A bill to be entitled

An act relating to insurance regulation; amending s. 624.316, F.S.; increasing a time period for required insurer examinations by the Department of Financial Services; deleting provisions authorizing the department to accept certain accountant audit reports in lieu of examinations; expanding the group of entities authorized to conduct insurer examinations; revising commission examination rules criteria; amending s. 624.319, F.S.; requiring insurers to provide copies of certain documents; creating s. 624.4045, F.S.; authorizing the office to examine certain insurers for compliance with certain federal laws; authorizing the office to report to and cooperate with certain federal authorities; amending s. 624.4095, F.S.; requiring certain parent companies to maintain certain premium to surplus ratios; amending s. 624.413, F.S.; requiring certain insurers to provide the Office of Insurance Regulation with certain additional documents when applying for a certificate of authority; amending s. 624.418, F.S.; providing an additional criterion requiring the office to suspend or revoke an insurer's certificate of authority; amending s. 624.424, F.S.; authorizing the office to require insurers to submit certain actuarial certifications in annual statements; amending s. 624.4622, F.S.; specifying organization and operation requirements for certain local government self-insurance funds; creating s. 624.4685, F.S.; authorizing the department to establish and order certain financial requirements for commercial self-insurance funds;

providing limitations; specifying certain reinsurance financial requirements for such funds; amending s. 624.610, F.S.; specifying certain asset requirements for funds in certain trusts; authorizing certain letters of credit to be used to fund certain trust financial requirements; amending s. 625.121, F.S.; providing additional standards for valuation of certain insurance policies and contracts; amending s. 625.131, F.S.; requiring insurers to establish and maintain certain reserves as to certain life insurance policies; amending s. 625.304, F.S.; requiring an insurers' board of directors or governing body to adopt certain investment plans; providing criteria; specifying duties and responsibilities of such boards of directors relating to investments and such plan; amending s. 625.326, F.S.; specifying additional limitations on certain foreign bonds, notes, or stocks an insurer is authorized to invest in; amending s. 626.88, F.S.; revising definitions; amending s. 626.8805, F.S.; specifying additional documents required to be filed with the office by an administrator applying for a certificate of authority; specifying document requirements; amending s. 626.8817, F.S.; specifying duties and responsibilities for insurers using administrator services; amending s. 626.89, F.S.; specifying certain annual report financial statement requirements; authorizing the commission to require by rule electronic filing of reports or filings; amending s. 626.901, F.S.; limiting application of certain prohibited practices provisions to certain independently procured out

of state coverages; amending s. 626.902, F.S.; limiting application of certain penalties for representing unauthorized insurers to certain matters authorized by the office; amending s. 626.9913, F.S.; authorizing the commission to require by rule electronic filing of reports or filings; creating s. 627.0646, F.S.; authorizing the office to develop and recommend commission adoption of certain uniform rate adjustment factors; providing limitations on and requirements for certain rate adjustment filings using such factors; authorizing the commission to adopt implementing rules; preserving application; providing for flex rate filings; providing for application to certain types of insurance; providing exemptions; providing limitations on and requirements for flex rate filings; providing responsibilities of the office; providing for effects of flex rate filings; authorizing the commission to adopt certain procedural rules; prohibiting excessive, inadequate, or unfairly discriminatory flex rate filings; authorizing the commission to adopt rules; amending s. 627.351, F.S.; requiring the Joint Underwriting Association to include a Florida Patient's Compensation Fund Account under a joint underwriting plan for certain purposes; requiring certain insurers to be members of a separate Coverage Account within the association; providing for transfer of certain property of the association to the Coverage Account; prohibiting use of assets or revenues of either account for certain purposes; requiring both accounts to be subject to the board of directors of the association;

specifying plan coverage requirements for the Coverage Account; amending s. 627.476, F.S.; providing an additional table option for calculating certain insurance policy premiums and values; amending s. 627.836, F.S.; authorizing the commission to require by rule electronic filing of reports or filings; creating s. 627.8401, F.S.; prohibiting certain investments by premium finance companies; amending s. 627.915, F.S.; revising a market share percentage calculation methodology for certain insurer premiums; amending s. 627.943, F.S.; specifying certain feasibility study preparation requirements; requiring periodic update of the study under certain circumstances; providing for exempting certain insurer certificate of authority applications from certain capital funds and surplus requirements; authorizing the office to contract for independent expert review of the study; amending s. 628.071, F.S.; providing an additional criterion for office examination and investigation of certain permit applications; creating s. 628.072, F.S.; requiring certain insurers to establish and maintain certain governance practices for certificate of authority purposes; providing requirements; authorizing the commission to adopt rules for certain governance practices; providing rule requirements; amending s. 628.371, F.S.; providing limitations on certain extraordinary dividends or distributions by domestic insurers; providing a definition; providing criteria; providing an exception; deleting certain dividend or distribution limitations; providing additional factors for

office review of certain distributions or dividends; amending ss. 628.461 and 628.4615, F.S.; specifying additional nonapplication of certain acquisition of controlling stock provisions to changes in ownership of certain insurers under certain circumstances; amending s. 628.709, F.S.; deleting a provision excluding certain mutual insurers from authorization to undergo certain reorganization; creating s. 634.042, F.S.; prohibiting certain investments or loans by motor vehicle service agreement companies; creating s. 634.3076, F.S.; prohibiting certain investments or loans by home warranty associations; creating s. 634.4062, F.S.; prohibiting certain investments or loans by service warranty associations; amending s. 636.043, F.S.; revising certain financial condition reporting requirements for prepaid limited health service organizations; authorizing the office to require certain certification updates under certain circumstances; requiring such organizations to periodically file certain financial statements; providing fines for failure to file certain reports; providing for deposit of such fines into the Insurance Regulatory Trust Fund; limiting the total amount of such fines; requiring such organizations to retain certain accountants for certain purposes; specifying duties and responsibilities of such accountants; authorizing the commission to adopt certain financial statement forms by rule; authorizing the commission to require filing certain information electronically; requiring such organizations to file certain information with the office; requiring such

organizations to file certain statements electronically; requiring such organizations to pay certain document filing and analysis fees; amending s. 641.22, F.S.; providing an additional criterion for office issuance of a certificate of authority to certain health maintenance organizations; amending s. 641.23, F.S.; providing an additional criterion for office suspension or revocation of certain health maintenance organization authority or certificate; amending s. 641.27, F.S.; increasing a time period for required health maintenance organization examinations by the office; deleting provisions authorizing the office to accept certain accountant audit reports in lieu of examinations; deleting an expense limitation on certain examinations; amending s. 641.30, F.S.; requiring health maintenance organizations to comply with certain governance requirements; amending s. 641.409, F.S.; authorizing prepaid health clinics to make certain deposits with the office in lieu of certain surety bond requirements; increasing a required cash deposit by such clinics for certain purposes; amending ss. 651.026 and 651.0261, F.S.; authorizing the commission to require by rule electronic submission of certain reports or filings; creating s. 651.0265, F.S.; prohibiting certain investments or loans by certain providers; amending s. 651.033, F.S.; clarifying certain escrow account requirements; amending s. 766.105, F.S.; specifying that the Florida Patient's Compensation Fund is the Florida Patient's Compensation Fund Account within a medical malpractice risk apportionment plan; requiring such

account to be subject to supervision and approval by the plan's board of governors; deleting provisions specifying membership of the board of governors; revising and clarifying provisions relating to the fund as relating to the fund account; granting certain domestic insurers on year to comply with certain rules; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (a), (e), and (f) of subsection (2) of section 624.316, Florida Statutes, are amended to read:

624.316 Examination of insurers.--

(2)(a) Except as provided in paragraph (f), the office may examine each insurer as often as may be warranted for the protection of the policyholders and in the public interest, and shall examine each domestic insurer not less frequently than once every 5 ~~3~~ years. The examination shall cover the preceding 5 ~~3~~ fiscal years of the insurer and shall be commenced within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the insurer's operations since the last previous examination. The examination may include examination of events subsequent to the end of the most recent fiscal year and the events of any prior period that affect the present financial condition of the insurer. ~~In lieu of making its own examination, the office may accept an independent certified public accountant's audit report prepared on a statutory basis consistent with the Florida Insurance Code on that specific company. The office may not~~

~~accept the report in lieu of the requirement imposed by paragraph (1)(b). When an examination is conducted by the office for the sole purpose of examining the 3 preceding fiscal years of the insurer within 12 months after the opinion date of an independent certified public accountant's audit report prepared on a statutory basis on that specific company consistent with the Florida Insurance Code, the cost of the examination as charged to the insurer pursuant to s. 624.320 shall be reduced by the cost to the insurer of the independent certified public accountant's audit reports. Requests for the reduction in cost of examination must be submitted to the office in writing no later than 90 days after the conclusion of the examination and shall include sufficient documentation to support the charges incurred for the statutory audit performed by the independent certified public accountant.~~

(e) The commission shall adopt rules providing that~~, upon agreement between the office and the insurer,~~ an examination under this section may be conducted by independent certified public accountants, actuaries, investment specialists, information technology specialists ~~meeting criteria specified by rule~~, and reinsurance specialists meeting criteria specified by rule. The rules shall provide:

~~1. That the agreement of the insurer is not required if the office reasonably suspects criminal misconduct on the part of the insurer.~~

~~2. That the office shall provide the insurer with a list of three firms acceptable to the office, and that the insurer shall select the firm to conduct the examination from the list provided by the office.~~

1.~~3.~~ That the insurer being examined must make payment for the examination directly to the firm performing the examination in accordance with the rates and terms established ~~agreed to~~ by the office~~, the insurer,~~ and the firm performing the examination.

2. That the rates charged to the insurer being examined are consistent with rates charged by other firms in a similar profession.

3. That the firm selected by the office to perform the examination has no conflicts of interest that might affect its ability to independently perform its responsibilities on the examination.

~~4. That if the examination is conducted without the consent of the insurer, the insurer must pay all reasonable charges of the examining firm if the examination finds impairment, insolvency, or criminal misconduct on the part of the insurer.~~

(f)~~1.a.~~ An examination under this section must be conducted at least once every year with respect to a domestic insurer that has continuously held a certificate of authority for less than 3 years. The examination must cover the preceding fiscal year or the period since the last examination of the insurer. The office may limit the scope of the examination.

~~b. The office may not accept an independent certified public accountant's audit report in lieu of an examination required by this subparagraph.~~

~~c. An insurer may not be required to pay more than $25,000 to cover the costs of any one examination under this subparagraph.~~

~~2. An examination under this section must be conducted not less frequently than once every 5 years with respect to an insurer that has continuously held a certificate of authority, without a change in ownership subject to s. 624.4245 or s. 628.461, for more than 15 years. The examination must cover the preceding 5 fiscal years of the insurer or the period since the last examination of the insurer. This subparagraph does not limit the ability of the office to conduct more frequent examinations.~~

Section 2. Subsection (1) of section 624.319, Florida Statutes, is amended to read:

624.319 Examination and investigation reports.—

(1) The department or office or its examiner shall make a full and true written report of each examination. The examination report shall contain only information obtained from examination of the records, accounts, files, and documents of or relative to the insurer examined or from testimony of individuals under oath, together with relevant conclusions and recommendations of the examiner based thereon. The insurer shall provide copies of documents upon request by the examiner. The department or office shall furnish a copy of the examination report to the insurer examined not less than 30 days prior to filing the examination report in its office. If such insurer so requests in writing within such 30-day period, the department or office shall grant a hearing with respect to the examination report and shall not so file the examination report until after the hearing and after such modifications have been made therein as the department or office deems proper.

Section 3. Section 624.4045, Florida Statutes, is created

to read:

624.4045 Compliance with federal laws.--Any entity issued a certificate of authority by the office, or otherwise regulated by the office under the Insurance Code or any part thereof, when such entity is subject to compliance with Pub. L. No. 107-56, commonly referred to as the "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT Act) Act of 2001," may be examined or investigated by the office to determine compliance with such law. The office may report and provide evidence to the appropriate federal authorities of any possible violations of such law which are discovered and may cooperate with any subsequent federal investigation.

Section 4. Subsection (7) is added to section 624.4095, Florida Statutes, to read:

624.4095 Premiums written; restrictions.--

(7) If the parent company and its subsidiary are both insurers, in addition to individual insurer compliance pursuant to subsection (1), the parent company must also comply with this section using consolidated direct and net premium compared to the parent company's surplus.

Section 5. Effective January 1, 2005, paragraph (k) is added to subsection (1) of section 624.413, Florida Statutes, to read:

624.413 Application for certificate of authority.--

(1) To apply for a certificate of authority, an insurer shall file its application therefor with the office, upon a form adopted by the commission and furnished by the office, showing its name; location of its home office and, if an alien insurer,

its principal office in the United States; kinds of insurance to be transacted; state or country of domicile; and such additional information as the commission reasonably requires, together with the following documents:

(k) If a domestic stock or mutual insurer, documents that demonstrate the ability to comply with s. 628.072 and rules adopted under such section.

Section 6. Effective January 1, 2005, paragraph (h) is added to subsection (1) of section 624.418, Florida Statutes, to read:

624.418 Suspension, revocation of certificate of authority for violations and special grounds.--

(1) The office shall suspend or revoke an insurer's certificate of authority if it finds that the insurer:

(h) If a domestic stock or mutual insurer, failed to maintain and demonstrate compliance with s. 628.072 and rules adopted under such section.

Section 7. Paragraph (b) of subsection (1) of section 624.424, Florida Statutes, is amended to read:

624.424 Annual statement and other information.--

(1)

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require an insurer to submit an actuarial certification prepared

by an independent actuary and semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

Section 8. Subsections (3), (4), and (5) are added to section 624.4622, Florida Statutes, to read:

624.4622 Local government self-insurance funds.--

(3) Notwithstanding the provisions of subsection (2), a local government self-insurance fund created under this section after October 1, 2004, shall initially be organized as a commercial self-insurance fund under s. 624.462 or a group self-insurance fund under s. 624.4621 and, for the first 5 years of its existence, shall be subject to all the requirements applied to commercial self-insurance funds or to group self-insurance funds, respectively.

(4)(a) A local government self-insurance fund formed after January 1, 2005, shall, for its first 5 fiscal years, file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding fiscal year shall be filed within 60 days after the end of the fund's fiscal year and quarterly statements shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting

principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the self-insurance fund. The form for financial statements shall be the form currently approved by the National Association of Insurance Commissioners for use by property and casualty insurers.

(b) Each annual statement shall contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries. Workpapers in support of the statement of opinion must be provided to the office upon request.

(5) A local government self-insurance fund shall maintain surplus to policyholders in a positive amount.

Section 9. Section 624.4685, Florida Statutes, is created to read:

624.4685 Premiums written; restrictions.--

(1) If, during the first 6 full calendar years of its operation, a commercial self-insurance fund's actual or projected annual earned premiums exceed four times the sum of 10 percent of the fund's statutory unearned premium as reported in its most recent report made pursuant to s. 624.470(2)(a) plus the aggregate excess of loss reinsurance limits available for the year reported, established in accordance with subsection (2), the department may establish by order maximum net annual premiums to be written by the fund consistent with maintaining such ratio between actual or projected earned premiums and unearned premiums and aggregate excess of loss reinsurance, unless the fund demonstrates to the department's satisfaction that exceeding such limitations does not endanger the financial condition of the fund

or endanger the interest of the fund's members or that the fund's operation is and will be actuarially sound without obtaining excess reinsurance. Such orders shall be in effect no longer than the end of the current calendar year. The fund's self-funded reinsurance, if any, shall be included as aggregate excess of loss reinsurance at an amount that will be sufficient to cover unpaid losses as actuarially determined.

(2) With respect to subsection (1), the aggregate excess of loss reinsurance shall attach at a point, not greater than the loss ratio, above which an assessment would be indicated pursuant to rules of the department adopted under the authority of this chapter. At a minimum, the aggregate excess of loss reinsurance shall also provide coverage for 100 percent of the losses between the attachment point required by this subsection and a loss ratio of 100 percent.

(3) After the 6th full calendar year of operation, a commercial self-insurance fund may, instead of limiting actual or projected premium to the ratio specified in subsection (1), maintain aggregate excess of loss reinsurance limits, subject to minimum limits enumerated in subsection (4), equal to the difference between the loss ratio at which an assessment would be indicated pursuant to rules adopted by the department and a loss ratio 10 percentage points higher than the highest loss ratio from the most recent 6 calendar years as indicated on the property and casualty annual statement report, after including excess statutory reserves over statement reserves, for auto liability, other liability, medical malpractice, workers' compensation, and credit insurance. For commercial lines of business other than auto liability, other liability, medical

malpractice, workers' compensation, and credit, the amount required by Schedule P shall be calculated in the same manner as auto liability and shall be calculated for each line of business individually. However, if a fund fails or chooses not to maintain the aggregate excess reinsurance as specified in this subsection, the fund shall be subject to the provisions of subsection (1).

(4) A commercial self-insurance fund maintaining aggregate excess of loss reinsurance pursuant to subsection (3) must, at a minimum, maintain dollar limits of aggregate excess of loss reinsurance as follows:

(a) For funds with actual or projected earned premiums of $5,000,000 or less, the minimum shall be equal to 25 percent of actual or projected earned premiums or $500,000, whichever is greater.

(b) For funds with actual or projected earned premiums greater than $5,000,000, the minimum shall be:

Actual or Projected Earned Premiums	Percent of Earned Premium
$5,000,000.01-$10,000,000	22 percent
$10,000,000.01-$25,000,000	19 percent
$25,000,000.01-$50,000,000	16 percent
$50,000,000.01-$100,000,000	13 percent
$100,000,000.01-$250,000,000	10 percent
$250,000,000.01 and greater	7 percent

(5) Notwithstanding other provisions of this section, the department may, by order, establish maximum gross or net annual premiums to be written if the department, for good cause shown,

finds that the actual or projected premium volume of the fund endangers the interests of the fund's policyholders or the financial condition of the fund.

Section 10. Paragraph (c) of subsection (3) of section 624.610, Florida Statutes, is amended to read:

624.610 Reinsurance.--

(3)

(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (5)(b), for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.

2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(I) The insurance regulator of the state in which the trust is domiciled; or

(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the

ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.

c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.

3. The following requirements apply to the following categories of assuming insurer:

a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean,

irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (5)(a), effective no later than December 31 of the year for which the filing is made, and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.

b.(I) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this section, the trust consists of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(II) The incorporated members of the group must not be engaged in any business other than underwriting of a member of the group, and are subject to the same level of regulation and

solvency control by the group's domiciliary regulator as the unincorporated members.

(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

Section 11. Effective July 1, 2004, paragraphs (a), (e), and (f) of subsection (5) of section 625.121, Florida Statutes, are amended, and paragraphs (k) and (l) are added to said subsection, to read:

625.121 Standard Valuation Law; life insurance.--

(5) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.--Except as otherwise provided in paragraph (h) and subsections (6), (11), and (14), the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of s. 627.476 (Standard Nonforfeiture Law for Life Insurance) shall be the commissioners' reserve valuation method defined in subsections (7), (11), and (14); 5 percent interest for group annuity and pure endowment contracts and 3.5 percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, 4 percent interest for such policies issued prior to October 1, 1979, and 4.5

percent interest for such policies issued on or after October 1, 1979; and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies:

1. For policies issued prior to the operative date of s. 627.476(9), the commissioners' 1958 Standard Ordinary Mortality Table; except that, for any category of such policies issued on female risks, modified net premiums and present values, referred to in subsection (7), may be calculated according to an age not more than 6 years younger than the actual age of the insured.~~; and~~

2. For policies issued on or after the operative date of s. 627.476(9), the commissioners' 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioners' 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.

3. For policies issued on or after July 1, 2004, ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for such policies.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:

1. For policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit.~~;~~

2. For policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either those tables or, at the option of the insurer, the class three disability table (1926).~~; and~~

3. For policies issued prior to January 1, 1961, the class three disability table (1926); and

4. For policies or contracts issued on or after July 1, 2004, tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies or contracts.

Any such table for active lives shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies:

1. For policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table.~~;~~

2. For policies issued on or after January 1, 1961, and prior to January 1, 1966, either that table or, at the option of the insurer, the Intercompany Double Indemnity Mortality Table.~~;~~ ~~and~~

3. For policies issued prior to January 1, 1961, the Intercompany Double Indemnity Mortality Table; and

4. For policies issued on or after July 1, 2004, tables of accidental death benefits adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the

commission for use in determining the minimum standard of valuation for those policies.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(k) For individual annuity and pure endowment contracts issued on or after July 1, 2004, excluding any disability and accidental death benefits purchased under those contracts, individual annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

(l) For all annuities and pure endowments purchased on or after July 1, 2004, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts, group annuity mortality tables adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.

Section 12. Effective July 1, 2004, section 625.131, Florida Statutes, is amended to read:

625.131 Credit life and disability policies, special reserve bases.--

(1) The minimum reserve for single-premium credit disability insurance, monthly premium credit life insurance and monthly premium credit disability insurance shall be the unearned gross premium.

(2) As to single-premium credit life insurance policies,

the insurer shall establish and maintain reserves which are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the National Association of Insurance Commissioners' 1980 Standard Ordinary Mortality Table and 3.5 percent interest. At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.

(3) As to single-premium credit life insurance policies, issued on or after July 1, 2004, the insurer shall establish and maintain reserves which are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners, that are adopted by rule by the commission, and 3.5 percent interest. At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of such requirement, reserves based upon unearned gross premiums may be used at the option of the insurer.

Section 13. Section 625.304, Florida Statutes, is amended to read:

625.304 Authorization of investment.--

(1) An insurer shall not make any investment or loan, other than a policy loan or annuity contract loan of a life insurer, unless the same is authorized or approved by the

insurer's board of directors or by a committee authorized by such board and charged with the supervision or making of such investment or loan. The minutes of any such committee shall be recorded and regular reports of such committee shall be submitted to the board of directors.

(2) An insurer's board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity, and diversification of investments and other specifications, including, but not limited to, investment strategies intended to ensure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus. The board shall review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written plan concerning an investment strategy or investment practice.

(3) Investments acquired and held under this section shall be acquired and held under the supervision and direction of the board of directors of the insurer. The board of directors shall evidence by formal resolution, at least annually, that the board has determined whether all investments have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

(4) On no less than a quarterly basis, and more often if deemed appropriate, an insurer's board of directors or committee of the board of directors shall:

(a) Receive and review a summary report on the insurer's investment portfolio, its investment activities, and its investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan.

(b) Review and revise, as appropriate, the written plan.

(5) In discharging its duties under this section, the board of directors shall require that records of any authorizations or approvals, or other documentation as the board may require, and reports of any action taken under authority delegated under the plan referred to in subsection (2), shall be made available on a regular basis to the board of directors.

(6) In discharging their duties under this section, the directors of an insurer shall perform their duties in good faith and with that degree of care that ordinarily prudent individuals in like positions would use under similar circumstances.

(7) If an insurer does not have a board of directors, all references to the board of directors in this section shall be deemed to be references to the governing body of the insurer having authority equivalent to that of a board of directors.

Section 14. Subsection (2) of section 625.326, Florida Statutes, is amended to read:

625.326 Foreign investments.--An insurer authorized to transact insurance in a foreign country may have funds invested in such securities as may be required for such authority and for the transaction of such business. Canadian securities eligible for investment under other provisions of this part are not subject to this section. Subject to the approval of the office:

(2) In addition to Canadian securities eligible for

investment and to investments in countries in which an insurer transacts insurance, an insurer may invest in bonds, notes, or stocks of any foreign country or corporation if such securities meet ~~security meets~~ the general requirements of s. 625.303 and in the aggregate do not exceed 10 ~~does not exceed, in total, 5~~ percent of admitted assets, subject to the following limitations:

(a) No more than 3 percent of the insurer's assets shall be invested in any security not rated by the Security Valuation Office of the National Association of Insurance Commissioners as 1 or 2, except that securities rated as 5 or 6 by the Security Valuation Office of the National Association of Insurance Commissioners shall not exceed 1.5 percent of assets in total with no more than 0.5 percent of assets in securities that have been given a rating of 6.

(b) No more than 3 percent of the insurer's assets shall be invested in the common stock of any one corporation.

(c) In determining the financial condition of an insurer, any amounts that exceed the limitations in paragraphs (a) and (b) in valuation shall be considered as non-admitted assets unless the investments otherwise qualify under the provision of s. 625.331(1).

Section 15. Section 626.88, Florida Statutes, is amended to read:

626.88 Definitions of "administrator" and "insurer".--

(1) For the purposes of this part, an "administrator" is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with

authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage or coverage of any other expenses described in s. 624.33(1) or any person who, through a health care risk contract as defined in s. 641.234 with an insurer or health maintenance organization, provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers, other than any of the following persons:

(a) An employer or wholly owned direct or indirect subsidiary of an employer, on behalf of such employer's employees or the employees of one or more subsidiary or affiliated corporations of such employer.

(b) A union on behalf of its members.

(c) An insurance company which is either authorized to transact insurance in this state or is acting as an insurer with respect to a policy lawfully issued and delivered by such company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business.

(d) A health care services plan, health maintenance organization, professional service plan corporation, or person in the business of providing continuing care, possessing a valid certificate of authority issued by the office, and the sales representatives thereof, if the activities of such entity are limited to the activities permitted under the certificate of authority.

(e) An administrator who is affiliated with an insurer and who only performs the contractual duties, between the administrator and the insurer, of an administrator for the direct and assumed insurance business of the affiliated insurer.

The insurer is responsible for the acts of the administrator and is responsible for providing all of the administrator's books and records to the insurance commissioner, upon a request from the insurance commissioner. For purposes of this paragraph, "insurer" means a licensed insurance company, prepaid hospital or medical care plan, or a health maintenance organization.

(f) A nonresident administrator licensed in its state of domicile if the administrator's duties in this state are limited to the administration of a group policy or plan of insurance and no more than a total of 100 lives for all plans reside in this state.

(g)~~(e)~~ An insurance agent licensed in this state whose activities are limited exclusively to the sale of insurance.

(h) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license.

(i)~~(f)~~ An adjuster licensed in this state whose activities are limited to the adjustment of claims.

(j)~~(g)~~ A creditor on behalf of such creditor's debtors with respect to insurance covering a debt between the creditor and its debtors.

(k)~~(h)~~ A trust and its trustees, agents, and employees acting pursuant to such trust established in conformity with 29 U.S.C. s. 186.

(l)~~(i)~~ A trust exempt from taxation under s. 501(a) of the Internal Revenue Code, a trust satisfying the requirements of ss. 624.438 and 624.439, or any governmental trust as defined in s. 624.33(3), and the trustees and employees acting pursuant to such trust, or a custodian and its agents and employees,

including individuals representing the trustees in overseeing the activities of a service company or administrator, acting pursuant to a custodial account which meets the requirements of s. 401(f) of the Internal Revenue Code.

(m)~~(j)~~ A financial institution which is subject to supervision or examination by federal or state authorities or a mortgage lender licensed under chapter 494 who collects and remits premiums to licensed insurance agents or authorized insurers concurrently or in connection with mortgage loan payments.

(n)~~(k)~~ A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized such collection if such company does not adjust or settle claims.

(o)~~(l)~~ A person who adjusts or settles claims in the normal course of such person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life or health insurance coverage.

(p)~~(m)~~ A person approved by the department who administers only self-insured workers' compensation plans.

(q)~~(n)~~ A service company or service agent and its employees, authorized in accordance with ss. 626.895-626.899, serving only a single employer plan, multiple-employer welfare arrangements, or a combination thereof.

(r)~~(o)~~ Any provider or group practice, as defined in s. 456.053, providing services under the scope of the license of the provider or the member of the group practice.

(s)~~(p)~~ Any hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

A person who provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers shall comply with the provisions of ss. 627.6131, 641.3155, and 641.51(4).

(2) For the purposes of this part, the term:

(a) ~~an~~ "Insurer" includes an authorized commercial self-insurance fund and includes any person undertaking to provide life or health insurance coverage or coverage of any of the other expenses described in s. 624.33(1).

(b) "Affiliate," including the term "affiliated," means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(c) "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person.

Section 16. Subsection (2) of section 626.8805, Florida Statutes, is amended to read:

626.8805 Certificate of authority to act as administrator.--

(2) The administrator shall file with the office an application for a certificate of authority upon a form to be adopted by the commission and furnished by the office, which application shall include or have attached the following information and documents:

(a) All basic organizational documents of the administrator, such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents, and all amendments to those documents.

(b) The bylaws, rules, and regulations or similar documents regulating the conduct or the internal affairs of the administrator.

(c) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of the affairs of the administrator, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association, and any other person who exercises control or influence over the affairs of the administrator.

(d) Audited annual financial statements for the 2 most recent fiscal years that prove that the applicant has a positive net worth. If the applicant has been in existence for less than

2 fiscal years, the application shall include financial statements or reports, certified by an officer of the applicant and prepared in accordance with generally accepted accounting principles consistently applied in the United States, for any completed fiscal years, and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial statement or report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and shall comply with the following:

1. Amounts shown on the consolidated audited financial report shall be included on the worksheet.

2. Amounts for each entity shall be stated separately.

3. Explanations of consolidating and eliminating entries shall be included.

The applicant shall also include such other information as the office may require in order to review the current financial condition of the applicant ~~Annual statements or reports for the 3 most recent years, or such other information as the office may require in order to review the current financial condition of the applicant~~.

(e) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting.

(f)~~(e)~~ If the applicant is not currently acting as an administrator, a statement of the amounts and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other principals.

Section 17. Section 626.8817, Florida Statutes, is amended to read:

626.8817 Responsibilities of insurance company with respect to administration of coverage insured.--

(1) If an insurer uses the services of an administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. The rules pertaining to these matters shall be provided, in writing, by the insurer to the administrator. The responsibilities of the administrator as to any of these matters shall be set forth in the written agreement between the administrator and the insurer.

(2) It is the sole responsibility of the insurer to provide for competent administration of its programs.

(3) In cases in which an administrator administers benefits for more than 100 certificateholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least one such review shall be an on-site audit of the operations of the administrator.

(4) For purposes of this section, "insurer" means a licensed insurance company, health maintenance organization, prepaid limited health service organization, or prepaid health

clinic ~~As to the administration of coverage insured by an insurance company, the insurance company, and not the administrator, shall be responsible for determining the benefits, rates, underwriting criteria, and claims payment procedures applicable to such coverage and for securing reinsurance, if any~~.

Section 18. Section 626.89, Florida Statutes, is amended to read:

626.89 Annual financial statement and filing fee; notice of change of ownership.--

(1) Each authorized administrator shall file with the office a full and true statement of its financial condition, transactions, and affairs. The statement shall be filed annually on or before March 1 or within such extension of time therefor as the office for good cause may have granted and shall be for the preceding calendar year. The statement shall be in such form and contain such matters as the commission prescribes and shall be verified by at least two officers of such administrator.

(2) The annual report shall include an audited financial statement performed by an independent certified public accountant. An audited financial report or annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and shall comply with the following:

(a) Amounts shown on the consolidated audited financial report shall be shown on the worksheet.

(b) Amounts for each entity shall be stated separately.

(c) Explanations of consolidating and eliminating entries shall be included.

(3)~~(2)~~ At the time of filing its annual statement, the administrator shall pay a filing fee in the amount specified in s. 624.501 for the filing of an annual statement by an insurer.

(4)~~(3)~~ In addition, the administrator shall immediately notify the office of any material change in its ownership.

(5) The commission may by rule require all or part of the reports or filings required under this section to be submitted by electronic means in a computer-readable form compatible with an electronic data format specified by the commission.

Section 19. Paragraph (d) of subsection (4) of section 626.901, Florida Statutes, is amended to read:

626.901 Representing or aiding unauthorized insurer prohibited.--

(4) This section does not apply to:

(d) Independently procured coverage written pursuant to s. 626.938, which is not solicited, marketed, negotiated, or sold in this state.

Section 20. Subsection (3) is added to section 626.902, Florida Statutes, to read:

626.902 Penalty for representing unauthorized insurer.—

(3) This section does not apply to matters authorized to be done by the office under ss. 626.904-626.912, the Unauthorized Insurers Process Law.

Section 21. Subsection (2) of section 626.9913, Florida Statutes, is amended to read:

626.9913 Viatical settlement provider license continuance; annual report; fees; deposit.--

(2) Annually, on or before March 1, the viatical settlement provider licensee shall file a statement containing

information the commission requires and shall pay to the office a license fee in the amount of $500. A viatical settlement provider shall include in all statements filed with the office all information requested by the office regarding a related provider trust established by the viatical settlement provider. The office may require more frequent reporting. Failure to timely file the annual statement or to timely pay the license fee is grounds for immediate suspension of the license. The commission may by rule require all or part of the reports or filings required under this section to be submitted by electronic means in a computer-readable form compatible with an electronic data format specified by the commission.

Section 22. Section 627.0646, Florida Statutes, is created to read:

627.0646 Uniform rate adjustment factors.--

(1)(a) The office may examine trends in premiums and in average cost and frequency of claims and develop and recommend for adoption by the commission uniform rate adjustment factors that are reflective of such trends for personal lines homeowners insurance and private passenger motor vehicle insurance. The purpose of the uniform rate adjustment factors is to allow insurers to submit rate filings adjusting their rates by incremental measures for changes in the cost and frequency of claims, if any, without having to provide supporting data for the proposed rates.

(b)1. The submission of a rate filing seeking to adjust rates by the application of the uniform rate adjustment factors shall not include any other changes. The office shall approve or disapprove the filing within 30 days after receiving the filing.

2. Submission of a rate filing seeking to adjust rates by the application of the uniform rate adjustment factors precludes the insurer from submitting any subsequent rate filing the effective dates of which are sooner than 6 months following filing effective dates of the uniform rate adjustment factors. This limitation does not apply to recoupment filings submitted pursuant to s. 627.062, s. 627.3512, or s. 631.64.

3. The submission of a rate filing seeking to adjust rates by the application of the uniform rate adjustment factors shall be accompanied by a certification by an actuary that the filing seeks to implement a rate that is actuarially sound and not inadequate, which certification satisfies the rate filing requirement pursuant to s. 627.0645.

4. In order to develop uniform rate adjustment factors, the office may annually solicit from insurers information on trends that the insurers are experiencing. Insurers from whom data is solicited must provide the solicited information to the office within 30 days after the date of the request. The office shall determine the type of data necessary and the format of this data for its examination and, if rulemaking is required, submit its recommendation to the commission for consideration and rule adoption.

5. The uniform rate adjustment factors shall be applied uniformly to all subject policies in force on each policy's effective date at renewal and all new business written on or after the effective date of the uniform rate adjustment factors by any insurer that has submitted such a filing, provided notice required by law is provided.

6. The first filing of uniform rate adjustment factors

permitted for an insurer by this section may be submitted at any time after the publication of the initial uniform rate adjustment factors. A rate determined by a subsequent filing of uniform rate adjustment factors by an insurer shall not be effective any sooner than 12 months after the effective date of the previous filing of uniform rate adjustment factors.

Neither the calculation nor the publication of the factors by the office constitutes an order or a rule that is subject to chapter 120. Nothing in this section precludes the office from requesting necessary information on a case by case basis from an insurer submitting a filing pursuant to this section.

(c) The commission may adopt rules and forms necessary to implement this section.

(d) Nothing in this subsection affects the application of s. 627.066.

(2)(a) This subsection applies to commercial property, casualty, and surety insurance on subjects of insurance resident, located, or to be performed in this state. Medical malpractice insurance, title insurance, workers' compensation and employer's liability insurance, commercial property and casualty insurance issued to condominium associations, and such commercial insurance exempted from the scope of this chapter under s. 627.021(2) are exempt from this section.

(b) The purpose of this subsection is to enhance competition and reduce the frictional costs associated with rate filings for insurance subject to this subsection through the use of flex rate filings, which do not require submission of supporting data for the proposed rates. Submission of a flex

rate filing precludes the insurer from submitting any subsequent rate filing the effective date of which is earlier than 6 months following the flex rate filing effective date. This limitation does not apply to recoupment filings submitted pursuant to s. 627.062, s. 627.3512, or s. 631.64.

(c) The submission of a rate filing seeking to adjust rates by the application of the flex rate filing shall not include any other changes. A flex rate filing shall be effective on or after the date of filing as specified by the filer and is exempt from any otherwise applicable provision of this part requiring office approval of the filing prior to its implementation.

(d) The submission of a flex rate filing satisfies the annual rate filing requirement pursuant to s. 627.0645, if applicable.

(e) In order to evaluate the impact of flex rate filings on compliance with s. 627.062, the office may annually solicit from insurers information concerning compliance by insurers. Insurers from whom data is solicited must provide the solicited information to the office within 30 days after the date of the request. The office shall determine the type of data necessary and the format of this data for its examination.

(f) The rate change set forth in the flex rate filing shall be applied by the insurer uniformly to all policies within the class of insurance to which it applies that are in force on the filing's effective date at renewal and all new business written on or after the filing's effective date by any insurer that has submitted such a filing, provided the insurer provides the policyholder with notice of the renewal premium as required

by s. 627.4133 or any other applicable provision of the Florida Insurance Code or rules of the Office.

(g) The commission may establish by rule the procedures the office will use to evaluate the market place with respect to the effect flex rates are having on whether the resultant rates are excessive, inadequate, or unfairly discriminatory. The rules may specify data collection requirements for insurers to provide to the office and related forms.

(h)1. An insurer may submit a maximum of three consecutive flex rate filings before it must submit a complete rate revision as specified by s. 627.062 and the rules of the office.

2. For rate filings involving reference to approved loss costs filed by a licensed advisory organization or licensed rating organization, the commission shall develop by rule a procedure which establishes an average loss cost multiplier based on average insurer expenses and a reasonable margin for profit and contingencies for each type of loss cost. The office shall publish annually by a method set forth by rule adopted by the commission a list of average loss cost multipliers for each type of loss cost. If an insurer files to adopt a loss cost multiplier for a particular type of loss cost which is within 15 percent of the most recent average loss cost multiplier published by the office for that particular type of loss cost, the proposed loss cost multiplier shall be approved or disapproved within 30 days after its receipt. The first rate filing filed pursuant to this subsection may be submitted at any time after the publication of the initial average loss cost multipliers.

3. For all other rate filings made pursuant to this

subsection, a flex rate filing may not provide a rate change greater than 7 percent from the rate in effect at the time of the flex rate filing. The first flex rate filing permitted by this subsection may be submitted at any time after the effective date of this act.

4. Subsequent flex rate filings shall not be effective any sooner than 12 months after the effective dates of the previous flex rate filing.

(i) A flex rate filing may not provide a rate that is excessive, inadequate, or unfairly discriminatory.

(j) The commission may adopt rules or forms necessary to implement this subsection.

Section 23. Effective July 1, 2004, subsection (4) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.--

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--

(a) The office shall, after consultation with insurers as set forth in paragraph (b), adopt a joint underwriting plan as set forth in paragraph (d). Additionally, effective July 1, 2004, the Joint Underwriting Association established pursuant to this subsection shall include a separate and discrete account, known as the Florida Patient's Compensation Fund Account, for the assets, liabilities, rights, and obligations and members of the fund account created pursuant to s. 766.105.

(b) Entities licensed to issue casualty insurance as defined in s. 624.605(1)(b), (k), and (q) and self-insurers authorized to issue medical malpractice insurance under s. 627.357 shall participate in the plan as set forth in paragraph (d) and shall be members of a separate and discrete account

within the Joint Underwriting Association to be known as the Coverage Account. The policies, assets, liabilities, rights, and obligations of the Joint Underwriting Association as of June 30, 2004, are transferred to the Coverage Account, effective July 1, 2004. In no instance shall the assets or revenues of the Coverage Account be used to satisfy or secure any debt, obligation, or expense of the Florida Patient's Compensation Fund Account nor shall the assets or revenues of the Florida Patient's Compensation Fund Account be used to satisfy or secure any debt, obligation, or expense of the Coverage Account.

(c) The Coverage Account and Florida Patient's Compensation Fund Account of the Joint Underwriting Association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the Coverage Account of the Joint Underwriting Association, an attorney to be named by The Florida Bar, a physician to be named by the Florida Medical Association, a dentist to be named by the Florida Dental Association, and a hospital representative to be named by the Florida Hospital Association. The Chief Financial Officer shall select the representatives of the five insurers. One insurer representative shall be selected from recommendations of the American Insurance Association. One insurer representative shall be selected from recommendations of the Alliance of American Insurers. One insurer representative shall be selected from recommendations of the National Association of Independent Insurers. Two insurer representatives shall be selected to represent insurers that are not affiliated with these associations. The board of governors shall choose, during the first meeting of the board after June

30 of each year, one of its members to serve as chair of the board and another member to serve as vice chair of the board. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, self-insurer, or its agents or employees, the Joint Underwriting Association or its agents or employees, members of the board of governors, or the office or its representatives for any action taken by them in the performance of their powers and duties under this subsection.

(d) The plan shall provide coverage through the Coverage Account 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 Coverage Account provisions of the plan shall include, but ~~shall~~ not be limited to:

1. Classifications of risks and rates for the Coverage Account which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas. To assure that plan rates for the Coverage Account 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 office in sufficient detail to make a determination of rate adequacy. Within 60 days after a rate filing, the office 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 Coverage Account rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to Coverage Account rates for:

a. Insureds who are retired or semiretired.

b. The estates of deceased insureds.

c. Part-time professionals.

4. Coverage Account protection in an amount not to exceed $250,000 per claim, $750,000 annual aggregate for health care providers other than hospitals and in an amount not to exceed $1.5 million per claim, $5 million annual aggregate for hospitals. Such coverage for health care providers other than hospitals shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and the total limits of $250,000 per claim, $750,000 annual aggregate. The plan shall also provide tail coverage in these amounts to insureds whose claims-made coverage with another insurer or trust has or will be terminated. Such tail coverage shall provide coverage for incidents that occurred during the claims-made policy period for which a claim is made after the policy period.

5. A risk management program for insureds of the association Coverage Account. This program shall include, but not be limited to: investigation and analysis of frequency, severity, and causes of adverse or untoward medical injuries; development of measures to control these injuries; systematic reporting of medical incidents; investigation and analysis of

patient complaints; and auditing of association members to assure implementation of this program. The plan may refuse to insure any insured who refuses or fails to comply with the risk management program implemented by the association. Prior to cancellation or refusal to renew an insured, the association shall provide the insured 60 days' notice of intent to cancel or nonrenew and shall further notify the insured of any action which must be taken to be in compliance with the risk management program.

(e) In the event an underwriting deficit exists in the Coverage Account for any policy year the plan is in effect, any surplus which has accrued from previous years and is not projected within reasonable actuarial certainty to be needed for payment of 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 Coverage Account 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 for the Coverage Account after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan Coverage Account 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, for Coverage Account claims, 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. The plan shall also provide for Florida Patients' Compensation Fund Account claims to be serviced by the Joint Underwriting Association or through contracts with claims handling entities. 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 confidential and exempt from the provisions of s. 119.07(1) during the processing of that claim. Any information contained in these files that identifies an injured person is confidential and exempt from the provisions of s. 119.07(1).

(h) For purposes of the Coverage Account ~~As used in this subsection~~:

1. "Health care provider" means hospitals licensed under chapter 395; physicians licensed under chapter 458; osteopathic physicians licensed under chapter 459; podiatric physicians

licensed under chapter 461; dentists licensed under chapter 466; chiropractic physicians licensed under chapter 460; naturopaths licensed under chapter 462; nurses licensed under part I of chapter 464; midwives licensed under chapter 467; clinical laboratories registered under chapter 483; physician assistants licensed under chapter 458 or chapter 459; physical therapists and physical therapist assistants licensed under chapter 486; health maintenance organizations certificated under part I of chapter 641; ambulatory surgical centers licensed under chapter 395; other medical facilities as defined in subparagraph 2.; blood banks, plasma centers, industrial clinics, and renal dialysis facilities; or professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.

2. "Other medical facility" means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, to which facility the patient is admitted and from which facility the patient is discharged within the same working day, and which facility is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine shall not be construed to be an "other medical facility."

3. "Health care facility" means any hospital licensed under chapter 395, health maintenance organization certificated under part I of chapter 641, ambulatory surgical center licensed under chapter 395, or other medical facility as defined in subparagraph 2.

(i) The manager of the plan or the manager's assistant is the agent for service of process for the plan.

Section 24. Paragraph (h) of subsection (9) of section 627.476, Florida Statutes, is amended to read:

627.476 Standard Nonforfeiture Law for Life Insurance.--

(9) CALCULATION OF ADJUSTED PREMIUMS AND PRESENT VALUES FOR POLICIES ISSUED AFTER OPERATIVE DATE OF THIS SUBSECTION.--

(h) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the Commissioners' 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners' 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. However:

1. At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

2. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (2), shall be calculated on the basis of the mortality table and rate of interest used in

determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

3. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

4. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners' 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

5. In lieu of the mortality tables specified in this section, at the option of the insurance company and subject to rules adopted by the commission, the insurance company may substitute:

a. The 1958 CSO or CET Smoker and Nonsmoker Mortality Tables, whichever is applicable, for policies issued on or after the operative date of this subsection and before January 1, 1989;

b. The 1980 CSO or CET Smoker and Nonsmoker Mortality Tables, whichever is applicable, for policies issued on or after the operative date of this subsection;

c. A mortality table that is a blend of the sex-distinct 1980 CSO or CET mortality table standard, whichever is applicable, or a mortality table that is a blend of the sex-distinct 1980 CSO or CET smoker and nonsmoker mortality table

standards, whichever is applicable, for policies that are subject to the United States Supreme Court decision in *Arizona Governing Committee v. Norris* to prevent unfair discrimination in employment situations.

6. Ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, adopted by rule by the commission for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners' 1980 Extended Term Insurance Table.

7.~~6.~~ For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

Section 25. Subsection (2) of section 627.836, Florida Statutes, is amended to read:

627.836 Licensee's books and records; reports.--

(2) Each licensee shall annually, on or before March 1, file a report with the office giving such information as the office may require. The report shall be made under oath and in the form prescribed by the commission and shall be accompanied by the annual report filing fee specified in s. 627.849. The office may make and publish annually an analysis and recapitulation of such reports. In addition, the office may require such additional regular or special reports as it may deem necessary. The commission may by rule require all or part of the reports or filings required under this section to be submitted by electronic means in a computer-readable form

compatible with an electronic data format specified by the commission.

Section 26. Section 627.8401, Florida Statutes, is created to read:

627.8401 Prohibited investments and loans.--A premium finance company shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the premium finance company.

Section 27. Subsection (5) of section 627.915, Florida Statutes, is amended to read:

627.915 Insurer experience reporting.--

(5) Any insurer or insurer group which does not write at least 0.5 percent of the Florida market based on premiums written shall not have to file any report required by subsection (2) other than a report indicating its percentage of the market share. That percentage shall be calculated by dividing the insurer's preceding year's ~~current~~ premiums written by the preceding year's total premiums written in the state for that line of insurance.

Section 28. Subsection (2) of section 627.943, Florida Statutes, is amended, and subsections (6) and (7) are added to said section, to read:

627.943 Risk retention groups certified in Florida.--

(2) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the office a plan of operation or a feasibility study. The feasibility study shall be prepared by an independent qualified actuary or an independent certified public accountant and address market

potential, market penetration, market competition, operating expenses, gross revenues, minimum capital and surplus required, net income, total assets and liabilities, cash flow, and such other items as the office may require. The study shall continue for the greater of 3 years or until the arrangement has been projected to be profitable for 12 consecutive months. The study must demonstrate the financial ability of the fund to meet its claims and obligations and reflect and support all premium, reserve, and other financial requirements with which the risk retention group must comply. Before additional lines of liability insurance are offered in this or any other state approval shall be obtained from the office.

(6) Domestic risk retention groups shall periodically update the feasibility study required pursuant to s. 627.943(2), if requested by the office.

(7) An application for a domestic risk retention group certificate of authority may be exempted from the requirements of ss. 624.407 and 624.408 upon the determination by the office that the feasibility study required pursuant to subsection (2) adequately addresses minimum capital and surplus. Prior to such an exemption, the office may contract with an independent expert to the review the feasibility study. In making the determination, the office shall consider:

(a) The applicant's line of business.

(b) The applicant's business plan, including premium volume.

(c) The applicant's scope of coverage and coverage limits.

(d) Other relevant factors.

Section 29. Effective January 1, 2005, subsection (1) of section 628.071, Florida Statutes, is amended to read:

628.071 Granting, denial of permit.--

(1) The office shall expeditiously examine and investigate the application for a permit as referred to in s. 628.051. If the office finds that:

(a) The application is complete;

(b) The documents therewith filed are in compliance with law;

(c) None of the stockholders, organizers, incorporators, subscribers, and other persons who directly or indirectly exercise or have the ability to exercise effective control of the proposed insurer or who will be involved in its management have been found guilty of, or have pleaded guilty or nolo contendere to, a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States or any state thereof, or under the law of any other country, which involves moral turpitude, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases;

(d) The proposed financial structure is adequate; ~~and~~

(e) All stockholders, organizers, incorporators, subscribers, and other persons who directly or indirectly exercise or have the ability to exercise effective control of the proposed insurer or who will be involved in management of the proposed insurer possess the financial standing and business experience to form an insurer; and

(f) The applicant, if a domestic stock or mutual insurer, has demonstrated the ability to comply with s. 628.072 and rules adopted under such section,

the office ~~it~~ shall issue to the applicant a permit to form the proposed insurer.

Section 30. Effective January 1, 2005, section 628.072, Florida Statutes, is created to read:

628.072 Domestic insurers, corporate good governance.-—

(1) Each domestic stock or domestic mutual insurer shall establish and maintain corporate good governance practices as a condition to obtain or retain a certificate of authority.

(2) Each domestic stock or domestic mutual insurer shall annually demonstrate to the office adherence to the requirements of this section. The method of demonstration shall be on a form or in accordance with rules adopted by the commission.

(3) A publicly traded domestic stock insurer, in lieu of complying with subsection (4), may satisfy the requirements of this section by demonstrating compliance with the applicable provisions of 15 U.S.C. s. 7201.

(4) The commission shall adopt rules providing for corporate good governance practices to be met by all domestic insurers. In adopting the rules, the commission shall consider:

(a) Practices which avoid fraud.

(b) Corporate accountability and transparency with respect to the fiduciary responsibilities of officers and board of directors.

(c) Controls with respect to insurer operations and other management practices to avoid waste or misuse of the insurer's assets.

(d) With respect to corporate directors:

1. Requiring board meetings at least quarterly or more frequently as prudent.

2. Requiring the insurer to have at least one independent director.

3. Requiring the board of directors to review and approve minutes of any audit committee, with the board's review and approval being reflected in board's minutes.

(e) With respect to management:

1. Requiring a written code of ethics and conduct addressing director and officer conflicts of interest and corporate, director, and officer compliance with laws and rules.

2. Requiring approval by the corporate chief executive officer and chief financial officer of all annual and quarterly financial reports, attesting that he or she reviewed the report, that to the best of his or her knowledge the report fairly represents the financial condition of the insurer, and that the financial statements do not, to the officer's best knowledge, contain a misstatement of material fact or omission of material fact.

(f) With respect to the corporate audit committee:

1. Requiring that the audit committee chair have accounting or financial management experience.

2. Requiring that the audit committee members be financially literate.

3. Requiring that the audit committee meet at least quarterly, and more frequently as prudent.

4. Prohibiting payments by the insurer to any audit committee member except for services on the board and audit committee.

5. Requiring an audit committee charter and specifying requirements therefore.

6. Requiring, with respect to the audit committee, that the committee must:

a. Approve all related party transactions.

b. Meet in executive session regularly and as often as prudent.

c. Oversee the internal audit functions, including reporting and personnel matters.

d. Oversee performance evaluations and compensation of the internal audit director.

e. Oversee the outside auditor, including recommending the firm, evaluating the auditor's performance; and the rotation of the senior audit personnel.

f. Oversee the financial reporting process.

g. Certify in correspondence to the office and signed by all the audit committee members that they have reviewed the financials and, to the best of their knowledge, quarterly and annual financial statements submitted to the office contain no material omissions or inaccuracies and reflect no questionable accounting practices, the frequency of such certification to be governed by rule of the commission.

(g) With respect to an outside auditor, requiring:

1. That the outside auditor report directly to the audit committee or to the full board if there is no audit committee, in which case, the board shall act as the audit committee and meet all requirements of the audit committee as set forth by rule of the commission.

2. That outside firms provide a concurring or second partner review of audit reports.

3. That outside auditors should limit their non-audit services to a client to avoid conflicts.

(h) With respect to audit reports, requiring that the outside audit report describe the extent of testing of internal controls.

(i) Requiring the insurer to establish an internal audit function either in house or outside that is independent from the regular outside auditor.

(j) Requiring the insurer to establish internal policies and procedures that encourage employees to come forward with allegations of misconduct without fear of retribution.

(k) Requiring other procedures that provide substantially equivalent safeguards as those specified within this subsection standards where appropriate to operate in lieu thereof.

In adopting the rules, the commission shall consider the corporate good governance practices set forth in 15 U.S.C. s. 7201 to the degree such practices may be applied to mutual domestic insurers or publicly traded or closely held stock domestic insurers; provided, a rule which is applicable to a publicly traded domestic stock insurer may not conflict with the

provisions of 15 U.S.C. s. 7201. The commission may adopt forms necessary to implement this section.

Section 31. Subsections (2), (3), and (4) of section 628.371, Florida Statutes, are amended to read:

628.371 Dividends to stockholders.--

(2)(a) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until 30 days after the office has received notice of the declaration of such dividend or distribution and has not within that period disapproved the payment, or until the office has approved the payment within the 30 day period.

(b) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value, together with that of other dividends or distributions made within the preceding 12 months, exceeds the lesser of:

1. Ten percent of the insurer's surplus as regards policyholders as of the date of the most recent quarterly statement filed with the office; or

2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income of the insurer, if the insurer is not a life insurer, not including realized capital gains, for the 12 month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous 2 calendar years that has not already been paid out as dividends. This carryforward shall

be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediately preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the approval of the office, and the declaration shall confer no rights upon shareholders until:

1. The office has approved the payment of the dividend or distribution; or

2. The office has not disapproved payment within the 30-day period pursuant to paragraph (a). ~~Dividend payments or distributions to stockholders, without prior written approval of the office, shall not exceed the larger of:~~

~~(a) The lesser of 10 percent of surplus or net gain from operations (life and health companies) or net income (property and casualty companies), not including realized capital gains, plus a 2-year carryforward for property and casualty companies;~~

~~(b) Ten percent of surplus, with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains;~~

~~(c) The lesser of 10 percent of surplus or net investment income (net gain before capital gains for life and health companies) plus a 3-year carryforward (2-year carryforward for life and health companies) with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains.~~

~~(3) In lieu of the provisions in subsection (2), an insurer may pay a dividend or make a distribution without the prior written approval of the office when:~~

~~(a) The dividend is equal to or less than the greater of:~~

~~1. Ten percent of the insurer's surplus as to policyholders derived from realized net operating profits on its business and net realized capital gains; or~~

~~2. The insurer's entire net operating profits and realized net capital gains derived during the immediately preceding calendar year; and~~

~~(b) The insurer will have surplus as to policyholders equal to or exceeding 115 percent of the minimum required statutory surplus as to policyholders after the dividend or distribution is made; and~~

~~(c) The insurer has filed notice with the office at least 10 business days prior to the dividend payment or distribution, or such shorter period of time as approved by the office on a case-by-case basis. Such notice shall not create a right in the office to approve or disapprove a dividend otherwise properly payable hereunder; and~~

~~(d) The notice includes a certification by an officer of the insurer attesting that after payment of the dividend or distribution the insurer will have at least 115 percent of required statutory surplus as to policyholders.~~

(3)~~(4)~~ The office shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless the office~~, considering the following factors, it~~ determines that the distribution or dividend would not jeopardize the financial condition of the insurer, based upon a review of the following factors:

(a) The liquidity, quality, and diversification of the insurer's assets and the effect on its ability to meet its obligations.

(b) Reduction of investment portfolio and investment income.

(c) Effects on the written premium to surplus ratios as required by the Florida Insurance Code.

(d) Industrywide financial conditions.

(e) Prior dividend distributions of the insurer.

(f) Whether the dividend is only a "pass-through" dividend from a subsidiary of the insurer.

(g) Risk-based capital of the insurer.

(h) Any other relevant factor.

Section 32. Subsection (2) of section 628.461, Florida Statutes, is amended to read:

628.461 Acquisition of controlling stock.--

(2) This section does not apply to any acquisition of voting securities of a domestic stock insurer or of a controlling company by any person who, on July 1, 1976, is the owner of a majority of such voting securities or who, on or after July 1, 1976, becomes the owner of a majority of such voting securities with the approval of the office pursuant to this section. Further, the provisions of this section shall not apply to a change of ownership of a domestic insurer resulting from changes within an insurance holding company of which the insurer is a member, provided the insurer establishes that no new person or entity will have the ability to influence or control the activities of the insurer and that the reorganization will not result in any changes in the officers,

directors, or business plan of the domestic insurer.

Section 33. Subsection (3) of section 628.4615, Florida Statutes, is amended to read:

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.--

(3) This section does not apply to any acquisition of voting securities or ownership interest of a specialty insurer or of a controlling company by any person who, on July 9, 1986, is the owner of a majority of such voting securities or ownership interest or who, on or after July 9, 1986, becomes the owner of a majority of such voting securities or ownership interest with the approval of the office pursuant to this section. Further, the provisions of this section shall not apply to a change of ownership of a specialty insurer resulting from changes within a holding company of which the specialty insurer is a member, provided the specialty insurer establishes that no new person or entity will have the ability to influence or control the activities of the specialty insurer and that the reorganization will not result in any changes in the officers, directors, or business plan of the specialty insurer.

Section 34. Subsection (1) of section 628.709, Florida Statutes, is amended to read:

628.709 Formation of a mutual insurance holding company.--

(1) A domestic mutual insurance company~~, other than a mutual insurer that issued assessable policies as a mutual insurer and which held a certificate of authority in this state on July 1, 1997,~~ may, pursuant to a plan of reorganization, reorganize as a mutual insurance holding company system that

must consist of a mutual insurance holding company and one or more controlled subsidiaries and which may consist of one or more intermediate stock holding companies and other subsidiaries. The reorganization may be effected by the organization of one or more companies, amendment or restatement of the articles of incorporation and bylaws of one or more companies, transfer of assets and liabilities among two or more companies, issuance, acquisition or transfer of capital stock of one or more companies, or merger or consolidation of two or more companies. On and after the effective date of a plan of reorganization, the mutual insurance holding company shall at all times have the power, directly or indirectly, to cast at least a majority of the votes for the election of the board of directors of each controlled subsidiary and any intermediate stock holding company.

Section 35. Section 634.042, Florida Statutes, is created to read:

634.042 Prohibited investments and loans.--A motor vehicle service agreement company shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the motor vehicle service agreement company.

Section 36. Section 634.3076, Florida Statutes, is created to read:

634.3076 Prohibited investments and loans.--A home warranty association shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director.

Section 37. Section 634.4062, Florida Statutes, is created to read:

634.4062 Prohibited investments and loans.--A service warranty association shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the service warranty association.

Section 38. Section 636.043, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 636.043, Florida Statutes, for present text.)

636.043 Annual, quarterly, and miscellaneous reports.--

(1) Every prepaid limited health service organization shall, annually within 3 months after the end of the calendar year, or within an extension of time therefore as the office, for good cause, may grant, in a form prescribed by the commission, file a report with the office, verified by the oath of two officers of the corporation, or if not a corporation, of two persons who are principal managing directors of the organization, or if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. Such report shall include:

(a) A financial statement of the prepaid limited health service, organization filed by electronic means in a computer-readable form using a format acceptable to the office.

(b) A financial statement of the prepaid limited health service organization filed on forms acceptable to the office.

(c) An audited financial statement of the prepaid limited health service organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.

(d) The number of prepaid limited health service contracts issued and outstanding and the number of prepaid limited health service organization contracts terminated.

(e) The number and amount of damage claims for medical injury initiated against the prepaid limited health service organization and any of the providers engaged by the organization during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.

(f) An actuarial certification that:

1. The prepaid limited health service organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization.

2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.

4. The prepaid limited health service organization has adequately provided for all obligations required by s. 641.35(3)(a).

(g) A report prepared by the certified public accountant and filed with the office describing any material weaknesses in

the prepaid limited health service organization's internal control structure as noted by the certified public accountant during the audit. The report must be filed with the annual audited financial report as required in paragraph (c). The prepaid limited health service organization shall provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.

(h) Such other information relating to the performance of prepaid limited health service organizations as is required by the commission or office.

(2) The office may require updates of the actuarial certification as to a particular prepaid limited health service organization if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the prepaid limited health service organization. Workpapers in support of the statement of the updated actuarial certification must be provided to the office upon request.

(3) Every prepaid limited health service organization shall file quarterly, for the first three calendar quarters of each year, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The statement for the quarter ending March 31 shall be filed on or before May 15, the statement for the quarter ending June 30 shall be filed on or before August 15, and the statement for the quarter ending September 30 shall be filed on or before November 15. The quarterly report shall be verified by the oath of two officers of the organization, properly notarized.

(4) Any prepaid limited health service organization that neglects to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $1,000 for each day for the first 10 days during which the neglect continues and shall forfeit up to $2,000 for each day after the first 10 days during which the neglect continues and, upon notice by the office to that effect, the organization's authority to enroll new subscribers or to do business in this state shall cease while such default continues. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund. The office shall not collect more than $100,000 for each report.

(5) Each authorized prepaid limited health service organization shall retain an independent certified public accountant, referred to in this subsection as "accountant," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this part.

(a) The accountant shall provide to the prepaid limited health service organization audited financial statements consistent with this part.

(b) Any determination by the accountant that the prepaid limited health service organization does not meet minimum surplus requirements as set forth in this part shall be stated by the accountant, in writing, in the audited financial statement.

(c) The completed work papers and any written communications between the accountant firm and the prepaid limited health service organization relating to the audit of the prepaid limited health service organization shall be made

available for review on a visual-inspection-only basis by the office at the offices of the prepaid limited health service organization, at the office, or at any other reasonable place as mutually agreed between the office and the prepaid limited health service organization. The accountant must retain for review the work papers and written communications for a period of not less than 6 years.

(d) The accountant shall provide to the office a written report describing material weaknesses in the prepaid limited health service organization's internal control structure as noted during the audit.

(6) To facilitate uniformity in financial statements and analysis by the office, the commission may by rule adopt the form for financial statements of a prepaid limited health service organization, including supplements, as approved by the National Association of Insurance Commissioners in 2004 and may adopt subsequent amendments to such form if the methodology remains substantially consistent. The commission may by rule require each prepaid limited health service organization to submit to the office all or part of the information contained in the annual statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(7) In addition to information required and furnished in connection with its annual or quarterly statements, the prepaid limited health service organization shall furnish to the office as soon as reasonably possible such information as to its material transactions which, in the office's opinion, may have a material adverse effect on the prepaid limited health service organization's financial condition, as the office requests in

writing. All such information furnished pursuant to the office's request must be verified by the oath of two executive officers of the prepaid limited health service organization.

(8) Each prepaid limited health service organization shall file one copy of its annual statement convention blank in electronic form, along with such additional filings as prescribed by the commission for the preceding calendar year or quarter, with the National Association of Insurance Commissioners. Each prepaid limited health service organization shall pay fees assessed by the National Association of Insurance Commissioners to cover costs associated with the filing and analysis of the documents by the National Association of Insurance Commissioners.

(9) The office may require monthly reports if the financial condition of the prepaid limited health service organization has deteriorated from previous periods or if the financial condition of the organization is such that it may be hazardous to subscribers if not monitored more frequently.

Section 39. Effective January 1, 2005, subsection (10) is added to section 641.22, Florida Statutes, to read:

641.22 Issuance of certificate of authority.--The office shall issue a certificate of authority to any entity filing a completed application in conformity with s. 641.21, upon payment of the prescribed fees and upon the office's being satisfied that:

(10) The health maintenance organization has demonstrated that it will meet the applicable requirements of ss. 641.30(6) and 628.072.

Section 40. Effective January 1, 2005, paragraph (f) is added to subsection (2) of section 641.23, Florida Statutes, to read:

641.23 Revocation or cancellation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.--

(2) The office may suspend the authority of a health maintenance organization to enroll new subscribers or revoke any certificate issued to a health maintenance organization, or order compliance within 30 days, if it finds that any of the following conditions exists:

(f) That the organization has failed to meet and maintain the applicable requirements of ss. 641.30(6) and 628.072.

Section 41. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the office ~~department~~.--

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 ~~3~~ years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part.~~ However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of

good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. ~~In no event shall expenses of all examinations exceed a maximum of $20,000 for any 1-year period.~~ Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, reorganization, conservation, or dissolution of life insurance companies.

Section 42. Effective January 1, 2005, subsection (6) is added to section 641.30, Florida Statutes, to read:

641.30 Construction and relationship to other laws.--

(6) Each health maintenance organization shall comply with the applicable provisions of s. 628.072 and rules adopted under such section. Applicability shall be based on the organizational structure of the health maintenance organization.

Section 43. Subsection (3) of section 641.409, Florida Statutes, is renumbered as subsection (4) and amended, and a new subsection (3) is added to said section, to read:

641.409 Insolvency protection.--

(3) In lieu of the surety bond required under paragraph (1)(b), the prepaid health clinic may deposit with the office the amount determined in subsection (2). The deposit shall not be considered as an admitted asset in determining the statutory financial condition of the prepaid health clinic. The deposit

shall be released to the prepaid health clinic if replaced by a surety bond that meets the requirements of subsection (2).

(4)~~(3)~~ Every prepaid health clinic shall deposit with the department a cash deposit in the amount of $50,000 ~~$30,000~~ to guarantee that the obligations to the subscribers will be performed.

Section 44. Subsection (9) is added to section 651.026, Florida Statutes, to read:

651.026 Annual reports.--

(9) The commission may by rule require all or part of the reports or filings required under this section to be submitted by an a computer-readable form compatible with an electronic data format specified by the commission.

Section 45. Section 651.0261, Florida Statutes, is amended to read:

651.0261 Quarterly statements.--If the office finds, pursuant to rules of the commission, that such information is needed to properly monitor the financial condition of a provider or facility or is otherwise needed to protect the public interest, the office may require the provider to file, within 45 days after the end of each fiscal quarter, a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule. The commission may by rule require all or part of the reports or filings required under this section to be submitted by an a computer-readable form compatible with an electronic data format specified by the commission.

Section 46. Section 651.0265, Florida Statutes, is created to read:

651.0265 Prohibited investments and loans.--A provider shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the provider.

Section 47. Paragraph (a) of subsection (1) of section 651.033, Florida Statutes, is amended to read:

651.033 Escrow accounts.--

(1) When funds are required to be deposited in an escrow account pursuant to s. 651.022, s. 651.023, s. 651.035, or s. 651.055:

(a) The escrow account shall be established in a federal or state chartered ~~Florida~~ bank, ~~Florida~~ savings and loan association, or ~~Florida~~ trust company having a physical presence and doing business in this state and otherwise acceptable to the office or on deposit with the department; and the funds deposited therein shall be kept and maintained in an account separate and apart from the provider's business accounts.

Section 48. Effective July 1, 2004, paragraph (a) of subsection (1), paragraphs (b) and (c) of subsection (2), and subsection (3) of section 766.105, Florida Statutes, are amended to read:

766.105 Florida Patient's Compensation Fund.--

(1) DEFINITIONS.--The following definitions apply in the interpretation and enforcement of this section:

(a) The term "fund" means the Florida Patient's Compensation Fund Account within the medical malpractice risk apportionment plan adopted pursuant to s. 627.351(4). The fund account is not a state agency, board, or commission. However,

for the purposes of s. 199.183(1) only, the fund account shall be considered a political subdivision of this state.

(2) COVERAGE.--

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from January 1 to December 31. The fund may also provide coverages for portions of each fiscal year. The limits of such coverage afforded by the fund for each health care provider other than a hospital may not exceed the total limits for both entry level and fund coverage of $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, as selected by the health care provider. In the case of coverage for a hospital, the limit of coverage afforded by the fund may not exceed the total limits for both entry level and fund coverage of $2.5 million per claim with no annual aggregate. The health care provider is responsible for the payment of any amount of a claim in excess of the elected limit. The fund is not responsible for the payment of punitive

damages awarded for actual or direct negligence of the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods:

1. A bond purchased from a licensed surety company, which bond is in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however, a total bond amount for all years equal to reserved loss and expense amounts for known cases plus 3 times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required;

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however, a total escrow account for all years equal to reserved loss and expense amounts for known cases plus 3 times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required;

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from a private insurer or the Coverage Account of the Joint Underwriting Association established under s. 627.351(4); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.

(c) Any hospital that can meet one of the following provisions for demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) is not required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2.5 million annual aggregate.

2. Establish an escrow account in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2.5 million annual aggregate, to the satisfaction of the Agency for Health Care Administration.

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each bed in such hospital from a private insurer, from the Coverage Account of the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. However, no hospital may be required to obtain such coverage in an amount exceeding a $2.5 million annual aggregate.

(3) THE FUND ACCOUNT.--

(a) Purposes.--The ~~There is created a~~ "Florida Patient's Compensation Fund," originally created by this section, shall, as of July 1, 2004, be known as the Florida Patient's Compensation Fund Account, hereinafter referred to as the "fund account", and shall be a discrete and separate account within the medical malpractice risk apportionment plan adopted pursuant to s. 627.351(4). The fund account shall continue to serve ~~for~~ the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members' activities for those health care providers set forth in subparagraphs (1)(b)1., 5., 6., and 7. which is in excess of the fund account entry level selected and less than the limit selected under paragraph (2)(b). The fund account shall be responsible only for payment of claims against health care providers who are in compliance with the provisions of paragraph (2)(b), of reasonable and necessary expenses incurred in the payment of claims, and of fund account administrative expenses.

(b) Fund account administration and operation.--

~~1.~~ The fund account, as a separate and discrete account within the medical malpractice risk apportionment plan adopted pursuant to s. 627.351(4), shall be subject to the supervision and approval of the board of governors of such plan ~~shall operate subject to the supervision and approval of a board of governors consisting of a representative of the insurance industry appointed by the Chief Financial Officer, an attorney~~

~~appointed by The Florida Bar, a representative of physicians appointed by the Florida Medical Association, a representative of physicians' insurance appointed by the Chief Financial Officer, a representative of physicians' self-insurance appointed by the Chief Financial Officer, two representatives of hospitals appointed by the Florida Hospital Association, a representative of hospital insurance appointed by the Chief Financial Officer, a representative of hospital self-insurance appointed by the Chief Financial Officer, a representative of the osteopathic physicians' or podiatric physicians' insurance or self-insurance appointed by the Chief Financial Officer, and a representative of the general public appointed by the Chief Financial Officer. The board of governors shall, during the first meeting after June 30 of each year, choose one of its members to serve as chair of the board and another member to serve as vice chair of the board. The members of the board shall be appointed to serve terms of 4 years, except that the initial appointments of a representative of the general public by the Chief Financial Officer, an attorney by The Florida Bar, a representative of physicians by the Florida Medical Association, and one of the two representatives of the Florida Hospital Association shall be for terms of 3 years; thereafter, such representatives shall be appointed for terms of 4 years. Subsequent to initial appointments for 4-year terms, the representative of the osteopathic physicians' or podiatric physicians' insurance or self-insurance appointed by the Chief Financial Officer and the representative of hospital self-insurance appointed by the Chief Financial Officer shall be appointed for 2-year terms; thereafter, such representatives~~

~~shall be appointed for terms of 4 years. Each appointed member may designate in writing to the chair an alternate to act in the member's absence or incapacity. A member of the board, or the member's alternate, may be reimbursed from the assets of the fund for expenses incurred by him or her as a member, or alternate member, of the board and for committee work, but he or she may not otherwise be compensated by the fund for his or her service as a board member or alternate~~.

~~2. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the fund or its agents or employees, professional advisers or consultants, members of the board of governors or their alternates, or the Department of Financial Services or the Office of Insurance Regulation of the Financial Services Commission or their representatives for any action taken by them in the performance of their powers and duties pursuant to this section.~~

(c) *Powers of the fund account.*--The fund account, as a separate and discrete account within the medical malpractice risk apportionment plan established pursuant to s. 627.351(4), has the power through the plan board of governors and staff to:

1. Sue and be sued, and appear and defend, in all actions and proceedings in its name to the same extent as a natural person.

2. Adopt, change, amend, and repeal a plan of operation for the fund account as part of the plan of operation of the medical malpractice risk apportionment plan adopted pursuant to s. 627.351(4), not inconsistent with law, for the regulation and administration of the affairs of the fund account. The plan and any changes thereto shall be filed with the Office of Insurance

Regulation of the Financial Services Commission and are all subject to its approval before implementation by the fund account. All fund members, board members, and employees shall comply with the plan of operation.

3. Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the fund account is created.

4. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this section.

5. Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the fund account and to perform other necessary or proper functions unless prohibited by law.

6. Take such legal action as may be necessary to avoid payment of improper claims.

7. Indemnify any employee, agent, member of the board of governors or his or her alternate, or person acting on behalf of the fund account in an official capacity, for expenses, including attorney's fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by him or her in connection with any action, suit, or proceeding, including any appeal thereof, arising out of his or her capacity in acting on behalf of the fund account, if he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the fund account and, with respect to any criminal action or proceeding, he or she had reasonable cause to believe his or her conduct was lawful.

(d) *Fees and assessments.*--Each health care provider, as set forth in subsection (2), electing to comply with paragraph

(2)(b) for a given fiscal year shall pay the fees and any assessments established under this section relative to such fiscal year, for deposit into the fund account. Those entering the fund account after the fiscal year has begun shall pay a prorated share of the yearly fees for a prorated membership. Actuarially sound membership fees payable annually, semiannually, or quarterly with appropriate service charges shall be established by the fund account before January 1 of each fiscal year, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;

2. The prior claims experience of the members covered under the fund account; and

3. Risk factors for persons who are retired, semiretired, or part-time professionals.

Such fees shall be based on not more than three geographical areas, not necessarily contiguous, with five categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. The fund account is authorized to adjust the fees of an individual member to reflect the claims experience of such member. Each fiscal year of the fund account shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund account; in cases in which a participant is a member of the fund account for less than the

total fiscal year, a member shall be subject to assessments for that year on a pro rata basis determined by the percentage of participation for the year. The fund account shall submit to the Office of Insurance Regulation the classifications and membership fees to be charged, and the Office of Insurance Regulation shall review such fees and shall approve them if they comply with all the requirements of this section and fairly reflect the considerations provided for in this section. If the classifications or membership fees do not comply with this section, the Office of Insurance Regulation shall set classifications or membership fees which do comply and which give due recognition to all considerations provided for in this section. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund account deficit on the Joint Underwriting Association authorized by s. 627.351(4) or its member insurers. If the fund account determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund account shall certify the amount of the projected excess or insufficiency to the Office of Insurance Regulation and request the office to levy an assessment against or refund to all participants in the fund account for that fiscal year, prorated, based on the number of days of participation during the year in question. The Office of Insurance Regulation shall approve the request of the fund account to refund to, or levy any assessment against, the participants, provided the refund or assessment fairly reflects the same considerations and classifications upon which the membership fees were based. The assessment shall be in an amount

sufficient to satisfy reserve requirements for known claims, including expenses to satisfy the claims, made against the account for a given fiscal year. In any proceeding to challenge the amount of the refund or assessment, it is to be presumed that the amount of refund or assessment requested by the fund account is correct, if the fund demonstrates that it has used reasonable claims handling and reserving procedures. Additional assessments may be certified and levied in accordance with this paragraph as necessary for any fiscal year. If a fund account member objects to his or her assessment, he or she shall, as a condition precedent to bringing legal action contesting the assessment, pay the assessment, under protest, to the fund account. The fund account may borrow money needed for current operations, if necessary to pay claims and related expenses, fees, and costs timely for a given fiscal year, from an account for another fiscal year until such time as sufficient funds have been obtained through the assessment process. Any such money, together with interest at the mean interest rate earned on the investment portfolio of the fund account, shall be repaid from the next assessment for the given fiscal year. If any assessments are levied in accordance with this subsection as a result of claims in excess of $500,000 per occurrence, and such assessments are a result of the liability of certain individuals and entities specified in paragraph (2)(e), only hospitals shall be subject to such assessments. Before approving the request of the fund account to charge membership fees, issue refunds, or levy assessments, the Office of Insurance Regulation shall publish notice of the request in the Florida Administrative Weekly. Pursuant to chapter 120, any party substantially

affected may request an appropriate proceeding. Any petition for such a proceeding shall be filed with the Office of Insurance Regulation within 21 days after the date of publication of the notice in the Florida Administrative Weekly.

(e) *Fund account accounting and audit.*--

1. Money shall be withdrawn from the fund account only upon a voucher as authorized by the board of governors.

2. All books, records, and audits of the fund account shall be open for reasonable inspection to the general public, except that a claim file in possession of the fund account, fund account members, and their insurers is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until termination of litigation or settlement of the claim, although medical records and other portions of the claim file may remain confidential and exempt as otherwise provided by law. Any book, record, document, audit, or asset acquired by, prepared for, or paid for by the fund account is subject to the authority of the board of governors, which shall be responsible therefor.

3. Persons authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any fund account moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund account assets. The cost of such bond shall be paid from the fund account.

4. Annually, the fund account shall furnish, upon request, audited financial reports to any fund participant and to the Office of Insurance Regulation and the Joint Legislative Auditing Committee. The reports shall be prepared in accordance with accepted accounting procedures and shall include income and

such other information as may be required by the Office of Insurance Regulation or the Joint Legislative Auditing Committee.

5. Any money held in the fund account shall be invested in interest-bearing investments by the board of governors of the fund account as administrator. However, in no case may any such money be invested in the stock of any insurer participating in the Joint Underwriting Association authorized by s. 627.351(4) or in the parent company of, or company owning a controlling interest in, such insurer. All income derived from such investments shall be credited to the fund account.

6. Any health care provider participating in the fund account may withdraw from such participation only at the end of a fiscal year; however, such health care provider shall remain subject to any assessment or any refund pertaining to any year in which such member participated in the fund account.

(f) Claims procedures.--

1. Any person may file an action against a participating health care provider for damages covered under the fund account, except that the person filing the claim may not recover against the fund account unless the fund account was named as a defendant in the suit. The fund account is not required to actively defend a claim until the fund account is named therein. If, after the facts upon which the claim is based are reviewed, it appears that the claim will exceed the applicable amount set forth in paragraph (2)(f) or, if greater, the amount of the health care provider's basic coverage, the fund account shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund account shall retain counsel

and pay out of the account for the appropriate year attorneys' fees and expenses, including court costs incurred in defending the fund account. In any claim, the attorney or law firm retained to defend the fund account may not be retained to defend the Joint Underwriting Association authorized by s. 627.351(4) in any situation giving rise to a conflict of interest. The fund account is authorized to negotiate with any claimant having a judgment exceeding the applicable amount set forth in paragraph (2)(f) to reach an agreement as to the manner in which that portion of the judgment exceeding such amount is to be paid. Any judgment affecting the fund account may be appealed under the Florida Rules of Appellate Procedure, as with any defendant.

2. It is the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund account to provide an adequate defense on any claim filed which potentially affects the fund account, with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in a fiduciary relationship toward the fund account with respect to any claim affecting the fund account. No settlement exceeding the applicable amount set forth in paragraph (2)(f), or any other amount which could require payment by the fund account, may be agreed to unless approved by the fund account.

3. A person who has recovered a final judgment against the fund account or against a health care provider who is covered by the fund account may file a claim with the fund account to recover that portion of such judgment which is in excess of the applicable amount set forth in paragraph (2)(f) or the amount of

the health care provider's basic coverage, if greater, as set forth in paragraph (2)(b). The amount of liability of the fund account under a judgment, including court costs, reasonable attorney's fees, and interest, shall be paid in a lump sum, except that any claims for future special damages, as set forth in 768.48(1)(a) and (b), shall be paid periodically as they are incurred by the claimant. If a claimant dies while receiving periodic payments, payment for future medical expenses shall cease, but payment for future wage loss, if any, shall continue at a rate of not more than $100,000 per year. The fund account may pay a lump sum reflecting the present value of future wage losses in lieu of continuing the periodic payments.

4. Payment of settlements or judgments involving the fund account shall be paid in the order received within 60 days after the date of settlement or judgment, unless appealed by the fund account. If the account for a given year does not have enough money to pay all of the settlements or judgments, those claims received after the funds are exhausted shall be payable in the order in which they are received. However, no claimant has the right to execute against the fund account to the extent that the judgment is for a claim covered in a membership year for which the fund account has insufficient assets to pay the claim, as determined by membership fees for such year, investment income generated by such fees, and assessments collected from members for such year. When the fund account has insufficient assets to pay claims for a fund account year, the fund will not be required to post a supersedeas bond in order to stay execution of a judgment pending appeal. The fund account shall retain a

reasonable sum of money for payment of administrative and claims expense, which money will not be subject to execution.

5. Except to the extent of the appropriate fund account entry level amount selected, if a judgment is entered against the fund account for a year in which there are insufficient assets to satisfy the claim, an automatic stay of execution and collection in favor of the fund account member shall exist for that portion of the judgment which exceeds the selected entry level amount, and for which fund account coverage exists. Such stay shall only be granted to those members who have fully complied with the requirements of fund account membership, and such stay shall remain in effect until adequate assessments are collected by the fund account to pay the claim. Upon competent proof that the portion of any claim covered by the fund account is uncollectible from the fund, the member's stay of execution may be vacated by the court, upon application by the plaintiff and hearing thereon.

6. If a health care provider participating in the fund account has coverage in excess of the applicable amount set forth in paragraph (2)(f), such health care provider shall be liable for losses up to the amount of his or her coverage, and such health care provider shall receive an appropriate reduction of the fees and assessments for participation in the fund account. Such reduction shall be granted only after such health care provider has proved to the satisfaction of the fund account that such health care provider had such coverage during the period of membership of the fiscal year.

7. The manager of the fund account or his or her assistant is the agent for service of process for the plan.

(g) Risk management program.--The fund account shall establish a risk management program as part of its administrative functions. All health care providers, as defined in subparagraphs (1)(b)1., 5., 6., and 7., participating in the fund account shall comply with the provisions of the risk management program established by the fund account. The risk management program shall include the following components:

1. The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

2. The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients;

3. The analysis of patient grievances which relate to patient care and the quality of medical services;

4. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of health care providers and health care facilities to report injuries and incidents; and

5. Auditing of participating health care providers to assure compliance with the provisions of the risk management program.

The fund account shall establish a schedule of fee surcharges which it shall levy upon participating health care providers found to be in violation of the provisions of the risk management program. Such schedule shall be subject to approval by the Office of Insurance Regulation and shall provide an escalating scale of surcharges based upon the frequency and

severity of the incidents in violation of the risk management program. No health care provider shall be required to pay a surcharge if it has corrected all violations of the provisions of the risk management program and established an affirmative program to remain in compliance by the time its next fee or assessment is due.

(h) Nonavailability of coverage.--The fund account shall determine, no later than 7 days before the beginning of each fiscal year, whether the total amount of the membership fees to be charged for the fiscal year to health care provider applicants other than hospitals exceeds $5 million and whether the total amount of the membership fees to be charged to hospital applicants exceeds $12.5 million. If the total amount of the membership fees to be charged to health care provider applicants other than hospitals does not exceed $5 million, the fund account shall return the membership fees collected from such providers and shall, not later than the day before the beginning of the fiscal year, notify all such providers, advising them that coverage will not be available from the fund account. Thereafter, the fund account may not issue coverage to any health care provider, including any hospital, for that fiscal year. If the total amount of the membership fees to be charged to hospital applicants for the fiscal year does not exceed $12.5 million, the fund account shall return the membership fees collected from the hospitals and shall, not later than the day before the beginning of the fiscal year, notify such hospitals that coverage of hospitals will not be available from the fund account. Thereafter, the fund account may not issue coverage to any hospital for that fiscal year. If

the fund account ceases to provide coverage to hospitals, hospitals shall continue to meet the financial responsibility requirements of subparagraph (2)(c)1., subparagraph (2)(c)2., or subparagraph (2)(c)3. An application for fund account membership for a particular fiscal year does not guarantee coverage for that year, and the fund account is not liable for coverage of an applicant for any fiscal year in which the fund account does not provide coverage in accordance with the provisions of this paragraph.

Section 49. Any domestic insurer with a certificate of authority in effect on January 1, 2005, shall have 12 months to comply with any rules adopted pursuant to this act.

Section 50. Except as otherwise provided herein, this act shall take effect October 1, 2004.