Bill No. HB 739, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate		House
	.	

Senator Latvala moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Effective January 7, 2003, section 17.001, Florida Statutes, is created to read:

17.001 Financial Officer.--As provided in s. 4(c), Art. IV of the State Constitution, the Chief Financial Officer is the chief fiscal officer of the state and is responsible for settling and approving accounts against the state and keeping all state funds and securities.

Section 2. Effective January 7, 2003, section 20.121, Florida Statutes, is created to read:

20.121 Department of Financial Services.--There is created a Department of Financial Services.

(1) The head of the Department of Financial Services is the Chief Financial Officer.

(2)(a) The Division of Administration is created within the Office of the Chief Financial Officer. The division

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

1. Division of Insurance Agents and Agencies;
2. Division of Insurance Consumer Services;
3. Division of Insurer Services;
4. Division of Rehabilitation and Liquidation;
5. Division of Risk Management; and
6. Division of State Fire Marshal.

(5)(a) The Office of the Commissioner of Financial Institutions is established in the Department of Financial Services. The office shall be headed by the Commissioner of Financial Institutions. Prior to appointment, the Commissioner of Financial Institutions must have had, within the previous 10 years, at least 5 years of experience as a senior officer of a financial institution, as defined in s. 655.005(h), or as an examiner or other senior employee of a state or federal agency having regulatory responsibility over financial institutions.

(b) The Office of the Commissioner of Financial Institutions shall consist of the following divisions:

1. Division of Banking; and
2. Division of Credit Unions.

(c) For purposes of chapter 120, the Commissioner of Financial Institutions is the agency head for all divisions within the Office of the Commissioner of Financial Institutions. The commissioner shall be responsible for, and take final agency action related to, the implementation and enforcement of all statutes and rules within the regulatory authority delegated to the Office of the Commissioner of Financial Institutions and the divisions created within that office. The Commissioner of Financial Institutions may serve as the Director of the Division of Banking or the Director of the Division of Credit Unions, or both.

1 (6)(a) The Office of the Commissioner of Securities
2 and Finance is established within the Department of Financial
3 Services. The office shall be headed by the Commissioner of
4 Securities and Finance. Prior to appointment, the Commissioner
5 of Securities and Finance must have had, within the previous
6 10 years, at least 5 years of experience as a senior officer
7 of a securities or finance company or as an examiner or other
8 senior employee of a state or federal agency having regulatory
9 responsibility over securities or finance companies.
10 (b) The Office of the Commissioner of Securities and
11 Finance shall consist of the following divisions:
12 1. Division of Securities and Finance; and
13 2. Division of Certified Public Accounting.
14 (c) For purposes of chapter 120, the Commissioner of
15 Securities and Finance is the agency head for all divisions
16 within the Office of the Commissioner of Securities and
17 Finance. The commissioner shall be responsible for, and take
18 final agency action related to, the implementation and
19 enforcement of all statutes and rules within the regulatory
20 authority delegated to the Office of the Commissioner of
21 Securities and Finance. The Commissioner of Securities and
22 Finance may serve as Director of the Division of Securities
23 and Finance.
24 (7)(a) The Office of the Commissioner of Treasury is
25 established in the Department of Financial Services. The
26 office shall be headed by the Commissioner of the Treasury.
27 The Commissioner of the Treasury must possess sufficient
28 education, business experience, and managerial ability to
29 effectively perform his or her duties.
30 (b) The Office of the Commissioner of the Treasury
31 shall consist of the following divisions:

1. Division of Accounting and Auditing, which is responsible for, without limitation, unclaimed property;

2. Division of Information Services; and

3. Division of Treasury. A section of Government Employee Deferred Compensation is created within the Division of Treasury which shall administer the Government Employees Deferred Compensation Plan established under s. 112.215 for state employees.

Section 3. Effective January 7, 2003, the Department of Banking and Finance is transferred by a type two transfer, as defined in section 20.06, Florida Statutes, to the Department of Financial Services.

Section 4. Effective January 7, 2003, the Department of Insurance is transferred by a type two transfer, as defined in section 20.06, Florida Statutes, to the Department of Financial Services.

Section 5. Effective January 7, 2003, section 20.12, Florida Statutes, is repealed.

Section 6. Effective January 7, 2003, section 20.13, Florida Statutes, is repealed.

Section 7. Effective January 7, 2003, subsections (2) and (4) of section 20.165, Florida Statutes, are amended to read:

20.165 Department of Business and Professional Regulation.--There is created a Department of Business and Professional Regulation.

(2) The following divisions of the Department of Business and Professional Regulation are established:

(a) Division of Administration.

(b) Division of Alcoholic Beverages and Tobacco.

~~(c) Division of Certified Public Accounting.~~

~~1. The director of the division shall be appointed by the secretary of the department, subject to approval by a majority of the Board of Accountancy.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Barbers' Board, created under chapter 476.

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

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

6. Board of Cosmetology, created under chapter 477.

7. Electrical Contractors' Licensing Board, created

1 under part II of chapter 489.
2 8. Board of Employee Leasing Companies, created under
3 part XI of chapter 468.
4 9. Board of Funeral Directors and Embalmers, created
5 under chapter 470.
6 10. Board of Landscape Architecture, created under
7 part II of chapter 481.
8 11. Board of Pilot Commissioners, created under
9 chapter 310.
10 12. Board of Professional Engineers, created under
11 chapter 471.
12 13. Board of Professional Geologists, created under
13 chapter 492.
14 14. Board of Professional Surveyors and Mappers,
15 created under chapter 472.
16 15. Board of Veterinary Medicine, created under
17 chapter 474.
18 (b) The following board and commission are established
19 within the Division of Real Estate:
20 1. Florida Real Estate Appraisal Board, created under
21 part II of chapter 475.
22 2. Florida Real Estate Commission, created under part
23 I of chapter 475.
24 ~~(c) The following board is established within the~~
25 ~~Division of Certified Public Accounting:~~
26 ~~1. Board of Accountancy, created under chapter 473.~~
27 Section 8. Effective January 7, 2003, the Division of
28 Certified Public Accounting and the Board of Accountancy
29 created under chapter 473, Florida Statutes, are transferred
30 to the Department of Financial Services by a type two
31 transfer, as defined in section 20.06, Florida Statutes.

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

350.061 Public Counsel; appointment; oath; restrictions on Public Counsel and his or her employees.--

(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

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

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

1 624.37 Insurance Rating Commission; creation;
2 legislative intent.--There is created the Insurance Rating
3 Commission, an independent commission housed within the
4 Department of Insurance. The Insurance Rating Commission shall
5 have authority to regulate rates for insurance and such
6 related matters as provided in this code, effective January 1,
7 2001, and shall exercise the powers and duties with respect to
8 insurance rates which are provided to the department.
9 624.371 Insurance Rating Commission; terms of
10 commissioners.--
11 (1) The Insurance Rating Commission is
12 administratively housed in, but independent of, the
13 department. The commission shall have such powers and duties
14 regarding rates for insurance policies and health maintenance
15 organization contracts as are provided in the Florida
16 Insurance Code.
17 (2) The commission shall consist of three full-time,
18 salaried commissioners appointed by the Governor and confirmed
19 by the Senate.
20 (3) For the initial appointment of the commission, one
21 member must be appointed for a 2-year term, one member must be
22 appointed for a 3-year term, and one member must be appointed
23 for a 4-year term. All subsequent appointments of
24 commissioners will be for 4-year terms. Vacancies on the
25 commission shall be filled for the unexpired portion of the
26 term.
27 (4) One member of the commission shall be elected by
28 majority vote to serve as chair for a term of 2 years. A
29 member may not serve two consecutive terms as chair.
30 (5) The primary duty of the chair is to serve as chief
31 administrative officer of the commission. The chair may also

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

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

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

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

1 624.375 Enforcement and interpretation.--Any violation
2 of s. 624.372, s. 624.373, or s. 624.377 by a commissioner,
3 former commissioner, or former employee is punishable as
4 provided in ss. 112.317 and 112.324. The Commission on Ethics
5 may investigate complaints of violation of such sections in
6 the manner provided in part III of chapter 112. A commissioner
7 may request an advisory opinion from the Commission of Ethics
8 as provided by s. 112.322(3)(a).
9 624.376 Place of meeting; expenditures; employment of
10 personnel.--
11 (1) The offices of the commission must be located in
12 the vicinity of Tallahassee, but the commissioners may hold
13 sessions or hearings anywhere in the state at their
14 discretion.
15 (2) The commission constitutes a separate budget
16 entity to be funded by appropriations from the Insurance
17 Commissioner's Regulatory Trust Fund.
18 (3) The commission may employ clerical, technical, and
19 professional personnel reasonably necessary for the
20 performance of its duties.
21 (4) The commission may employ actuaries, who shall be
22 at-will employees and who shall serve at the pleasure of the
23 commission. Actuaries employed under this subsection must be
24 members of the Society of Actuaries or the Casualty Actuarial
25 Society and are exempt from the Career Service System
26 established under chapter 110. The commission shall set the
27 salaries of the actuaries employed under this subsection in
28 accordance with s. 216.251(2)(a)5. at levels that are
29 commensurate with salary levels paid to actuaries by the
30 insurance industry.
31 624.377 Former commissioners and employees;

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

1 to the Department of Revenue as provided by law.
2 Section 16. Section 185.12, Florida Statutes, is
3 amended to read:
4 185.12 Payment of excise tax credit on similar state
5 excise or license tax.--The tax herein authorized shall in
6 nowise be additional to the similar state excise or license
7 tax imposed by part V ~~IV~~, chapter 624, but the payor of the
8 tax hereby authorized shall receive credit therefor on his or
9 her state excise or license tax and the balance of said state
10 excise or license tax shall be paid to the Department of
11 Revenue as provided by law.
12 Section 17. Subsection (14) of section 408.701,
13 Florida Statutes, is amended to read:
14 408.701 Community health purchasing; definitions.--As
15 used in ss. 408.70-408.706, the term:
16 (14) "Health insurer" or "insurer" means an
17 organization licensed by the department under part IV ~~III~~ of
18 chapter 624 or part I of chapter 641.
19 Section 18. Section 651.018, Florida Statutes, is
20 amended to read:
21 651.018 Administrative supervision.--The department
22 may place a facility in administrative supervision pursuant to
23 part VII ~~VI~~ of chapter 624.
24 Section 19. Section 624.19, Florida Statutes, is
25 amended to read:
26 624.19 Existing forms and filings.--Every form of
27 insurance document and every rate or other filing lawfully in
28 use immediately prior to October 1, 1959, may continue to be
29 so used or be effective until the department or commission
30 otherwise prescribes pursuant to this code.
31 Section 20. Subsection (1) of section 624.321, Florida

1 Statutes, is amended to read:
2 624.321 Witnesses and evidence.--
3 (1) As to any examination, investigation, or hearing
4 being conducted under this code, the Insurance Commissioner
5 ~~and Treasurer~~ or her or his designee <u>or a member of the</u>
6 <u>Insurance Rating Commission or his or her designee</u>:
7 (a) May administer oaths, examine and cross-examine
8 witnesses, receive oral and documentary evidence; and
9 (b) Shall have the power to subpoena witnesses, compel
10 their attendance and testimony, and require by subpoena the
11 production of books, papers, records, files, correspondence,
12 documents, or other evidence which is relevant to the inquiry.
13 Section 21. Section 624.322, Florida Statutes, is
14 amended to read:
15 624.322 Testimony compelled; immunity from
16 prosecution.--
17 (1) If any natural person asks to be excused from
18 attending or testifying or from producing any books, papers,
19 records, contracts, documents, or other evidence in connection
20 with any examination, hearing, or investigation being
21 conducted by the department or <u>the commission or the examiners</u>
22 <u>of either</u> ~~its examiner~~, on the ground that the testimony or
23 evidence required of her or him may tend to incriminate the
24 person or subject her or him to a penalty or forfeiture, and
25 shall notwithstanding be directed to give such testimony or
26 produce such evidence, the person must, if so directed by the
27 department <u>or commission</u> and the Department of Legal Affairs,
28 nonetheless comply with such direction; but she or he shall
29 not thereafter be prosecuted or subjected to any penalty or
30 forfeiture for or on account of any transaction, matter, or
31 thing concerning which she or he may have so testified or

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

1 charges for insurance.--
2 1. Knowingly collecting any sum as a premium or charge
3 for insurance, which is not then provided, or is not in due
4 course to be provided, subject to acceptance of the risk by
5 the insurer, by an insurance policy issued by an insurer as
6 permitted by this code.
7 2. Knowingly collecting as a premium or charge for
8 insurance any sum in excess of or less than the premium or
9 charge applicable to such insurance, in accordance with the
10 applicable classifications and rates as filed with and
11 approved by the commission ~~department~~, and as specified in the
12 policy; or, in cases when classifications, premiums, or rates
13 are not required by this code to be so filed and approved,
14 premiums and charges in excess of or less than those specified
15 in the policy and as fixed by the insurer. This provision
16 shall not be deemed to prohibit the charging and collection,
17 by surplus lines agents licensed under part VIII of this
18 chapter, of the amount of applicable state and federal taxes,
19 or fees as authorized by s. 626.916(4), in addition to the
20 premium required by the insurer or the charging and
21 collection, by licensed agents, of the exact amount of any
22 discount or other such fee charged by a credit card facility
23 in connection with the use of a credit card, as authorized by
24 subparagraph (q)3., in addition to the premium required by the
25 insurer. This subparagraph shall not be construed to prohibit
26 collection of a premium for a universal life or a variable or
27 indeterminate value insurance policy made in accordance with
28 the terms of the contract.
29 3.a. Imposing or requesting an additional premium for
30 a policy of motor vehicle liability, personal injury
31 protection, medical payment, or collision insurance or any

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

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.

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,

1 rating plans, or other matters governed by this part comply
2 with the law, the appellate court shall set aside a final
3 order of the department or commission if the department or
4 commission has violated s. 120.57(1)(k) by substituting its
5 findings of fact for findings of an administrative law judge
6 which were supported by competent substantial evidence.
7 Section 26. Subsection (3) of section 627.0613,
8 Florida Statutes, is amended to read:
9 627.0613 Consumer advocate.--The Insurance
10 Commissioner must appoint a consumer advocate who must
11 represent the general public of the state before the
12 department. The consumer advocate must report directly to the
13 Insurance Commissioner, but is not otherwise under the
14 authority of the department or of any employee of the
15 department. The consumer advocate has such powers as are
16 necessary to carry out the duties of the office of consumer
17 advocate, including, but not limited to, the powers to:
18 (3) Examine ~~rate and~~ form filings submitted to the
19 department, hire consultants as necessary to aid in the review
20 process, and recommend to the department any position deemed
21 by the consumer advocate to be in the public interest.
22 Section 27. Subsections (2), (3), and (6) of section
23 627.062, Florida Statutes, are amended to read:
24 627.062 Rate standards.--
25 (2) As to all such classes of insurance:
26 (a) Insurers or rating organizations shall establish
27 and use rates, rating schedules, or rating manuals to allow
28 the insurer a reasonable rate of return on such classes of
29 insurance written in this state. A copy of rates, rating
30 schedules, rating manuals, premium credits or discount
31 schedules, and surcharge schedules, and changes thereto, shall

be filed with the commission ~~department~~ under one of the following procedures:

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

1 is excessive, inadequate, or unfairly discriminatory. In
2 making that determination, the commission ~~department~~ shall, in
3 accordance with generally accepted and reasonable actuarial
4 techniques, consider the following factors:
5 1. Past and prospective loss experience within and
6 without this state.
7 2. Past and prospective expenses.
8 3. The degree of competition among insurers for the
9 risk insured.
10 4. Investment income reasonably expected by the
11 insurer, consistent with the insurer's investment practices,
12 from investable premiums anticipated in the filing, plus any
13 other expected income from currently invested assets
14 representing the amount expected on unearned premium reserves
15 and loss reserves. The commission ~~department~~ may adopt
16 ~~promulgate~~ rules using ~~utilizing~~ reasonable techniques of
17 actuarial science and economics to specify the manner in which
18 insurers shall calculate investment income attributable to
19 such classes of insurance written in this state and the manner
20 in which such investment income shall be used in the
21 calculation of insurance rates. Such manner shall contemplate
22 allowances for an underwriting profit factor and full
23 consideration of investment income which produce a reasonable
24 rate of return; however, investment income from invested
25 surplus shall not be considered. The profit and contingency
26 factor as specified in the filing shall be used ~~utilized~~ in
27 computing excess profits in conjunction with s. 627.0625.
28 5. The reasonableness of the judgment reflected in the
29 filing.
30 6. Dividends, savings, or unabsorbed premium deposits
31 allowed or returned to Florida policyholders, members, or

subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance.

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

10. Conflagration and catastrophe hazards, if applicable.

11. A reasonable margin for underwriting profit and contingencies.

12. The cost of medical services, if applicable.

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

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

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

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

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

1 expense all information necessary to evaluate the condition of
2 the company and the reasonableness of the filing according to
3 the criteria enumerated in this section.
4 (g) The commission ~~department~~ may at any time review a
5 rate, rating schedule, rating manual, or rate change; the
6 pertinent records of the insurer; and market conditions. If
7 the commission ~~department~~ finds on a preliminary basis that a
8 rate may be excessive, inadequate, or unfairly discriminatory,
9 the commission ~~department~~ shall initiate proceedings to
10 disapprove the rate and shall so notify the insurer. However,
11 the commission ~~department~~ may not disapprove as excessive any
12 rate for which it has given final approval or which has been
13 deemed approved for a period of 1 year after the effective
14 date of the filing unless the commission ~~department~~ finds that
15 a material misrepresentation or material error was made by the
16 insurer or was contained in the filing. Upon being so
17 notified, the insurer or rating organization shall, within 60
18 days, file with the commission ~~department~~ all information
19 which, in the belief of the insurer or organization, proves
20 the reasonableness, adequacy, and fairness of the rate or rate
21 change. The commission ~~department~~ shall issue a notice of
22 intent to approve or a notice of intent to disapprove pursuant
23 to the procedures of paragraph (a) within 90 days after
24 receipt of the insurer's initial response. In such instances
25 and in any administrative proceeding relating to the legality
26 of the rate, the insurer or rating organization shall carry
27 the burden of proof by a preponderance of the evidence to show
28 that the rate is not excessive, inadequate, or unfairly
29 discriminatory. After the commission ~~department~~ notifies an
30 insurer that a rate may be excessive, inadequate, or unfairly
31 discriminatory, unless the commission ~~department~~ withdraws the

notification, the insurer shall not alter the rate except to conform with the commission's ~~department's~~ notice 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.

(h) 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 subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the commission ~~department~~ finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the commission ~~department~~ in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, the commission ~~department~~ shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from

including the full amount of acquisition costs in a rate filing.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

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

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

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

~~(6)(a) After any action with respect to a rate filing that constitutes agency action for purposes of the Administrative Procedure Act, an insurer may, in lieu of~~

~~demanding a hearing under s. 120.57, require arbitration of the rate filing. Arbitration shall be conducted by a board of arbitrators consisting of an arbitrator selected by the department, an arbitrator selected by the insurer, and an arbitrator selected jointly by the other two arbitrators. Each arbitrator must be certified by the American Arbitration Association. A decision is valid only upon the affirmative vote of at least two of the arbitrators. No arbitrator may be an employee of any insurance regulator or regulatory body or of any insurer, regardless of whether or not the employing insurer does business in this state. The department and the insurer must treat the decision of the arbitrators as the final approval of a rate filing. Costs of arbitration shall be paid by the insurer.~~

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

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

Section 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

1 member of the faculty of the State University System and who
2 has a background in actuarial science.
3 d. An expert in statistics who is a full time member
4 of the faculty of the State University System and who has a
5 background in insurance.
6 e. An expert in computer system design who is a full
7 time member of the faculty of the State University System.
8 f. An expert in meteorology who is a full time member
9 of the faculty of the State University System and who
10 specializes in hurricanes.
11 (c) Members designated under subparagraphs (b)1.-5.
12 shall serve on the commission as long as they maintain the
13 respective offices designated in subparagraphs (b)1.-5.
14 Members appointed by the Insurance Rating Commission
15 ~~Commissioner~~ under subparagraph (b)6. shall serve on the
16 Florida Commission on Hurricane Loss Projection Methodology
17 for a 4-year term ~~until the end of the term of office of the~~
18 ~~Insurance Commissioner who appointed them~~, unless earlier
19 removed by the Insurance Rating Commission ~~Commissioner~~ for
20 cause. Vacancies on the Florida Commission on Hurricane Loss
21 Projection Methodology shall be filled in the same manner as
22 the original appointment.
23 (d) The State Board of Administration shall annually
24 appoint one of the members of the commission to serve as
25 chair.
26 (e) Members of the commission shall serve without
27 compensation, but shall be reimbursed for per diem and travel
28 expenses pursuant to s. 112.061.
29 (f) The State Board of Administration shall, as a cost
30 of administration of the Florida Hurricane Catastrophe Fund,
31 provide for travel, expenses, and staff support for the

1 commission.
2 (g) There shall be no liability on the part of, and no
3 cause of action of any nature shall arise against, any member
4 of the commission, any member of the State Board of
5 Administration, or any employee of the State Board of
6 Administration for any action taken in the performance of
7 their duties under this section. In addition, the commission
8 may, in writing, waive any potential cause of action for
9 negligence of a consultant, contractor, or contract employee
10 engaged to assist the commission.
11 (3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.--
12 (a) The commission shall consider any actuarial
13 methods, principles, standards, models, or output ranges that
14 have the potential for improving the accuracy of or
15 reliability of the hurricane loss projections used in
16 residential property insurance rate filings. The commission
17 shall, from time to time, adopt findings as to the accuracy or
18 reliability of particular methods, principles, standards,
19 models, or output ranges.
20 (b) In establishing reimbursement premiums for the
21 Florida Hurricane Catastrophe Fund, the State Board of
22 Administration must, to the extent feasible, employ actuarial
23 methods, principles, standards, models, or output ranges found
24 by the commission to be accurate or reliable.
25 (c) With respect to a rate filing under s. 627.062, an
26 insurer may employ actuarial methods, principles, standards,
27 models, or output ranges found by the commission to be
28 accurate or reliable to determine hurricane loss factors for
29 use in a rate filing under s. 627.062, which findings and
30 factors are admissible and relevant in consideration of a rate
31 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 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 which insurers shall calculate investment income attributable to motor vehicle insurance policies written in this state and the manner in which such investment income is used in the calculation of insurance rates. Such manner shall contemplate the use of a positive underwriting profit allowance in the rates that will be compatible with a reasonable rate of return plus provisions for contingencies. The total of the profit and contingency factor as specified in the filing shall be

1 utilized in computing excess profits in conjunction with s.
2 627.066. In adopting ~~promulgating~~ such rules, the commission
3 ~~department~~ shall in all instances adhere to and implement the
4 provisions of this paragraph.
5 (e) The reasonableness of the judgment reflected in
6 the filing.
7 (f) Dividends, savings, or unabsorbed premium deposits
8 allowed or returned to Florida policyholders, members, or
9 subscribers.
10 (g) The cost of repairs to motor vehicles.
11 (h) The cost of medical services, if applicable.
12 (i) The adequacy of loss reserves.
13 (j) The cost of reinsurance.
14 (k) Trend factors, including trends in actual losses
15 per insured unit for the insurer making the filing.
16 (l) Other relevant factors which impact upon the
17 frequency or severity of claims or upon expenses.
18 (5)(a) Rates shall be deemed inadequate if they are
19 clearly insufficient, together with the investment income
20 attributable to them, to sustain projected losses and expenses
21 in the class of business to which they apply.
22 (b) The commission ~~Insurance Commissioner~~ shall have
23 the responsibility to ensure that rates for private passenger
24 vehicle insurance are adequate. To that end, the commission
25 ~~department~~ shall adopt ~~promulgate~~ rules and regulations
26 establishing standards defining inadequate rates on private
27 passenger vehicle insurance as defined in s. 627.041(8). If ~~In~~
28 ~~the event that~~ the commission ~~department~~ finds that a rate or
29 rate change is inadequate, the commission ~~department~~ shall
30 order that a new rate or rate schedule be thereafter filed by
31 the insurer and shall further provide information as to the

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

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

(b) The submission of rates, rating schedules, and

1 rating manuals to the commission ~~department~~ by a licensed
2 rating organization of which an insurer is a member or
3 subscriber will be sufficient compliance with this subsection
4 for any insurer maintaining membership or subscribership in
5 such organization, to the extent that the insurer uses the
6 rates, rating schedules, and rating manuals of such
7 organization. All such information shall be available for
8 public inspection, upon receipt by the commission ~~department~~,
9 during usual business hours.
10 Section 33. Section 627.0653, Florida Statutes, is
11 amended to read:
12 627.0653 Insurance discounts for specified motor
13 vehicle equipment.--
14 (1) Any rates, rating schedules, or rating manuals for
15 the liability, personal injury protection, and collision
16 coverages of a motor vehicle insurance policy filed with the
17 commission ~~department~~ shall provide a premium discount if the
18 insured vehicle is equipped with factory-installed, four-wheel
19 antilock brakes.
20 (2) Each insurer writing motor vehicle comprehensive
21 coverage in this state shall include in its rating manual
22 discount provisions for comprehensive coverage which
23 specifically relate to an antitheft device or vehicle recovery
24 system utilized in the insured vehicle which are factory
25 installed or approved by the commission ~~department~~. The
26 commission ~~department~~ shall adopt, by rule, procedures under
27 which manufacturers, distributors, or sellers may apply to the
28 commission ~~department~~ for approval of non-factory-installed
29 devices under this subsection. The rules must include, at a
30 minimum, the test results that must accompany the application
31 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

1 vehicle, unless the commission ~~Department of Insurance~~
2 determines from actuarial data submitted to it that the
3 surcharge is justified.
4 Section 35. Subsection (1) of section 627.0654,
5 Florida Statutes, is amended to read:
6 627.0654 Insurance discounts for buildings with fire
7 sprinklers.--
8 (1) Any rates, rating schedules, or rating manuals for
9 a new or renewal fire insurance policy for an existing or
10 newly constructed building, whether used for commercial or
11 residential purposes, must provide for a premium discount if a
12 fire sprinkler system has been installed in the building in
13 accordance with nationally accepted fire sprinkler design
14 standards, as adopted by the commission ~~department~~, and if the
15 fire sprinkler system is maintained in accordance with
16 nationally accepted standards.
17 Section 36. Subsections (2), (7), (10), (11), and (13)
18 of section 627.066, Florida Statutes, are amended to read:
19 627.066 Excessive profits for motor vehicle insurance
20 prohibited.--
21 (2) Each Florida private passenger automobile insurer
22 group shall file with the commission ~~department~~, prior to July
23 1 of each year on forms prescribed by the commission
24 ~~department~~, the following data for Florida private passenger
25 automobile business. The data filed for the group shall be a
26 consolidation of the data of the individual insurers of the
27 group. The data shall include both voluntary and joint
28 underwriting association business, as follows:
29 (a) Calendar-year total limits earned premium.
30 (b) Accident-year incurred losses and loss adjustment
31 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 hereinafter. Prior to July 1, 1982, the data required by this section shall be submitted to the department for the years 1979, 1980, and 1981. Excessive profits shall be calculated in accordance with the provisions of this section. However, only the excessive profits realized by the insurer group in 1981 shall be refunded to policyholders, and such refunds shall be made in accordance with this section. Prior to July 1, 1983, the data required by this section shall be submitted to the department for the years 1980, 1981, and 1982. Excessive profits shall be calculated in accordance with this~~

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

Section 37. Subsection (4) of section 627.072, Florida Statutes, is amended to read:

627.072 Making and use of rates.--

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

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

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

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. shall be required to commence such reporting procedures as of January 1, 1980.

~~(c) The Insurance Commissioner is directed to consider using the methodology specified in paragraph (a) prior to March 31, 1980; and, in the event the Insurance Commissioner decides not to use this methodology, she or he shall report such decision and the reasons therefor to the committees of substance in the area of insurance in each house of the Legislature by March 31, 1980.~~

Section 38. Subsections (1), (5), and (6) of section

1 627.091, Florida Statutes, are amended to read:
2 627.091 Rate filings; workers' compensation and
3 employer's liability insurances.--
4 (1) As to workers' compensation and employer's
5 liability insurances, every insurer shall file with the
6 commission ~~department~~ every manual of classifications, rules,
7 and rates, every rating plan, and every modification of any of
8 the foregoing which it proposes to use. Every insurer is
9 authorized to include deductible provisions in its manual of
10 classifications, rules, and rates. Such deductibles shall in
11 all cases be in a form and manner which is consistent with the
12 underlying purpose of chapter 440.
13 (5) Pursuant to the provisions of s. 624.3161, the
14 commission ~~department~~ may examine the underlying statistical
15 data used in such filings.
16 (6) Whenever the committee of a recognized rating
17 organization with responsibility for workers' compensation and
18 employer's liability insurance rates in this state meets to
19 discuss the necessity for, or a request for, Florida rate
20 increases or decreases, the determination of Florida rates,
21 the rates to be requested, and any other matters pertaining
22 specifically and directly to such Florida rates, such meetings
23 shall be held in this state and shall be subject to s.
24 286.011. The committee of such a rating organization shall
25 provide at least 3 weeks' prior notice of such meetings to the
26 commission ~~department~~ and shall provide at least 14 days'
27 prior notice of such meetings to the public by publication in
28 the Florida Administrative Weekly.
29 Section 39. Section 627.0915, Florida Statutes, is
30 amended to read:
31 627.0915 Rate filings; workers' compensation,

1 drug-free workplace, and safe employers.--The commission
2 ~~Department of Insurance~~ shall approve rating plans for
3 workers' compensation insurance that give specific
4 identifiable consideration in the setting of rates to
5 employers that either implement a drug-free workplace program
6 pursuant to rules adopted by the Division of Workers'
7 Compensation of the Department of Labor and Employment
8 Security or implement a safety program approved by the
9 Division of Safety pursuant to rules adopted by the Division
10 of Safety of the Department of Labor and Employment Security
11 or implement both a drug-free workplace program and a safety
12 program. The Division of Safety may by rule require that the
13 client of a help supply services company comply with the
14 essential requirements of a workplace safety program as a
15 condition for receiving a premium credit. The plans must take
16 effect January 1, 1994, must be actuarially sound, and must
17 state the savings anticipated to result from such drug-testing
18 and safety programs.
19 Section 40. Section 627.0916, Florida Statutes, is
20 amended to read:
21 627.0916 Agricultural horse farms.--Notwithstanding
22 any other provision of this chapter to the contrary, any
23 rates, rating schedules, or rating manuals for workers'
24 compensation and employer's liability insurance filed with the
25 commission ~~Department of Insurance~~ shall provide for the rates
26 of an agricultural horse farm engaged in breeding or training
27 to be separated into the following three rate classifications
28 and the premium paid shall be applied proportionately
29 according to payroll: breeding activity involving stallions;
30 breeding activity not involving stallions, including but not
31 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:

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

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

(2) The commission ~~department~~ shall specifically

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

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

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

Section 43. Section 627.111, Florida Statutes, is amended to read:

627.111 Effective date of filing.--

(1) If, pursuant to s. 627.101(2), the commission ~~department~~ determines to hold a public hearing as to a filing, or it holds such a public hearing pursuant to request therefor

under s. 627.101(3), it shall give written notice thereof to the rating organization or insurer that made the filing and shall hold such hearing within 30 days, and not less than 10 days prior to the date of the hearing, it shall give written notice of the hearing to the insurer or rating organization that made the filing. The commission ~~department~~ may also, in its discretion, give advance public notice of such hearing by publication of notice in one or more daily newspapers of general circulation in this state.

(2) If the order of the commission ~~department~~ disapproves the filing, the filing shall not become effective during the effectiveness of such order. If the order of the commission ~~department~~ approves the filing, the filing shall become effective upon the date of the order or upon such subsequent date as may be satisfactory to the insurer or rating organization that made the filing.

Section 44. Section 627.141, Florida Statutes, is amended to read:

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 relies. A copy of the application and data shall be sent simultaneously to the rating organization.

(2) Every member or subscriber to a rating organization may, as to workers' compensation and employer's liability insurance, file a plan or plans to use deviations that vary according to factors present in each insured's individual risk. The insurer that files for the deviations provided in this subsection shall file the qualifications for the plans, schedules of rating factors, and the maximum deviation factors which shall be subject to the approval of the commission ~~department~~ pursuant to s. 627.091. The actual deviation which shall be used for each insured that qualifies under this subsection may not exceed the maximum filed deviation under that plan and shall be based on the merits of

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

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

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

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

1 component types of such insurance as provided in the form:
2 1. Calendar-year earned premium.
3 2. Accident-year incurred losses and loss adjustment
4 expenses.
5 3. The administrative and selling expenses incurred in
6 this state or allocated to this state for the calendar year.
7 4. Policyholder dividends applicable to the calendar
8 year.
9
10 Nothing herein is intended to prohibit an insurer from filing
11 on a calendar-year basis.
12 (b) The data filed for the group shall be a
13 consolidation of the data of the individual insurers of the
14 group. However, an insurer may elect to either consolidate
15 commercial umbrella liability insurance data with commercial
16 casualty insurance data or to separately file data for
17 commercial umbrella liability insurance. Each insurer shall
18 elect its method of filing commercial umbrella liability
19 insurance at the time of filing data for accident year 1987
20 and shall thereafter continue filing under the same method. In
21 the case of commercial umbrella liability insurance data
22 reported separately, a separate excessive profits test shall
23 be applied and the test period shall be 10 years. ~~In the case~~
24 ~~of workers' compensation and employer's liability insurance,~~
25 ~~the final report for the test period including accident years~~
26 ~~1984, 1985, and 1986 must be filed prior to July 1, 1988. In~~
27 ~~the case of commercial property and commercial casualty~~
28 ~~insurance, the final report for the test period including~~
29 ~~accident years 1987, 1988, and 1989 must be filed prior to~~
30 ~~July 1, 1991.~~
31 (9) If the insurer group has realized an excessive

1 profit, the department shall order a return of the excessive
2 amounts after affording the insurer group an opportunity for
3 hearing and otherwise complying with the requirements of
4 chapter 120. Such excessive amounts shall be refunded in all
5 instances unless the insurer group affirmatively demonstrates
6 to the commission ~~department~~ that the refund of the excessive
7 amounts will render a member of the insurer group financially
8 impaired or will render it insolvent under the provisions of
9 the Florida Insurance Code.
10 (12)(a) Refunds shall be completed in one of the
11 following ways:
12 1. If the insurer group elects to make a cash refund,
13 the refund shall be completed within 60 days of entry of a
14 final order indicating that excessive profits have been
15 realized.
16 2. If the insurer group elects to make refunds in the
17 form of a credit to renewal policies, such credits shall be
18 applied to policy renewal premium notices which are forwarded
19 to insureds more than 60 calendar days after entry of a final
20 order indicating that excessive profits have been realized.
21 If an insurer group has made this election but an insured
22 thereafter cancels her or his policy or otherwise allows the
23 policy to terminate, the insurer group shall make a cash
24 refund not later than 60 days after termination of such
25 coverage.
26 (b) Upon completion of the renewal credits or refund
27 payments, the insurer group shall immediately certify to the
28 commission ~~department~~ that the refunds have been made.
29 Section 50. Subsection (1) of section 627.221, Florida
30 Statutes, is amended to read:
31 627.221 Rating organizations; licensing; fee.--

1 (1) A person, whether located within or outside this
2 state, may make application to the commission ~~department~~ for a
3 license as a rating organization. As to property or inland
4 marine insurance, the application shall be for such kinds of
5 insurance or subdivisions thereof or classes of risk or a part
6 or combination thereof as are specified in the application.
7 As to casualty and surety insurances, the application shall be
8 for such kinds of insurance or subdivisions thereof as are
9 specified in the application. The applicant shall file with
10 its application:
11 (a) A copy of its constitution, its articles of
12 agreement or association or its certificate of incorporation,
13 and of its bylaws, rules, and regulations governing the
14 conduct of its business;
15 (b) A list of its members and subscribers;
16 (c) The name and address of a resident of this state
17 upon whom notices or orders of the department or process
18 affecting such rating organization may be served; and
19 (d) A statement of its qualifications as a rating
20 organization.
21
22 If the commission ~~department~~ finds that the applicant is
23 competent, trustworthy, and otherwise qualified to act as a
24 rating organization and that its constitution, articles of
25 agreement or association or certificate of incorporation, and
26 its bylaws, rules, and regulations governing the conduct of
27 its business conform to the requirements of law, it shall
28 issue a license specifying (in the case of a casualty or
29 surety rating organization) the kinds of insurance or
30 subdivisions thereof, or (in the case of a property insurance
31 rating organization) the kinds of insurance or subdivisions

1 thereof or classes of risk or a part or combination thereof,
2 for which the applicant is authorized to act as a rating
3 organization.
4 Section 51. Section 627.231, Florida Statutes, is
5 amended to read:
6 627.231 Subscribers to rating organizations.--
7 (1) Subject to rules and regulations which have been
8 approved by the commission ~~department~~ as reasonable, each
9 rating organization shall permit any insurer, not a member, to
10 subscribe to its rating services. As to property and marine
11 rating organizations, an insurer shall be so permitted to
12 subscribe to rating services for any kind of insurance,
13 subdivision thereof, or class of risk or a part or combination
14 thereof for which the rating organization is authorized so to
15 act. As to casualty and surety rating organizations, an
16 insurer shall be so permitted to subscribe to rating services
17 for any kind of insurance or subdivision thereof for which the
18 rating organization is authorized so to act. The rating
19 organization shall give notice to subscribers of proposed
20 changes in such rules and regulations.
21 (2) The reasonableness of any rule or regulation in
22 its application to subscribers, or the refusal of any rating
23 organization to admit an insurer as a subscriber, shall, at
24 the request of any subscriber or any such insurer, be reviewed
25 by the commission ~~department~~. If the commission ~~department~~
26 finds that such rule or regulation is unreasonable in its
27 application to subscribers, it shall order that such rule or
28 regulation shall not be applicable to subscribers. If the
29 rating organization fails to grant or reject an insurer's
30 application for subscribership within 30 days after it was
31 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) Its constitution, its articles of agreement or association, or its certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business;

(2) Its list of members and subscribers; and

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

Section 53. Section 627.281, Florida Statutes, is amended to read:

627.281 Appeal from rating organization; workers' compensation and employer's liability insurance filings.--

(1) Any member or subscriber to a rating organization may appeal to the commission ~~department~~ from the action or decision of such rating organization in approving or rejecting any proposed change in or addition to the workers'

compensation or employer's liability insurance filings of such rating organization, and the commission ~~department~~ shall issue an order approving the decision of such rating organization or directing it to give further consideration to such proposal. If such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, the commission ~~department~~ may, if ~~in the event that~~ it finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with its findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions 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

1 state reasonable means whereby any person aggrieved by the
2 application of its rating system may be heard, in person or by
3 his or her authorized representative, on his or her written
4 request to review the manner in which such rating system has
5 been applied in connection with the insurance afforded him or
6 her. If the rating organization or insurer fails to grant or
7 rejects such request within 30 days after it is made, the
8 applicant may proceed in the same manner as if his or her
9 application had been rejected. Any party affected by the
10 action of such rating organization or insurer on such request
11 may, within 30 days after written notice of such action,
12 appeal to the commission ~~department~~, which may affirm or
13 reverse such action.
14 Section 55. Section 627.301, Florida Statutes, is
15 amended to read:
16 627.301 Advisory organizations.--
17 (1) No advisory organization shall conduct its
18 operations in this state unless and until it has filed with
19 the commission ~~department~~:
20 (a) A copy of its constitution, articles of
21 incorporation, articles of agreement or of association, and
22 bylaws or rules and regulations governing its activities, all
23 duly certified by the custodian of the originals thereof;
24 (b) A list of its members and subscribers; and
25 (c) The name and address of a resident of this state
26 upon whom notices or orders of the department or process may
27 be served.
28 (2) Every such advisory organization shall notify the
29 commission ~~department~~ promptly of every change in:
30 (a) Its constitution;
31 (b) Its articles of incorporation, agreement, or

1 association;
2 (c) Its bylaws, rules and regulations governing the
3 conduct of its business;
4 (d) The list of members and subscribers; and
5 (e) The name and address of the resident of this state
6 designated by it upon whom notices or orders of the commission
7 ~~department~~ or process affecting such organization may be
8 served.
9 (3) No such advisory organization shall engage in any
10 unfair or unreasonable practice with respect to such
11 activities.
12 Section 56. Subsection (4) of section 627.311, Florida
13 Statutes, is amended to read:
14 627.311 Joint underwriters and joint reinsurers.--
15 (4)(a) ~~Effective upon this act becoming a law,~~The
16 department shall, after consultation with insurers, approve a
17 joint underwriting plan of insurers which shall operate as a
18 nonprofit entity. For the purposes of this subsection, the
19 term "insurer" includes group self-insurance funds authorized
20 by s. 624.4621, commercial self-insurance funds authorized by
21 s. 624.462, assessable mutual insurers authorized under s.
22 628.6011, and insurers licensed to write workers' compensation
23 and employer's liability insurance in this state. The purpose
24 of the plan is to provide workers' compensation and employer's
25 liability insurance to applicants who are required by law to
26 maintain workers' compensation and employer's liability
27 insurance and who are in good faith entitled to but who are
28 unable to purchase such insurance through the voluntary
29 market. The joint underwriting plan shall issue policies
30 beginning January 1, 1994. The plan must have actuarially
31 sound rates that assure that the plan is self-supporting.

1 (b) The operation of the plan is subject to the
2 supervision of a 13-member board of governors. The board of
3 governors shall be comprised of:
4 1. Five of the 20 domestic insurers, as defined in s.
5 624.06(1), having the largest voluntary direct premiums
6 written in this state for workers' compensation and employer's
7 liability insurance, which shall be elected by those 20
8 domestic insurers;
9 2. Five of the 20 foreign insurers as defined in s.
10 624.06(2) having the largest voluntary direct premiums written
11 in this state for workers' compensation and employer's
12 liability insurance, which shall be elected by those 20
13 foreign insurers;
14 3. One person, who shall serve as the chair, appointed
15 by the Insurance Commissioner;
16 4. One person appointed by the largest property and
17 casualty insurance agents' association in this state; and
18 5. The consumer advocate appointed under s. 627.0613
19 or the consumer advocate's designee.
20
21 Each board member shall serve a 4-year term and may serve
22 consecutive terms. No board member shall be an insurer which
23 provides service to the plan or which has an affiliate which
24 provides services to the plan or which is serviced by a
25 service company or third-party administrator which provides
26 services to the plan or which has an affiliate which provides
27 services to the plan. The minutes, audits, and procedures of
28 the board of governors are subject to chapter 119.
29 (c) The operation of the plan shall be governed by a
30 plan of operation that is prepared at the direction of the
31 board of governors. The plan of operation may be changed at

any time by the board of governors or upon request of the department or commission. The plan of operation and all changes thereto are subject to the approval of the department, except that all changes related to rates are subject to approval of the commission. The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market. Any insured may voluntarily elect to accept coverage from an insurer for a premium equal to or greater than the plan premium if the insurer writing the coverage adheres to the provisions of s. 627.171.

3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.

4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:

a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

1 b. Developing forms and procedures that provide an
2 insurer with the information necessary to determine whether
3 the insurer wants to write particular applicants to the plan
4 or insureds of the plan.
5 c. Developing procedures for notice to the plan and
6 the applicant to the plan or insured of the plan that an
7 insurer will insure the applicant or the insured of the plan,
8 and notice of the cost of the coverage offered; and developing
9 procedures for the selection of an insuring entity by the
10 applicant or insured of the plan.
11 d. Provide for a market-assistance plan to assist in
12 the placement of employers. All applications for coverage in
13 the plan received 45 days before the effective date for
14 coverage shall be processed through the market-assistance
15 plan. A market-assistance plan specifically designed to serve
16 the needs of small good policyholders as defined by the board
17 must be finalized by January 1, 1994.
18 5. Provide for policy and claims services to the
19 insureds of the plan of the nature and quality provided for
20 insureds in the voluntary market.
21 6. Provide for the review of applications for coverage
22 with the plan for reasonableness and accuracy, using any
23 available historic information regarding the insured.
24 7. Provide for procedures for auditing insureds of the
25 plan which are based on reasonable business judgment and are
26 designed to maximize the likelihood that the plan will collect
27 the appropriate premiums.
28 8. Authorize the plan to terminate the coverage of and
29 refuse future coverage for any insured that submits a
30 fraudulent application to the plan or provides fraudulent or
31 grossly erroneous records to the plan or to any service

1 provider of the plan in conjunction with the activities of the
2 plan.
3 9. Establish service standards for agents who submit
4 business to the plan.
5 10. Establish criteria and procedures to prohibit any
6 agent who does not adhere to the established service standards
7 from placing business with the plan or receiving, directly or
8 indirectly, any commissions for business placed with the plan.
9 11. Provide for the establishment of reasonable safety
10 programs for all insureds in the plan.
11 12. Authorize the plan to terminate the coverage of
12 and refuse future coverage to any insured who fails to pay
13 premiums or surcharges when due; who, at the time of
14 application, is delinquent in payments of workers'
15 compensation or employer's liability insurance premiums or
16 surcharges owed to an insurer, group self-insurers' fund,
17 commercial self-insurance fund, or assessable mutual insurer
18 licensed to write such coverage in this state; or who refuses
19 to substantially comply with any safety programs recommended
20 by the plan.
21 13. Authorize the board of governors to provide the
22 services required by the plan through staff employed by the
23 plan, through reasonably compensated service providers who
24 contract with the plan to provide services as specified by the
25 board of governors, or through a combination of employees and
26 service providers.
27 14. Provide for service standards for service
28 providers, methods of determining adherence to those service
29 standards, incentives and disincentives for service, and
30 procedures for terminating contracts for service providers
31 that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the department on a date specified by the department and containing such information as the department reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate small-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. Establish three subplans as follows:

a. Subplan "A" must include those insureds whose annual premium does not exceed $2,500 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of their premium for the immediate 2 years.

b. Subplan "B" must include insureds that are employers identified by the board of governors as high-risk

employers due solely to the nature of the operations being performed by those insureds and for whom no market exists in the voluntary market, and whose experience modifications are less than 1.00.

c. Subplan "C" must include all other insureds within the plan.

(d) The plan must be funded through actuarially sound premiums charged to insureds of the plan. The plan may issue assessable policies only to those insureds in subplan "C." Those assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less 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

1 use.
2 (i) The decisions of the board of governors do not
3 constitute final agency action and are not subject to chapter
4 120.
5 (j) Policies for insureds shall be issued by the plan.
6 (k) The plan created under this subsection is liable
7 only for payment for losses arising under policies issued by
8 the plan with dates of accidents occurring on or after January
9 1, 1994.
10 (l) Plan losses are the sole and exclusive
11 responsibility of the plan, and payment for such losses must
12 be funded in accordance with this subsection and must not
13 come, directly or indirectly, from insurers or any guaranty
14 association for such insurers.
15 (m) Each joint underwriting plan or association
16 created under this section is not a state agency, board, or
17 commission. However, for the purposes of s. 199.183(1) only,
18 the joint underwriting plan is a political subdivision of the
19 state and is exempt from the corporate income tax.
20 (n) Each joint underwriting plan or association may
21 elect to pay premium taxes on the premiums received on its
22 behalf or may elect to have the member insurers to whom the
23 premiums are allocated pay the premium taxes if the member
24 insurer had written the policy. The joint underwriting plan or
25 association shall notify the member insurers and the
26 Department of Revenue by January 15 of each year of its
27 election for the same year. As used in this paragraph, the
28 term "premiums received" means the consideration for
29 insurance, by whatever name called, but does not include any
30 policy assessment or surcharge received by the joint
31 underwriting association as a result of apportioning losses or

1 deficits of the association pursuant to this section.
2 (o) Effective midnight, December 31, 1993, the Florida
3 Workers' Compensation Insurance Plan, administered by the
4 National Council on Compensation Insurance, shall terminate,
5 except with respect to workers' compensation policies issued
6 pursuant to such Florida Workers' Compensation Insurance Plan
7 with inception dates on or before December 31, 1993.
8 (p) Neither the plan nor any member of the board of
9 governors is liable for monetary damages to any person for any
10 statement, vote, decision, or failure to act, regarding the
11 management or policies of the plan, unless:
12 1. The member breached or failed to perform her or his
13 duties as a member; and
14 2. The member's breach of, or failure to perform,
15 duties constitutes:
16 a. A violation of the criminal law, unless the member
17 had reasonable cause to believe her or his conduct was
18 unlawful. A judgment or other final adjudication against a
19 member in any criminal proceeding for violation of the
20 criminal law estops that member from contesting the fact that
21 her or his breach, or failure to perform, constitutes a
22 violation of the criminal law; but does not estop the member
23 from establishing that she or he had reasonable cause to
24 believe that her or his conduct was lawful or had no
25 reasonable cause to believe that her or his conduct was
26 unlawful;
27 b. A transaction from which the member derived an
28 improper personal benefit, either directly or indirectly; or
29 c. Recklessness or any act or omission that was
30 committed in bad faith or with malicious purpose or in a
31 manner exhibiting wanton and willful disregard of human

1 rights, safety, or property. For purposes of this
2 sub-subparagraph, the term "recklessness" means the acting, or
3 omission to act, in conscious disregard of a risk:
4 (I) Known, or so obvious that it should have been
5 known, to the member; and
6 (II) Known to the member, or so obvious that it should
7 have been known, to be so great as to make it highly probable
8 that harm would follow from such act or omission.
9 (q) No insurer shall provide workers' compensation and
10 employer's liability insurance to any person who is delinquent
11 in the payment of premiums, assessments, penalties, or
12 surcharges owed to the plan.
13 (5) As used in this section and ss. 215.555 and
14 627.351, the term "collateral protection insurance" means
15 commercial property insurance of which a creditor is the
16 primary beneficiary and policyholder and which protects or
17 covers an interest of the creditor arising out of a credit
18 transaction secured by real or personal property. Initiation
19 of such coverage is triggered by the mortgagor's failure to
20 maintain insurance coverage as required by the mortgage or
21 other lending document. Collateral protection insurance is not
22 residential coverage.
23 Section 57. Subsection (6) of section 627.314, Florida
24 Statutes, is amended to read:
25 627.314 Concerted action by two or more insurers.--
26 (6) Notwithstanding any other provisions of this part,
27 insurers shall not participate directly or indirectly in the
28 deliberations or decisions of rating organizations on private
29 passenger automobile insurance. However, such rating
30 organizations shall, upon request of individual insurers, be
31 required to furnish at reasonable cost the rate indications

1 resulting from the loss and expense statistics gathered by
2 them. Individual insurers may modify the indications to
3 reflect their individual experience in determining their own
4 rates. Such rates shall be filed with the commission
5 ~~department~~ for public inspection whenever requested and shall
6 be available for public announcement only by the press,
7 commission ~~department~~, or insurer.
8 Section 58. Section 627.331, Florida Statutes, is
9 amended to read:
10 627.331 Recording and reporting of loss, expense, and
11 claims experience; rating information.--
12 (1) The commission ~~department~~ may adopt ~~promulgate~~
13 rules and statistical plans which shall thereafter be used by
14 each insurer in the recording and reporting of its loss,
15 expense, and claims experience, in order that the experience
16 of all insurers may be made available at least annually in
17 such form and detail as may be necessary to aid the department
18 in determining whether the insurer's activities comply with
19 the applicable standards of this code.
20 (2) In adopting ~~promulgating~~ such rules and plans, the
21 commission ~~department~~ shall give due consideration to the
22 rating systems in use in this state and, in order that such
23 rules and plans may be as uniform as is practicable among the
24 several states, to the rules and to the form of the plans used
25 for such rating systems in other states. No insurer shall be
26 required to record or report its loss experience on a
27 classification basis that is inconsistent with the rating
28 system used by it, except for motor vehicle insurance as
29 otherwise provided by law.
30 (3) The commission ~~department~~ may designate one or
31 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 surety insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but are unable to, procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance. Such agreements and rate modifications shall be subject to the approval of the department. The department shall, after consultation with the insurers licensed to write automobile liability insurance in this state, adopt a reasonable plan or plans for the equitable apportionment among such insurers of applicants for such insurance who are in good faith entitled to, but are unable to, procure such insurance through ordinary methods, and, when such plan has been adopted, all such insurers shall subscribe thereto and shall participate therein. Such plan or plans shall include rules for classification of risks and rates therefor. The plan or plans shall make available noncancelable coverage as provided in s. 627.7275(2). Any insured placed with the plan shall be notified of the fact that insurance coverage is being afforded through the plan and not through the private market, and such notification shall be given in writing within 10 days of such placement. To assure

1 that plan rates are made adequate to pay claims and expenses,
2 insurers shall develop a means of obtaining loss and expense
3 experience at least annually, and the plan shall file such
4 experience, when available, with the commission ~~department~~ in
5 sufficient detail to make a determination of rate adequacy.
6 Prior to the filing of such experience with the commission
7 ~~department~~, the plan shall poll each member insurer as to the
8 need for an actuary who is a member of the Casualty Actuarial
9 Society and who is not affiliated with the plan's statistical
10 agent to certify the plan's rate adequacy. If a majority of
11 those insurers responding indicate a need for such
12 certification, the plan shall include the certification as
13 part of its experience filing. Such experience shall be filed
14 with the commission ~~department~~ not more than 9 months
15 following the end of the annual statistical period under
16 review, together with a rate filing based on that ~~said~~
17 experience. The commission ~~department~~ shall initiate
18 proceedings to disapprove the rate and so notify the plan or
19 shall finalize its review within 60 days after ~~of~~ receipt of
20 the filing. Notification to the plan by the commission
21 ~~department~~ of its preliminary findings, which include a point
22 of entry to the plan pursuant to chapter 120, shall toll the
23 60-day period during any such proceedings and subsequent
24 judicial review. The rate shall be deemed approved if the
25 commission ~~department~~ does not issue notice to the plan of its
26 preliminary findings within 60 days of the filing. In
27 addition to provisions for claims and expenses, the ratemaking
28 formula shall include a factor for projected claims trending
29 and 5 percent for contingencies. In no instance shall the
30 formula include a renewal discount for plan insureds. However,
31 the plan shall reunderwrite each insured on an annual basis,

1 based upon all applicable rating factors approved by the
2 department. Trend factors shall not be found to be
3 inappropriate if not in excess of trend factors normally used
4 in the development of residual market rates by the appropriate
5 licensed rating organization. Each application for coverage
6 in the plan shall include, in boldfaced 12-point type
7 immediately preceding the applicant's signature, the following
8 statement:
9
10 "THIS INSURANCE IS BEING AFFORDED THROUGH THE
11 FLORIDA JOINT UNDERWRITING ASSOCIATION AND NOT
12 THROUGH THE PRIVATE MARKET. PLEASE BE ADVISED
13 THAT COVERAGE WITH A PRIVATE INSURER MAY BE
14 AVAILABLE FROM ANOTHER AGENT AT A LOWER COST.
15 AGENT AND COMPANY LISTINGS ARE AVAILABLE IN THE
16 LOCAL YELLOW PAGES."
17
18 The plan shall annually report to the commission
19 ~~department~~ the number and percentage of plan insureds
20 who are not surcharged due to their driving record.
21 (2) WINDSTORM INSURANCE RISK APPORTIONMENT.--
22 (a) Agreements may be made among property insurers
23 with respect to the equitable apportionment among them of
24 insurance which may be afforded applicants who are in good
25 faith entitled to, but are unable to procure, such insurance
26 through ordinary methods; and such insurers may agree among
27 themselves on the use of reasonable rate modifications for
28 such insurance. Such agreements and rate modifications shall
29 be subject to the applicable provisions of this chapter.
30 (b) The department shall require all insurers holding
31 a certificate of authority to transact property insurance on a

1 direct basis in this state, other than joint underwriting
2 associations and other entities formed pursuant to this
3 section, to provide windstorm coverage to applicants from
4 areas determined to be eligible pursuant to paragraph (c) who
5 in good faith are entitled to, but are unable to procure, such
6 coverage through ordinary means; or it shall adopt a
7 reasonable plan or plans for the equitable apportionment or
8 sharing among such insurers of windstorm coverage, which may
9 include formation of an association for this purpose. As used
10 in this subsection, the term "property insurance" means
11 insurance on real or personal property, as defined in s.
12 624.604, including insurance for fire, industrial fire, allied
13 lines, farmowners multiperil, homeowners' multiperil,
14 commercial multiperil, and mobile homes, and including
15 liability coverages on all such insurance, but excluding
16 inland marine as defined in s. 624.607(3) and excluding
17 vehicle insurance as defined in s. 624.605(1)(a) other than
18 insurance on mobile homes used as permanent dwellings. The
19 department shall adopt rules that provide a formula for the
20 recovery and repayment of any deferred assessments.
21 1. For the purpose of this section, properties
22 eligible for such windstorm coverage are defined as dwellings,
23 buildings, and other structures, including mobile homes which
24 are used as dwellings and which are tied down in compliance
25 with mobile home tie-down requirements prescribed by the
26 Department of Highway Safety and Motor Vehicles pursuant to s.
27 320.8325, and the contents of all such properties. An
28 applicant or policyholder is eligible for coverage only if an
29 offer of coverage cannot be obtained by or for the applicant
30 or policyholder from an admitted insurer at approved rates.
31 2.a.(I) All insurers required to be members of such

1 association shall participate in its writings, expenses, and
2 losses. Surplus of the association shall be retained for the
3 payment of claims and shall not be distributed to the member
4 insurers. Such participation by member insurers shall be in
5 the proportion that the net direct premiums of each member
6 insurer written for property insurance in this state during
7 the preceding calendar year bear to the aggregate net direct
8 premiums for property insurance of all member insurers, as
9 reduced by any credits for voluntary writings, in this state
10 during the preceding calendar year. For the purposes of this
11 subsection, the term "net direct premiums" means direct
12 written premiums for property insurance, reduced by premium
13 for liability coverage and for the following if included in
14 allied lines: rain and hail on growing crops; livestock;
15 association direct premiums booked; National Flood Insurance
16 Program direct premiums; and similar deductions specifically
17 authorized by the plan of operation and approved by the
18 department. A member's participation shall begin on the first
19 day of the calendar year following the year in which it is
20 issued a certificate of authority to transact property
21 insurance in the state and shall terminate 1 year after the
22 end of the calendar year during which it no longer holds a
23 certificate of authority to transact property insurance in the
24 state. The commissioner, after review of annual statements,
25 other reports, and any other statistics that the commissioner
26 deems necessary, shall certify to the association the
27 aggregate direct premiums written for property insurance in
28 this state by all member insurers.
29 (II) The plan of operation shall provide for a board
30 of directors consisting of the Insurance Consumer Advocate
31 appointed under s. 627.0613, 1 consumer representative

1 appointed by the Insurance Commissioner, 1 consumer
2 representative appointed by the Governor, and 12 additional
3 members appointed as specified in the plan of operation. One
4 of the 12 additional members shall be elected by the domestic
5 companies of this state on the basis of cumulative weighted
6 voting based on the net direct premiums of domestic companies
7 in this state. Nothing in the 1997 amendments to this
8 paragraph terminates the existing board or the terms of any
9 members of the board.
10 (III) The plan of operation shall provide a formula
11 whereby a company voluntarily providing windstorm coverage in
12 affected areas will be relieved wholly or partially from
13 apportionment of a regular assessment pursuant to
14 sub-sub-subparagraph d.(I) or sub-sub-subparagraph d.(II).
15 (IV) A company which is a member of a group of
16 companies under common management may elect to have its
17 credits applied on a group basis, and any company or group may
18 elect to have its credits applied to any other company or
19 group.
20 (V) There shall be no credits or relief from
21 apportionment to a company for emergency assessments collected
22 from its policyholders under sub-sub-subparagraph d.(III).
23 (VI) The plan of operation may also provide for the
24 award of credits, for a period not to exceed 3 years, from a
25 regular assessment pursuant to sub-sub-subparagraph d.(I) or
26 sub-sub-subparagraph d.(II) as an incentive for taking
27 policies out of the Residential Property and Casualty Joint
28 Underwriting Association. In order to qualify for the
29 exemption under this sub-sub-subparagraph, the take-out plan
30 must provide that at least 40 percent of the policies removed
31 from the Residential Property and Casualty Joint Underwriting

1 Association cover risks located in Dade, Broward, and Palm
2 Beach Counties or at least 30 percent of the policies so
3 removed cover risks located in Dade, Broward, and Palm Beach
4 Counties and an additional 50 percent of the policies so
5 removed cover risks located in other coastal counties, and
6 must also provide that no more than 15 percent of the policies
7 so removed may exclude windstorm coverage. With the approval
8 of the department, the association may waive these geographic
9 criteria for a take-out plan that removes at least the lesser
10 of 100,000 Residential Property and Casualty Joint
11 Underwriting Association policies or 15 percent of the total
12 number of Residential Property and Casualty Joint Underwriting
13 Association policies, provided the governing board of the
14 Residential Property and Casualty Joint Underwriting
15 Association certifies that the take-out plan will materially
16 reduce the Residential Property and Casualty Joint
17 Underwriting Association's 100-year probable maximum loss from
18 hurricanes. With the approval of the department, the board
19 may extend such credits for an additional year if the insurer
20 guarantees an additional year of renewability for all policies
21 removed from the Residential Property and Casualty Joint
22 Underwriting Association, or for 2 additional years if the
23 insurer guarantees 2 additional years of renewability for all
24 policies removed from the Residential Property and Casualty
25 Joint Underwriting Association.
26 b. Assessments to pay deficits in the association
27 under this subparagraph shall be included as an appropriate
28 factor in the making of rates as provided in s. 627.3512.
29 c. The Legislature finds that the potential for
30 unlimited deficit assessments under this subparagraph may
31 induce insurers to attempt to reduce their writings in the

1 voluntary market, and that such actions would worsen the
2 availability problems that the association was created to
3 remedy. It is the intent of the Legislature that insurers
4 remain fully responsible for paying regular assessments and
5 collecting emergency assessments for any deficits of the
6 association; however, it is also the intent of the Legislature
7 to provide a means by which assessment liabilities may be
8 amortized over a period of years.
9 d.(I) When the deficit incurred in a particular
10 calendar year is 10 percent or less of the aggregate statewide
11 direct written premium for property insurance for the prior
12 calendar year for all member insurers, the association shall
13 levy an assessment on member insurers in an amount equal to
14 the deficit.
15 (II) When the deficit incurred in a particular
16 calendar year exceeds 10 percent of the aggregate statewide
17 direct written premium for property insurance for the prior
18 calendar year for all member insurers, the association shall
19 levy an assessment on member insurers in an amount equal to
20 the greater of 10 percent of the deficit or 10 percent of the
21 aggregate statewide direct written premium for property
22 insurance for the prior calendar year for member insurers. Any
23 remaining deficit shall be recovered through emergency
24 assessments under sub-sub-subparagraph (III).
25 (III) Upon a determination by the board of directors
26 that a deficit exceeds the amount that will be recovered
27 through regular assessments on member insurers, pursuant to
28 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
29 board shall levy, after verification by the department,
30 emergency assessments to be collected by member insurers and
31 by underwriting associations created pursuant to this section

1 which write property insurance, upon issuance or renewal of
2 property insurance policies other than National Flood
3 Insurance policies in the year or years following levy of the
4 regular assessments. The amount of the emergency assessment
5 collected in a particular year shall be a uniform percentage
6 of that year's direct written premium for property insurance
7 for all member insurers and underwriting associations,
8 excluding National Flood Insurance policy premiums, as
9 annually determined by the board and verified by the
10 department. The department shall verify the arithmetic
11 calculations involved in the board's determination within 30
12 days after receipt of the information on which the
13 determination was based. Notwithstanding any other provision
14 of law, each member insurer and each underwriting association
15 created pursuant to this section shall collect emergency
16 assessments from its policyholders without such obligation
17 being affected by any credit, limitation, exemption, or
18 deferment. The emergency assessments so collected shall be
19 transferred directly to the association on a periodic basis as
20 determined by the association. The aggregate amount of
21 emergency assessments levied under this sub-sub-subparagraph
22 in any calendar year may not exceed the greater of 10 percent
23 of the amount needed to cover the original deficit, plus
24 interest, fees, commissions, required reserves, and other
25 costs associated with financing of the original deficit, or 10
26 percent of the aggregate statewide direct written premium for
27 property insurance written by member insurers and underwriting
28 associations for the prior year, plus interest, fees,
29 commissions, required reserves, and other costs associated
30 with financing the original deficit. The board may pledge the
31 proceeds of the emergency assessments under this

1 sub-sub-subparagraph as the source of revenue for bonds, to
2 retire any other debt incurred as a result of the deficit or
3 events giving rise to the deficit, or in any other way that
4 the board determines will efficiently recover the deficit. The
5 emergency assessments under this sub-sub-subparagraph shall
6 continue as long as any bonds issued or other indebtedness
7 incurred with respect to a deficit for which the assessment
8 was imposed remain outstanding, unless adequate provision has
9 been made for the payment of such bonds or other indebtedness
10 pursuant to the document governing such bonds or other
11 indebtedness. Emergency assessments collected under this
12 sub-sub-subparagraph are not part of an insurer's rates, are
13 not premium, and are not subject to premium tax, fees, or
14 commissions; however, failure to pay the emergency assessment
15 shall be treated as failure to pay premium.
16 (IV) Each member insurer's share of the total regular
17 assessments under sub-sub-subparagraph (I) or
18 sub-sub-subparagraph (II) shall be in the proportion that the
19 insurer's net direct premium for property insurance in this
20 state, for the year preceding the assessment bears to the
21 aggregate statewide net direct premium for property insurance
22 of all member insurers, as reduced by any credits for
23 voluntary writings for that year.
24 (V) If regular deficit assessments are made under
25 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), or by
26 the Residential Property and Casualty Joint Underwriting
27 Association under sub-subparagraph (6)(b)3.a. or
28 sub-subparagraph (6)(b)3.b., the association shall levy upon
29 the association's policyholders, as part of its next rate
30 filing, or by a separate rate filing solely for this purpose,
31 a market equalization surcharge in a percentage equal to the

1 total amount of such regular assessments divided by the
2 aggregate statewide direct written premium for property
3 insurance for member insurers for the prior calendar year.
4 Market equalization surcharges under this sub-sub-subparagraph
5 are not considered premium and are not subject to commissions,
6 fees, or premium taxes; however, failure to pay a market
7 equalization surcharge shall be treated as failure to pay
8 premium.
9 e. The governing body of any unit of local government,
10 any residents of which are insured under the plan, may issue
11 bonds as defined in s. 125.013 or s. 166.101 to fund an
12 assistance program, in conjunction with the association, for
13 the purpose of defraying deficits of the association. In order
14 to avoid needless and indiscriminate proliferation,
15 duplication, and fragmentation of such assistance programs,
16 any unit of local government, any residents of which are
17 insured by the association, may provide for the payment of
18 losses, regardless of whether or not the losses occurred
19 within or outside of the territorial jurisdiction of the local
20 government. Revenue bonds may not be issued until validated
21 pursuant to chapter 75, unless a state of emergency is
22 declared by executive order or proclamation of the Governor
23 pursuant to s. 252.36 making such findings as are necessary to
24 determine that it is in the best interests of, and necessary
25 for, the protection of the public health, safety, and general
26 welfare of residents of this state and the protection and
27 preservation of the economic stability of insurers operating
28 in this state, and declaring it an essential public purpose to
29 permit certain municipalities or counties to issue bonds as
30 will provide relief to claimants and policyholders of the
31 association and insurers responsible for apportionment of plan

losses. Any such unit of local government may enter into such contracts with the association and with any other entity created pursuant to this subsection as are necessary to carry out this paragraph. Any bonds issued under this sub-subparagraph shall be payable from and secured by moneys received by the association from assessments under this subparagraph, and assigned and pledged to or on behalf of the unit of local government for the benefit of the holders of such bonds. The funds, credit, property, and taxing power of the state or of the unit of local government shall not be pledged for the payment of such bonds. If any of the bonds remain unsold 60 days after issuance, the department shall require all insurers subject to assessment to purchase the bonds, which shall be treated as admitted assets; each insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the insurer's relative share of assessment liability under this subsection. An insurer shall not be required to purchase the bonds to the extent that the department determines that the purchase would endanger or impair the solvency of the insurer. The authority granted by this sub-subparagraph is additional to any bonding authority granted by subparagraph 6.

3. The plan shall also provide that any member with a surplus as to policyholders of $20 million or less writing 25 percent or more of its total countrywide property insurance premiums in this state may petition the department, within the first 90 days of each calendar year, to qualify as a limited apportionment company. The apportionment of such a member company in any calendar year for which it is qualified shall not exceed its gross participation, which shall not be affected by the formula for voluntary writings. In no event

1 shall a limited apportionment company be required to
2 participate in any apportionment of losses pursuant to
3 sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II)
4 in the aggregate which exceeds $50 million after payment of
5 available plan funds in any calendar year. However, a limited
6 apportionment company shall collect from its policyholders any
7 emergency assessment imposed under sub-sub-subparagraph
8 2.d.(III). The plan shall provide that, if the department
9 determines that any regular assessment will result in an
10 impairment of the surplus of a limited apportionment company,
11 the department may direct that all or part of such assessment
12 be deferred. However, there shall be no limitation or
13 deferment of an emergency assessment to be collected from
14 policyholders under sub-sub-subparagraph 2.d.(III).
15 4. The plan shall provide for the deferment, in whole
16 or in part, of a regular assessment of a member insurer under
17 sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II),
18 but not for an emergency assessment collected from
19 policyholders under sub-sub-subparagraph 2.d.(III), if, in the
20 opinion of the commissioner, payment of such regular
21 assessment would endanger or impair the solvency of the member
22 insurer. In the event a regular assessment against a member
23 insurer is deferred in whole or in part, the amount by which
24 such assessment is deferred may be assessed against the other
25 member insurers in a manner consistent with the basis for
26 assessments set forth in sub-sub-subparagraph 2.d.(I) or
27 sub-sub-subparagraph 2.d.(II).
28 5.a. The plan of operation may include deductibles and
29 rules for classification of risks and rate modifications
30 consistent with the objective of providing and maintaining
31 funds sufficient to pay catastrophe losses.

1 b. ~~The association may require arbitration of a rate~~
2 ~~filing under s. 627.062(6).~~It is the intent of the
3 Legislature that the rates for coverage provided by the
4 association be actuarially sound and not competitive with
5 approved rates charged in the admitted voluntary market such
6 that the association functions as a residual market mechanism
7 to provide insurance only when the insurance cannot be
8 procured in the voluntary market. The plan of operation shall
9 provide a mechanism to assure that, beginning no later than
10 January 1, 1999, the rates charged by the association for each
11 line of business are reflective of approved rates in the
12 voluntary market for hurricane coverage for each line of
13 business in the various areas eligible for association
14 coverage.
15 c. The association shall provide for windstorm
16 coverage on residential properties in limits up to $10 million
17 for commercial lines residential risks and up to $1 million
18 for personal lines residential risks. If coverage with the
19 association is sought for a residential risk valued in excess
20 of these limits, coverage shall be available to the risk up to
21 the replacement cost or actual cash value of the property, at
22 the option of the insured, if coverage for the risk cannot be
23 located in the authorized market. The association must accept
24 a commercial lines residential risk with limits above $10
25 million or a personal lines residential risk with limits above
26 $1 million if coverage is not available in the authorized
27 market. The association may write coverage above the limits
28 specified in this subparagraph with or without facultative or
29 other reinsurance coverage, as the association determines
30 appropriate.
31 d. The plan of operation must provide objective

1 criteria and procedures, approved by the department, to be
2 uniformly applied for all applicants in determining whether an
3 individual risk is so hazardous as to be uninsurable. In
4 making this determination and in establishing the criteria and
5 procedures, the following shall be considered:
6 (I) Whether the likelihood of a loss for the
7 individual risk is substantially higher than for other risks
8 of the same class; and
9 (II) Whether the uncertainty associated with the
10 individual risk is such that an appropriate premium cannot be
11 determined.
12
13 The acceptance or rejection of a risk by the association
14 pursuant to such criteria and procedures must be construed as
15 the private placement of insurance, and the provisions of
16 chapter 120 do not apply.
17 e. The policies issued by the association must provide
18 that if the association obtains an offer from an authorized
19 insurer to cover the risk at its approved rates under either a
20 standard policy including wind coverage or, if consistent with
21 the insurer's underwriting rules as filed with the department,
22 a basic policy including wind coverage, the risk is no longer
23 eligible for coverage through the association. Upon
24 termination of eligibility, the association shall provide
25 written notice to the policyholder and agent of record stating
26 that the association policy must be canceled as of 60 days
27 after the date of the notice because of the offer of coverage
28 from an authorized insurer. Other provisions of the insurance
29 code relating to cancellation and notice of cancellation do
30 not apply to actions under this sub-subparagraph.
31 f. Association policies and applications must include

1 a notice that the association policy could, under this
2 section, be replaced with a policy issued by an authorized
3 insurer that does not provide coverage identical to the
4 coverage provided by the association. The notice shall also
5 specify that acceptance of association coverage creates a
6 conclusive presumption that the applicant or policyholder is
7 aware of this potential.
8 6.a. The plan of operation may authorize the formation
9 of a private nonprofit corporation, a private nonprofit
10 unincorporated association, a partnership, a trust, a limited
11 liability company, or a nonprofit mutual company which may be
12 empowered, among other things, to borrow money by issuing
13 bonds or by incurring other indebtedness and to accumulate
14 reserves or funds to be used for the payment of insured
15 catastrophe losses. The plan may authorize all actions
16 necessary to facilitate the issuance of bonds, including the
17 pledging of assessments or other revenues.
18 b. Any entity created under this subsection, or any
19 entity formed for the purposes of this subsection, may sue and
20 be sued, may borrow money; issue bonds, notes, or debt
21 instruments; pledge or sell assessments, market equalization
22 surcharges and other surcharges, rights, premiums, contractual
23 rights, projected recoveries from the Florida Hurricane
24 Catastrophe Fund, other reinsurance recoverables, and other
25 assets as security for such bonds, notes, or debt instruments;
26 enter into any contracts or agreements necessary or proper to
27 accomplish such borrowings; and take other actions necessary
28 to carry out the purposes of this subsection. The association
29 may issue bonds or incur other indebtedness, or have bonds
30 issued on its behalf by a unit of local government pursuant to
31 subparagraph (g)2., in the absence of a hurricane or other

1 weather-related event, upon a determination by the association
2 subject to approval by the department that such action would
3 enable it to efficiently meet the financial obligations of the
4 association and that such financings are reasonably necessary
5 to effectuate the requirements of this subsection. Any such
6 entity may accumulate reserves and retain surpluses as of the
7 end of any association year to provide for the payment of
8 losses incurred by the association during that year or any
9 future year. The association shall incorporate and continue
10 the plan of operation and articles of agreement in effect on
11 the effective date of chapter 76-96, Laws of Florida, to the
12 extent that it is not inconsistent with chapter 76-96, and as
13 subsequently modified consistent with chapter 76-96. The board
14 of directors and officers currently serving shall continue to
15 serve until their successors are duly qualified as provided
16 under the plan. The assets and obligations of the plan in
17 effect immediately prior to the effective date of chapter
18 76-96 shall be construed to be the assets and obligations of
19 the successor plan created herein.
20 c. In recognition of s. 10, Art. I of the State
21 Constitution, prohibiting the impairment of obligations of
22 contracts, it is the intent of the Legislature that no action
23 be taken whose purpose is to impair any bond indenture or
24 financing agreement or any revenue source committed by
25 contract to such bond or other indebtedness issued or incurred
26 by the association or any other entity created under this
27 subsection.
28 7. On such coverage, an agent's remuneration shall be
29 that amount of money payable to the agent by the terms of his
30 or her contract with the company with which the business is
31 placed. However, no commission will be paid on that portion of

1 the premium which is in excess of the standard premium of that
2 company.
3 8. Subject to approval by the department, the
4 association may establish different eligibility requirements
5 and operational procedures for any line or type of coverage
6 for any specified eligible area or portion of an eligible area
7 if the board determines that such changes to the eligibility
8 requirements and operational procedures are justified due to
9 the voluntary market being sufficiently stable and competitive
10 in such area or for such line or type of coverage and that
11 consumers who, in good faith, are unable to obtain insurance
12 through the voluntary market through ordinary methods would
13 continue to have access to coverage from the association. When
14 coverage is sought in connection with a real property
15 transfer, such requirements and procedures shall not provide
16 for an effective date of coverage later than the date of the
17 closing of the transfer as established by the transferor, the
18 transferee, and, if applicable, the lender.
19 9. Notwithstanding any other provision of law:
20 a. The pledge or sale of, the lien upon, and the
21 security interest in any rights, revenues, or other assets of
22 the association created or purported to be created pursuant to
23 any financing documents to secure any bonds or other
24 indebtedness of the association shall be and remain valid and
25 enforceable, notwithstanding the commencement of and during
26 the continuation of, and after, any rehabilitation,
27 insolvency, liquidation, bankruptcy, receivership,
28 conservatorship, reorganization, or similar proceeding against
29 the association under the laws of this state or any other
30 applicable laws.
31 b. No such proceeding shall relieve the association of

1 its obligation, or otherwise affect its ability to perform its
2 obligation, to continue to collect, or levy and collect,
3 assessments, market equalization or other surcharges,
4 projected recoveries from the Florida Hurricane Catastrophe
5 Fund, reinsurance recoverables, or any other rights, revenues,
6 or other assets of the association pledged.
7 c. Each such pledge or sale of, lien upon, and
8 security interest in, including the priority of such pledge,
9 lien, or security interest, any such assessments, emergency
10 assessments, market equalization or renewal surcharges,
11 projected recoveries from the Florida Hurricane Catastrophe
12 Fund, reinsurance recoverables, or other rights, revenues, or
13 other assets which are collected, or levied and collected,
14 after the commencement of and during the pendency of or after
15 any such proceeding shall continue unaffected by such
16 proceeding.
17 d. As used in this subsection, the term "financing
18 documents" means any agreement, instrument, or other document
19 now existing or hereafter created evidencing any bonds or
20 other indebtedness of the association or pursuant to which any
21 such bonds or other indebtedness has been or may be issued and
22 pursuant to which any rights, revenues, or other assets of the
23 association are pledged or sold to secure the repayment of
24 such bonds or indebtedness, together with the payment of
25 interest on such bonds or such indebtedness, or the payment of
26 any other obligation of the association related to such bonds
27 or indebtedness.
28 e. Any such pledge or sale of assessments, revenues,
29 contract rights or other rights or assets of the association
30 shall constitute a lien and security interest, or sale, as the
31 case may be, that is immediately effective and attaches to

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

1 development is being deterred or otherwise stifled in such
2 county or area, mortgages are in default, and financial
3 institutions are unable to make loans;
4 b. The county or area so affected has adopted and is
5 enforcing the structural requirements of the State Minimum
6 Building Codes, as defined in s. 553.73, for new construction
7 and has included adequate minimum floor elevation requirements
8 for structures in areas subject to inundation; and
9 c. Extending windstorm insurance coverage to such
10 county or area is consistent with and will implement and
11 further the policies and objectives set forth in applicable
12 state laws, rules, and regulations governing coastal
13 management, coastal construction, comprehensive planning,
14 beach and shore preservation, barrier island preservation,
15 coastal zone protection, and the Coastal Zone Protection Act
16 of 1985.
17
18 Any time after the department has determined that the criteria
19 referred to in this subparagraph do not exist with respect to
20 any county or area of the state, it may, after a subsequent
21 public hearing, declare that such county or area is no longer
22 eligible for windstorm coverage through the plan.
23 (d) For the purpose of evaluating whether the criteria
24 of paragraph (c) are met, such criteria shall be applied as
25 the situation would exist if policies had not been written by
26 the Florida Residential Property and Casualty Joint
27 Underwriting Association and property insurance for such
28 policyholders was not available.
29 (e) Notwithstanding the provisions of subparagraph
30 (c)2. or paragraph (d), eligibility shall not be extended to
31 any area that was not eligible on March 1, 1997, except that

1 the department may act with respect to any petition on which a
2 hearing was held prior to May 9, 1997.
3 (4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
4 (a) The department shall, after consultation with
5 insurers as set forth in paragraph (b), adopt a joint
6 underwriting plan as set forth in paragraph (d).
7 (b) Entities licensed to issue casualty insurance as
8 defined in s. 624.605(1)(b), (k), and (q) and self-insurers
9 authorized to issue medical malpractice insurance under s.
10 627.357 shall participate in the plan and shall be members of
11 the Joint Underwriting Association.
12 (c) The Joint Underwriting Association shall operate
13 subject to the supervision and approval of a board of
14 governors consisting of representatives of five of the
15 insurers participating in the Joint Underwriting Association,
16 an attorney to be named by The Florida Bar, a physician to be
17 named by the Florida Medical Association, a dentist to be
18 named by the Florida Dental Association, and a hospital
19 representative to be named by the Florida Hospital
20 Association. The board of governors shall choose, during the
21 first meeting of the board after June 30 of each year, one of
22 its members to serve as chair of the board and another member
23 to serve as vice chair of the board. There shall be no
24 liability on the part of, and no cause of action of any nature
25 shall arise against, any member insurer, self-insurer, or its
26 agents or employees, the Joint Underwriting Association or its
27 agents or employees, members of the board of governors, or the
28 department or its representatives for any action taken by them
29 in the performance of their powers and duties under this
30 subsection.
31 (d) The plan shall provide coverage for claims arising

out of the rendering of, or failure to render, medical care or services and, in the case of health care facilities, coverage for bodily injury or property damage to the person or property of any patient arising out of the insured's activities, in appropriate policy forms for all health care providers as 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

1 million per claim, $5 million annual aggregate for hospitals.
2 Such coverage for health care providers other than hospitals
3 shall be available as primary coverage and as excess coverage
4 for the layer of coverage between the primary coverage and the
5 total limits of $250,000 per claim, $750,000 annual aggregate.
6 The plan shall also provide tail coverage in these amounts to
7 insureds whose claims-made coverage with another insurer or
8 trust has or will be terminated. Such tail coverage shall
9 provide coverage for incidents that occurred during the
10 claims-made policy period for which a claim is made after the
11 policy period.
12 5. A risk management program for insureds of the
13 association. This program shall include, but not be limited
14 to: investigation and analysis of frequency, severity, and
15 causes of adverse or untoward medical injuries; development of
16 measures to control these injuries; systematic reporting of
17 medical incidents; investigation and analysis of patient
18 complaints; and auditing of association members to assure
19 implementation of this program. The plan may refuse to insure
20 any insured who refuses or fails to comply with the risk
21 management program implemented by the association. Prior to
22 cancellation or refusal to renew an insured, the association
23 shall provide the insured 60 days' notice of intent to cancel
24 or nonrenew and shall further notify the insured of any action
25 which must be taken to be in compliance with the risk
26 management program.
27 (e) In the event an underwriting deficit exists for
28 any policy year the plan is in effect, any surplus which has
29 accrued from previous years and is not projected within
30 reasonable actuarial certainty to be needed for payment of
31 claims in the year the surplus arose shall be used to offset

the deficit to the extent available.

1. As to remaining deficit, except those relating to deficit assessment coverage, each policyholder shall pay to the association a premium contingency assessment not to exceed one-third of the premium payment paid by such policyholder to the association for that policy year. The association shall pay no further claims on any policy for the policyholder who fails to pay the premium contingency assessment.

2. If there is any remaining deficit under the plan after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct premiums of each such member written during the calendar year immediately preceding the end of the policy year for which there is a deficit assessment bear to the aggregate net direct premiums written in this state by all members of the association. The term "premiums" as used herein means premiums for the lines of insurance defined in s. 624.605(1)(b), (k), and (q), including premiums for such coverage issued under package policies.

(f) The plan shall provide for one or more insurers able and willing to provide policy service through licensed resident agents and claims service on behalf of all other insurers participating in the plan. In the event no insurer is able and willing to provide such services, the Joint Underwriting Association is authorized to perform any and all such services.

(g) All books, records, documents, or audits relating to the Joint Underwriting Association or its operation shall be open to public inspection, except that a claim file in the possession of the Joint Underwriting Association is

1 confidential and exempt from the provisions of s. 119.07(1)
2 during the processing of that claim. Any information
3 contained in these files that identifies an injured person is
4 confidential and exempt from the provisions of s. 119.07(1).
5 (h) As used in this subsection:
6 1. "Health care provider" means hospitals licensed
7 under chapter 395; physicians licensed under chapter 458;
8 osteopathic physicians licensed under chapter 459; podiatric
9 physicians licensed under chapter 461; dentists licensed under
10 chapter 466; chiropractic physicians licensed under chapter
11 460; naturopaths licensed under chapter 462; nurses licensed
12 under chapter 464; midwives licensed under chapter 467;
13 clinical laboratories registered under chapter 483; physician
14 assistants licensed under chapter 458 or chapter 459; physical
15 therapists and physical therapist assistants licensed under
16 chapter 486; health maintenance organizations certificated
17 under part I of chapter 641; ambulatory surgical centers
18 licensed under chapter 395; other medical facilities as
19 defined in subparagraph 2.; blood banks, plasma centers,
20 industrial clinics, and renal dialysis facilities; or
21 professional associations, partnerships, corporations, joint
22 ventures, or other associations for professional activity by
23 health care providers.
24 2. "Other medical facility" means a facility the
25 primary purpose of which is to provide human medical
26 diagnostic services or a facility providing nonsurgical human
27 medical treatment, to which facility the patient is admitted
28 and from which facility the patient is discharged within the
29 same working day, and which facility is not part of a
30 hospital. However, a facility existing for the primary
31 purpose of performing terminations of pregnancy or an office

1 maintained by a physician or dentist for the practice of
2 medicine shall not be construed to be an "other medical
3 facility."
4 3. "Health care facility" means any hospital licensed
5 under chapter 395, health maintenance organization
6 certificated under part I of chapter 641, ambulatory surgical
7 center licensed under chapter 395, or other medical facility
8 as defined in subparagraph 2.
9 (i) The manager of the plan or the manager's assistant
10 is the agent for service of process for the plan.
11 (5) PROPERTY AND CASUALTY INSURANCE RISK
12 APPORTIONMENT.--The department shall adopt by rule a joint
13 underwriting plan to equitably apportion among insurers
14 authorized in this state to write property insurance as
15 defined in s. 624.604 or casualty insurance as defined in s.
16 624.605, the underwriting of one or more classes of property
17 insurance or casualty insurance, except for the types of
18 insurance that are included within property insurance or
19 casualty insurance for which an equitable apportionment plan,
20 assigned risk plan, or joint underwriting plan is authorized
21 under s. 627.311 or subsection (1), subsection (2), subsection
22 (3), subsection (4), or subsection (6) and except for risks
23 eligible for flood insurance written through the federal flood
24 insurance program to persons with risks eligible under
25 subparagraph (a)1. and who are in good faith entitled to, but
26 are unable to, obtain such property or casualty insurance
27 coverage, including excess coverage, through the voluntary
28 market. For purposes of this subsection, an adequate level of
29 coverage means that coverage which is required by state law or
30 by responsible or prudent business practices. The Joint
31 Underwriting Association shall not be required to provide

1 coverage for any type of risk for which there are no insurers
2 providing similar coverage in this state. The department may
3 designate one or more participating insurers who agree to
4 provide policyholder and claims service, including the
5 issuance of policies, on behalf of the participating insurers.
6 (a) The plan shall provide:
7 1. A means of establishing eligibility of a risk for
8 obtaining insurance through the plan, which provides that:
9 a. A risk shall be eligible for such property
10 insurance or casualty insurance as is required by Florida law
11 if the insurance is unavailable in the voluntary market,
12 including the market assistance program and the surplus lines
13 market.
14 b. A commercial risk not eligible under
15 sub-subparagraph a. shall be eligible for property or casualty
16 insurance if:
17 (I) The insurance is unavailable in the voluntary
18 market, including the market assistance plan and the surplus
19 lines market;
20 (II) Failure to secure the insurance would
21 substantially impair the ability of the entity to conduct its
22 affairs; and
23 (III) The risk is not determined by the Risk
24 Underwriting Committee to be uninsurable.
25 c. In the event the Federal Government terminates the
26 Federal Crime Insurance Program established under 44 C.F.R.
27 ss. 80-83, Florida commercial and residential risks previously
28 insured under the federal program shall be eligible under the
29 plan.
30 d.(I) In the event a risk is eligible under this
31 paragraph and in the event the market assistance plan receives

1 a minimum of 100 applications for coverage within a 3-month
2 period, or 200 applications for coverage within a 1-year
3 period or less, for a given class of risk contained in the
4 classification system defined in the plan of operation of the
5 Joint Underwriting Association, and unless the market
6 assistance plan provides a quotation for at least 80 percent
7 of such applicants, such classification shall immediately be
8 eligible for coverage in the Joint Underwriting Association.
9 (II) Any market assistance plan application which is
10 rejected because an individual risk is so hazardous as to be
11 practically uninsurable, considering whether the likelihood of
12 a loss for such a risk is substantially higher than for other
13 risks of the same class due to individual risk
14 characteristics, prior loss experience, unwillingness to
15 cooperate with a prior insurer, physical characteristics and
16 physical location shall not be included in the minimum
17 percentage calculation provided above. In the event that there
18 is any legal or administrative challenge to a determination by
19 the department that the conditions of this subparagraph have
20 been met for eligibility for coverage in the Joint
21 Underwriting Association for a given classification, any
22 eligible risk may obtain coverage during the pendency of any
23 such challenge.
24 e. In order to qualify as a quotation for the purpose
25 of meeting the minimum percentage calculation in this
26 subparagraph, the quoted premium must meet the following
27 criteria:
28 (I) In the case of an admitted carrier, the quoted
29 premium must not exceed the premium available for a given
30 classification currently in use by the Joint Underwriting
31 Association or the premium developed by using the rates and

1 rating plans on file with the department by the quoting
2 insurer, whichever is greater.
3 (II) In the case of an authorized surplus lines
4 insurer, the quoted premium must not exceed the premium
5 available for a given classification currently in use by the
6 Joint Underwriting Association by more than 25 percent, after
7 consideration of any individual risk surcharge or credit.
8 f. Any agent who falsely certifies the unavailability
9 of coverage as provided by sub-subparagraphs a. and b., is
10 subject to the penalties provided in s. 626.611.
11 2. A means for the equitable apportionment of profits
12 or losses and expenses among participating insurers.
13 3. Rules for the classification of risks and rates
14 which reflect the past and prospective loss experience.
15 4. A rating plan which reasonably reflects the prior
16 claims experience of the insureds. Such rating plan shall
17 include at least two levels of rates for risks that have
18 favorable loss experience and risks that have unfavorable loss
19 experience, as established by the plan.
20 5. Reasonable limits to available amounts of
21 insurance. Such limits may not be less than the amounts of
22 insurance required of eligible risks by Florida law.
23 6. Risk management requirements for insurance where
24 such requirements are reasonable and are expected to reduce
25 losses.
26 7. Deductibles as may be necessary to meet the needs
27 of insureds.
28 8. Policy forms which are consistent with the forms in
29 use by the majority of the insurers providing coverage in the
30 voluntary market for the coverage requested by the applicant.
31 9. A means to remove risks from the plan once such

1 risks no longer meet the eligibility requirements of this
2 paragraph. For this purpose, the plan shall include the
3 following requirements: At each 6-month interval after the
4 activation of any class of insureds, the board of governors or
5 its designated committee shall review the number of
6 applications to the market assistance plan for that class. If,
7 based on these latest numbers, at least 90 percent of such
8 applications have been provided a quotation, the Joint
9 Underwriting Association shall cease underwriting new
10 applications for such class within 30 days, and notification
11 of this decision shall be sent to the Insurance Commissioner,
12 the major agents' associations, and the board of directors of
13 the market assistance plan. A quotation for the purpose of
14 this subparagraph shall meet the same criteria for a quotation
15 as provided in sub-subparagraph d. All policies which were
16 previously written for that class shall continue in force
17 until their normal expiration date, at which time, subject to
18 the required timely notification of nonrenewal by the Joint
19 Underwriting Association, the insured may then elect to
20 reapply to the Joint Underwriting Association according to the
21 requirements of eligibility. If, upon reapplication, those
22 previously insured Joint Underwriting Association risks meet
23 the eligibility requirements, the Joint Underwriting
24 Association shall provide the coverage requested.
25 10. A means for providing credits to insurers against
26 any deficit assessment levied pursuant to paragraph (c), for
27 risks voluntarily written through the market assistance plan
28 by such insurers.
29 11. That the Joint Underwriting Association shall
30 operate subject to the supervision and approval of a board of
31 governors consisting of 13 individuals appointed by the

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

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

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

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

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

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

1 The acceptance or rejection of a risk by the underwriting
2 committee shall be construed as the private placement of
3 insurance, and the provisions of chapter 120 shall not apply.
4 (f) There shall be no liability on the part of, and no
5 cause of action of any nature shall arise against, any member
6 insurer or its agents or employees, the Florida Property and
7 Casualty Joint Underwriting Association or its agents or
8 employees, members of the board of governors, or the
9 department or its representatives for any action taken by them
10 in the performance of their duties under this subsection. Such
11 immunity does not apply to actions for breach of any contract
12 or agreement pertaining to insurance, or any other willful
13 tort.
14 (6) RESIDENTIAL PROPERTY AND CASUALTY JOINT
15 UNDERWRITING ASSOCIATION.--
16 (a) There is created a joint underwriting association
17 for equitable apportionment or sharing among insurers of
18 property and casualty insurance covering residential property,
19 for applicants who are in good faith entitled, but are unable,
20 to procure insurance through the voluntary market. The
21 association shall operate pursuant to a plan of operation
22 approved by order of the department. The plan is subject to
23 continuous review by the department. The department may, by
24 order, withdraw approval of all or part of a plan if the
25 department determines that conditions have changed since
26 approval was granted and that the purposes of the plan require
27 changes in the plan. For the purposes of this subsection,
28 residential coverage includes both personal lines residential
29 coverage, which consists of the type of coverage provided by
30 homeowner's, mobile home owner's, dwelling, tenant's,
31 condominium unit owner's, and similar policies, and commercial

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

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

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

result of deficits or events giving rise to deficits, or in any other way that the board determines will efficiently recover such deficits. The purpose of the lines of credit or other financing mechanisms is to provide additional resources to assist the association in covering claims and expenses attributable to a catastrophe. As used in this subsection, the term "assessments" includes regular assessments under sub-subparagraph a., sub-subparagraph b., or subparagraph (g)1. and emergency assessments under sub-subparagraph d. Emergency assessments collected under sub-subparagraph d. are not part of an insurer's rates, are not premium, and are not subject to premium tax, fees, or commissions; however, failure to pay the emergency assessment shall be treated as failure to pay premium. The emergency assessments under sub-subparagraph d. shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the payment of such bonds or other indebtedness pursuant to the documents governing such bonds or other indebtedness.

f. As used in this subsection, the term "subject lines of business" means, with respect to the personal lines account, any personal lines policy defined in s. 627.4025, and means, with respect to the commercial lines account, all commercial property and commercial fire insurance.

(c) The plan of operation of the association:

1. May provide for one or more designated insurers, able and willing to provide policy and claims service, to act on behalf of the association to provide such service. Each licensed agent shall be entitled to indicate the order of preference regarding who will service the business placed by

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

1 of full coverage obtainable for commercial residential
2 structures in the admitted voluntary market.
3 f. Commercial lines residential policy forms without
4 wind coverage, which are the same as the policies described in
5 sub-subparagraph e. except that they do not include wind
6 coverage.
7 3. May provide that the association may employ or
8 otherwise contract with individuals or other entities to
9 provide administrative or professional services that may be
10 appropriate to effectuate the plan. The association shall
11 have the power to borrow funds, by issuing bonds or by
12 incurring other indebtedness, and shall have other powers
13 reasonably necessary to effectuate the requirements of this
14 subsection. The association may issue bonds or incur other
15 indebtedness, or have bonds issued on its behalf by a unit of
16 local government pursuant to subparagraph (g)2., in the
17 absence of a hurricane or other weather-related event, upon a
18 determination by the association, subject to approval by the
19 department, that such action would enable it to efficiently
20 meet the financial obligations of the association and that
21 such financings are reasonably necessary to effectuate the
22 requirements of this subsection. The association is
23 authorized to take all actions needed to facilitate tax-free
24 status for any such bonds or indebtedness, including formation
25 of trusts or other affiliated entities. The association shall
26 have the authority to pledge assessments, projected recoveries
27 from the Florida Hurricane Catastrophe Fund, other reinsurance
28 recoverables, market equalization and other surcharges, and
29 other funds available to the association as security for bonds
30 or other indebtedness. In recognition of s. 10, Art. I of the
31 State Constitution, prohibiting the impairment of obligations

1 of contracts, it is the intent of the Legislature that no
2 action be taken whose purpose is to impair any bond indenture
3 or financing agreement or any revenue source committed by
4 contract to such bond or other indebtedness.
5 4. Must require that the association operate subject
6 to the supervision and approval of a board of governors
7 consisting of 13 individuals, including 1 who is elected as
8 chair. The board shall consist of:
9 a. The insurance consumer advocate appointed under s.
10 627.0613.
11 b. Five members designated by the insurance industry.
12 c. Five consumer representatives appointed by the
13 Insurance Commissioner. Two of the consumer representatives
14 must, at the time of appointment, be holders of policies
15 issued by the association, who are selected with consideration
16 given to reflecting the geographic balance of association
17 policyholders. Two of the consumer members must be individuals
18 who are minority persons as defined in s. 288.703(3). One of
19 the consumer members shall have expertise in the field of
20 mortgage lending.
21 d. Two representatives of the insurance industry
22 appointed by the Insurance Commissioner. Of the two insurance
23 industry representatives appointed by the Insurance
24 Commissioner, at least one must be an individual who is a
25 minority person as defined in s. 288.703(3).
26
27 Any board member may be disapproved or removed and replaced by
28 the commissioner at any time for cause. All board members,
29 including the chair, must be appointed to serve for 3-year
30 terms beginning annually on a date designated by the plan.
31 5. Must provide a procedure for determining the

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

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

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

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 2. For each county, the average rates of the

association for each line of business for personal lines residential policies shall be no lower than the average rates charged by the insurer that had the highest average rate in that county among the 20 insurers with the greatest total direct written premium in the state for that line of business in the preceding year, except that with respect to mobile home coverages, the average rates of the association shall be no lower than the average rates charged by the insurer that had the highest average rate in that county among the 5 insurers with the greatest total written premium for mobile home owner's policies in the state in the preceding year.

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

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

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

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

1. If the market assistance plan receives a minimum of 100 applications for coverage within a 3-month period, or 200

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

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

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

writings, but must adopt at least a credit against assessment liability or other liability that provides an incentive for insurers to take risks out of the association and to keep risks out of the association by maintaining or increasing voluntary writings in counties in which association risks are highly concentrated and a program to provide a formula under which an insurer voluntarily taking risks out of the association by maintaining or increasing voluntary writings will be relieved wholly or partially from assessments under sub-subparagraphs (b)3.a. and b.

b. Any credit or exemption from regular assessments adopted under this subparagraph shall last no longer than the 3 years following the cancellation or expiration of the policy by the association. With the approval of the department, the board may extend such credits for an additional year if the insurer guarantees an additional year of renewability for all policies removed from the association, or for 2 additional years if the insurer guarantees 2 additional years of renewability for all policies so removed.

c. There shall be no credit, limitation, exemption, or deferment from emergency assessments to be collected from policyholders pursuant to sub-subparagraph (b)3.d.

4. The plan shall provide for the deferment, in whole or in part, of the assessment of a member insurer, other than an emergency assessment collected from policyholders pursuant to sub-subparagraph (b)3.d., if the department finds that payment of the assessment would endanger or impair the solvency of the insurer. In the event an 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

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

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

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

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

investigation, until the investigation is closed or ceases to be active. An investigation is considered "active" while the investigation is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings.

d. Matters reasonably encompassed in privileged attorney-client communications.

e. Proprietary information licensed to the association under contract and the contract provides for the confidentiality of such proprietary information.

f. All information relating to the medical condition or medical status of an association employee which is not relevant to the employee's capacity to perform his or her duties, except as otherwise provided in this paragraph. Information which is exempt shall include, but is not limited to, information relating to workers' compensation, insurance benefits, and retirement or disability benefits.

g. Upon an employee's entrance into the employee assistance program, a program to assist any employee who has a behavioral or medical disorder, substance abuse problem, or emotional difficulty which affects the employee's job performance, all records relative to that participation shall be confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, except as otherwise provided in s. 112.0455(11).

h. Information relating to negotiations for financing, reinsurance, depopulation, or contractual services, until the conclusion of the negotiations.

i. Minutes of closed meetings regarding underwriting files, and minutes of closed meetings regarding an open claims file until termination of all litigation and settlement of all

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

1 confidential open claims files are discussed. All portions of
2 association meetings which are closed to the public shall be
3 recorded by a court reporter. The court reporter shall record
4 the times of commencement and termination of the meeting, all
5 discussion and proceedings, the names of all persons present
6 at any time, and the names of all persons speaking. No
7 portion of any closed meeting shall be off the record.
8 Subject to the provisions hereof and s. 119.07(2)(a), the
9 court reporter's notes of any closed meeting shall be retained
10 by the association for a minimum of 5 years. A copy of the
11 transcript, less any exempt matters, of any closed meeting
12 wherein claims are discussed shall become public as to
13 individual claims after settlement of the claim.
14 Section 60. Subsections (3) and (4) of section
15 627.3512, Florida Statutes, are amended to read:
16 627.3512 Recoupment of residual market deficit
17 assessments.--
18 (3) The insurer or insurer group shall file with the
19 commission ~~department~~ a statement setting forth the amount of
20 the assessment factor and an explanation of how the factor
21 will be applied, at least 15 days prior to the factor being
22 applied to any policies. The statement shall include
23 documentation of the assessment paid by the insurer or insurer
24 group and the arithmetic calculations supporting the
25 assessment factor. The commission ~~department~~ shall complete
26 its review within 15 days after receipt of the filing and
27 shall limit its review to verification of the arithmetic
28 calculations. The insurer or insurer group may use the
29 assessment factor at any time after the expiration of the
30 15-day period unless the commission ~~department~~ has notified
31 the insurer or insurer group in writing that the arithmetic

calculations are incorrect.

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

Section 61. Subsection (8) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

(8) The expense factors associated with rates used by a fund shall be filed with the commission ~~department~~ at least 30 days prior to use and may not be used until approved by the commission ~~department~~. The commission ~~department~~ shall disapprove the rates unless the filed expense factors associated therewith are justified and reasonable for the benefits and services provided.

Section 62. Section 627.361, Florida Statutes, is amended to read:

627.361 False or misleading information.--No person shall willfully withhold information from or knowingly give false or misleading information to the department, commission, any statistical agency designated by the department or commission, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this part.

Section 63. Subsections (6), (7), and (8) of section 627.410, Florida Statutes, are amended to read:

627.410 Filing, approval of forms.--

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the commission ~~department~~ a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the commission ~~department~~ applicable premium

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

1 authorized by law, order the insurer to discontinue the
2 issuance of policies for which the required filing was not
3 made, until ~~such time as~~ the commission ~~department~~ determines
4 that the required filing is properly submitted.
5 (8)(a) For the purposes of subsections (6) and (7),
6 benefits of an individual accident and health insurance policy
7 form, including Medicare supplement policies as defined in s.
8 627.672, when authorized by rules adopted by the commission
9 ~~department~~, and excluding long-term care insurance policies as
10 defined in s. 627.9404, and other policy forms under which
11 more than 50 percent of the policies are issued to individuals
12 age 65 and over, are deemed to be reasonable in relation to
13 premium rates if the rates are filed pursuant to a loss ratio
14 guarantee and both the initial rates and the durational and
15 lifetime loss ratios have been approved by the commission
16 ~~department~~, and such benefits shall continue to be deemed
17 reasonable for renewal rates while the insurer complies with
18 such guarantee, provided the currently expected lifetime loss
19 ratio is not more than 5 percent less than the filed lifetime
20 loss ratio as certified to by an actuary. The commission
21 ~~department~~ shall have the right to bring an administrative
22 action should it deem that the lifetime loss ratio will not be
23 met. For Medicare supplement filings, the commission
24 ~~department~~ may withdraw a previously approved filing which was
25 made pursuant to a loss ratio guarantee if it determines that
26 the filing is not in compliance with ss. 627.671-627.675 or
27 the currently expected lifetime loss ratio is less than the
28 filed lifetime loss ratio as certified by an actuary in the
29 initial guaranteed loss ratio filing. If this section
30 conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall
31 control.

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

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

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

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

4. A guarantee that affected policyholders in this

state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the commission ~~department~~ has adequate time to review the report.

5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years 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

1 attributable solely to this state if there are 2,000 or more
2 policyholders in the state. If there are 500 or more
3 policyholders in this state but less than 2,000, it is the
4 linear interpolation of the nationwide loss ratio and the loss
5 ratio for this state. If there are less than 500
6 policyholders in this state, it is the nationwide loss ratio.
7 3. "Experience period" means the period, ordinarily a
8 calendar year, for which a loss ratio guarantee is calculated.
9 Section 64. Section 627.411, Florida Statutes, is
10 amended to read:
11 627.411 Grounds for disapproval.--
12 (1) The department shall disapprove any form filed
13 under s. 627.410(1)-(5)~~s. 627.410~~, or withdraw any previous
14 approval thereof, only if the form:
15 (a) Is in any respect in violation of, or does not
16 comply with, this code.
17 (b) Contains or incorporates by reference, where such
18 incorporation is otherwise permissible, any inconsistent,
19 ambiguous, or misleading clauses, or exceptions and conditions
20 which deceptively affect the risk purported to be assumed in
21 the general coverage of the contract.
22 (c) Has any title, heading, or other indication of its
23 provisions which is misleading.
24 (d) Is printed or otherwise reproduced in such manner
25 as to render any material provision of the form substantially
26 illegible.
27 (e) Is for health insurance~~,~~and ~~provides benefits~~
28 ~~which are unreasonable in relation to the premium charged,~~
29 contains provisions that ~~which~~ are unfair or inequitable or
30 contrary to the public policy of this state or that ~~which~~
31 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.

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

(d) Acquisition costs.

Section 65. Paragraph (c) of subsection (7) of section 627.6475, Florida Statutes, is amended to read:

627.6475 Individual reinsurance pool.--

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

(c)1. The board, as part of the plan of operation,

1 shall establish a methodology for determining premium rates to
2 be charged by the program for reinsuring eligible individuals
3 pursuant to this section. The methodology must include a
4 system for classifying individuals which reflects the types of
5 case characteristics commonly used by carriers in this state.
6 The methodology must provide for the development of basic
7 reinsurance premium rates, which shall be multiplied by the
8 factors set for them in this paragraph to determine the
9 premium rates for the program. The basic reinsurance premium
10 rates shall be established by the board, subject to the
11 approval of the commission ~~department~~, and shall be set at
12 levels that reasonably approximate gross premiums charged to
13 eligible individuals for individual health insurance by health
14 insurance issuers. The premium rates set by the board may vary
15 by geographical area, as determined under this section, to
16 reflect differences in cost. An eligible individual may be
17 reinsured for a rate that is five times the rate established
18 by the board.
19 2. The board shall periodically review the methodology
20 established, including the system of classification and any
21 rating factors, to ensure that it reasonably reflects the
22 claims experience of the program. The board may propose
23 changes to the rates that are subject to the approval of the
24 commission ~~department~~.
25 Section 66. Paragraph (a) of subsection (4) of section
26 627.6498, Florida Statutes, is amended to read:
27 627.6498 Minimum benefits coverage; exclusions;
28 premiums; deductibles.--
29 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--
30 (a) The plan shall provide for annual deductibles for
31 major medical expense coverage in the amount of $1,000 or any

1 higher amounts proposed by the board and approved by the
2 commission ~~department~~, plus the benefits payable under any
3 other type of insurance coverage or workers' compensation.
4 The schedule of premiums and deductibles shall be established
5 by the association. With regard to any preferred provider
6 arrangement used ~~utilized~~ by the association, the deductibles
7 provided in this paragraph shall be the minimum deductibles
8 applicable to the preferred providers and higher deductibles,
9 as approved by the department, may be applied to providers who
10 are not preferred providers.

11 1. Separate schedules of premium rates based on age
12 may apply for individual risks.

13 2. Rates are subject to approval by the commission
14 ~~department~~.

15 3. Standard risk rates for coverages issued by the
16 association shall be established by the commission ~~department~~,
17 pursuant to s. 627.6675(3).

18 4. The board shall establish separate premium
19 schedules for low-risk individuals, medium-risk individuals,
20 and high-risk individuals and shall revise premium schedules
21 annually beginning January 1999. No rate shall exceed 200
22 percent of the standard risk rate for low-risk individuals,
23 225 percent of the standard risk rate for medium-risk
24 individuals, or 250 percent of the standard risk rate for
25 high-risk individuals. For the purpose of determining what
26 constitutes a low-risk individual, medium-risk individual, or
27 high-risk individual, the board shall consider the anticipated
28 claims payment for individuals based upon an individual's
29 health condition.

30 Section 67. Section 627.6675, Florida Statutes, is
31 amended to read:

1 627.6675 Conversion on termination of
2 eligibility.--Subject to all of the provisions of this
3 section, a group policy delivered or issued for delivery in
4 this state by an insurer or nonprofit health care services
5 plan that provides, on an expense-incurred basis, hospital,
6 surgical, or major medical expense insurance, or any
7 combination of these coverages, shall provide that an employee
8 or member whose insurance under the group policy has been
9 terminated for any reason, including discontinuance of the
10 group policy in its entirety or with respect to an insured
11 class, and who has been continuously insured under the group
12 policy, and under any group policy providing similar benefits
13 that the terminated group policy replaced, for at least 3
14 months immediately prior to termination, shall be entitled to
15 have issued to him or her by the insurer a policy or
16 certificate of health insurance, referred to in this section
17 as a "converted policy." A group insurer may meet the
18 requirements of this section by contracting with another
19 insurer, authorized in this state, to issue an individual
20 converted policy, which policy has been approved by the
21 department under s. 627.410. An employee or member shall not
22 be entitled to a converted policy if termination of his or her
23 insurance under the group policy occurred because he or she
24 failed to pay any required contribution, or because any
25 discontinued group coverage was replaced by similar group
26 coverage within 31 days after discontinuance.
27 (1) TIME LIMIT.--Written application for the converted
28 policy shall be made and the first premium must be paid to the
29 insurer, not later than 63 days after termination of the group
30 policy. However, if termination was the result of failure to
31 pay any required premium or contribution and such nonpayment

1 of premium was due to acts of an employer or policyholder
2 other than the employee or certificateholder, written
3 application for the converted policy must be made and the
4 first premium must be paid to the insurer not later than 63
5 days after notice of termination is mailed by the insurer or
6 the employer, whichever is earlier, to the employee's or
7 certificateholder's last address as shown by the record of the
8 insurer or the employer, whichever is applicable. In such case
9 of termination due to nonpayment of premium by the employer or
10 policyholder, the premium for the converted policy may not
11 exceed the rate for the prior group coverage for the period of
12 coverage under the converted policy prior to the date notice
13 of termination is mailed to the employee or certificateholder.
14 For the period of coverage after such date, the premium for
15 the converted policy is subject to the requirements of
16 subsection (3).
17 (2) EVIDENCE OF INSURABILITY.--The converted policy
18 shall be issued without evidence of insurability.
19 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR
20 GROUP COVERAGE.--
21 (a) The premium for the converted policy shall be
22 determined in accordance with premium rates applicable to the
23 age and class of risk of each person to be covered under the
24 converted policy and to the type and amount of insurance
25 provided. However, the premium for the converted policy may
26 not exceed 200 percent of the standard risk rate as
27 established by the commission ~~department~~, pursuant to this
28 subsection.
29 (b) Actual or expected experience under converted
30 policies may be combined with such experience under group
31 policies for the purposes of determining premium and loss

experience and establishing premium rate levels for group coverage.

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

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

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

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

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

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

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

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

(5) SCOPE OF COVERAGE.--The converted policy shall

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

1 (7) INFORMATION REQUESTED BY INSURER.--
2 (a) A converted policy may include a provision under
3 which the insurer may request information, in advance of any
4 premium due date, of any person covered thereunder as to
5 whether:
6 1. The person is covered for similar benefits by
7 another hospital, surgical, medical, or major medical expense
8 insurance policy or hospital or medical service subscriber
9 contract or medical practice or other prepayment plan or by
10 any other plan or program.
11 2. The person is covered for similar benefits under
12 any arrangement of coverage for individuals in a group,
13 whether on an insured or uninsured basis.
14 3. Similar benefits are provided for or are available
15 to the person under any state or federal law.
16 (b) The converted policy may provide that the insurer
17 may refuse to renew the policy or the coverage of any person
18 only for one or more of the following reasons:
19 1. Either the benefits provided under the sources
20 referred to in subparagraphs (a)1. and 2. for the person or
21 the benefits provided or available under the sources referred
22 to in subparagraph (a)3. for the person, together with the
23 benefits provided by the converted policy, would result in
24 overinsurance according to the insurer's standards on file
25 with the department.
26 2. The converted policyholder fails to provide the
27 information requested pursuant to paragraph (a).
28 3. Fraud or intentional misrepresentation in applying
29 for any benefits under the converted policy.
30 4. Other reasons approved by the department.
31 (8) BENEFITS OFFERED.--

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

(b) Payment of benefits at the rate of 80 percent of covered medical expenses which are in excess of the deductible, until 20 percent of such expenses in a benefit period reaches $2,000, after which benefits will be paid at the rate of 90 percent during the remainder of the contract year unless the insured is in the insurer's case management program, in which case benefits shall be paid at the rate of 100 percent during the remainder of the contract year. For the purposes of this paragraph, "case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the insurer. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50 percent.

(c) A deductible for each calendar year that must be $500, $1,000, or $2,000, at the option of the policyholder.

(d) The term "covered medical expenses," as used in this subsection, shall be consistent with those customarily offered by the insurer under group or individual health insurance policies but is not required to be identical to the covered medical expenses provided in the group policy from which the individual converted.

(11) ALTERNATIVE PLANS.--The insurer shall, in addition to the option required by subsection (10), offer the standard health benefit plan, as established pursuant to s. 627.6699(12). The insurer may, at its option, also offer alternative plans for group health conversion in addition to the plans required by this section.

(12) RETIREMENT COVERAGE.--If coverage would be continued under the group policy on an employee following the

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

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

1 accidental injuries only, disability income, Medicare
2 supplement, hospital indemnity, limited benefit,
3 nonconventional, or excess policies.
4 (20) Nothing in this section or in the incorporation
5 of it into insurance policies shall be construed to require
6 insurers to provide benefits equal to those provided in the
7 group policy from which the individual converted; provided,
8 however, that comprehensive benefits are offered which shall
9 be subject to approval by the Insurance Commissioner.
10 Section 68. Subsections (3), (6), (8), (11), (12), and
11 (16) of section 627.6699, Florida Statutes, are amended to
12 read:
13 627.6699 Employee Health Care Access Act.--
14 (3) DEFINITIONS.--As used in this section, the term:
15 (a) "Actuarial certification" means a written
16 statement, by a member of the American Academy of Actuaries or
17 another person acceptable to the commission ~~department~~, that a
18 small employer carrier is in compliance with subsection (6),
19 based upon the person's examination, including a review of the
20 appropriate records and of the actuarial assumptions and
21 methods used by the carrier in establishing premium rates for
22 applicable health benefit plans.
23 (b) "Basic health benefit plan" and "standard health
24 benefit plan" mean low-cost health care plans developed
25 pursuant to subsection (12).
26 (c) "Board" means the board of directors of the
27 program.
28 (d) "Carrier" means a person who provides health
29 benefit plans in this state, including an authorized insurer,
30 a health maintenance organization, a multiple-employer welfare
31 arrangement, or any other person providing a health benefit

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

1 the employee, regardless of health status, preexisting
2 conditions, or claims history.
3 (k) "Health benefit plan" means any hospital or
4 medical policy or certificate, hospital or medical service
5 plan contract, or health maintenance organization subscriber
6 contract. The term does not include accident-only, specified
7 disease, individual hospital indemnity, credit, dental-only,
8 vision-only, Medicare supplement, long-term care, or
9 disability income insurance; similar supplemental plans
10 provided under a separate policy, certificate, or contract of
11 insurance, which cannot duplicate coverage under an underlying
12 health plan and are specifically designed to fill gaps in the
13 underlying health plan, coinsurance, or deductibles; coverage
14 issued as a supplement to liability insurance; workers'
15 compensation or similar insurance; or automobile
16 medical-payment insurance.
17 (l) "Late enrollee" means an eligible employee or
18 dependent as defined under s. 627.6561(1)(b).
19 (m) "Limited benefit policy or contract" means a
20 policy or contract that provides coverage for each person
21 insured under the policy for a specifically named disease or
22 diseases, a specifically named accident, or a specifically
23 named limited market that fulfills an experimental or
24 reasonable need, such as the small group market.
25 (n) "Modified community rating" means a method used to
26 develop carrier premiums which spreads financial risk across a
27 large population and allows adjustments for age, gender,
28 family composition, tobacco usage, and geographic area as
29 determined under paragraph (5)(j).
30 (o) "Participating carrier" means any carrier that
31 issues health benefit plans in this state except a small

1 employer carrier that elects to be a risk-assuming carrier.
2 (p) "Plan of operation" means the plan of operation of
3 the program, including articles, bylaws, and operating rules,
4 adopted by the board under subsection (11).
5 (q) "Program" means the Florida Small Employer Carrier
6 Reinsurance Program created under subsection (11).
7 (r) "Rating period" means the calendar period for
8 which premium rates established by a small employer carrier
9 are assumed to be in effect.
10 (s) "Reinsuring carrier" means a small employer
11 carrier that elects to comply with the requirements set forth
12 in subsection (11).
13 (t) "Risk-assuming carrier" means a small employer
14 carrier that elects to comply with the requirements set forth
15 in subsection (10).
16 (u) "Self-employed individual" means an individual or
17 sole proprietor who derives his or her income from a trade or
18 business carried on by the individual or sole proprietor which
19 results in taxable income as indicated on IRS Form 1040,
20 schedule C or F, and which generated taxable income in one of
21 the 2 previous years.
22 (v) "Small employer" means, in connection with a
23 health benefit plan with respect to a calendar year and a plan
24 year, any person, sole proprietor, self-employed individual,
25 independent contractor, firm, corporation, partnership, or
26 association that is actively engaged in business, has its
27 principal place of business in this state, employed an average
28 of at least 1 but not more than 50 eligible employees on
29 business days during the preceding calendar year, and employs
30 at least 1 employee on the first day of the plan year. For
31 purposes of this section, a sole proprietor, an independent

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

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

1 this section and that the rating methods of the carrier are
2 actuarially sound. The certification must be in a form and
3 manner and contain the information prescribed by the
4 commission ~~department~~. The carrier must retain a copy of the
5 certification at its principal place of business.
6 (c) A small employer carrier must make the information
7 and documentation described in paragraph (a) available to the
8 commission and the department upon request. The information
9 constitutes proprietary and trade secret information and may
10 not be disclosed by the commission or the department to
11 persons outside the commission or department, except as agreed
12 to by the carrier or as ordered by a court of competent
13 jurisdiction.
14 (d) Each small employer carrier must file with the
15 department quarterly an enrollment report as directed by the
16 department. Such report shall not constitute proprietary or
17 trade secret information.
18 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
19 (a) There is created a nonprofit entity to be known as
20 the "Florida Small Employer Health Reinsurance Program."
21 (b)1. The program shall operate subject to the
22 supervision and control of the board.
23 2. Effective upon this act becoming a law, the board
24 shall consist of the commissioner or his or her designee, who
25 shall serve as the chairperson, and 13 additional members who
26 are representatives of carriers and insurance agents and are
27 appointed by the commissioner and serve as follows:
28 a. The commissioner shall include representatives of
29 small employer carriers subject to assessment under this
30 subsection. If two or more carriers elect to be risk-assuming
31 carriers, the membership must include at least two

1 representatives of risk-assuming carriers; if one carrier is
2 risk-assuming, one member must be a representative of such
3 carrier. At least one member must be a carrier who is subject
4 to the assessments, but is not a small employer carrier.
5 Subject to such restrictions, at least five members shall be
6 selected from individuals recommended by small employer
7 carriers pursuant to procedures provided by rule of the
8 department. Three members shall be selected from a list of
9 health insurance carriers that issue individual health
10 insurance policies. At least two of the three members selected
11 must be reinsuring carriers. Two members shall be selected
12 from a list of insurance agents who are actively engaged in
13 the sale of health insurance.
14 b. A member appointed under this subparagraph shall
15 serve a term of 4 years and shall continue in office until the
16 member's successor takes office, except that, in order to
17 provide for staggered terms, the commissioner shall designate
18 two of the initial appointees under this subparagraph to serve
19 terms of 2 years and shall designate three of the initial
20 appointees under this subparagraph to serve terms of 3 years.
21 3. The commissioner may remove a member for cause.
22 4. Vacancies on the board shall be filled in the same
23 manner as the original appointment for the unexpired portion
24 of the term.
25 5. The commissioner may require an entity that
26 recommends persons for appointment to submit additional lists
27 of recommended appointees.
28 (c)1.
29 a. No later than August 15, 1992, the board shall
30 submit to the department a plan of operation to assure the
31 fair, reasonable, and equitable administration of the program.

1 The board may at any time submit to the department any
2 amendments to the plan that the board finds to be necessary or
3 suitable.
4 b. No later than September 15, 1992, the department
5 shall, after notice and hearing, approve the plan of operation
6 if it determines that the plan submitted by the board is
7 suitable to assure the fair, reasonable, and equitable
8 administration of the program and provides for the sharing of
9 program gains and losses equitably and proportionately in
10 accordance with paragraph (j).
11 c. The plan of operation, or any amendment thereto,
12 becomes effective upon written approval of the department.
13 2. If the board fails to submit a suitable plan of
14 operation by August 15, 1992, the department shall, after
15 notice and hearing, adopt a temporary plan of operation by
16 September 15, 1992. The department shall amend or rescind the
17 temporary plan of operation, as appropriate, after it approves
18 a suitable plan of operation submitted by the board.
19 (d) The plan of operation must, among other things:
20 1. Establish procedures for handling and accounting
21 for program assets and moneys and for an annual fiscal
22 reporting to the department.
23 2. Establish procedures for selecting an administering
24 carrier and set forth the powers and duties of the
25 administering carrier.
26 3. Establish procedures for reinsuring risks.
27 4. Establish procedures for collecting assessments
28 from participating carriers to provide for claims reinsured by
29 the program and for administrative expenses, other than
30 amounts payable to the administrative carrier, incurred or
31 estimated to be incurred during the period for which the

1 assessment is made.
2 5. Provide for any additional matters at the
3 discretion of the board.
4 (e) The board shall:
5 1. Recommend to the department market conduct
6 requirements and other requirements for carriers and agents,
7 including requirements relating to:
8 a. Registration by each carrier with the department of
9 its intention to be a small employer carrier under this
10 section;
11 b. Publication by the department of a list of all
12 small employer carriers, including a requirement applicable to
13 agents and carriers that a health benefit plan may not be sold
14 by a carrier that is not identified as a small employer
15 carrier;
16 c. The availability of a broadly publicized, toll-free
17 telephone number for access by small employers to information
18 concerning this section;
19 d. Periodic reports by carriers and agents concerning
20 health benefit plans issued; and
21 e. Methods concerning periodic demonstration by small
22 employer carriers and agents that they are marketing or
23 issuing health benefit plans to small employers.
24 2. By January 1, 1995, the board shall conduct a study
25 of the effectiveness of this section and may recommend, to the
26 department, improvements to achieve greater rate stability,
27 accessibility, and affordability in the small employer
28 marketplace.
29 (f) The program has the general powers and authority
30 granted under the laws of this state to insurance companies
31 and health maintenance organizations licensed to transact

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

1 9. Borrow money to effect the purposes of the program.
2 Any notes or other evidences of indebtedness of the program
3 which are not in default constitute legal investments for
4 carriers and may be carried as admitted assets.
5 10. To the extent necessary, increase the $5,000
6 deductible reinsurance requirement to adjust for the effects
7 of inflation.
8 (g) A reinsuring carrier may reinsure with the program
9 coverage of an eligible employee of a small employer, or any
10 dependent of such an employee, subject to each of the
11 following provisions:
12 1. With respect to a standard and basic health care
13 plan, the program must reinsure the level of coverage
14 provided; and, with respect to any other plan, the program
15 must reinsure the coverage up to, but not exceeding, the level
16 of coverage provided under the standard and basic health care
17 plan.
18 2. Except in the case of a late enrollee, a reinsuring
19 carrier may reinsure an eligible employee or dependent within
20 60 days after the commencement of the coverage of the small
21 employer. A newly employed eligible employee or dependent of a
22 small employer may be reinsured within 60 days after the
23 commencement of his or her coverage.
24 3. A small employer carrier may reinsure an entire
25 employer group within 60 days after the commencement of the
26 group's coverage under the plan. The carrier may choose to
27 reinsure newly eligible employees and dependents of the
28 reinsured group pursuant to subparagraph 1.
29 4. The program may not reimburse a participating
30 carrier with respect to the claims of a reinsured employee or
31 dependent until the carrier has paid incurred claims of at

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

case management, as defined by the board.

9. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the commission ~~department~~, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:

a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.

b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

1 2. The board periodically shall review the methodology
2 established, including the system of classification and any
3 rating factors, to assure that it reasonably reflects the
4 claims experience of the program. The board may propose
5 changes to the rates which shall be subject to the approval of
6 the commission ~~department~~.
7 (i) If a health benefit plan for a small employer
8 issued in accordance with this subsection is entirely or
9 partially reinsured with the program, the premium charged to
10 the small employer for any rating period for the coverage
11 issued must be consistent with the requirements relating to
12 premium rates set forth in s. 627.4106.
13 (j)1. Before March 1 of each calendar year, the board
14 shall determine and report to the department the program net
15 loss for the previous year, including administrative expenses
16 for that year, and the incurred losses for the year, taking
17 into account investment income and other appropriate gains and
18 losses.
19 2. Any net loss for the year shall be recouped by
20 assessment of the carriers, as follows:
21 a. The operating losses of the program shall be
22 assessed in the following order subject to the specified
23 limitations. The first tier of assessments shall be made
24 against reinsuring carriers in an amount which shall not
25 exceed 5 percent of each reinsuring carrier's premiums from
26 health benefit plans covering small employers. If such
27 assessments have been collected and additional moneys are
28 needed, the board shall make a second tier of assessments in
29 an amount which shall not exceed 0.5 percent of each carrier's
30 health benefit plan premiums. Except as provided in paragraph
31 (n), risk-assuming carriers are exempt from all assessments

1 authorized pursuant to this section. The amount paid by a
2 reinsuring carrier for the first tier of assessments shall be
3 credited against any additional assessments made.
4 b. The board shall equitably assess carriers for
5 operating losses of the plan based on market share. The board
6 shall annually assess each carrier a portion of the operating
7 losses of the plan. The first tier of assessments shall be
8 determined by multiplying the operating losses by a fraction,
9 the numerator of which equals the reinsuring carrier's earned
10 premium pertaining to direct writings of small employer health
11 benefit plans in the state during the calendar year for which
12 the assessment is levied, and the denominator of which equals
13 the total of all such premiums earned by reinsuring carriers
14 in the state during that calendar year. The second tier of
15 assessments shall be based on the premiums that all carriers,
16 except risk-assuming carriers, earned on all health benefit
17 plans written in this state. The board may levy interim
18 assessments against carriers to ensure the financial ability
19 of the plan to cover claims expenses and administrative
20 expenses paid or estimated to be paid in the operation of the
21 plan for the calendar year prior to the association's
22 anticipated receipt of annual assessments for that calendar
23 year. Any interim assessment is due and payable within 30
24 days after receipt by a carrier of the interim assessment
25 notice. Interim assessment payments shall be credited against
26 the carrier's annual assessment. Health benefit plan premiums
27 and benefits paid by a carrier that are less than an amount
28 determined by the board to justify the cost of collection may
29 not be considered for purposes of determining assessments.
30 c. Subject to the approval of the department, the
31 board shall make an adjustment to the assessment formula for

1 reinsuring carriers that are approved as federally qualified
2 health maintenance organizations by the Secretary of Health
3 and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to
4 the extent, if any, that restrictions are placed on them that
5 are not imposed on other small employer carriers.
6 3. Before March 1 of each year, the board shall
7 determine and file with the department an estimate of the
8 assessments needed to fund the losses incurred by the program
9 in the previous calendar year.
10 4. If the board determines that the assessments needed
11 to fund the losses incurred by the program in the previous
12 calendar year will exceed the amount specified in subparagraph
13 2., the board shall evaluate the operation of the program and
14 report its findings, including any recommendations for changes
15 to the plan of operation, to the department within 90 days
16 following the end of the calendar year in which the losses
17 were incurred. The evaluation shall include an estimate of
18 future assessments, the administrative costs of the program,
19 the appropriateness of the premiums charged and the level of
20 carrier retention under the program, and the costs of coverage
21 for small employers. If the board fails to file a report with
22 the department within 90 days following the end of the
23 applicable calendar year, the department may evaluate the
24 operations of the program and implement such amendments to the
25 plan of operation the department deems necessary to reduce
26 future losses and assessments.
27 5. If assessments exceed the amount of the actual
28 losses and administrative expenses of the program, the excess
29 shall be held as interest and used by the board to offset
30 future losses or to reduce program premiums. As used in this
31 paragraph, the term "future losses" includes reserves for

incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the commissioner, a deferment, in whole or in part, from any assessment made by the board. The department may defer, in whole or in part, the assessment of a carrier if, in the opinion of the department, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such

standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the department any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The department shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the department.

(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator

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

1 might be appropriate, the commissioner shall appoint a new
2 health benefit plan committee in the manner provided in
3 subparagraph 1. to submit recommended modifications to the
4 department for approval.
5 (b)1. Each small employer carrier issuing new health
6 benefit plans shall offer to any small employer, upon request,
7 a standard health benefit plan and a basic health benefit plan
8 that meets the criteria set forth in this section.
9 2. For purposes of this subsection, the terms
10 "standard health benefit plan" and "basic health benefit plan"
11 mean policies or contracts that a small employer carrier
12 offers to eligible small employers that contain:
13 a. An exclusion for services that are not medically
14 necessary or that are not covered preventive health services;
15 and
16 b. A procedure for preauthorization by the small
17 employer carrier, or its designees.
18 3. A small employer carrier may include the following
19 managed care provisions in the policy or contract to control
20 costs:
21 a. A preferred provider arrangement or exclusive
22 provider organization or any combination thereof, in which a
23 small employer carrier enters into a written agreement with
24 the provider to provide services at specified levels of
25 reimbursement or to provide reimbursement to specified
26 providers. Any such written agreement between a provider and a
27 small employer carrier must contain a provision under which
28 the parties agree that the insured individual or covered
29 member has no obligation to make payment for any medical
30 service rendered by the provider which is determined not to be
31 medically necessary. A carrier may use preferred provider

1 arrangements or exclusive provider arrangements to the same
2 extent as allowed in group products that are not issued to
3 small employers.
4 b. A procedure for utilization review by the small
5 employer carrier or its designees.
6
7 This subparagraph does not prohibit a small employer carrier
8 from including in its policy or contract additional managed
9 care and cost containment provisions, subject to the approval
10 of the department, which have potential for controlling costs
11 in a manner that does not result in inequitable treatment of
12 insureds or subscribers. The carrier may use such provisions
13 to the same extent as authorized for group products that are
14 not issued to small employers.
15 4. The standard health benefit plan shall include:
16 a. Coverage for inpatient hospitalization;
17 b. Coverage for outpatient services;
18 c. Coverage for newborn children pursuant to s.
19 627.6575;
20 d. Coverage for child care supervision services
21 pursuant to s. 627.6579;
22 e. Coverage for adopted children upon placement in the
23 residence pursuant to s. 627.6578;
24 f. Coverage for mammograms pursuant to s. 627.6613;
25 g. Coverage for handicapped children pursuant to s.
26 627.6615;
27 h. Emergency or urgent care out of the geographic
28 service area; and
29 i. Coverage for services provided by a hospice
30 licensed under s. 400.602 in cases where such coverage would
31 be the most appropriate and the most cost-effective method for

1 treating a covered illness.
2 5. The standard health benefit plan and the basic
3 health benefit plan may include a schedule of benefit
4 limitations for specified services and procedures. If the
5 committee develops such a schedule of benefits limitation for
6 the standard health benefit plan or the basic health benefit
7 plan, a small employer carrier offering the plan must offer
8 the employer an option for increasing the benefit schedule
9 amounts by 4 percent annually.
10 6. The basic health benefit plan shall include all of
11 the benefits specified in subparagraph 4.; however, the basic
12 health benefit plan shall place additional restrictions on the
13 benefits and utilization and may also impose additional cost
14 containment measures.
15 7. Sections 627.419(2), (3), and (4), 627.6574,
16 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668,
17 and 627.66911 apply to the standard health benefit plan and to
18 the basic health benefit plan. However, notwithstanding said
19 provisions, the plans may specify limits on the number of
20 authorized treatments, if such limits are reasonable and do
21 not discriminate against any type of provider.
22 8. Each small employer carrier that provides for
23 inpatient and outpatient services by allopathic hospitals may
24 provide as an option of the insured similar inpatient and
25 outpatient services by hospitals accredited by the American
26 Osteopathic Association when such services are available and
27 the osteopathic hospital agrees to provide the service.
28 (c) If a small employer rejects, in writing, the
29 standard health benefit plan and the basic health benefit
30 plan, the small employer carrier may offer the small employer
31 a limited benefit policy or contract.

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

1 benefit plan, a basic health benefit plan, or a limited
2 benefit policy or contract, the person making such
3 misrepresentations forfeits coverage provided by the policy or
4 contract; and
5 d. If a limited plan is requested, acknowledges that
6 the prospective policyholder had been offered, at the time of
7 application for the insurance policy or contract, the
8 opportunity to purchase any health benefit plan offered by the
9 carrier and that the prospective policyholder had rejected
10 that coverage.
11
12 A copy of such written statement shall be provided to the
13 prospective policyholder no later than at the time of delivery
14 of the policy or contract, and the original of such written
15 statement shall be retained in the files of the small employer
16 carrier for the period of time that the policy or contract
17 remains in effect or for 5 years, whichever period is longer.
18 3. Any material statement made by an applicant for
19 coverage under a health benefit plan which falsely certifies
20 as to the applicant's eligibility for coverage serves as the
21 basis for terminating coverage under the policy or contract.
22 4. Each marketing communication that is intended to be
23 used in the marketing of a health benefit plan in this state
24 must be submitted for review by the department prior to use
25 and must contain the disclosures stated in this subsection.
26 (e)1. A small employer carrier may not use any policy,
27 contract, or form~~, or rate~~ under this section, including
28 applications, enrollment forms, policies, contracts,
29 certificates, evidences of coverage, riders, amendments,
30 endorsements, and disclosure forms, until the carrier insurer
31 has filed it with the department and the department has

approved it under ss. 627.410, ~~627.4106,~~and 627.411.

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

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

Section 69. Subsections (2), (4), and (7) of section 627.6745, Florida Statutes, are amended to read:

627.6745 Loss ratio standards; public rate hearings.--

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

(4) Each insurer providing Medicare supplement insurance to residents of this state shall annually submit to the commission ~~department~~ information on actual loss ratios on forms prescribed by the National Association of Insurance Commissioners pursuant to the Omnibus Budget Reconciliation

1 Act of 1990 (Pub. L. No. 101-508).
2 (7) The commission ~~department~~ shall adopt a written
3 policy statement regarding the holding of public hearings
4 prior to approval of any premium increases for Medicare
5 supplement insurance policies.
6 Section 70. Section 627.678, Florida Statutes, is
7 amended to read:
8 627.678 Rules.--
9 (1) For the effective protection of the public
10 interest, the department shall have full power and authority
11 to adopt, promulgate, and enforce separate rules pertaining to
12 issuance and use of each type of credit insurance defined in
13 s. 627.677, except for matters related to rates. The
14 commission may adopt rules related to rates for credit life
15 and disability insurance consistent with the provisions of
16 this part.
17 (2) Rules made pursuant to this section shall be
18 principally designed, and shall be promulgated with the
19 purpose of protecting the borrower from excessive charges by
20 or collected through the lender for insurance in relation to
21 the amount of the loan, to avoid duplication or overlapping of
22 insurance coverage and to avoid loss of the borrower's funds
23 by short-rate cancellation or termination of such insurance.
24 However, nothing in such rules shall be construed to authorize
25 the department to prohibit operation of normal dividend
26 distributions under participating insurance contracts.
27 Section 71. Section 627.6785, Florida Statutes, is
28 amended to read:
29 627.6785 Filing of rates with department.--
30 (1) Credit disability and credit life insurers shall
31 file with the commission ~~department~~ a copy of all rates and

1 any rate changes used in this state, subject to the procedures
2 specified in s. 627.410.
3 (2) No credit disability rate and no credit life rate
4 shall exceed the maximum allowable rate promulgated by the
5 commission ~~department~~.
6 (3) No credit life rate or credit disability rate
7 shall be deemed to comply with the allowable rate criteria
8 contained in this part if the benefits provided are not
9 reasonable in relation to the premium charged or if the rate
10 ~~it~~ contains age restrictions which make ineligible for credit
11 life those debtors or lessors 70 years of age or under, or for
12 credit disability those debtors or lessors 65 years of age or
13 under, at the time the indebtedness is incurred. However, for
14 credit life, the coverage shall be provided, at a minimum,
15 until the earlier of the maturity date of the loan or the loan
16 anniversary at age 71, and, for credit disability, the
17 coverage shall be provided, at a minimum, until the earlier of
18 the maturity date of the loan or the loan anniversary at age
19 66.
20 Section 72. Section 627.682, Florida Statutes, is
21 amended to read:
22 627.682 Filing, approval of forms.--All forms of
23 policies, certificates of insurance, statements of insurance,
24 applications for insurance, binders, endorsements, and riders
25 of credit life or disability insurance delivered or issued for
26 delivery in this state shall be filed with and approved by the
27 department before use as provided in ss. 627.410 and 627.411.
28 In addition to grounds as specified in s. 627.411, the
29 department, upon compliance with the procedures set forth in
30 s. 627.410, shall disapprove any such form and may withdraw
31 any previous approval thereof ~~if the benefits provided therein~~

1 ~~are not reasonable in relation to the premiums charged, or~~ if
2 it contains provisions that ~~which~~ are unjust, unfair,
3 inequitable, misleading, or deceptive or that ~~which~~ encourage
4 misrepresentation of such policy.
5 Section 73. Subsection (9) of section 627.727, Florida
6 Statutes, is amended to read:
7 627.727 Motor vehicle insurance; uninsured and
8 underinsured vehicle coverage; insolvent insurer protection.--
9 (9) Insurers may offer policies of uninsured motorist
10 coverage containing policy provisions, in language approved by
11 the department, establishing that if the insured accepts this
12 offer:
13 (a) The coverage provided as to two or more motor
14 vehicles shall not be added together to determine the limit of
15 insurance coverage available to an injured person for any one
16 accident, except as provided in paragraph (c).
17 (b) If at the time of the accident the injured person
18 is occupying a motor vehicle, the uninsured motorist coverage
19 available to her or him is the coverage available as to that
20 motor vehicle.
21 (c) If the injured person is occupying a motor vehicle
22 which is not owned by her or him or by a family member
23 residing with her or him, the injured person is entitled to
24 the highest limits of uninsured motorist coverage afforded for
25 any one vehicle as to which she or he is a named insured or
26 insured family member. Such coverage shall be excess over the
27 coverage on the vehicle the injured person is occupying.
28 (d) The uninsured motorist coverage provided by the
29 policy does not apply to the named insured or family members
30 residing in her or his household who are injured while
31 occupying any vehicle owned by such insureds for which

1 uninsured motorist coverage was not purchased.
2 (e) If, at the time of the accident the injured person
3 is not occupying a motor vehicle, she or he is entitled to
4 select any one limit of uninsured motorist coverage for any
5 one vehicle afforded by a policy under which she or he is
6 insured as a named insured or as an insured resident of the
7 named insured's household.
8
9 In connection with the offer authorized by this subsection,
10 insurers shall inform the named insured, applicant, or lessee,
11 on a form approved by the department, of the limitations
12 imposed under this subsection and that such coverage is an
13 alternative to coverage without such limitations. If this
14 form is signed by a named insured, applicant, or lessee, it
15 shall be conclusively presumed that there was an informed,
16 knowing acceptance of such limitations. When the named
17 insured, applicant, or lessee has initially accepted such
18 limitations, such acceptance shall apply to any policy which
19 renews, extends, changes, supersedes, or replaces an existing
20 policy unless the named insured requests deletion of such
21 limitations and pays the appropriate premium for such
22 coverage. Any insurer who provides coverage which includes
23 the limitations provided in this subsection shall file revised
24 premium rates with the commission ~~department~~ for such
25 uninsured motorist coverage to take effect prior to initially
26 providing such coverage. The revised rates shall reflect the
27 anticipated reduction in loss costs attributable to such
28 limitations but shall in any event reflect a reduction in the
29 uninsured motorist coverage premium of at least 20 percent for
30 policies with such limitations. Such filing shall not
31 increase the rates for coverage which does not contain the

limitations authorized by this subsection, and such rates shall remain in effect until the insurer demonstrates the need for a change in uninsured motorist rates pursuant to s. 627.0651.

Section 74. Subsection (1) of section 627.780, Florida Statutes, is amended to read:

627.780 Illegal dealings in risk premium.--

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

Section 75. Section 627.782, Florida Statutes, is amended to read:

627.782 Adoption of rates.--

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

1 (a) The title insurers' loss experience and
2 prospective loss experience under closing protection letters
3 and policy liabilities.
4 (b) A reasonable margin for underwriting profit and
5 contingencies, including contingent liability under s.
6 627.7865, sufficient to allow title insurers, agents, and
7 agencies to earn a rate of return on their capital that will
8 attract and retain adequate capital investment in the title
9 insurance business and maintain an efficient title insurance
10 delivery system.
11 (c) Past expenses and prospective expenses for
12 administration and handling of risks.
13 (d) Liability for defalcation.
14 (e) Other relevant factors.
15 (3) Rates may be grouped by classification or schedule
16 and may differ as to class of risk assumed.
17 (4) Rates may not be excessive, inadequate, or
18 unfairly discriminatory.
19 (5) The premium applies to each $100 of insurance
20 issued to an insured.
21 (6) The premium rates apply throughout this state.
22 (7) The commission ~~department~~ shall, in accordance
23 with the standards provided in subsection (2), review the
24 premium as needed, but not less frequently than once every 3
25 years, and shall, based upon the review required by this
26 subsection, revise the premium if the results of the review so
27 warrant.
28 (8) The commission ~~department~~ may, by rule, require
29 licensees under this part to annually submit statistical
30 information, including loss and expense data, as the
31 department determines to be necessary to analyze premium

rates, retention rates, and the condition of the title insurance industry.

Section 76. Section 627.7825, Florida Statutes, is amended to read:

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

(1) ORIGINAL TITLE INSURANCE RATES.--

(a) For owner and leasehold title insurance:

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

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

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

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

(b) For mortgage title insurance:

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

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

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

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 commission ~~department~~ for an order authorizing a specific deviation from the adopted premium, and a title insurer or title insurance agent may petition the commission ~~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 commission ~~department~~ shall rule on all such petitions simultaneously.

(2) If, in the judgment of the commission ~~department~~, the requested deviation is not justified, the commission ~~department~~ may enter an order denying the petition. An order

granting a petition constitutes an amendment to the adopted premium as to the petitioners named in the order, and is subject to s. 627.782.

Section 78. Section 627.793, Florida Statutes, is amended to read:

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

Section 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

1 organizations, may define by rule what constitutes excessive,
2 inadequate, or unfairly discriminatory rates and may require
3 whatever information it deems necessary to determine that a
4 rate or proposed rate meets the requirements of this
5 subsection.
6 (3)(a) If a health maintenance organization desires to
7 amend any contract with its subscribers or any certificate or
8 member handbook, or desires to change any basic health
9 maintenance contract, certificate, grievance procedure, or
10 member handbook form, or application form where written
11 application is required and is to be made a part of the
12 contract, or printed amendment, addendum, rider, or
13 endorsement form or form of renewal certificate, it may do so,
14 upon filing with the department the proposed change or
15 amendment. Any proposed change shall be effective
16 immediately, subject to disapproval by the department.
17 Following receipt of notice of such disapproval or withdrawal
18 of approval, no health maintenance organization shall issue or
19 use any form disapproved by the department or as to which the
20 department has withdrawn approval.
21 (b) Any change in the rate is subject to paragraph (d)
22 and requires at least 30 days' advance written notice to the
23 subscriber. In the case of a group member, there may be a
24 contractual agreement with the health maintenance organization
25 to have the employer provide the required notice to the
26 individual members of the group.
27 (c) The department shall disapprove any form filed
28 under this subsection, or withdraw any previous approval
29 thereof, if the form:
30 1. Is in any respect in violation of, or does not
31 comply with, any provision of this part or rule adopted

thereunder.

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 any title, heading, or other indication of its provisions which is misleading.

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

1 affirmatively approve or disapprove any such filing, by giving
2 notice of such extension before expiration of the initial
3 30-day period. At the expiration of any such period as so
4 extended, and in the absence of such prior affirmative
5 approval or disapproval, any such filing shall be deemed
6 approved.
7 (e) It is not the intent of this subsection to
8 restrict unduly the right to modify rates in the exercise of
9 reasonable business judgment.
10 (38)(a) Notwithstanding any other provision of this
11 part, a health maintenance organization that meets the
12 requirements of paragraph (b) may, through a point-of-service
13 rider to its contract providing comprehensive health care
14 services, include a point-of-service benefit. Under such a
15 rider, a subscriber or other covered person of the health
16 maintenance organization may choose, at the time of covered
17 service, a provider with whom the health maintenance
18 organization does not have a health maintenance organization
19 provider contract. The rider may not require a referral from
20 the health maintenance organization for the point-of-service
21 benefits.
22 (b) A health maintenance organization offering a
23 point-of-service rider under this subsection must have a valid
24 certificate of authority issued under the provisions of the
25 chapter, must have been licensed under this chapter for a
26 minimum of 3 years, and must at all times that it has riders
27 in effect maintain a minimum surplus of $5 million.
28 (c) Premiums paid in for the point-of-service riders
29 may not exceed 15 percent of total premiums for all health
30 plan products sold by the health maintenance organization
31 offering the rider. If the premiums paid for point-of-service

1 riders exceed 15 percent, the health maintenance organization
2 must notify the department and the commission and, once this
3 fact is known, must immediately cease offering such a rider
4 until it is in compliance with the rider premium cap.
5 (d) Notwithstanding the limitations of deductibles and
6 copayment provisions in this part, a point-of-service rider
7 may require the subscriber to pay a reasonable copayment for
8 each visit for services provided by a noncontracted provider
9 chosen at the time of the service. The copayment by the
10 subscriber may either be a specific dollar amount or a
11 percentage of the reimbursable provider charges covered by the
12 contract and must be paid by the subscriber to the
13 noncontracted provider upon receipt of covered services. The
14 point-of-service rider may require that a reasonable annual
15 deductible for the expenses associated with the
16 point-of-service rider be met and may include a lifetime
17 maximum benefit amount. The rider must include the language
18 required by s. 627.6044 and must comply with copayment limits
19 described in s. 627.6471. Section 641.315(2) and (3) does not
20 apply to a point-of-service rider authorized under this
21 subsection.
22 (e) The term "point of service" may not be used by a
23 health maintenance organization except with riders permitted
24 under this section or with forms approved by the department in
25 which a point-of-service product is offered with an indemnity
26 carrier.
27 (f) A point-of-service rider must be filed and
28 approved under ss. 627.410 and 627.411.
29 Section 83. Paragraph (b) of subsection (10) of
30 section 641.3903, Florida Statutes, is amended to read:
31 641.3903 Unfair methods of competition and unfair or

1 deceptive acts or practices defined.--The following are
2 defined as unfair methods of competition and unfair or
3 deceptive acts or practices:
4 (10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED
5 CHARGES FOR HEALTH MAINTENANCE COVERAGE.--
6 (b) Knowingly collecting as a premium or charge for
7 health maintenance coverage any sum in excess of or less than
8 the premium or charge applicable to health maintenance
9 coverage, in accordance with the applicable classifications
10 and rates as filed with the commission ~~department~~, and as
11 specified in the health maintenance contract.
12 Section 84. Subsection (3) of section 641.3922,
13 Florida Statutes, is amended to read:
14 641.3922 Conversion contracts; conditions.--Issuance
15 of a converted contract shall be subject to the following
16 conditions:
17 (3) CONVERSION PREMIUM.--The premium for the converted
18 contract shall be determined in accordance with premium rates
19 applicable to the age and class of risk of each person to be
20 covered under the converted contract and to the type and
21 amount of coverage provided. However, the premium for the
22 converted contract may not exceed 200 percent of the standard
23 risk rate, as established by the commission ~~department~~ under
24 s. 627.6675(3). The mode of payment for the converted contract
25 shall be quarterly or more frequently at the option of the
26 organization, unless otherwise mutually agreed upon between
27 the subscriber and the organization.
28 Section 85. Present subsections (2) through (11) of
29 section 641.402, Florida Statutes, are redesignated as
30 subsections (3) through (12), respectively, and a new
31 subsection (2) is added to that section to read:

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

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

Section 86. Subsection (2) and (7) of section 641.42, Florida Statutes, are amended to read:

641.42 Prepaid health clinic contracts.--

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

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

1 form has been affirmatively approved or disapproved by the
2 department. The approval of any such form by the department
3 constitutes a waiver of any unexpired portion of such waiting
4 period. The department may extend by not more than an
5 additional 15 days the period within which the department may
6 so affirmatively approve or disapprove any such form, by
7 giving notice of such extension before the expiration of the
8 initial 30-day period. At the expiration of any such period
9 as so extended, and in the absence of such prior affirmative
10 approval or disapproval, such form shall be deemed approved.
11 The department may, for cause, withdraw a previous approval.
12 No clinic shall issue or use any form which has been
13 disapproved by the department or any form for which the
14 department has withdrawn approval.
15 (c) The department shall disapprove any form filed
16 under this subsection, or withdraw any previous approval of
17 the form, only if the form:
18 1. Is in any respect in violation of, or does not
19 comply with, any provision of this part or rule adopted under
20 this part.
21 2. Contains or incorporates by reference, where such
22 incorporation is otherwise permissible, any inconsistent,
23 ambiguous, or misleading clauses, or exceptions and conditions
24 which deceptively affect the risk purported to be assumed in
25 the general coverage of the contract.
26 3. Has a misleading title, misleading heading, or
27 other indication of the provisions of the form which is
28 misleading.
29 4. Is printed or otherwise reproduced in such manner
30 as to render any material provision of the form substantially
31 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

1 that are excessive, inadequate, or unfairly discriminatory.
2 Rates are not unfairly discriminatory because they are
3 averaged broadly among persons insured under group, blanket,
4 or franchise policies. The commission ~~department~~ may require
5 the submission of any other information reasonably necessary
6 in determining whether to approve or disapprove a filing made
7 under this section or s. 642.025.
8 Section 88. Subsection (2) of section 648.33, Florida
9 Statutes, is amended to read:
10 648.33 Bail bond rates.--
11 (2) It is unlawful for a bail bond agent to execute a
12 bail bond without charging a premium therefor, and the premium
13 rate may not exceed or be less than the premium rate as filed
14 with and approved by the commission ~~department~~.
15 Section 89. Effective upon this act becoming law, the
16 Governor may make appointments to the Insurance Rating
17 Commission pursuant to section 624.371, Florida Statutes, as
18 created by this act, for terms of office beginning on January
19 1, 2001.
20 Section 90. Effective January 1, 2001, all activities
21 and functions of the Department of Insurance related to
22 reviewing, approving, or establishing rates for insurers and
23 other entities regulated by the department are transferred to
24 the Insurance Rating Commission pursuant to a type two
25 transfer as defined in section 20.06, Florida Statutes.
26 Effective upon this act becoming law, the Department of
27 Insurance and the Executive Office of the Governor shall
28 jointly prepare a budget amendment pursuant to chapter 216,
29 Florida Statutes, to implement the plan, in consultation with
30 the legislative committees having jurisdiction over the
31 Department of Insurance.

1 Section 91. Effective January 1, 2001, the sum of
2 $334,125 is appropriated for the 2000-2001 fiscal year from
3 the Insurance Commissioner's Regulatory Trust Fund to the
4 Insurance Rating Commission for the purposes of carrying out
5 the provisions of this act.
6 Section 92. By January 31, 2001, the Division of
7 Statutory Revision of the Office of Legislative Services shall
8 prepare and submit to the President of the Senate and the
9 Speaker of the House of Representatives draft substantive
10 legislation to conform the Florida Statutes to the provisions
11 of this act. The legislation shall not be drafted as a
12 reviser's bill. The draft shall include provisions:
13 (1) Changing the term "Comptroller" or "Treasurer" to
14 "Chief Financial Officer" with respect to functions of the
15 Chief Financial Officer where appropriate;
16 (2) Changing references to the "Department of Banking
17 and Finance" or the "Department of Insurance" to the
18 "Department of Financial Services" where appropriate; and
19 (3) Otherwise conforming the statutes to the abolition
20 of the offices of Comptroller and Treasurer, the creation of
21 the Office of the Chief Financial Officer, the abolition of
22 the Department of Banking and Finance and the Department of
23 Insurance, and the creation of the Department of Financial
24 Services.
25 Section 93. (1) The Financial Services Transition
26 Task Force is established. All members of the task force shall
27 be appointed prior to September 1, 2000. The task force shall
28 be composed of:
29 (a) One consumer a representative appointed by the
30 Governor;
31 (b) Two members appointed by the President of the

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

1 (5) The task force shall submit an initial report to
2 the Governor, the President of the Senate, and the Speaker of
3 the House of Representatives by January 1, 2001.
4 (6) The task force shall submit a final report to the
5 Governor, the President of the Senate, and the Speaker of the
6 House of Representatives by January 1, 2002.
7 (7) The task force terminates upon submission of its
8 final report.
9 Section 94. Effective July 1, 2000, section 442.0011,
10 Florida Statutes, is created to read:
11 442.0011 Exclusion from chapter.--This chapter is not
12 applicable to any firefighter employee, and firefighter
13 employer, or any place of firefighter employment covered by
14 ss. 633-801 through 633.830.
15 Section 95. Effective July 1, 2000, section 633.801,
16 Florida Statutes, is created to read:
17 633.801 Short title.--Sections 633.801 through 633.830
18 may be cited as the "Florida Firefighters Occupational Safety
19 and Health Act."
20 Section 96. Effective July 1, 2000, section 633.802,
21 Florida Statutes, is created to read:
22 633.802 Definitions.--Unless the context clearly
23 requires otherwise, the following definitions apply to ss.
24 633.801 through 633.830:
25 (1) "Department" means the Department of Insurance.
26 (2) "Division" means the Division of State Fire
27 Marshal of the Department of Insurance.
28 (3) "Firefighter employee" means any person engaged in
29 any employment, public or private, as a firefighter under any
30 appointment or contract of hire or apprenticeship, express or
31 implied, oral or written, whether lawfully or unlawfully

1 employed, and includes all volunteer firefighters responding
2 to or assisting with fire or medical emergencies whether or
3 not the firefighter is on duty.
4 (4) "Firefighter employer" means the state and all
5 political subdivisions thereof, all public and quasi-public
6 corporations therein, and every person carrying on any
7 employment thereof, which employs firefighters or which uses
8 volunteer firefighters.
9 (5) "Firefighter employment" or "employment" means any
10 service performed by a firefighter employee for the
11 firefighter employer, and includes the use of all volunteer
12 firefighters.
13 (6) "Firefighter place of employment" or "place of
14 employment" means the physical location at which the
15 firefighter is employed.
16 Section 97. Effective July 1, 2000, section 633.803,
17 Florida Statutes, is created to read:
18 633.803 Legislative intent.--It is the intent of the
19 Legislature to enhance firefighter occupational safety and
20 health in this state through the implementation and
21 maintenance of policies, procedures, practices, rules, and
22 standards that reduce the incidence of firefighter employee
23 accidents, firefighter occupational diseases, and firefighter
24 fatalities compensable under chapter 440 or otherwise. The
25 Legislature further intends that the division develop a means
26 by which it can identify individual firefighter employers with
27 a high frequency or severity of work-related injuries; conduct
28 safety inspections of those firefighter employers; and assist
29 those firefighter employers in the development and
30 implemention of firefighter employee safety and health
31 programs. In addition, it is the intent of the Legislature

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

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

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

1 accordance with chapter 120.
2 (3) Assist firefighter employers in the development
3 and implementation of firefighter employee safety training
4 programs by contracting with professional safety
5 organizations.
6 (4) Adopt rules prescribing recordkeeping
7 responsibilities for firefighter employers, which may include
8 rules for maintaining a log and summary of occupational
9 injuries, diseases, and illnesses and for producing on request
10 a notice of injury and firefighter employee accident
11 investigation records, and rules prescribing a retention
12 schedule for such records.
13 Section 103. Effective July 1, 2000, section 633.809,
14 Florida Statutes, is created to read:
15 633.809 Right of entry.--The division and its
16 authorized representatives may enter at any reasonable time
17 any firefighter place of employment for the purpose of
18 examining any tool, appliance, or machinery used in such
19 employment and may make inspections for the proper enforcement
20 of ss. 633.801 through 633.830. A firefighter employer or
21 owner may not refuse to admit any member of the division or
22 its authorized representatives to any firefighter place of
23 employment.
24 Section 104. Effective July 1, 2000, section 633.810,
25 Florida Statutes, is created to read:
26 633.810 Firefighter employers whose firefighter
27 employees have a high frequency of work-related injuries.--The
28 division shall develop a means by which it can identify
29 individual firefighter employers whose firefighter employees
30 have a high frequency or severity of work-related injuries.
31 The division shall carry out safety inspections of the

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

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

1 employee representatives, who are volunteers or are elected by
2 their peers, and of firefighter employer representatives, and
3 specifying the frequency of meetings.
4 (b) Requiring firefighter employers to make adequate
5 records of each meeting and to file and to maintain the
6 records subject to inspection by the division.
7 (c) Prescribing the duties and functions of the
8 workplace safety committee and workplace safety coordinator,
9 which include, but are not limited to:
10 1. Establishing procedures for workplace safety
11 inspections by the committee.
12 2. Establishing procedures investigating all workplace
13 accidents, safety-related incidents, illnesses, and deaths.
14 3. Evaluating accident-prevention and
15 illness-prevention programs.
16 4. Prescribing guidelines for the training of safety
17 committee members.
18 (3) The composition, selection, and function of safety
19 committees shall be a mandatory topic of negotiations with any
20 certified collective bargaining agent for firefighter
21 employers that operate under a collective bargaining
22 agreement. Firefighter employers that operate under a
23 collective bargaining agreement that contains provisions
24 regulating the formation and operation of workplace safety
25 committees that meet or exceed the minimum requirements
26 contained in this section, or firefighter employers who
27 otherwise have existing workplace safety committees that meet
28 or exceed the minimum requirements established by this section
29 are in compliance with this section.
30 (4) Firefighter employees must be compensated their
31 regular hourly wage while engaged in workplace safety

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:
31 633.814 Division cooperation with Federal Government;

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

1 shall be subject to the rules of the division until the
2 firefighter employer complies with subsection (2) and
3 recertifies that fact to the division.
4 (4) This section shall not restrict the division from
5 performing any duties pursuant to a written contract between
6 the division and the Federal Occupational Safety and Health
7 Administration (OSHA).
8 Section 109. Effective July 1, 2000, section 633.815,
9 Florida Statutes, is created to read:
10 633.815 Failure to implement a safety and health
11 program; cancellations.--If a firefighter employer that is
12 found by the division to have a high frequency or severity of
13 work-related injuries fails to implement a safety and health
14 program, the insurer or self-insurer's fund that is providing
15 coverage fo r the firefighter employer may cancel the contract
16 for insurance with the firefighter employer. In the
17 alternative, the insurer or fund may terminate any discount or
18 deviation granted to the firefighter employer for the
19 remainder of the term of the policy. If the contract is
20 canceled or the discount or deviation is terminated, the
21 insurer must make such reports as are required by law.
22 Section 110. Effective July 1, 2000, section 633.816,
23 Florida Statutes, is created to read:
24 633.816 Expenses of administration.--The amounts that
25 are needed to administer ss. 633.801 through 633.830 shall be
26 disbursed from the Insurance Commissioner's Regulatory Trust
27 Fund.
28 Section 111. Effective July 1, 2000, section 633.817,
29 Florida Statutes, is created to read:
30 633.817 Refusal to admit; penalty.--The division and
31 its authorized representatives may enter and inspect any place

1 of firefighter employment at any reasonable time for the
2 purpose of investigating compliance with ss. 633.801 through
3 633.830 and conducting inspections for the proper enforcement
4 of ss. 633.801 through 633.830. A firefighter employer who
5 refuses to admit any member of the division or its authorized
6 representative to any place of employment or to allow
7 investigation and inspection pursuant to this section commits
8 a misdemeanor of the second degree, punishable as provided in
9 s. 775.082 or s. 775.083.
10 Section 112. Effective July 1, 2000, section 633.818,
11 Florida Statutes, is created to read:
12 633.818 Firefighter employee rights and
13 responsibilities.--
14 (1) Each firefighter employee of a firefighter
15 employer covered under ss. 633.801 through 633.830 shall
16 comply with rules adopted by the division and with reasonable
17 workplace safety and health standards, rules, policies,
18 procedures, and work practices established by the firefighter
19 employer and the workplace safety committee. A firefighter
20 employee who knowingly fails to comply with this subsection
21 maybe disciplined or discharged by the firefighter employer.
22 (2) A firefighter employer may not discharge, threaten
23 to discharge, cause to be discharged, intimidate, coerce,
24 otherwise discipline, or in any manner discriminate against a
25 firefighter employee for any of the following reasons:
26 (a) The firefighter employee has testified or is about
27 to testify, on her or his own behalf, or on behalf of others,
28 in any proceeding instituted under ss. 633.801 through
29 633.830;
30 (b) The firefighter employee has exercised any other
31 right afforded under ss. 633.801 through 633.830; or

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

1 hearing in accordance with chapter 120, may assess against the
2 insurer a civil penalty of not less than $100 nor more than
3 $5,000 each day the violation, failure, or refusal continues
4 after the insurer has been given written notice thereof. The
5 total penalty for each violation, failure, or refusal may not
6 exceed $50,000. The division shall adopt rules providing for
7 penalties for noncompliance with ss. 633.801 through 633.830
8 by insurers. All penalties assessed and collected under this
9 section shall be deposited in the Insurance Commissioner's
10 Regulatory Trust Fund.
11 Section 116. Effective July 1, 2000, section 633.823,
12 Florida Statutes, is created to read:
13 633.823 Matters within jurisdiction of the division;
14 false, fictitious, or fraudulent acts, statements, and
15 representations prohibited; penalty; statute of
16 limitations.--A person may not, in any matter within the
17 jurisdiction of the division, knowingly and willfully falsify
18 or conceal a material fact; make any false, fictitious, or
19 fraudulent statement or representation; or make or use any
20 false document, knowing the same to contain any false,
21 fictitious, or fraudulent statement or entry. A person who
22 violates this section commits a misdemeanor of the second
23 degree, punishable as provided in s. 775.082 or s. 775.083.
24 The statute of limitations for prosecution of an act committed
25 in violation of this section is 5 years after the date the act
26 was committed or, if not discovered within 30 days after the
27 act was committed, 5 years after the date the act was
28 discovered.
29 Section 117. Effective July 1, 2000, section 633.825,
30 Florida Statutes, is created to read:
31 633.825 Workplace safety.--

1 (1) The division shall assist in making the workplace
2 a safer place to work and decreasing the frequency and
3 severity of on-the-job injuries.
4 (2) The division shall have the authority to adopt
5 rules for the purpose of assuring safe working conditions for
6 all firefighter employees by authorizing the enforcement of
7 effective standards, assisting and encouraging firefighter
8 employers to maintain safe working conditions, and by
9 providing for education and training in the field of safety.
10 For firefighter employers, the division may by rule adopt
11 subparts C through T and subpart Z of 29 C.F.R. part 1910;
12 subparts C through Z of 29 C.F.R. part 1926; subparts A
13 through D, subpart I, and subpart M of 29 C.F.R. part 1928;
14 subparts A through G of 29 C.F.R. part 1917; subparts A
15 through L and subpart Z of 29 C.F.R. part 1915; subparts A
16 through J of 29 C.F.R. part 1918, latest revision, provided
17 that 29 C.F.R. s. 1910.156 applies to volunteer firefighters
18 and fire departments operated by the state or political
19 subdivisions; the National Fire Protection Association, Inc.,
20 Standard 1500, paragraph 5-7 (Personal Alert Safety System)
21 (1992 edition); and ANSI A 10.4-1990.
22 (3) The provisions of chapter 440 which pertain to
23 workplace safety shall be applicable to the division.
24 (4) The division shall have authority to adopt any
25 rule necessary to implement, interpret, and make specific any
26 matter pertaining to any subject or reference contained in
27 this section, including all of the provisions referred to in
28 subsection (2), as they relate to firefighter employees,
29 firefighter employers, and firefighter places of employment.
30 Section 118. Except as otherwise provided in this act,
31 this act shall take effect January 1, 2001.

1 =============== T I T L E A M E N D M E N T ===============
2 And the title is amended as follows:
3 Delete everything before the enacting clause
4
5 and insert:
6 A bill to be entitled
7 An act relating to governmental reorganization;
8 creating s. 17.001, F.S.; establishing the
9 Office of the Chief Financial Officer; creating
10 s. 20.121, F.S.; creating the Department of
11 Financial Services; providing for the Office of
12 the Commissioner of Insurance; providing for
13 the Office of the Commissioner of Financial
14 Institutions; providing for the Office of the
15 Commissioner of Securities and Finance;
16 providing for the office of the Commissioner of
17 the Treasury; establishing the manner of
18 appointment; providing qualifications;
19 transferring the Department of Banking and
20 Finance to the Department of Financial
21 Services; transferring the Department of
22 Insurance to the Department of Financial
23 Services; repealing s. 20.12, F.S.; abolishing
24 the Department of Banking and Finance;
25 repealing s. 20.13, F.S.; abolishing the
26 Department of Insurance; amending s. 20.165,
27 F.S.; transferring the Division of Certified
28 Public Accounting and the Board of Accountancy,
29 of the Department of Business and Professional
30 Regulation to the Department of Financial
31 Services; amending s. 350.061, F.S.;

1 authorizing the Public Counsel to represent the
2 public before the Insurance Rating Commission;
3 amending s. 350.0611, F.S.; authorizing the
4 Public Counsel to represent the public before
5 the Insurance Rating Commission; amending s.
6 350.0613, F.S.; requiring the Insurance Rating
7 Commission to furnish pleadings to the Public
8 Counsel; creating s. 624.055, F.S.; defining
9 the term "commission"; redesignating parts of
10 ch. 624, F.S.; creating sections
11 624.37-624.377, F.S.; creating the Insurance
12 Rating Commission; establishing its powers and
13 duties; providing for the appointment and
14 confirmation of commissioners; establishing
15 terms of office and qualifications of
16 commissioners; establishing standards of
17 conduct; amending ss. 175.141, 185.12, 408.701,
18 651.018, F.S.; conforming references; amending
19 s. 624.19, F.S.; authorizing the use of forms;
20 amending s. 624.321, F.S.; conforming
21 provisions to include the Insurance Rating
22 Commission; amending s. 624.322, F.S.;
23 conforming provisions to include the Insurance
24 Rating Commission; amending s. 626.9541, F.S.;
25 conforming provisions to substitute the
26 Insurance Rating Commission for the Department
27 of Insurance; amending s. 626.9926, F.S.;
28 conforming provisions to include the Insurance
29 Rating Commission; amending s. 627.031, F.S.;
30 substituting the Insurance Rating Commission
31 for the Department of Insurance; amending s.

1 627.0612, F.S.; conforming provisions to
2 include the commission; amending s. 627.0613,
3 F.S.; removing authority of the consumer
4 advocate; amending s. 627.062, F.S.; conforming
5 provisions to substitute the commission for the
6 department; repealing arbitration provisions;
7 amending s. 627.0628, F.S.; modifying
8 membership on the Florida Commission on
9 Hurricane Loss Projection Methodology; amending
10 ss. 627.0645, 627.06501, 627.0651, 627.0653,
11 627.06535, 627.0654, 627.066, 627.072, 627.091,
12 627.0915, 627.0916, 627.096, 627.101, 627.111,
13 627.141, 627.151, 627.192, 627.211, 627.212,
14 627.215, 627.221, 627.231, F.S.; substituting
15 the Insurance Rating Commission for the
16 department; amending ss. 627.241, 627.281,
17 627.291, 627.301, 627.311, 627.314, 627.331,
18 627.351, 627.3512, 627.357, 627.361, 627.410,
19 627.411, 627.6475, 627.6498, 627.6675,
20 627.6699, 627.6745, 627.678, 627.682, 627.727,
21 627.780, 627.782, 627.7825, 627.783, 627.793,
22 627.9407, 636.017, 641.19, 641.31, 641.3903,
23 641.3922, 641.402, 641.42, 642.027, 648.33,
24 F.S.; conforming provisions to changes made by
25 this act; authorizing the Governor to make
26 appointments to the Insurance Rating
27 Commission; transferring regulatory authority
28 related to rates to the Insurance Rating
29 Commission; providing an appropriation;
30 directing the Division of Statutory Revision to
31 prepare draft legislation; establishing the

1 Financial Services Transition Task Force;
2 providing membership; establishing duties;
3 creating ss. 442.0011 and 633.801-633.825,
4 F.S.; transferring to the Division of State
5 Fire Marshal, Department of Insurance, all
6 powers, duties, and responsibilities of chapter
7 442, excluding ss. 442.101 through 442.127,
8 which relate to firefighter employers,
9 firefighter employees, and firefighter places
10 of employment, from the Division of Safety,
11 Department of Labor and Employment Security;
12 providing an effective date.
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