plan, and shall submit the forms, and
4 levels of coverages to the department by September 30, 1993.
5 The department must approve such forms and levels of coverages
6 by November 30, 1993, and may return the submissions to the
7 committee for modification on a schedule that allows the
8 department to grant final approval by November 30, 1993.
9 3. The plans shall comply with all of the requirements
10 of this subsection.
11 4. The plans must be filed with and approved by the
12 department prior to issuance or delivery by any small employer
13 carrier.
14 5. After approval of the revised health benefit plans,
15 if the department determines that modifications to a plan
16 might be appropriate, the commissioner shall appoint a new
17 health benefit plan committee in the manner provided in
18 subparagraph 1. to submit recommended modifications to the
19 department for approval.
20 (b)1. Each small employer carrier issuing new health
21 benefit plans shall offer to any small employer, upon request,
22 a standard health benefit plan and a basic health benefit plan
23 that meets the criteria set forth in this section.
24 2. For purposes of this subsection, the terms
25 "standard health benefit plan" and "basic health benefit plan"
26 mean policies or contracts that a small employer carrier
27 offers to eligible small employers that contain:
28 a. An exclusion for services that are not medically
29 necessary or that are not covered preventive health services;
30 and
31

1 b. A procedure for preauthorization by the small
2 employer carrier, or its designees.
3 3. A small employer carrier may include the following
4 managed care provisions in the policy or contract to control
5 costs:
6 a. A preferred provider arrangement or exclusive
7 provider organization or any combination thereof, in which a
8 small employer carrier enters into a written agreement with
9 the provider to provide services at specified levels of
10 reimbursement or to provide reimbursement to specified
11 providers. Any such written agreement between a provider and a
12 small employer carrier must contain a provision under which
13 the parties agree that the insured individual or covered
14 member has no obligation to make payment for any medical
15 service rendered by the provider which is determined not to be
16 medically necessary. A carrier may use preferred provider
17 arrangements or exclusive provider arrangements to the same
18 extent as allowed in group products that are not issued to
19 small employers.
20 b. A procedure for utilization review by the small
21 employer carrier or its designees.
22
23 This subparagraph does not prohibit a small employer carrier
24 from including in its policy or contract additional managed
25 care and cost containment provisions, subject to the approval
26 of the department, which have potential for controlling costs
27 in a manner that does not result in inequitable treatment of
28 insureds or subscribers. The carrier may use such provisions
29 to the same extent as authorized for group products that are
30 not issued to small employers.
31 4. The standard health benefit plan shall include:

1 a. Coverage for inpatient hospitalization;
2 b. Coverage for outpatient services;
3 c. Coverage for newborn children pursuant to s.
4 627.6575;
5 d. Coverage for child care supervision services
6 pursuant to s. 627.6579;
7 e. Coverage for adopted children upon placement in the
8 residence pursuant to s. 627.6578;
9 f. Coverage for mammograms pursuant to s. 627.6613;
10 g. Coverage for handicapped children pursuant to s.
11 627.6615;
12 h. Emergency or urgent care out of the geographic
13 service area; and
14 i. Coverage for services provided by a hospice
15 licensed under s. 400.602 in cases where such coverage would
16 be the most appropriate and the most cost-effective method for
17 treating a covered illness.
18 5. The standard health benefit plan and the basic
19 health benefit plan may include a schedule of benefit
20 limitations for specified services and procedures. If the
21 committee develops such a schedule of benefits limitation for
22 the standard health benefit plan or the basic health benefit
23 plan, a small employer carrier offering the plan must offer
24 the employer an option for increasing the benefit schedule
25 amounts by 4 percent annually.
26 6. The basic health benefit plan shall include all of
27 the benefits specified in subparagraph 4.; however, the basic
28 health benefit plan shall place additional restrictions on the
29 benefits and utilization and may also impose additional cost
30 containment measures.
31

1 7. Sections 627.419(2), (3), and (4), 627.6574,
2 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668,
3 and 627.66911 apply to the standard health benefit plan and to
4 the basic health benefit plan. However, notwithstanding said
5 provisions, the plans may specify limits on the number of
6 authorized treatments, if such limits are reasonable and do
7 not discriminate against any type of provider.
8 8. Each small employer carrier that provides for
9 inpatient and outpatient services by allopathic hospitals may
10 provide as an option of the insured similar inpatient and
11 outpatient services by hospitals accredited by the American
12 Osteopathic Association when such services are available and
13 the osteopathic hospital agrees to provide the service.
14 (c) If a small employer rejects, in writing, the
15 standard health benefit plan and the basic health benefit
16 plan, the small employer carrier may offer the small employer
17 a limited benefit policy or contract.
18 (d)1. Upon offering coverage under a standard health
19 benefit plan, a basic health benefit plan, or a limited
20 benefit policy or contract for any small employer, the small
21 employer carrier shall provide such employer group with a
22 written statement that contains, at a minimum:
23 a. An explanation of those mandated benefits and
24 providers that are not covered by the policy or contract;
25 b. An explanation of the managed care and cost control
26 features of the policy or contract, along with all appropriate
27 mailing addresses and telephone numbers to be used by insureds
28 in seeking information or authorization; and
29 c. An explanation of the primary and preventive care
30 features of the policy or contract.
31

1 Such disclosure statement must be presented in a clear and
2 understandable form and format and must be separate from the
3 policy or certificate or evidence of coverage provided to the
4 employer group.
5 2. Before a small employer carrier issues a standard
6 health benefit plan, a basic health benefit plan, or a limited
7 benefit policy or contract, it must obtain from the
8 prospective policyholder a signed written statement in which
9 the prospective policyholder:
10 a. Certifies as to eligibility for coverage under the
11 standard health benefit plan, basic health benefit plan, or
12 limited benefit policy or contract;
13 b. Acknowledges the limited nature of the coverage and
14 an understanding of the managed care and cost control features
15 of the policy or contract;
16 c. Acknowledges that if misrepresentations are made
17 regarding eligibility for coverage under a standard health
18 benefit plan, a basic health benefit plan, or a limited
19 benefit policy or contract, the person making such
20 misrepresentations forfeits coverage provided by the policy or
21 contract; and
22 d. If a limited plan is requested, acknowledges that
23 the prospective policyholder had been offered, at the time of
24 application for the insurance policy or contract, the
25 opportunity to purchase any health benefit plan offered by the
26 carrier and that the prospective policyholder had rejected
27 that coverage.
28
29 A copy of such written statement shall be provided to the
30 prospective policyholder no later than at the time of delivery
31 of the policy or contract, and the original of such written

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statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be 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,

1 except for rules related to rates. The commission may adopt
2 rules to administer this section related to rates.
3 Section 69. Subsections (2), (4), and (7) of section
4 627.6745, Florida Statutes, are amended to read:
5 627.6745 Loss ratio standards; public rate hearings.--
6 (2) Each entity providing Medicare supplement policies
7 or certificates in this state shall file annually its rates,
8 rating schedules, and supporting documentation with the
9 commission demonstrating that it is in compliance with the
10 applicable loss ratio standards of this code. The filing of
11 rates and rating schedules shall demonstrate that the actual
12 and expected losses in relation to premiums comply with the
13 requirements of this section.
14 (4) Each insurer providing Medicare supplement
15 insurance to residents of this state shall annually submit to
16 the commission ~~department~~ information on actual loss ratios on
17 forms prescribed by the National Association of Insurance
18 Commissioners pursuant to the Omnibus Budget Reconciliation
19 Act of 1990 (Pub. L. No. 101-508).
20 (7) The commission ~~department~~ shall adopt a written
21 policy statement regarding the holding of public hearings
22 prior to approval of any premium increases for Medicare
23 supplement insurance policies.
24 Section 70. Section 627.678, Florida Statutes, is
25 amended to read:
26 627.678 Rules.--
27 (1) For the effective protection of the public
28 interest, the department shall have full power and authority
29 to adopt, promulgate, and enforce separate rules pertaining to
30 issuance and use of each type of credit insurance defined in
31 s. 627.677, except for matters related to rates. The

1 <u>commission may adopt rules related to rates for credit life</u>
2 <u>and disability insurance consistent with the provisions of</u>
3 <u>this part.</u>
4 (2) Rules made pursuant to this section shall be
5 principally designed, and shall be promulgated with the
6 purpose of protecting the borrower from excessive charges by
7 or collected through the lender for insurance in relation to
8 the amount of the loan, to avoid duplication or overlapping of
9 insurance coverage and to avoid loss of the borrower's funds
10 by short-rate cancellation or termination of such insurance.
11 However, nothing in such rules shall be construed to authorize
12 the department to prohibit operation of normal dividend
13 distributions under participating insurance contracts.
14 Section 71. Section 627.6785, Florida Statutes, is
15 amended to read:
16 627.6785 Filing of rates with department.--
17 (1) Credit disability and credit life insurers shall
18 file with the <u>commission</u> ~~department~~ a copy of all rates and
19 any rate changes used in this state<u>, subject to the procedures</u>
20 <u>specified in s. 627.410</u>.
21 (2) No credit disability rate and no credit life rate
22 shall exceed the maximum allowable rate promulgated by the
23 <u>commission</u> ~~department~~.
24 (3) No credit life rate or credit disability rate
25 shall be deemed to comply with the allowable rate criteria
26 contained in this part if <u>the benefits provided are not</u>
27 <u>reasonable in relation to the premium charged or if the rate</u>
28 ~~it~~ contains age restrictions which make ineligible for credit
29 life those debtors or lessors 70 years of age or under, or for
30 credit disability those debtors or lessors 65 years of age or
31 under, at the time the indebtedness is incurred. However, for

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1 credit life, the coverage shall be provided, at a minimum,
2 until the earlier of the maturity date of the loan or the loan
3 anniversary at age 71, and, for credit disability, the
4 coverage shall be provided, at a minimum, until the earlier of
5 the maturity date of the loan or the loan anniversary at age
6 66.
7 Section 72. Section 627.682, Florida Statutes, is
8 amended to read:
9 627.682 Filing, approval of forms.--All forms of
10 policies, certificates of insurance, statements of insurance,
11 applications for insurance, binders, endorsements, and riders
12 of credit life or disability insurance delivered or issued for
13 delivery in this state shall be filed with and approved by the
14 department before use as provided in ss. 627.410 and 627.411.
15 In addition to grounds as specified in s. 627.411, the
16 department, upon compliance with the procedures set forth in
17 s. 627.410, shall disapprove any such form and may withdraw
18 any previous approval thereof ~~if the benefits provided therein~~
19 ~~are not reasonable in relation to the premiums charged, or~~ if
20 it contains provisions that ~~which~~ are unjust, unfair,
21 inequitable, misleading, or deceptive or that ~~which~~ encourage
22 misrepresentation of such policy.
23 Section 73. Subsection (9) of section 627.727, Florida
24 Statutes, is amended to read:
25 627.727 Motor vehicle insurance; uninsured and
26 underinsured vehicle coverage; insolvent insurer protection.--
27 (9) Insurers may offer policies of uninsured motorist
28 coverage containing policy provisions, in language approved by
29 the department, establishing that if the insured accepts this
30 offer:
31

1 (a) The coverage provided as to two or more motor
2 vehicles shall not be added together to determine the limit of
3 insurance coverage available to an injured person for any one
4 accident, except as provided in paragraph (c).
5 (b) If at the time of the accident the injured person
6 is occupying a motor vehicle, the uninsured motorist coverage
7 available to her or him is the coverage available as to that
8 motor vehicle.
9 (c) If the injured person is occupying a motor vehicle
10 which is not owned by her or him or by a family member
11 residing with her or him, the injured person is entitled to
12 the highest limits of uninsured motorist coverage afforded for
13 any one vehicle as to which she or he is a named insured or
14 insured family member. Such coverage shall be excess over the
15 coverage on the vehicle the injured person is occupying.
16 (d) The uninsured motorist coverage provided by the
17 policy does not apply to the named insured or family members
18 residing in her or his household who are injured while
19 occupying any vehicle owned by such insureds for which
20 uninsured motorist coverage was not purchased.
21 (e) If, at the time of the accident the injured person
22 is not occupying a motor vehicle, she or he is entitled to
23 select any one limit of uninsured motorist coverage for any
24 one vehicle afforded by a policy under which she or he is
25 insured as a named insured or as an insured resident of the
26 named insured's household.
27
28 In connection with the offer authorized by this subsection,
29 insurers shall inform the named insured, applicant, or lessee,
30 on a form approved by the department, of the limitations
31 imposed under this subsection and that such coverage is an

1 alternative to coverage without such limitations. If this
2 form is signed by a named insured, applicant, or lessee, it
3 shall be conclusively presumed that there was an informed,
4 knowing acceptance of such limitations. When the named
5 insured, applicant, or lessee has initially accepted such
6 limitations, such acceptance shall apply to any policy which
7 renews, extends, changes, supersedes, or replaces an existing
8 policy unless the named insured requests deletion of such
9 limitations and pays the appropriate premium for such
10 coverage. Any insurer who provides coverage which includes
11 the limitations provided in this subsection shall file revised
12 premium rates with the <u>commission</u> ~~department~~ for such
13 uninsured motorist coverage to take effect prior to initially
14 providing such coverage. The revised rates shall reflect the
15 anticipated reduction in loss costs attributable to such
16 limitations but shall in any event reflect a reduction in the
17 uninsured motorist coverage premium of at least 20 percent for
18 policies with such limitations. Such filing shall not
19 increase the rates for coverage which does not contain the
20 limitations authorized by this subsection, and such rates
21 shall remain in effect until the insurer demonstrates the need
22 for a change in uninsured motorist rates pursuant to s.
23 627.0651.
24 Section 74. Subsection (1) of section 627.780, Florida
25 Statutes, is amended to read:
26 627.780 Illegal dealings in risk premium.--
27 (1) A person may not knowingly quote, charge, accept,
28 collect, or receive a premium for title insurance other than
29 the premium adopted by the <u>commission</u> ~~department~~.
30 Section 75. Section 627.782, Florida Statutes, is
31 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 title service shall be paid to or retained by any person who does not actually perform or is not liable for the performance of such service. The commission ~~department~~ may, by rule, establish limitations on related title services charges made in addition to the premium based upon the expenses associated with the services rendered and other relevant factors.

(2) In adopting premium rates, the commission ~~department~~ must give due consideration to the following:

(a) The title insurers' loss experience and prospective loss experience under closing protection letters and policy liabilities.

(b) A reasonable margin for underwriting profit and contingencies, including contingent liability under s. 627.7865, sufficient to allow title insurers, agents, and agencies to earn a rate of return on their capital that will attract and retain adequate capital investment in the title insurance business and maintain an efficient title insurance delivery system.

(c) Past expenses and prospective expenses for administration and handling of risks.

1 (d) Liability for defalcation.
2 (e) Other relevant factors.
3 (3) Rates may be grouped by classification or schedule
4 and may differ as to class of risk assumed.
5 (4) Rates may not be excessive, inadequate, or
6 unfairly discriminatory.
7 (5) The premium applies to each $100 of insurance
8 issued to an insured.
9 (6) The premium rates apply throughout this state.
10 (7) The commission ~~department~~ shall, in accordance
11 with the standards provided in subsection (2), review the
12 premium as needed, but not less frequently than once every 3
13 years, and shall, based upon the review required by this
14 subsection, revise the premium if the results of the review so
15 warrant.
16 (8) The commission ~~department~~ may, by rule, require
17 licensees under this part to annually submit statistical
18 information, including loss and expense data, as the
19 department determines to be necessary to analyze premium
20 rates, retention rates, and the condition of the title
21 insurance industry.
22 Section 76. Section 627.7825, Florida Statutes, is
23 amended to read:
24 627.7825 Alternative rate adoption.--Notwithstanding
25 s. 627.782(1) and (7), the premium rates to be charged by
26 title insurers in this state from July 1, 1999, through June
27 30, 2002, for title insurance contracts shall be as set forth
28 in this section. The rules related to premium rates for title
29 insurance, including endorsements, adopted by the department
30 and in effect on April 1, 1999, that do not conflict with the
31 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:

	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

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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. 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

3. Mortgage policies issued on refinancing of property insured by an original owner's policy which insured the title of the current mortgagor.

(c) Any amount of new insurance, in the aggregate, in excess of the amount under the previous policy shall be computed at the original owner's or leasehold rates, as provided in subsection (1).

(3) NEW HOME PURCHASE DISCOUNT.--Provided the seller has not leased or occupied the premises, the original premium for a policy on the first sale of residential property with a one to four family improvement that is granted a certificate of occupancy shall be discounted by the amount of premium paid for any prior loan policies insuring the lien of a mortgage executed by the seller on the premises. In the case of prior loan policies insuring the lien of a mortgage on multiple units or parcels, the discount shall be prorated by dividing the amount of the premium paid for the prior loan policies by the total number of units or parcels without regard to varying unit or parcel value. The minimum new home purchase premium shall be $200. The new home purchase discount may not be combined with any other reduction from original premium rates provided for in this section. The insurer shall reserve for unearned premiums only on the excess amount of the policy over

the amount of the actual or prorated amount of the prior loan policy.

(4) SUBSTITUTION LOANS RATES.--

(a) When the same borrower and the same 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 following premium rates for substitution loans shall 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 77. 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 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 <u>commission</u> ~~department~~ shall rule on all such petitions simultaneously.

(2) If, in the judgment of the <u>commission</u> ~~department~~, the requested deviation is not justified, the <u>commission</u> ~~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 78. Section 627.793, Florida Statutes, is amended to read:

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

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

Section 79. 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. 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 80. 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 81. 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:

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

Section 82. Subsections (2), (3), and (38) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.--

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission ~~department~~, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written

1 application is required and is to be made a part of the
2 contract, or printed amendment, addendum, rider, or
3 endorsement form or form of renewal certificate, it may do so,
4 upon filing with the department the proposed change or
5 amendment. Any proposed change shall be effective
6 immediately, subject to disapproval by the department.
7 Following receipt of notice of such disapproval or withdrawal
8 of approval, no health maintenance organization shall issue or
9 use any form disapproved by the department or as to which the
10 department has withdrawn approval.
11 (b) Any change in the rate is subject to paragraph (d)
12 and requires at least 30 days' advance written notice to the
13 subscriber. In the case of a group member, there may be a
14 contractual agreement with the health maintenance organization
15 to have the employer provide the required notice to the
16 individual members of the group.
17 (c) The department shall disapprove any form filed
18 under this subsection, or withdraw any previous approval
19 thereof, if the form:
20 1. Is in any respect in violation of, or does not
21 comply with, any provision of this part or rule adopted
22 thereunder.
23 2. Contains or incorporates by reference, where such
24 incorporation is otherwise permissible, any inconsistent,
25 ambiguous, or misleading clauses or exceptions and conditions
26 which deceptively affect the risk purported to be assumed in
27 the general coverage of the contract.
28 3. Has any title, heading, or other indication of its
29 provisions which is misleading.
30
31

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

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus 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.

1 (e) It is not the intent of this subsection to
2 restrict unduly the right to modify rates in the exercise of
3 reasonable business judgment.
4 (38)(a) Notwithstanding any other provision of this
5 part, a health maintenance organization that meets the
6 requirements of paragraph (b) may, through a point-of-service
7 rider to its contract providing comprehensive health care
8 services, include a point-of-service benefit. Under such a
9 rider, a subscriber or other covered person of the health
10 maintenance organization may choose, at the time of covered
11 service, a provider with whom the health maintenance
12 organization does not have a health maintenance organization
13 provider contract. The rider may not require a referral from
14 the health maintenance organization for the point-of-service
15 benefits.
16 (b) A health maintenance organization offering a
17 point-of-service rider under this subsection must have a valid
18 certificate of authority issued under the provisions of the
19 chapter, must have been licensed under this chapter for a
20 minimum of 3 years, and must at all times that it has riders
21 in effect maintain a minimum surplus of $5 million.
22 (c) Premiums paid in for the point-of-service riders
23 may not exceed 15 percent of total premiums for all health
24 plan products sold by the health maintenance organization
25 offering the rider. If the premiums paid for point-of-service
26 riders exceed 15 percent, the health maintenance organization
27 must notify the department and the commission and, once this
28 fact is known, must immediately cease offering such a rider
29 until it is in compliance with the rider premium cap.
30 (d) Notwithstanding the limitations of deductibles and
31 copayment provisions in this part, a point-of-service rider

1 may require the subscriber to pay a reasonable copayment for
2 each visit for services provided by a noncontracted provider
3 chosen at the time of the service. The copayment by the
4 subscriber may either be a specific dollar amount or a
5 percentage of the reimbursable provider charges covered by the
6 contract and must be paid by the subscriber to the
7 noncontracted provider upon receipt of covered services. The
8 point-of-service rider may require that a reasonable annual
9 deductible for the expenses associated with the
10 point-of-service rider be met and may include a lifetime
11 maximum benefit amount. The rider must include the language
12 required by s. 627.6044 and must comply with copayment limits
13 described in s. 627.6471. Section 641.315(2) and (3) does not
14 apply to a point-of-service rider authorized under this
15 subsection.
16 (e) The term "point of service" may not be used by a
17 health maintenance organization except with riders permitted
18 under this section or with forms approved by the department in
19 which a point-of-service product is offered with an indemnity
20 carrier.
21 (f) A point-of-service rider must be filed and
22 approved under ss. 627.410 and 627.411.
23 Section 83. Paragraph (b) of subsection (10) of
24 section 641.3903, Florida Statutes, is amended to read:
25 641.3903 Unfair methods of competition and unfair or
26 deceptive acts or practices defined.--The following are
27 defined as unfair methods of competition and unfair or
28 deceptive acts or practices:
29 (10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED
30 CHARGES FOR HEALTH MAINTENANCE COVERAGE.--
31

1 (b) Knowingly collecting as a premium or charge for
2 health maintenance coverage any sum in excess of or less than
3 the premium or charge applicable to health maintenance
4 coverage, in accordance with the applicable classifications
5 and rates as filed with the commission ~~department~~, and as
6 specified in the health maintenance contract.
7 Section 84. Subsection (3) of section 641.3922,
8 Florida Statutes, is amended to read:
9 641.3922 Conversion contracts; conditions.--Issuance
10 of a converted contract shall be subject to the following
11 conditions:
12 (3) CONVERSION PREMIUM.--The premium for the converted
13 contract shall be determined in accordance with premium rates
14 applicable to the age and class of risk of each person to be
15 covered under the converted contract and to the type and
16 amount of coverage provided. However, the premium for the
17 converted contract may not exceed 200 percent of the standard
18 risk rate, as established by the commission ~~department~~ under
19 s. 627.6675(3). The mode of payment for the converted contract
20 shall be quarterly or more frequently at the option of the
21 organization, unless otherwise mutually agreed upon between
22 the subscriber and the organization.
23 Section 85. Present subsections (2) through (11) of
24 section 641.402, Florida Statutes, are redesignated as
25 subsections (3) through (12), respectively, and a new
26 subsection (2) is added to that section to read:
27 641.402 Definitions.--As used in this part, the term:
28 (2) "Commission" means the Insurance Rating
29 Commission.
30 Section 86. Subsection (2) and (7) of section 641.42,
31 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 department the proposed amendment to the contract or upon filing with the commission the proposed change in rates.

(b) No prepaid health clinic contract form or application form when written application is required and is to be made a part of the policy or contract, or no printed amendment, addendum, rider, or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the clinic which proposes to use such form and has been approved by the department. Every such filing shall be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed shall be deemed approved unless prior to the end of the 30 days the form has been affirmatively approved or disapproved by the department. The approval of any such form by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which the department may

so affirmatively approve or disapprove any such form, by giving notice of such extension before the 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, such form shall be deemed approved. The department may, for cause, withdraw a previous approval. No clinic shall issue or use any form which has been disapproved by the department or any form for which the department has withdrawn approval.

(c) The department shall disapprove any form filed under this subsection, or withdraw any previous approval of 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.

(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 87. 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

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in determining whether to approve or disapprove a filing made under this section or s. 642.025.

Section 88. 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 89. Effective upon this act becoming law, the Governor may make appointments to the Insurance Rating Commission pursuant to section 624.371, Florida Statutes, as created by this act, for terms of office beginning on January 1, 2001.

Section 90. Effective January 1, 2001, all activities and functions of the Department of Insurance related to reviewing, approving, or establishing rates for insurers and other entities regulated by the department are transferred to the Insurance Rating Commission pursuant to a type two transfer as defined in section 20.06, Florida Statutes. Effective upon this act becoming law, the Department of Insurance and the Executive Office of the Governor shall jointly prepare a budget amendment pursuant to chapter 216, Florida Statutes, to implement the plan, in consultation with the legislative committees having jurisdiction over the Department of Insurance.

Section 91. Effective January 1, 2001, the sum of $334,125 is appropriated for the 2000-2001 fiscal year from the Insurance Commissioner's Regulatory Trust Fund to the Insurance Rating Commission for the purposes of carrying out the provisions of this act.

1 Section 92. By January 31, 2001, the Division of
2 Statutory Revision of the Office of Legislative Services shall
3 prepare and submit to the President of the Senate and the
4 Speaker of the House of Representatives draft substantive
5 legislation to conform the Florida Statutes to the provisions
6 of this act. The legislation shall not be drafted as a
7 reviser's bill. The draft shall include provisions:
8 (1) Changing the term "Comptroller" or "Treasurer" to
9 "Chief Financial Officer" with respect to functions of the
10 Chief Financial Officer where appropriate;
11 (2) Changing references to the "Department of Banking
12 and Finance" or the "Department of Insurance" to the
13 "Department of Financial Services" where appropriate; and
14 (3) Otherwise conforming the statutes to the abolition
15 of the offices of Comptroller and Treasurer, the creation of
16 the Office of the Chief Financial Officer, the abolition of
17 the Department of Banking and Finance and the Department of
18 Insurance, and the creation of the Department of Financial
19 Services.
20 Section 93. (1) The Financial Services Transition
21 Task Force is established. All members of the task force shall
22 be appointed prior to September 1, 2000. The task force shall
23 be composed of:
24 (a) One consumer a representative appointed by the
25 Governor;
26 (b) Two members appointed by the President of the
27 Senate;
28 (c) Two members appointed by the Speaker of the House
29 of Representatives;
30 (d) Two members appointed by the Comptroller; and
31

1 (e) Two members appointed by the Insurance
2 Commissioner and Treasurer.
3 (2) The organizational meeting of the task force must
4 be held by October 1, 2000. The members of the task force
5 shall elect a chair by majority vote. Members of the task
6 force shall serve without compensation, but shall be
7 reimbursed for per diem and travel expenses as provided in
8 section 112.061, Florida Statutes.
9 (3) The purpose of the task force is to review the
10 Florida Statutes and rules and:
11 (a) Recommend amendments to statutes and rules made
12 necessary by the changes made by this act;
13 (b) Identify any organizational problems involving,
14 without limitation, communication among divisions, technical
15 assistance, and other services, and recommend solutions to the
16 identified problems;
17 (c) Identify any issues related to technology,
18 including the coordination or incompatibility of technology
19 systems, and suggest solutions to the identified problems;
20 (d) Recommend methods to improve departmental
21 accountability, including, but not limited to, modification of
22 performance measures.
23 (4) The task force may procure information and
24 assistance from any officer or agency of the state or any
25 subdivision thereof. All such officials and agencies shall
26 give the task force all relevant information and assistance
27 with respect to any matter within their knowledge or control.
28 (5) The task force shall submit an initial report to
29 the Governor, the President of the Senate, and the Speaker of
30 the House of Representatives by January 1, 2001.
31

1 (6) The task force shall submit a final report to the
2 Governor, the President of the Senate, and the Speaker of the
3 House of Representatives by January 1, 2002.
4 (7) The task force terminates upon submission of its
5 final report.
6 Section 94. Effective July 1, 2000, section 442.0011,
7 Florida Statutes, is created to read:
8 442.0011 Exclusion from chapter.--This chapter is not
9 applicable to any firefighter employee, and firefighter
10 employer, or any place of firefighter employment covered by
11 ss. 633-801 through 633.830.
12 Section 95. Effective July 1, 2000, section 633.801,
13 Florida Statutes, is created to read:
14 633.801 Short title.--Sections 633.801 through 633.830
15 may be cited as the "Florida Firefighters Occupational Safety
16 and Health Act."
17 Section 96. Effective July 1, 2000, section 633.802,
18 Florida Statutes, is created to read:
19 633.802 Definitions.--Unless the context clearly
20 requires otherwise, the following definitions apply to ss.
21 633.801 through 633.830:
22 (1) "Department" means the Department of Insurance.
23 (2) "Division" means the Division of State Fire
24 Marshal of the Department of Insurance.
25 (3) "Firefighter employee" means any person engaged in
26 any employment, public or private, as a firefighter under any
27 appointment or contract of hire or apprenticeship, express or
28 implied, oral or written, whether lawfully or unlawfully
29 employed, and includes all volunteer firefighters responding
30 to or assisting with fire or medical emergencies whether or
31 not the firefighter is on duty.

1 (4) "Firefighter employer" means the state and all
2 political subdivisions thereof, all public and quasi-public
3 corporations therein, and every person carrying on any
4 employment thereof, which employs firefighters or which uses
5 volunteer firefighters.
6 (5) "Firefighter employment" or "employment" means any
7 service performed by a firefighter employee for the
8 firefighter employer, and includes the use of all volunteer
9 firefighters.
10 (6) "Firefighter place of employment" or "place of
11 employment" means the physical location at which the
12 firefighter is employed.
13 Section 97. Effective July 1, 2000, section 633.803,
14 Florida Statutes, is created to read:
15 633.803 Legislative intent.--It is the intent of the
16 Legislature to enhance firefighter occupational safety and
17 health in this state through the implementation and
18 maintenance of policies, procedures, practices, rules, and
19 standards that reduce the incidence of firefighter employee
20 accidents, firefighter occupational diseases, and firefighter
21 fatalities compensable under chapter 440 or otherwise. The
22 Legislature further intends that the division develop a means
23 by which it can identify individual firefighter employers with
24 a high frequency or severity of work-related injuries; conduct
25 safety inspections of those firefighter employers; and assist
26 those firefighter employers in the development and
27 implemention of firefighter employee safety and health
28 programs. In addition, it is the intent of the Legislature
29 that the division administer the provisions of ss. 633.801
30 through 633.830; provide assistance to firefighter employers,
31

1 firefighter employees, and insurers; and enforce the policies,
2 rules, and standards set forth in ss. 633.801 through 633.830.
3 Section 98. Effective July 1, 2000, section 633.804,
4 Florida Statutes, is created to read:
5 633.804 Safety inspections, consultations; rules.--The
6 division shall adopt rules governing the manner, means, and
7 frequency of firefighter employer and firefighter employee
8 safety inspections and consultations by all insurers and
9 self-insurers.
10 Section 99. Effective July 1, 2000, section 633.805,
11 Florida Statutes, is created to read:
12 633.805 Division to make study of firefighter
13 occupational diseases, etc.--The division shall make a
14 continuous study of firefighter occupational diseases and the
15 ways and means for their control and prevention and shall make
16 and enforce necessary regulations for such control. For this
17 purpose, the division is authorized to cooperate with
18 firefighter employers, firefighter employees, and insurers and
19 with the Department of Health.
20 Section 100. Effective July 1, 2000, section 633.806,
21 Florida Statutes, is created to read:
22 633.806 Investigations by the division; refusal to
23 admit; penalty.--
24 (1) The division shall make studies and investigations
25 with respect to safety provisions and the causes of
26 firefighter injuries in firefighter places of employment, and
27 shall make to the Legislature and firefighter employers and
28 insurers such recommendations as it considers proper as to the
29 best means of preventing firefighter injuries. In making such
30 studies and investigations, the division may:
31

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1 (a) Cooperate with any agency of the United States
2 charged with the duty of enforcing any law securing safety
3 against injury in any place of firefighter employment covered
4 by ss. 633.801 through 633.830, or any agency or department of
5 the state engaged in enforcing any law to assure safety for
6 firefighter employees.
7 (b) Allow any such agency or department to have access
8 to the records of the division.
9 (2) The division and its authorized representatives
10 may enter and inspect any place of firefighter employment at
11 any reasonable time for the purpose of investigating
12 compliance with ss. 633.801 through 633.830 and making
13 inspections for the proper enforcement of ss. 633.801 through
14 633.830. Any firefighter employer who refuses to admit any
15 member of the division or its authorized representative to any
16 place of firefighter employment or to allow investigation and
17 inspection pursuant to this subsection is guilty of a
18 misdemeanor of the second degree, punishable as provided in s.
19 775.082 or s. 775.083.
20 (3) The division by rule may adopt procedures for
21 conducting investigations of firefighter employers under ss.
22 633.801 through 633.830.
23 Section 101. Effective July 1, 2000, section 633.807,
24 Florida Statutes, is created to read:
25 633.807 Safety; firefighter employer
26 responsibilities.--Every firefighter employer shall furnish to
27 firefighters employment that is safe for the firefighter
28 employees, furnish and use safety devices and safeguards,
29 adopt and use methods and processes reasonably adequate to
30 render such an employment and place of employment safe, and do
31 every other thing reasonably necessary to protect the lives,

1 health, and safety of such firefighter employees. As used in
2 this section, the terms "safe" and "safety" as applied to any
3 employment or place of firefighter employment mean such
4 freedom from danger as is reasonably necessary for the
5 protection of the lives, health, and safety of firefighter
6 employees, including conditions and methods of sanitation and
7 hygiene. Safety devices and safeguards required to be
8 furnished by the firefighter employer by this section or by
9 the division under authority of this section shall not include
10 personal apparel and protective devices that replace personal
11 apparel normally worn by firefighter employees during regular
12 working hours.
13 Section 102. Effective July 1, 2000, section 633.808,
14 Florida Statutes, is created to read:
15 633.808 Division authority.--The division shall:
16 (1) Investigate and prescribe by rule what safety
17 devices, safeguards, or other means of protection must be
18 adopted for the prevention of accidents in every firefighter
19 place of employment or at any fire scene; determine what
20 suitable devices, safeguards, or other means of protection for
21 the prevention of occupational diseases must be adopted or
22 followed in any or all such firefighter places of employment
23 or at any fire scene; and adopt reasonable rules for the
24 prevention of accidents, the safety, protection, and security
25 of firefighters engaged in interior firefighting, and the
26 prevention of occupational diseases.
27 (2) Ascertain, fix, and order such reasonable
28 standards and rules for the construction, repair, and
29 maintenance of firefighter places of employment as shall
30 render them safe. Such rules and standards must be adopted in
31 accordance with chapter 120.

1 (3) Assist firefighter employers in the development
2 and implementation of firefighter employee safety training
3 programs by contracting with professional safety
4 organizations.
5 (4) Adopt rules prescribing recordkeeping
6 responsibilities for firefighter employers, which may include
7 rules for maintaining a log and summary of occupational
8 injuries, diseases, and illnesses and for producing on request
9 a notice of injury and firefighter employee accident
10 investigation records, and rules prescribing a retention
11 schedule for such records.
12 Section 103. Effective July 1, 2000, section 633.809,
13 Florida Statutes, is created to read:
14 633.809 Right of entry.--The division and its
15 authorized representatives may enter at any reasonable time
16 any firefighter place of employment for the purpose of
17 examining any tool, appliance, or machinery used in such
18 employment and may make inspections for the proper enforcement
19 of ss. 633.801 through 633.830. A firefighter employer or
20 owner may not refuse to admit any member of the division or
21 its authorized representatives to any firefighter place of
22 employment.
23 Section 104. Effective July 1, 2000, section 633.810,
24 Florida Statutes, is created to read:
25 633.810 Firefighter employers whose firefighter
26 employees have a high frequency of work-related injuries.--The
27 division shall develop a means by which it can identify
28 individual firefighter employers whose firefighter employees
29 have a high frequency or severity of work-related injuries.
30 The division shall carry out safety inspections of the
31 facilities and operations of these firefighter employers in

1 order to assist them in reducing the frequency and severity of
2 work-related injuries. The division shall develop safety and
3 health programs for those firefighter employers. Insurers
4 shall distribute these safety and health programs to the
5 firefighter employers so identified by the division. Those
6 firefighter employers identified by the division as having a
7 high frequency or severity of work-related injuries shall
8 implement a division-developed safety and health program. The
9 division shall carry out safety inspections of those
10 firefighter employers so identified to ensure compliance with
11 the safety and health program and to assist such firefighter
12 employers in reducing the number of work-related injuries. The
13 division may not assess penalties as the result of such
14 inspections, except as provided by s. 633.813. Copies of any
15 report made as the result of such an inspection must be
16 provided to the firefighter employer and its insurer.
17 Firefighter employers may submit their own safety and health
18 programs to the division for approval in lieu of using the
19 division-developed safety and health program. The division
20 must promptly review the program submitted and approve or
21 disapprove it. Upon approval by the division, the program must
22 be implemented by the firefighter employer. If the program is
23 not approved or if a program is not submitted, the firefighter
24 employer must implement the division-developed program. The
25 division shall adopt rules setting forth the criteria for
26 safety and health programs.
27 Section 105. Effective July 1, 2000, section 633.811,
28 Florida Statutes, is created to read:
29 633.811 Insurer consultations.--Each insurer writing
30 workers' compensation insurance in this state, each
31 firefighter employer qualifying as an individual self-insurer

1 under s. 440.38, each self-insurance fund under s. 624.461,
2 and each assessable mutual insurer under s. 628.6011 must
3 provide safety consultations to each of its policyholders who
4 requests such consultations. Each such insurer or self-insurer
5 must inform its policyholders of the availability of such
6 consultations. The division is responsible for approving all
7 safety and health programs. The division shall aid all
8 insurers and self insurers in establishing their safety and
9 health programs by setting out criteria in an appropriate
10 format.
11 Section 106. Effective July 1, 2000, section 633.812,
12 Florida Statutes, is created to read:
13 633.812 Workplace safety committees and safety
14 coordinators.--
15 (1) In order to promote health and safety in places of
16 firefighter employment in this state:
17 (a) Each firefighter employer of 20 or more
18 firefighter employees shall establish and administer a
19 workplace safety committee in accordance with rules adopted
20 under this section.
21 (b) Each firefighter employer of fewer than 20
22 firefighter employees which is identified by the division as
23 having high frequency or severity of work-related injuries
24 shall establish and administer a workplace safety committee or
25 designate a workplace safety coordinator who shall establish
26 and administer workplace safety activities in accordance with
27 rules adopted under this section.
28 (2) The division shall adopt rules:
29 (a) Prescribing the membership of the workplace safety
30 committees so as to ensure an equal number of firefighter
31 employee representatives, who are volunteers or are elected by

1 their peers, and of firefighter employer representatives, and
2 specifying the frequency of meetings.
3 (b) Requiring firefighter employers to make adequate
4 records of each meeting and to file and to maintain the
5 records subject to inspection by the division.
6 (c) Prescribing the duties and functions of the
7 workplace safety committee and workplace safety coordinator,
8 which include, but are not limited to:
9 1. Establishing procedures for workplace safety
10 inspections by the committee.
11 2. Establishing procedures investigating all workplace
12 accidents, safety-related incidents, illnesses, and deaths.
13 3. Evaluating accident-prevention and
14 illness-prevention programs.
15 4. Prescribing guidelines for the training of safety
16 committee members.
17 (3) The composition, selection, and function of safety
18 committees shall be a mandatory topic of negotiations with any
19 certified collective bargaining agent for firefighter
20 employers that operate under a collective bargaining
21 agreement. Firefighter employers that operate under a
22 collective bargaining agreement that contains provisions
23 regulating the formation and operation of workplace safety
24 committees that meet or exceed the minimum requirements
25 contained in this section, or firefighter employers who
26 otherwise have existing workplace safety committees that meet
27 or exceed the minimum requirements established by this section
28 are in compliance with this section.
29 (4) Firefighter employees must be compensated their
30 regular hourly wage while engaged in workplace safety
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1 committee or workplace safety coordinator training, meetings,
2 or other duties prescribed under this section.
3 Section 107. Effective July 1, 2000, section 633.813,
4 Florida Statutes, is created to read:
5 633.813 Firefighter employer penalties.--If any
6 firefighter employer violates or fails or refuses to comply
7 with ss. 633.801 through 633.830, or with any rule adopted by
8 the division, in accordance with chapter 120, for the
9 prevention of injuries, accidents, or occupational diseases or
10 with any lawful order of the division in connection with ss.
11 633.801 through 633.830, or fails or refuses to furnish or
12 adopt any safety device, safeguard, or other means of
13 protection prescribed by the division under ss. 633.801
14 through 633.830 for the prevention of accidents or
15 occupational diseases, the division may assess against the
16 firefighter employer a civil penalty of not less than $100 nor
17 more than $5,000 for each day the violation, omission,
18 failure, or refusal continues after the firefighter employer
19 has been given notice thereof in writing. The total penalty
20 for each violation may not exceed $50,000. The division shall
21 adopt rules requiring penalties commensurate with the
22 frequency or severity, or both, of safety violations. A
23 hearing must be held in the county where the violation,
24 omission, failure, or refusal is alleged to have occurred,
25 unless otherwise agreed to by the firefighter employer and
26 authorized by the division. All penalties assessed and
27 collected under this section shall be deposited in the
28 Insurance Commissioner's Regulatory Trust Fund.
29 Section 108. Effective July 1, 2000, section 633.814,
30 Florida Statutes, is created to read:
31

1 633.814 Division cooperation with Federal Government;
2 exemption from division requirements.--
3 (1) The division shall cooperate with the Federal
4 Government so that duplicate inspections will be avoided yet
5 assure safe places of firefighter employment for the citizens
6 of this state.
7 (2) Except as provided in this section, a private
8 firefighter employer is not subject to the requirements of the
9 division if:
10 (a) The private firefighter employer is subject to the
11 federal regulations in 29 C.F.R. ss. 1910 and 1926;
12 (b) The private firefighter employer has adopted and
13 implemented a written safety program that conforms to the
14 requirements of 29 C.F.R. ss. 1910 and 1926;
15 (c) A private firefighter employer with 20 or more
16 full-time firefighter employees shall include provisions for a
17 safety committee in the safety program. The safety committee
18 must include firefighter employee representation and must meet
19 at least once each calendar quarter. The private firefighter
20 employer must make adequate records of each meeting and
21 maintain the records subject to inspections under subsection
22 (3). The safety committee shall, if appropriate, make
23 recommendations regarding improvements to the safety program
24 and corrections of hazards affecting workplace safety; and
25 (d) The private firefighter employer provides the
26 division with a written statement that certifies compliance
27 with this subsection.
28 (3) The division may enter at any reasonable time any
29 place of firefighter employment for the purposes of verifying
30 the accuracy of the written certification. If the division
31 determines that the firefighter employer has not complied with

1 the requirements of subsection (2), the firefighter employer
2 shall be subject to the rules of the division until the
3 firefighter employer complies with subsection (2) and
4 recertifies that fact to the division.
5 (4) This section shall not restrict the division from
6 performing any duties pursuant to a written contract between
7 the division and the Federal Occupational Safety and Health
8 Administration (OSHA).
9 Section 109. Effective July 1, 2000, section 633.815,
10 Florida Statutes, is created to read:
11 633.815 Failure to implement a safety and health
12 program; cancellations.--If a firefighter employer that is
13 found by the division to have a high frequency or severity of
14 work-related injuries fails to implement a safety and health
15 program, the insurer or self-insurer's fund that is providing
16 coverage fo r the firefighter employer may cancel the contract
17 for insurance with the firefighter employer. In the
18 alternative, the insurer or fund may terminate any discount or
19 deviation granted to the firefighter employer for the
20 remainder of the term of the policy. If the contract is
21 canceled or the discount or deviation is terminated, the
22 insurer must make such reports as are required by law.
23 Section 110. Effective July 1, 2000, section 633.816,
24 Florida Statutes, is created to read:
25 633.816 Expenses of administration.--The amounts that
26 are needed to administer ss. 633.801 through 633.830 shall be
27 disbursed from the Insurance Commissioner's Regulatory Trust
28 Fund.
29 Section 111. Effective July 1, 2000, section 633.817,
30 Florida Statutes, is created to read:
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1 633.817 Refusal to admit; penalty.--The division and
2 its authorized representatives may enter and inspect any place
3 of firefighter employment at any reasonable time for the
4 purpose of investigating compliance with ss. 633.801 through
5 633.830 and conducting inspections for the proper enforcement
6 of ss. 633.801 through 633.830. A firefighter employer who
7 refuses to admit any member of the division or its authorized
8 representative to any place of employment or to allow
9 investigation and inspection pursuant to this section commits
10 a misdemeanor of the second degree, punishable as provided in
11 s. 775.082 or s. 775.083.
12 Section 112. Effective July 1, 2000, section 633.818,
13 Florida Statutes, is created to read:
14 633.818 Firefighter employee rights and
15 responsibilities.--
16 (1) Each firefighter employee of a firefighter
17 employer covered under ss. 633.801 through 633.830 shall
18 comply with rules adopted by the division and with reasonable
19 workplace safety and health standards, rules, policies,
20 procedures, and work practices established by the firefighter
21 employer and the workplace safety committee. A firefighter
22 employee who knowingly fails to comply with this subsection
23 maybe disciplined or discharged by the firefighter employer.
24 (2) A firefighter employer may not discharge, threaten
25 to discharge, cause to be discharged, intimidate, coerce,
26 otherwise discipline, or in any manner discriminate against a
27 firefighter employee for any of the following reasons:
28 (a) The firefighter employee has testified or is about
29 to testify, on her or his own behalf, or on behalf of others,
30 in any proceeding instituted under ss. 633.801 through
31 633.830;

1 (b) The firefighter employee has exercised any other
2 right afforded under ss. 633.801 through 633.830; or
3 (c) The firefighter employee is engaged in activities
4 relating to the workplace safety committee.
5 (3) Neither pay, position, seniority, nor other
6 benefit may be lost for exercising any right under, or for
7 seeking compliance with, any requirement of ss. 633.801
8 through 633.830.
9 Section 113. Effective July 1, 2000, section 633.819,
10 Florida Statutes, is created to read:
11 633.819 Compliance.--Failure of a firefighter employer
12 or an insurer to comply with ss. 633.801 through 633.830, or
13 with any rules adopted under s.. 633.801 through 633.830,
14 constitutes grounds for the division to seek remedies,
15 including injunctive relief, for compliance by making
16 appropriate filings with the Circuit Court of Leon County.
17 Section 114. Effective July 1, 2000, section 633.820,
18 Florida Statutes, is created to read:
19 633.820 False statements to insurers.--A firefighter
20 employer who knowingly and willfully falsifies or conceals a
21 material fact, makes a false, fictitious, or fraudulent
22 statement or representation; or makes or uses any false
23 document knowing the document to contain any false fictitious,
24 or fraudulent entry or statement to an insurer of workers'
25 compensation insurance under ss. 633.801 through 633.830 is
26 guilty of a misdemeanor of the second degree, punishable as
27 provided in s. 775.082 or s. 775.083.
28 Section 115. Effective July 1, 2000, section 633.821,
29 Florida Statutes, is created to read:
30 633.821 Insurer penalties.--If any insurer violates,
31 or fails or refuses to comply with, ss. 633.801 through

1 633.830 or with any rule adopted or order issued under ss.
2 633.801 through 633.830, the division, after notice and
3 hearing in accordance with chapter 120, may assess against the
4 insurer a civil penalty of not less than $100 nor more than
5 $5,000 each day the violation, failure, or refusal continues
6 after the insurer has been given written notice thereof. The
7 total penalty for each violation, failure, or refusal may not
8 exceed $50,000. The division shall adopt rules providing for
9 penalties for noncompliance with ss. 633.801 through 633.830
10 by insurers. All penalties assessed and collected under this
11 section shall be deposited in the Insurance Commissioner's
12 Regulatory Trust Fund.
13 Section 116. Effective July 1, 2000, section 633.823,
14 Florida Statutes, is created to read:
15 633.823 Matters within jurisdiction of the division;
16 false, fictitious, or fraudulent acts, statements, and
17 representations prohibited; penalty; statute of
18 limitations.--A person may not, in any matter within the
19 jurisdiction of the division, knowingly and willfully falsify
20 or conceal a material fact; make any false, fictitious, or
21 fraudulent statement or representation; or make or use any
22 false document, knowing the same to contain any false,
23 fictitious, or fraudulent statement or entry. A person who
24 violates this section commits a misdemeanor of the second
25 degree, punishable as provided in s. 775.082 or s. 775.083.
26 The statute of limitations for prosecution of an act committed
27 in violation of this section is 5 years after the date the act
28 was committed or, if not discovered within 30 days after the
29 act was committed, 5 years after the date the act was
30 discovered.
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1 Section 117. Effective July 1, 2000, section 633.825,
2 Florida Statutes, is created to read:
3 633.825 Workplace safety.--
4 (1) The division shall assist in making the workplace
5 a safer place to work and decreasing the frequency and
6 severity of on-the-job injuries.
7 (2) The division shall have the authority to adopt
8 rules for the purpose of assuring safe working conditions for
9 all firefighter employees by authorizing the enforcement of
10 effective standards, assisting and encouraging firefighter
11 employers to maintain safe working conditions, and by
12 providing for education and training in the field of safety.
13 For firefighter employers, the division may by rule adopt
14 subparts C through T and subpart Z of 29 C.F.R. part 1910;
15 subparts C through Z of 29 C.F.R. part 1926; subparts A
16 through D, subpart I, and subpart M of 29 C.F.R. part 1928;
17 subparts A through G of 29 C.F.R. part 1917; subparts A
18 through L and subpart Z of 29 C.F.R. part 1915; subparts A
19 through J of 29 C.F.R. part 1918, latest revision, provided
20 that 29 C.F.R. s. 1910.156 applies to volunteer firefighters
21 and fire departments operated by the state or political
22 subdivisions; the National Fire Protection Association, Inc.,
23 Standard 1500, paragraph 5-7 (Personal Alert Safety System)
24 (1992 edition); and ANSI A 10.4-1990.
25 (3) The provisions of chapter 440 which pertain to
26 workplace safety shall be applicable to the division.
27 (4) The division shall have authority to adopt any
28 rule necessary to implement, interpret, and make specific any
29 matter pertaining to any subject or reference contained in
30 this section, including all of the provisions referred to in
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1 subsection (2), as they relate to firefighter employees,
2 firefighter employers, and firefighter places of employment.
3 Section 118. Except as otherwise provided in this act,
4 this act shall take effect January 1, 2001.
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