By Senator Alexander

17-1777-04

A bill to be entitled

An act relating to insurance; amending s. 624.316, F.S.; extending the interval at which insurers must be examined by the Office of Insurance Regulation; deleting provisions allowing the office to accept an audit report from a certified public accountant in lieu of conducting its own examination; revising guidelines for conducting such examinations; amending s. 624.319, F.S.; requiring an insurer to provide copies of documents to examiners; creating s. 624.4051, F.S.; requiring entities issued a certificate by the office to comply with specified federal legislation; amending s. 624.4095, F.S.; providing additional restrictions with respect to premiums written when both a parent company and its subsidiary are insurers; amending s. 624.413, F.S.; requiring additional documentation from applicants for a certificate of authority; amending s. 624.418, F.S.; prescribing additional grounds for suspension or revocation of a certificate of authority; amending s. 624.424, F.S.; prescribing additional actuarial certification that may be required by the office of an insurer; amending s. 624.4622, F.S.; prescribing additional requirements for local government self-insurance funds; requiring statements of financial condition, transactions, and affairs; creating s. 624.4691, F.S.; prescribing restrictions and

limits on premiums written by a commercial self-insurance fund; requiring certain excess of loss reinsurance; amending s. 624.610, F.S.; revising provisions relating to reinsurance; amending s. 625.121, F.S.; revising standard mortality tables, tables of disablement, and tables of accidental death benefits to be used in determining standard valuation; amending s. 625.131, F.S.; revising provisions relating to reserves for credit life and disability policies; amending s. 625.304, F.S.; providing for investment plans by insurers' boards of directors; amending s. 625.326, F.S.; revising limits on foreign investments by insurers; amending s. 626.88, F.S.; redefining the terms "administrator" and "insurer"; defining "affiliate," "control," and "GAAP"; amending s. 626.8805, F.S.; requiring additional information of applicants for a certificate of authority to act as an administrator; creating s. 626.8817, F.S.; revising responsibilities of an insurance company with respect to use of an administrator; amending s. 626.89, F.S.; requiring additional information in administrators' annual reports; amending s. 626.901, F.S.; revising exemptions from the prohibition against representing or aiding an unauthorized insurer; amending s. 626.902, F.S.; providing an exemption from the penalty for representing an unauthorized insurer; amending s. 626.9913, F.S.; providing for

viatical settlement providers to submit reports electronically; creating s. 627.0646, F.S.; providing for the adoption of flex rate adjustment factors the use of which will allow insurers to adjust rates based on uniform factors with a simplified review process; prescribing requirements for such rate filings and for determining such factors; amending s. 627.351, F.S.; creating separate accounts under the Medical Malpractice Risk Apportionment plan and providing for payments from the respective accounts; amending s. 627.476, F.S.; providing mortality tables that may be used to calculate premiums and present values under the Standard Nonforfeiture Law for Life Insurance; amending s. 627.836, F.S.; providing for premium finance companies to submit certain information electronically; creating s. 627.8401, F.S.; prohibiting certain investments and loans by premium finance companies; amending s. 627.915, F.S.; revising the method for calculating exemption from insurer experience reporting requirements; amending s. 627.943, F.S.; revising standards for feasibility studies by risk retention groups; prescribing grounds for exemption from risk retention group certificates of authority; amending s. 628.071, F.S.; prescribing additional grounds on issuance of a permit to form an insurer; creating s. 628.072, F.S.; requiring domestic insurers to establish and maintain corporate

good governance procedures; prescribing elements of such procedures; amending s. 628.371, F.S.; revising conditions on payment of dividends; amending s. 628.461, F.S.; providing additional grounds for exemption from provisions relating to acquisition of controlling stock; amending s. 628.4615, F.S.; providing additional grounds for exemption from provisions relating to acquisition of controlling stock in a specialty insurer; amending s. 628.709, F.S.; revising provisions relating to formation of a mutual insurance holding company; creating s. 634.042, F.S.; prohibiting certain investments and loans by motor vehicle service agreement companies; creating s. 634.3076, F.S.; prohibiting certain investments and loans by home warranty associations; creating s. 634.4062, F.S.; prohibiting certain investments and loans by service warranty associations; amending s. 636.043, F.S.; revising provisions relating to annual, quarterly, and miscellaneous reports by prepaid limited health service organizations; amending s. 641.22, F.S.; providing additional conditions on issuance of a certificate of authority to operate a health maintenance organization; creating s. 641.23, F.S.; providing additional grounds for revocation or cancellation of a certificate of a health maintenance organization or prepaid health clinic; amending s. 641.27, F.S.; increasing

the interval at which the office examines health maintenance organizations; amending s. 641.30, F.S.; providing requirements for health maintenance organizations relating to corporate good governance; amending s. 641.309, F.S.; revising requirements for prepaid health clinics with respect to insolvency protection; amending ss. 651.026, 651.0261, F.S.; providing for continuing care providers to submit certain information electronically; creating s. 651.0271, F.S.; prohibiting certain investments and loans by continuing care providers; amending s. 651.033, F.S.; revising provisions relating to escrow accounts; amending s. 766.105, F.S.; redefining the term "fund" for purposes of the Florida Patient's Compensation Fund; revising provisions relating to coverage; revising purposes of the fund; revising claim procedures; providing applicability; providing effective dates.

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

Section 1. Subsection (2) of section 624.316, Florida Statutes, is 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.~~

(b) The office shall examine each insurer applying for an initial certificate of authority to transact insurance in this state before granting the initial certificate.

(c) In lieu of making its own examination, the office may accept a full report of the last recent examination of a foreign insurer, certified to by the insurance supervisory official of another state.

(d) The examination by the office of an alien insurer shall be limited to the alien insurer's insurance transactions and affairs in the United States, except as otherwise required by the office.

(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 ~~meeting criteria specified by rule~~, investment specialists, information technology specialists, 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 624.4051, Florida Statutes, is created to read:

624.4051 Compliance with certain 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 115 Stat. 272 (commonly known 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 the USA PATRIOT Act. The office may

report and provide evidence to the appropriate federal authorities of any possible violations that 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) When the parent company and its subsidiary are both insurers, in addition to individual insurer compliance pursuant to subsection (1), the parent company must also maintain compliance with this section using consolidated direct and net premium compared to the parent company's surplus.

Section 5. 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 thereunder.

Section 6. Paragraph (e) 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:

(e) If a domestic stock or mutual insurer, failed to maintain and demonstrate compliance with s. 628.072 and rules adopted thereunder.

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. Section 624.4622, Florida Statutes, is amended to read:

624.4622 Local government self-insurance funds.--

(1) Any two or more local governmental entities may enter into interlocal agreements for the purpose of securing

the payment of benefits under chapter 440, provided the local government self-insurance fund that is created must:

(a) Have annual normal premiums in excess of $5 million;

(b) Maintain a continuing program of excess insurance coverage and reserve evaluation to protect the financial stability of the fund in an amount and manner determined by a qualified and independent actuary;

(c) Submit annually an audited fiscal year-end financial statement by an independent certified public accountant within 6 months after the end of the fiscal year to the office; and

(d) Have a governing body which is comprised entirely of local elected officials.

(2) A local government self-insurance fund that meets the requirements of this section is not subject to s. 624.4621 and is not required to file any report with the office under s. 440.38(2)(b) which is uniquely required of group self-insurer funds qualified under s. 624.4621. If any of the requirements of this section are not met, the local government self-insurance fund is subject to the requirements of s. 624.4621.

(3) Notwithstanding the provisions of subsection (2) to the contrary, a local government self-insurance fund created under this section after October 1, 2004, shall initially be organized as either 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, is subject to all the requirements applied to commercial self-insurance funds or to group self-insurance funds.

(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 fiscal year, and quarterly statements shall be filed within 45 days after the end of each quarter. 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 must 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 624.4691, Florida Statutes, is created to read:

624.4691 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 this 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. As 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 section 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 will 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, it 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, as a minimum, maintain dollar limits of aggregate excess of loss reinsurance as follows:

(a) For funds with actual or projected earned premiums of $5 million or less, the minimum shall be equal to either 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 million, 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 the 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 assuring 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 conformed 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. Paragraphs (a), (e), and (f) of subsection (5) of section 625.121, Florida Statutes, are amended, and paragraphs (k) and (l) are added to that 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; and~~.~~

(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. 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 that 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 which 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 the foregoing basis, 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 which specifies guidelines as to the quality, maturity, and diversification of investments and other specifications, including investment strategies intended to assure 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 it 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) No less frequently than quarterly, 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; and

(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, other documentation as the board requires, and reports of any action taken under authority delegated under the plan referred to in subsection (2) be made available regularly 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 ~~does~~ not exceed 10~~, in total,~~

~~5~~ percent of admitted assets, subject to the following limitations:~~.~~

(a) No more than 3 percent of the insurer's assets may 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 may not exceed 1.5 percent of assets in total with mo 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 may be invested in the common stock of any one corporation.

In determining the financial condition of an insurer, any amounts that exceed the limitations in valuation in this subsection will be considered as nonadmitted 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, the term "insurer" means a licensed insurance company, prepaid hospital or medical care plan, or 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" or "affiliated" means an entity or person who directly or indirectly through one or more intermediaries controls, 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 shall be 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.

(d) "GAAP" means United States generally accepted accounting principles consistently applied.

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 which 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 GAAP, 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 include the following:

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

2. Amounts for each entity shall be stated separately; and

3. Explanations of consolidating and eliminating entries.

The applicant shall also include such other information as the office requires 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, recordkeeping, 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 must be an on-site audit of the operations of the administrator.

(4) For purposes of this section, the term "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 or annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include 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; and

(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 the electronic data format specified by the commission.

Section 19. 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:

(a) Matters authorized to be done by the office under the Unauthorized Insurers Process Law, ss. 626.904-626.912.

(b) Surplus lines insurance when written pursuant to the Surplus Lines Law, ss. 626.913-626.937.

(c) Transactions as to which a certificate of authority is not required of an insurer, as stated in s. 624.402.

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

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

626.902 Penalty for representing unauthorized insurer.--

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

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 the electronic data format specified by the commission.

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

627.0646 Uniform and flex rate adjustment factors.--

(1)(a) The office may examine trends in premiums and trends in average cost and frequency of claims and develop and recommend for adoption by the commission uniform rate adjustment factors that are reflective thereof 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. Subject to the requirements of this section, insurers may submit a filing seeking to adjust rates by no more than the amount of the uniform rate adjustment factors.

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

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 the uniform rate adjustment factors filing effective dates. This limitation does not apply to recoupment filings submitted pursuant to ss. 627.062, 627.3512, and 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, by an experienced insurance company rate maker, or by a consultant that the filing seeks to implement a rate that is actuarially sound and not inadequate. Such certification shall satisfy 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 are solicited must provide the solicited information to the office within 30 days of the date of the request. The office shall determine the type of data necessary and the format of this data for their examination and, when rulemaking is required, submit its recommendation to the commission for consideration and rule adoption.

5. The uniform rate adjustment factor shall be applied uniformly to all subject policies in force on the filing's effective date at renewal and to all new business written on or after the uniform rates effective date by any insurer that has submitted such a filing, provided that the requisite statutory notice is given.

6. The first uniform rate adjustment factors filing 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 uniform rate adjustment factors filing of an insurer shall not be

effective any sooner than 12 months from the effective date of the previous uniform rate adjustment factors filing effective date.

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) This section does not affect the application of s. 627.066.

(2)(a) This section 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 section is to enhance competition and reduce the frictional costs associated with rate filings for insurance subject to this section 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 whose effective dates are sooner than 6 months following the flex filing effective dates. This limitation does not apply to recoupment filings submitted pursuant to ss. 627.062, 627.3512, and 631.64.

(c) The submission of a rate filing seeking to adjust rates by the application of the flex rate filing may 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 are solicited must provide the solicited information to the office within 30 days of the date of the request. The office shall determine the type of data necessary and the format of this data for their examination.

(f) The rate 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 which 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 that 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 marketplace 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. The first flex rate filing permitted by this section may be submitted at any time after the effective date of this act. Subsequent flex rate filings shall not be effective any sooner than 12 months from the effective dates of the previous flex rate filing. 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 of its receipt.

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.

(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 section.

Section 23. 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, obligations, and members of the fund 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 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 Joint Underwriting Association Coverage Account, 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 ~~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 Patient's Compensation Fund 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, the term ~~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 deems ~~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 the 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 may 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 (6) 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 that 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 requires. The study shall be for the greater of 3 years or until the arrangement has been projected to be profitable for 12 consecutive months. The feasibility 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 so 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 engage an independent expert to review the feasibility study. In making the determination, the office shall consider the applicant's:

(a) Line of business;

(b) Business plan, including premium volume;

(c) Scope of coverage and coverage limits; and

(d) Other relevant factors.

Section 29. 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 thereunder,

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

Section 30. 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 procedures 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 that 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 statutes 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 therefor;

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 the outside auditor, require:

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 nonaudit services to a client to avoid conflicts;

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

(i) A requirement that the insurer establish an internal audit function either in house or outside which is independent from the regular outside auditor;

(j) A requirement that the insurer should establish internal policies and procedures that encourage employees to come forward with allegations of misconduct without fear of retribution; and

(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 good governance practices set forth in 15 U.S.C. s. 7201 to the

degree they may be applied to mutual domestic insurers or publicly traded or closely held stock domestic insurers; however, a rule that 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. Section 628.371, Florida Statutes, is amended to read:

628.371 Dividends to stockholders.--

(1) A domestic stock insurer shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains.

(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 thereof 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, 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 2nd and 3rd preceding calendar years, not including realized capital gains, less dividends paid in the 2nd and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that 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 the 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, 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, this section does 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 that 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, this section does 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, F.S., 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 therefor as the office, for good cause, grants, 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 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 must 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 it 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 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 may 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 section as "CPA," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this part.

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

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

(c) The completed work papers and any written communications between the CPA 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 CPA must retain for review the work papers and written communications for a period of not less than 6 years.

(d) The CPA 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 to facilitate office analysis, 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; may adopt subsequent amendments thereto if the methodology remains substantially consistent; and 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 called for 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. 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. Subsection (2) of section 641.23, Florida Statutes, is amended 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:

(a) The organization is not operating in compliance with this part;

(b) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part;

(c) The existing contract rates are excessive, inadequate, or unfairly discriminatory;

(d) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or

(e) The organization is insolvent; or~~.~~

(f) 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 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. Subsection (6) is added to section 641.30, Florida Statutes, to read:

641.30 Construction and relationship to other laws.--

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

Section 43. Present subsection (3) of section 641.309, Florida Statutes, is renumbered as (4) and amended, and a new subsection (3) is added to that 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 electronic means in a computer-readable form compatible with the 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 electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

Section 46. Section 651.0271, Florida Statutes, is created to read:

651.0271 Prohibited investments and loans.--A provider may 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. Paragraph (a) of subsection (1), paragraphs (b) and (c) of subsection (2), and paragraphs (a),

(b), (c), and (f) of 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) Effective July 1, 2004, 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 Joint Underwriting Association Coverage Account 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 Joint Underwriting Association Coverage Account 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.--

(a) Purposes.--The ~~There is created a~~ "Florida Patient's Compensation Fund" originally created by this statute shall, as of July 1, 2004, be known as the Florida Patient's Compensation Fund Account, hereinafter referred to as the "fund" or 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 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 entry level selected and less than the limit selected under paragraph (2)(b). The fund 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 administrative expenses.

(b) Fund administration and operation.--Effective July 1, 2004, the fund, 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.

~~1. The fund 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.--The fund 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 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. 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. 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 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 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 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, 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 and, with respect to any criminal action or proceeding, he or she had reasonable cause to believe his or her conduct was lawful.

(f) Claims procedures.--

1. Any person may file an action against a participating health care provider for damages covered under the fund, except that the person filing the claim may not recover against the fund unless the fund was named as a defendant in the suit. The fund is not required to actively defend a claim until the fund 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 shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund 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. 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 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 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 to provide an adequate defense on any claim filed which potentially affects the fund, with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in a fiduciary relationship toward the

fund with respect to any claim affecting the fund. No settlement exceeding the applicable amount set forth in paragraph (2)(f), or any other amount which could require payment by the fund, may be agreed to unless approved by the fund.

3. A person who has recovered a final judgment against the fund or against a health care provider who is covered by the fund may file a claim with the fund 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 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 s. 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 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 shall be paid in the order received within 60 days after the date of settlement or judgment, unless appealed by the fund. 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 to the extent that the

judgment is for a claim covered in a membership year for which the fund 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 has insufficient assets to pay claims for a fund year, the fund will not be required to post a supersedeas bond in order to stay execution of a judgment pending appeal. The fund 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 entry level amount selected, if a judgment is entered against the fund 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 member shall exist for that portion of the judgment which exceeds the selected entry level amount, and for which fund coverage exists. Such stay shall only be granted to those members who have fully complied with the requirements of fund membership, and such stay shall remain in effect until adequate assessments are collected by the fund to pay the claim. Upon competent proof that the portion of any claim covered by the fund 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 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. Such reduction shall be granted only after such health care

provider has proved to the satisfaction of the fund that such health care provider had such coverage during the period of membership of the fiscal year.

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

Section 49. Sections 5, 6, 29, 30, 39, 40, and 42 shall take effect January 1, 2005; however, any domestic insurer with a certificate of authority in effect on that date shall have 12 months to comply with any rules adopted pursuant to this act.

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

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SENATE SUMMARY

Revises and creates a variety of provisions relating, generally, to insurance. (See bill for details.)