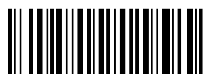
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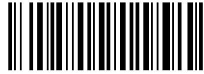
LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/13/2017	.	
	.	
	.	
	.	

The Committee on Appropriations (Bradley) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Subsection (40) of section 440.02, Florida
6 Statutes, is amended to read:
7 440.02 Definitions.—When used in this chapter, unless the
8 context clearly requires otherwise, the following terms shall
9 have the following meanings:
10 (40) "Specificity" means information on the petition for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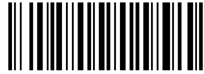
11 benefits sufficient to put the employer or carrier on notice of
12 the exact statutory classification and outstanding time period
13 for each requested benefit, the specific amount of each
14 requested benefit, the calculation used for computing the
15 requested benefit, ~~of benefits being requested~~ and ~~includes~~ a
16 detailed explanation of any benefits received that should be
17 increased, decreased, changed, or otherwise modified. If the
18 petition is for medical benefits, the information must ~~shall~~
19 include specific details as to why such benefits are being
20 requested, why such benefits are medically necessary, and why
21 current treatment, if any, is not sufficient. Any petition
22 requesting alternate or other medical care, including, but not
23 limited to, petitions requesting psychiatric or psychological
24 treatment, must specifically identify the physician, as defined
25 in s. 440.13(1), who is recommending such treatment. A copy of a
26 report from such physician making the recommendation for
27 alternate or other medical care must ~~shall~~ also be attached to
28 the petition. A judge of compensation claims may ~~shall~~ not order
29 such treatment if a physician is not recommending such
30 treatment.
31 Section 2. Paragraph (c) of subsection (3) of section
32 440.105, Florida Statutes, is amended to read:
33 440.105 Prohibited activities; reports; penalties;
34 limitations.—
35 (3) Whoever violates any provision of this subsection
36 commits a misdemeanor of the first degree, punishable as
37 provided in s. 775.082 or s. 775.083.
38 (c) Except for an attorney who is retained by or for an
39 injured worker and who receives a fee or other consideration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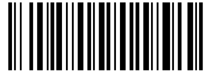
40 from or on behalf of such worker, it is unlawful for any
41 ~~attorney or other~~ person, in his or her individual capacity or
42 in his or her capacity as a public or private employee, or for
43 any firm, corporation, partnership, or association to receive
44 any fee or other consideration or any gratuity from a person on
45 account of services rendered for a person in connection with any
46 proceedings arising under this chapter, unless such fee,
47 consideration, or gratuity is approved by a judge of
48 compensation claims or by the Deputy Chief Judge of Compensation
49 Claims.
50 Section 3. Paragraph (f) of subsection (2), paragraphs (d)
51 and (i) of subsection (3), paragraph (a) of subsection (4),
52 paragraphs (a) and (c) of subsection (5), and paragraphs (c) and
53 (d) of subsection (9) of section 440.13, Florida Statutes, are
54 amended, to read:
55 440.13 Medical services and supplies; penalty for
56 violations; limitations.—
57 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
58 (f) Upon the written request of the employee, the carrier
59 shall give the employee the opportunity for one change of
60 physician during the course of treatment for any one accident.
61 Upon the granting of a change of physician, the originally
62 authorized physician in the same specialty as the changed
63 physician shall become deauthorized upon written notification by
64 the employer or carrier. The carrier shall authorize an
65 alternative physician who shall not be professionally affiliated
66 with the previous physician within 5 business days after receipt
67 of the request. If the carrier fails to provide a change of
68 physician as requested by the employee, the employee may select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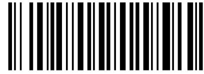
69 the physician and such physician shall be considered authorized
70 if the treatment being provided is compensable and medically
71 necessary.
72
73 Failure of the carrier to timely comply with this subsection
74 shall be a violation of this chapter and the carrier shall be
75 subject to penalties as provided for in s. 440.525.
76 (3) PROVIDER ELIGIBILITY; AUTHORIZATION.—
77 (d) A carrier ~~must respond~~, by telephone or in writing,
78 must authorize or deny ~~to~~ a request for authorization from an
79 authorized health care provider by the close of the third
80 business day after receipt of the request. A carrier authorizes
81 the request if it ~~who~~ fails to respond to a written request for
82 authorization for referral for medical treatment by the close of
83 the third business day after receipt of the request ~~consents to~~
84 ~~the medical necessity for such treatment~~. All such requests must
85 be made to the carrier. Notice to the carrier does not include
86 notice to the employer.
87 (i) Notwithstanding paragraph (d), a claim for specialist
88 consultations, surgical operations, physiotherapeutic or
89 occupational therapy procedures, X-ray examinations, or special
90 diagnostic laboratory tests that cost more than $1,000 and other
91 specialty services that the department identifies by rule is not
92 valid and reimbursable unless the services have been expressly
93 authorized by the carrier, unless the carrier has failed to
94 respond within 10 business days to a written request for
95 authorization, or unless emergency care is required. The insurer
96 shall authorize such consultation or procedure unless the health
97 care provider or facility is not authorized, unless such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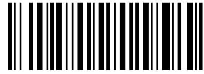
98 treatment is not in accordance with practice parameters and
99 protocols of treatment established in this chapter, or unless a
100 judge of compensation claims has determined that the
101 consultation or procedure is not medically necessary, not in
102 accordance with the practice parameters and protocols of
103 treatment established in this chapter, or otherwise not
104 compensable under this chapter. Authorization of a treatment
105 plan does not constitute express authorization for purposes of
106 this section, except to the extent the carrier provides
107 otherwise in its authorization procedures. This paragraph does
108 not limit the carrier's obligation to identify and disallow
109 overutilization or billing errors.
110 (4) NOTICE OF TREATMENT TO CARRIER; FILING WITH
111 DEPARTMENT.—
112 (a) Any health care provider providing necessary remedial
113 treatment, care, or attendance to any injured worker shall
114 submit treatment reports to the carrier in a format prescribed
115 by the department. A claim for medical or surgical treatment is
116 not valid or enforceable against such employer or employee,
117 unless, by the close of the third business day following the
118 first treatment, the physician providing the treatment furnishes
119 to the employer or carrier a preliminary notice of the injury
120 and treatment in a format prescribed by the department and,
121 within 15 business days thereafter, furnishes to the employer or
122 carrier a complete report, and subsequent thereto furnishes
123 progress reports, if requested by the employer or insurance
124 carrier, at intervals of not less than 15 business days ~~3 weeks~~
125 apart or at less frequent intervals if requested in a format
126 prescribed by the department.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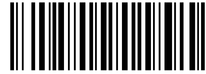
127 (5) INDEPENDENT MEDICAL EXAMINATIONS.—
128 (a) In any dispute concerning overutilization, medical
129 benefits, compensability, or disability under this chapter, the
130 carrier or the employee may select an independent medical
131 examiner. If the parties agree, the examiner may be a health
132 care provider treating or providing other care to the employee.
133 An independent medical examiner may not render an opinion
134 outside his or her area of expertise, as demonstrated by
135 licensure and applicable practice parameters. The employer and
136 employee shall be entitled to only one independent medical
137 examination per accident and not one independent medical
138 examination per medical specialty. The party requesting and
139 selecting the independent medical examination shall be
140 responsible for all expenses associated with said examination,
141 including, but not limited to, medically necessary diagnostic
142 testing performed and physician or medical care provider fees
143 for the evaluation. The party selecting the independent medical
144 examination shall identify the choice of the independent medical
145 examiner to all other parties within 15 business days after the
146 date the independent medical examination is to take place.
147 Failure to timely provide such notification shall preclude the
148 requesting party from submitting the findings of such
149 independent medical examiner in a proceeding before a judge of
150 compensation claims. The independent medical examiner may not
151 provide followup care if such recommendation for care is found
152 to be medically necessary. If the employee prevails in a medical
153 dispute as determined in an order by a judge of compensation
154 claims or if benefits are paid or treatment provided after the
155 employee has obtained an independent medical examination based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156 upon the examiner’s findings, the costs of such examination
157 shall be paid by the employer or carrier.
158 (c) The carrier may, at its election, contact the claimant
159 directly to schedule a reasonable time for an independent
160 medical examination. The carrier must confirm the scheduling
161 agreement in writing with the claimant and the claimant’s
162 counsel, if any, at least 7 business days before the date upon
163 which the independent medical examination is scheduled to occur.
164 An attorney representing a claimant is not authorized to
165 schedule the self-insured employer’s or carrier’s independent
166 medical evaluations under this subsection. Neither the self-
167 insured employer nor the carrier shall be responsible for
168 scheduling any independent medical examination other than an
169 employer or carrier independent medical examination.
170 (9) EXPERT MEDICAL ADVISORS.—
171 (c) If there is disagreement in the opinions of the health
172 care providers, if two health care providers disagree on medical
173 evidence supporting the employee’s complaints or the need for
174 additional medical treatment, or if two health care providers
175 disagree that the employee is able to return to work, the
176 department may, and the judge of compensation claims shall, upon
177 his or her own motion or within 15 business days after receipt
178 of a written request by either the injured employee, the
179 employer, or the carrier, order the injured employee to be
180 evaluated by an expert medical advisor. The injured employee and
181 the employer or carrier may agree on the health care provider to
182 serve as an expert medical advisor. If the parties do not agree,
183 the judge of compensation claims shall select an expert medical
184 advisor from the department’s list of certified expert medical

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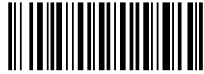
185 advisors. If a certified medical advisor within the relevant
186 medical specialty is unavailable, the judge of compensation
187 claims shall appoint any otherwise qualified health care
188 provider to serve as an expert medical advisor without obtaining
189 the department’s certification. The opinion of the expert
190 medical advisor is presumed to be correct unless there is clear
191 and convincing evidence to the contrary as determined by the
192 judge of compensation claims. The expert medical advisor
193 appointed to conduct the evaluation shall have free and complete
194 access to the medical records of the employee. An employee who
195 fails to report to and cooperate with such evaluation forfeits
196 entitlement to compensation during the period of failure to
197 report or cooperate.
198 (d) The expert medical advisor must complete his or her
199 evaluation and issue his or her report to the department or to
200 the judge of compensation claims within 15 business days after
201 receipt of all medical records. The expert medical advisor must
202 furnish a copy of the report to the carrier and to the employee.
203 Section 4. Paragraph (a) of subsection (2) and paragraph
204 (e) of subsection (4) of section 440.15, Florida Statutes, are
205 amended to read:
206 440.15 Compensation for disability.—Compensation for
207 disability shall be paid to the employee, subject to the limits
208 provided in s. 440.12(2), as follows:
209 (2) TEMPORARY TOTAL DISABILITY.—
210 (a) Subject to subsection (7), in case of disability total
211 in character but temporary in quality, 66 2/3 or 66.67 percent
212 of the average weekly wages shall be paid to the employee during
213 the continuance thereof, not to exceed 260 ~~104~~ weeks except as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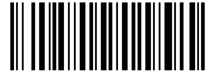
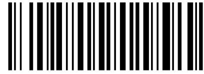
214 provided in this subsection, s. 440.12(1), and s. 440.14(3).
215 Once the employee reaches the maximum number of weeks allowed,
216 or the employee reaches the date of maximum medical improvement,
217 whichever occurs earlier, temporary disability benefits shall
218 cease and the injured worker’s permanent impairment shall be
219 determined.
220 (4) TEMPORARY PARTIAL DISABILITY.—
221 (e) Such benefits shall be paid during the continuance of
222 such disability, not to exceed a period of 260 ~~104~~ weeks, as
223 provided by this subsection and subsection (2). Once the injured
224 employee reaches the maximum number of weeks, temporary
225 disability benefits cease and the injured worker’s permanent
226 impairment must be determined. If the employee is terminated
227 from postinjury employment based on the employee’s misconduct,
228 temporary partial disability benefits are not payable as
229 provided for in this section. The department shall by rule
230 specify forms and procedures governing the method and time for
231 payment of temporary disability benefits for dates of accidents
232 before January 1, 1994, and for dates of accidents on or after
233 January 1, 1994.
234 Section 5. Subsections (2) and (5) of section 440.192,
235 Florida Statutes, are amended to read:
236 440.192 Procedure for resolving benefit disputes.—
237 (2) Upon receipt, the Office of the Judges of Compensation
238 Claims shall review each petition and shall dismiss each
239 petition or any portion of such a petition that does not on its
240 face meet the requirements of this section and the definition of
241 specificity under s. 440.02, and specifically identify or
242 itemize the following:

 251016

243 (a) The name, address, and telephone number, and social
244 security number of the employee.
245 (b) The name, address, and telephone number of the
246 employer.
247 (c) A detailed description of the injury and cause of the
248 injury, including the Florida county or, if outside of Florida,
249 the state location of the occurrence and the date or dates of
250 the accident.
251 (d) A detailed description of the employee's job, work
252 responsibilities, and work the employee was performing when the
253 injury occurred.
254 (e) The specific time period for which compensation and the
255 specific classification of compensation were not timely
256 provided.
257 (f) The specific date of maximum medical improvement,
258 character of disability, and specific statement of all benefits
259 or compensation that the employee is seeking. A claim for
260 permanent benefits must include the specific date of maximum
261 medical improvement and the specific date that such permanent
262 benefits are claimed to begin.
263 (g) All specific travel costs to which the employee
264 believes she or he is entitled, including dates of travel and
265 purpose of travel, means of transportation, and mileage and
266 including the date the request for mileage was filed with the
267 carrier and a copy of the request filed with the carrier.
268 (h) A specific listing of all medical charges alleged
269 unpaid, including the name and address of the medical provider,
270 the amounts due, and the specific dates of treatment.
271 (i) The type or nature of treatment care or attendance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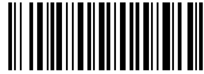
272 sought and the justification for such treatment. If the employee
273 is under the care of a physician for an injury identified under
274 paragraph (c), a copy of the physician’s request, authorization,
275 or recommendation for treatment, care, or attendance must
276 accompany the petition.
277 (j) The specific amount of compensation claimed to be
278 accurate and the methodology claimed to accurately calculate the
279 average weekly wage, if the average weekly wage calculated by
280 the employer or carrier is disputed. If the petition does not
281 include a claim under this paragraph, the average weekly wage
282 and corresponding compensation calculated by the employer or
283 carrier are presumed to be accurate.
284 (k) ~~(j)~~ A specific explanation of any other disputed issue
285 that a judge of compensation claims will be called to rule upon.
286
287 The dismissal of any petition or portion of such a petition
288 under this subsection ~~section~~ is without prejudice and does not
289 require a hearing.
290 (5)(a) All motions to dismiss must state with particularity
291 the basis for the motion. The judge of compensation claims shall
292 enter an order upon such motions without hearing, unless good
293 cause for hearing is shown. Dismissal of any petition or portion
294 of a petition under this subsection is without prejudice.
295 (b) Upon motion that a petition or portion of a petition be
296 dismissed for lack of specificity, the judge of compensation
297 claims shall enter an order on the motion, unless stipulated in
298 writing by the parties, within 10 days after the motion is filed
299 or, if good cause for hearing is shown, within 20 days after
300 hearing on the motion. When any petition or portion of a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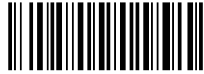
301 petition is dismissed for lack of specificity under this
302 subsection, the claimant must be allowed 20 days after the date
303 of the order of dismissal in which to file an amended petition.
304 Any grounds for dismissal for lack of specificity under this
305 section which are not asserted within 30 days after receipt of
306 the petition for benefits are thereby waived.
307 Section 6. Section 440.34, Florida Statutes, is amended to
308 read:
309 440.34 Attorney ~~Attorney's~~ fees; costs.—
310 (1)(a) A fee, gratuity, or other consideration may not be
311 paid by a carrier or employer ~~for a claimant~~ in connection with
312 any proceedings arising under this chapter, unless approved by
313 the judge of compensation claims or court having jurisdiction
314 over such proceedings. Any attorney fees ~~attorney's fee~~ approved
315 by a judge of compensation claims for benefits secured on behalf
316 of a claimant must equal to 20 percent of the first $5,000 of
317 the amount of the benefits secured, 15 percent of the next
318 $5,000 of the amount of the benefits secured, 10 percent of the
319 remaining amount of the benefits secured to be provided during
320 the first 10 years after the date the claim is filed, and 5
321 percent of the benefits secured after 10 years.
322 (b) However, the judge of compensation claims shall
323 consider the following factors in each case and may increase or
324 decrease the attorney fees, based on a maximum hourly rate of
325 $250 per hour, if in his or her judgment he or she expressly
326 finds that the circumstances of the particular case warrant such
327 action:
328 1. The time and labor required, the novelty and difficulty
329 of the questions involved, and the skill requisite to perform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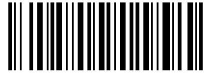
330 the legal service properly.
331 2. The fee customarily charged in the locality for similar
332 legal services.
333 3. The amount involved in the controversy and the benefits
334 resulting to the claimant.
335 4. The time limitation imposed by the claimant or the
336 circumstances.
337 5. The experience, reputation, and ability of the attorney
338 or attorneys performing services.
339 6. The contingency or certainty of a fee.
340 (c) The judge of compensation claims shall not approve a
341 compensation order~~, a joint stipulation for lump-sum settlement,~~
342 ~~a stipulation or agreement between a claimant and his or her~~
343 ~~attorney,~~ or any other agreement related to benefits under this
344 chapter which provides for attorney fees paid by a carrier or
345 employer ~~an attorney's fee~~ in excess of the amount permitted by
346 this section. The judge of compensation claims is not required
347 to approve any retainer agreement between the claimant and his
348 or her attorney. ~~The retainer agreement as to fees and costs may~~
349 ~~not be for compensation in excess of the amount allowed under~~
350 ~~this subsection or subsection (7).~~
351 (2) In awarding a claimant's attorney fees paid by a
352 carrier or employer ~~attorney's fee~~, the judge of compensation
353 claims shall consider only those benefits secured by the
354 attorney. An attorney is not entitled to attorney ~~attorney's~~
355 fees for representation in any issue that was ripe, due, and
356 owing and that reasonably could have been addressed, but was not
357 addressed, during the pendency of other issues for the same
358 injury. The amount, statutory basis, and type of benefits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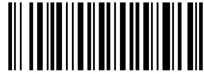
359 obtained through legal representation shall be listed on all
360 attorney ~~attorney’s~~ fees awarded by the judge of compensation
361 claims. For purposes of this section, the term “benefits
362 secured” does not include future medical benefits to be provided
363 on any date more than 5 years after the date the claim is filed.
364 In the event an offer to settle an issue pending before a judge
365 of compensation claims, including attorney ~~attorney’s~~ fees as
366 provided for in this section, is communicated in writing to the
367 claimant or the claimant’s attorney at least 30 days prior to
368 the trial date on such issue, for purposes of calculating the
369 amount of attorney ~~attorney’s~~ fees to be taxed against the
370 employer or carrier, the term “benefits secured” shall be deemed
371 to include only that amount awarded to the claimant above the
372 amount specified in the offer to settle. If multiple issues are
373 pending before the judge of compensation claims, said offer of
374 settlement shall address each issue pending and shall state
375 explicitly whether or not the offer on each issue is severable.
376 The written offer shall also unequivocally state whether or not
377 it includes medical witness fees and expenses and all other
378 costs associated with the claim.
379 (3) If any party should prevail in any proceedings before a
380 judge of compensation claims or court, there shall be taxed
381 against the nonprevailing party the reasonable costs of such
382 proceedings, not to include attorney ~~attorney’s~~ fees. A claimant
383 is responsible for the payment of her or his own attorney
384 ~~attorney’s~~ fees, except that a claimant is entitled to recover
385 attorney fees ~~an attorney’s fee~~ in an amount equal to the amount
386 provided for in subsection (1) ~~or subsection (7)~~ from a carrier
387 or employer: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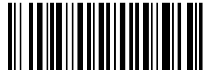
388 (a) Against whom she or he successfully asserts a petition
389 for medical benefits only, if the claimant has not filed or is
390 not entitled to file at such time a claim for disability,
391 permanent impairment, wage-loss, or death benefits, arising out
392 of the same accident;
393 (b) In any case in which the employer or carrier files a
394 response to petition denying benefits with the Office of the
395 Judges of Compensation Claims and the injured person has
396 employed an attorney in the successful prosecution of the
397 petition;
398 (c) In a proceeding in which a carrier or employer denies
399 that an accident occurred for which compensation benefits are
400 payable, and the claimant prevails on the issue of
401 compensability; or
402 (d) In cases where the claimant successfully prevails in
403 proceedings filed under s. 440.24 or s. 440.28.
404
405 Regardless of the date benefits were initially requested,
406 attorney ~~attorney's~~ fees shall not attach under this subsection
407 until 30 days after the date the carrier or employer, if self-
408 insured, receives the petition.
409 (4) In such cases in which the claimant is responsible for
410 the payment of her or his own attorney ~~attorney's~~ fees, such
411 fees are a lien upon compensation payable to the claimant,
412 notwithstanding s. 440.22.
413 (5) If any proceedings are had for review of any claim,
414 award, or compensation order before any court, the court may
415 award the injured employee or dependent attorney fees ~~an~~
416 ~~attorney's fee~~ to be paid by the employer or carrier, in its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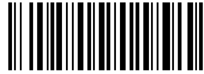
417 discretion, which shall be paid as the court may direct.
418 (6) A judge of compensation claims may not enter an order
419 approving the contents of a retainer agreement that permits
420 placing any portion of the employee’s compensation into an
421 escrow account until benefits have been secured.
422 (7) This section may not be interpreted to limit or
423 otherwise infringe on a claimant’s right to retain an attorney
424 and pay the attorney reasonable attorney fees for legal services
425 related to a claim under the Workers’ Compensation Law ~~If an~~
426 ~~attorney’s fee is owed under paragraph (3)(a), the judge of~~
427 ~~compensation claims may approve an alternative attorney’s fee~~
428 ~~not to exceed $1,500 only once per accident, based on a maximum~~
429 ~~hourly rate of $150 per hour, if the judge of compensation~~
430 ~~claims expressly finds that the attorney’s fee amount provided~~
431 ~~for in subsection (1), based on benefits secured, fails to~~
432 ~~fairly compensate the attorney for disputed medical-only claims~~
433 ~~as provided in paragraph (3)(a) and the circumstances of the~~
434 ~~particular case warrant such action~~.
435 Section 7. Effective July 1, 2018, subsection (10) of
436 section 624.482, Florida Statutes, is amended to read:
437 624.482 Making and use of rates.—
438 (10) Any self-insurance fund that writes workers’
439 compensation insurance and employer’s liability insurance is
440 subject to, and shall make all rate filings for workers’
441 compensation insurance and employer’s liability insurance in
442 accordance with, ss. 627.091, 627.101, 627.111, 627.141,
443 627.151, 627.171, and 627.191~~, and 627.211~~.
444 Section 8. Effective July 1, 2018, subsections (3), (4),
445 and (6) of section 627.041, Florida Statutes, are amended to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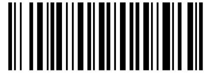
446 read:
447 627.041 Definitions.—As used in this part:
448 (3) "Rating organization" means every person, other than an
449 authorized insurer, whether located within or outside this
450 state, who has as his or her object or purpose the making of
451 prospective loss costs, rates, rating plans, or rating systems.
452 Two or more authorized insurers that act in concert for the
453 purpose of making prospective loss costs, rates, rating plans,
454 or rating systems, and that do not operate within the specific
455 authorizations contained in ss. 627.311, 627.314(2), (4), and
456 627.351, shall be deemed to be a rating organization. No single
457 insurer shall be deemed to be a rating organization.
458 (4) "Advisory organization" means every group, association,
459 or other organization of insurers, whether located within or
460 outside this state, which prepares policy forms or makes
461 underwriting rules incident to but not including the making of
462 prospective loss costs, rates, rating plans, or rating systems
463 or which collects and furnishes to authorized insurers or rating
464 organizations loss or expense statistics or other statistical
465 information and data and acts in an advisory, as distinguished
466 from a ratemaking, capacity.
467 (6) "Subscriber" means an insurer which is furnished at its
468 request:
469 (a) With prospective loss costs, rates, and rating manuals
470 by a rating organization of which it is not a member; or
471 (b) With advisory services by an advisory organization of
472 which it is not a member.
473 Section 9. Effective July 1, 2018, subsection (1) of
474 section 627.0612, Florida Statutes, is amended to read: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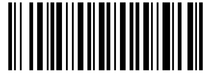
475 627.0612 Administrative proceedings in rating
476 determinations.—
477 (1) In any proceeding to determine whether prospective loss
478 costs, rates, rating plans, or other matters governed by this
479 part comply with the law, the appellate court shall set aside a
480 final order of the office if the office has violated s.
481 120.57(1)(k) by substituting its findings of fact for findings
482 of an administrative law judge which were supported by competent
483 substantial evidence.
484 Section 10. Effective July 1, 2018, subsection (1) of
485 section 627.062, Florida Statutes, is amended to read:
486 627.062 Rate standards.—
487 (1) The rates and loss costs for all classes of insurance
488 to which the provisions of this part are applicable may not be
489 excessive, inadequate, or unfairly discriminatory.
490 Section 11. Effective July 1, 2018, subsection (1) of
491 section 627.0645, Florida Statutes, is amended to read:
492 627.0645 Annual filings.—
493 (1) Each rating organization filing rates for, and each
494 insurer writing, any line of property or casualty insurance to
495 which this part applies, except:
496 ~~(a) Workers' compensation and employer's liability~~
497 ~~insurance;~~
498 (a) ~~(b)~~ Insurance as defined in ss. 624.604 and 624.605,
499 limited to coverage of commercial risks other than commercial
500 residential multiperil; or
501 (b) ~~(c)~~ Travel insurance, if issued as a master group policy
502 with a situs in another state where each certificateholder pays
503 less than $30 in premium for each covered trip and where the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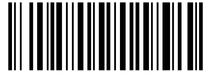
504 insurer has written less than $1 million in annual written
505 premiums in the travel insurance product in this state during
506 the most recent calendar year,
507
508 shall make an annual base rate filing for each such line with
509 the office no later than 12 months after its previous base rate
510 filing, demonstrating that its rates are not inadequate.
511 Section 12. Effective July 1, 2018, subsections (1) and (5)
512 of section 627.072, Florida Statutes, are amended to read:
513 627.072 Making and use of rates.—
514 (1) As to workers’ compensation and employer’s liability
515 insurance, the following factors shall be used in the
516 determination and fixing of loss costs or rates, as applicable:
517 (a) The past loss experience and prospective loss
518 experience within and outside this state;
519 (b) The conflagration and catastrophe hazards;
520 (c) A reasonable margin for underwriting profit and
521 contingencies;
522 (d) Dividends, savings, or unabsorbed premium deposits
523 allowed or returned by insurers to their policyholders, members,
524 or subscribers;
525 (e) Investment income on unearned premium reserves and loss
526 reserves;
527 (f) Past expenses and prospective expenses, both those
528 countrywide and those specifically applicable to this state; and
529 (g) All other relevant factors, including judgment factors,
530 within and outside this state.
531 ~~(5)(a) In the case of workers’ compensation and employer’s~~
532 ~~liability insurance, the office shall consider utilizing the~~

 251016

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

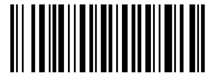
~~(b) If the methodology set forth in paragraph (a) is utilized, to facilitate the determination of such a cash-flow pattern methodology:~~

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

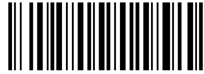
~~2. Each insurer shall submit financial reports to the rating bureau and the office which shall include total incurred claim amounts and paid-claim amounts by policy year and by injury types as of December 31 of each calendar year; and~~

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

~~Number of Risks in~~

 251016

562 ~~Premium Range Standard Premium Size~~
563
564 ~~...(to be filled in by carrier)... $300–999~~
565 ~~...(to be filled in by carrier)... 1,000–4,999~~
566 ~~...(to be filled in by carrier)... 5,000–49,999~~
567 ~~...(to be filled in by carrier)... 50,000–99,999~~
568 ~~...(to be filled in by carrier)... 100,000 or more~~
569 ~~Total:~~
570 Section 13. Effective July 1, 2018, section 627.091,
571 Florida Statutes, is amended to read:
572 627.091 Rate filings; workers' compensation and employer's
573 liability insurances.—
574 (1) As used in this section, the term:
575 (a) "Expenses" means the portion of a rate which is
576 attributable to acquisition, field supervision, collection
577 expenses, taxes, reinsurance, assessments, and general expenses.
578 (b) "Loss cost modifier" means an adjustment to, or a
579 deviation from, the approved prospective loss costs filed by a
580 licensed rating organization.
581 (c) "Loss cost multiplier" means the profit and expense
582 factor, expressed as a single nonintegral number to be applied
583 to the prospective loss costs, which is associated with writing
584 workers' compensation and employer's liability insurance and
585 which is approved by the office in making rates for each
586 classification of risks used by that insurer.
587 (d) "Prospective loss costs" means the portion of a rate
588 which reflects historical industry average aggregate losses and
589 loss adjustment expenses projected through development to their
590 ultimate value and through trending to a future point in time.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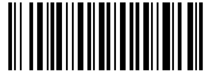
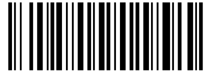
591 The term does not include provisions for profit or expenses
592 other than loss adjustment expense.
593 (2) ~~(1)~~ As to workers' compensation and employer's liability
594 insurances, every insurer shall file with the office every
595 manual of classifications, rules, and rates, every rating plan,
596 and every modification of any of the foregoing which it proposes
597 to use. Each insurer or insurer group shall independently and
598 individually file with the office the final rates it proposes to
599 use. An insurer may satisfy this filing requirement by adopting
600 the most recent loss costs filed by a licensed rating
601 organization and approved by the office, and by otherwise
602 complying with this part. Each insurer shall file data in
603 accordance with the uniform statistical plan approved by the
604 office. Every filing under this subsection:
605 (a) Must state the proposed effective date and must be made
606 at least 90 days before such proposed effective date;
607 (b) Must indicate the character and extent of the coverage
608 contemplated;
609 (c) May use the most recent approved prospective loss costs
610 filed by a licensed rating organization in combination with the
611 insurer's own approved loss cost multiplier and loss cost
612 modifier;
613 (d) Must include all deductibles required in chapter 440,
614 and may include additional deductible provisions in its manual
615 of classifications, rules, and rates. All deductibles must be in
616 a form and manner that is consistent with the underlying purpose
617 of chapter 440;
618 (e) May use variable or fixed expense loads or a
619 combination thereof, and may vary the expense, profit, or

 251016

620 contingency provisions by class or group of classes, if the
621 insurer files supporting data justifying such variations;
622 (f) May include a schedule of proposed premium discounts,
623 credits, and surcharges. The office may not approve discounts,
624 credits, and surcharges unless they are based on objective
625 criteria that bear a reasonable relationship to the expected
626 loss, expense, or profit experience of an individual
627 policyholder or a class of policyholders; and
628 (g) May file a minimum premium or expense constant ~~Every~~
629 ~~insurer is authorized to include deductible provisions in its~~
630 ~~manual of classifications, rules, and rates. Such deductibles~~
631 ~~shall in all cases be in a form and manner which is consistent~~
632 ~~with the underlying purpose of chapter 440~~.
633 (3)~~(2)~~ ~~Every such filing shall state the proposed effective~~
634 ~~date thereof, and shall indicate the character and extent of the~~
635 ~~coverage contemplated.~~ When a filing is not accompanied by the
636 information upon which the insurer or rating organization
637 supports the filing and the office does not have sufficient
638 information to determine whether the filing meets the applicable
639 requirements of this part, the office, ~~it shall~~ within 15 days
640 after the date of filing, shall require the insurer or rating
641 organization to furnish the information upon which it supports
642 the filing. The information furnished in support of a filing may
643 include:
644 (a) The experience or judgment of the insurer or rating
645 organization making the filing;
646 (b) The ~~Its~~ interpretation of any statistical data which
647 the insurer or rating organization making the filing ~~it~~ relies
648 upon;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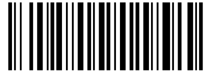
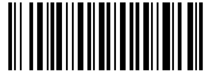
649 (c) The experience of other insurers or rating
650 organizations; or
651 (d) Any other factors which the insurer or rating
652 organization making the filing deems relevant.
653 (4)~~(3)~~ A filing and any supporting information are ~~shall be~~
654 open to public inspection as provided in s. 119.07(1).
655 (5)~~(4)~~ An insurer may become ~~satisfy its obligation to make~~
656 ~~such filings by becoming~~ a member of, or a subscriber to, a
657 licensed rating organization that ~~which~~ makes loss costs ~~such~~
658 filings and by authorizing the office to accept such filings in
659 its behalf; but nothing contained in this chapter shall be
660 construed as requiring any insurer to become a member or a
661 subscriber to any rating organization.
662 (6) A licensed rating organization may develop and file for
663 approval with the office reference filings containing
664 prospective loss costs and the underlying loss data, and other
665 supporting statistical and actuarial information. A rating
666 organization may not develop or file final rates or multipliers
667 for expenses, profit, or contingencies. After a loss cost
668 reference filing is filed with the office and is approved, the
669 rating organization must provide its member subscribers with a
670 copy of the approved reference filing.
671 (7) A rating organization may file supplementary rating
672 information and rules, including, but not limited to,
673 policywriting rules, rating plan classification codes and
674 descriptions, experience modification plans, statistical plans
675 and forms, and rules that include factors or relativities, such
676 as increased limits factors, classification relativities, or
677 similar factors, but that exclude minimum premiums. An insurer

 251016

678 may use supplementary rating information if such information is
679 approved by the office.
680 (8) ~~(5)~~ Pursuant to the provisions of s. 624.3161, the
681 office may examine the underlying statistical data used in such
682 filings.
683 (9) ~~(6)~~ Whenever the committee of a recognized rating
684 organization with authority to file prospective loss costs for
685 use by insurers in determining ~~responsibility for~~ workers'
686 compensation and employer's liability insurance rates in this
687 state meets to discuss the necessity for, or a request for,
688 Florida rate increases or decreases in prospective loss costs in
689 this state, the determination of prospective loss costs in this
690 state ~~Florida rates~~, the prospective loss costs ~~rates~~ to be
691 requested in this state, and any other matters pertaining
692 specifically and directly to prospective loss costs in this
693 state ~~such Florida rates~~, such meetings shall be held in this
694 state and are ~~shall be~~ subject to s. 286.011. The committee of
695 such a rating organization shall provide at least 3 weeks' prior
696 notice of such meetings to the office and shall provide at least
697 14 days' prior notice of such meetings to the public by
698 publication in the Florida Administrative Register.
699 (10) An insurer group with multiple insurers writing
700 workers' compensation and employer's liability insurance shall
701 file underwriting rules not contained in rating manuals.
702 Section 14. Effective July 1, 2018, section 627.093,
703 Florida Statutes, is amended to read:
704 627.093 Application of s. 286.011 to workers' compensation
705 and employer's liability insurances.—Section 286.011 shall be
706 applicable to every prospective loss cost and rate filing,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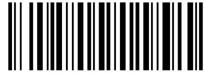
707 approval or disapproval of filing, rating deviation from filing,
708 or appeal from any of these regarding workers' compensation and
709 employer's liability insurances.
710 Section 15. Effective July 1, 2018, subsection (1) of
711 section 627.101, Florida Statutes, is amended to read:
712 627.101 When filing becomes effective; workers'
713 compensation and employer's liability insurances.—
714 (1) The office shall review all required filings as to
715 workers' compensation and employer's liability insurances as
716 soon as reasonably possible after they have been made in order
717 to determine whether they meet the applicable requirements of
718 this part. If the office determines that part of a required ~~rate~~
719 filing does not meet the applicable requirements of this part,
720 it may reject so much of the filing as does not meet these
721 requirements, and approve the remainder of the filing.
722 Section 16. Effective July 1, 2018, section 627.211,
723 Florida Statutes, is amended to read:
724 627.211 Annual report by the office on the workers'
725 compensation insurance market ~~Deviations; workers' compensation~~
726 ~~and employer's liability insurances~~.—
727 ~~(1) Every member or subscriber to a rating organization~~
728 ~~shall, as to workers' compensation or employer's liability~~
729 ~~insurance, adhere to the filings made on its behalf by such~~
730 ~~organization; except that any such insurer may make written~~
731 ~~application to the office for permission to file a uniform~~
732 ~~percentage decrease or increase to be applied to the premiums~~
733 ~~produced by the rating system so filed for a kind of insurance,~~
734 ~~for a class of insurance which is found by the office to be a~~
735 ~~proper rating unit for the application of such uniform~~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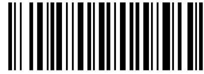
736 ~~percentage decrease or increase, or for a subdivision of~~
737 ~~workers' compensation or employer's liability insurance:~~
738 ~~(a) Comprised of a group of manual classifications which is~~
739 ~~treated as a separate unit for ratemaking purposes; or~~
740 ~~(b) For which separate expense provisions are included in~~
741 ~~the filings of the rating organization.~~
742
743 ~~Such application shall specify the basis for the modification~~
744 ~~and shall be accompanied by the data upon which the applicant~~
745 ~~relies. A copy of the application and data shall be sent~~
746 ~~simultaneously to the rating organization.~~
747 ~~(2) Every member or subscriber to a rating organization~~
748 ~~may, as to workers' compensation and employer's liability~~
749 ~~insurance, file a plan or plans to use deviations that vary~~
750 ~~according to factors present in each insured's individual risk.~~
751 ~~The insurer that files for the deviations provided in this~~
752 ~~subsection shall file the qualifications for the plans,~~
753 ~~schedules of rating factors, and the maximum deviation factors~~
754 ~~which shall be subject to the approval of the office pursuant to~~
755 ~~s. 627.091. The actual deviation which shall be used for each~~
756 ~~insured that qualifies under this subsection may not exceed the~~
757 ~~maximum filed deviation under that plan and shall be based on~~
758 ~~the merits of each insured's individual risk as determined by~~
759 ~~using schedules of rating factors which shall be applied~~
760 ~~uniformly. Insurers shall maintain statistical data in~~
761 ~~accordance with the schedule of rating factors. Such data shall~~
762 ~~be available to support the continued use of such varying~~
763 ~~deviations.~~
764 ~~(3) In considering an application for the deviation, the~~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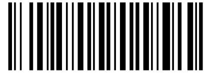
765 ~~office shall give consideration to the applicable principles for~~
766 ~~ratemaking as set forth in ss. 627.062 and 627.072 and the~~
767 ~~financial condition of the insurer. In evaluating the financial~~
768 ~~condition of the insurer, the office may consider: (1) the~~
769 ~~insurer's audited financial statements and whether the~~
770 ~~statements provide unqualified opinions or contain significant~~
771 ~~qualifications or "subject to" provisions; (2) any independent~~
772 ~~or other actuarial certification of loss reserves; (3) whether~~
773 ~~workers' compensation and employer's liability reserves are~~
774 ~~above the midpoint or best estimate of the actuary's reserve~~
775 ~~range estimate; (4) the adequacy of the proposed rate; (5)~~
776 ~~historical experience demonstrating the profitability of the~~
777 ~~insurer; (6) the existence of excess or other reinsurance that~~
778 ~~contains a sufficiently low attachment point and maximums that~~
779 ~~provide adequate protection to the insurer; and (7) other~~
780 ~~factors considered relevant to the financial condition of the~~
781 ~~insurer by the office. The office shall approve the deviation if~~
782 ~~it finds it to be justified, it would not endanger the financial~~
783 ~~condition of the insurer, and it would not constitute predatory~~
784 ~~pricing. The office shall disapprove the deviation if it finds~~
785 ~~that the resulting premiums would be excessive, inadequate, or~~
786 ~~unfairly discriminatory, would endanger the financial condition~~
787 ~~of the insurer, or would result in predatory pricing. The~~
788 ~~insurer may not use a deviation unless the deviation is~~
789 ~~specifically approved by the office. An insurer may apply the~~
790 ~~premiums approved pursuant to s. 627.091 or its uniform~~
791 ~~deviation approved pursuant to this section to a particular~~
792 ~~insured according to underwriting guidelines filed with and~~
793 ~~approved by the office, such approval to be based on ss. 627.062~~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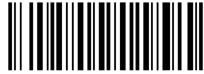
794 ~~and 627.072.~~
795 ~~(4) Each deviation permitted to be filed shall be effective~~
796 ~~for a period of 1 year unless terminated, extended, or modified~~
797 ~~with the approval of the office. If at any time after a~~
798 ~~deviation has been approved the office finds that the deviation~~
799 ~~no longer meets the requirements of this code, it shall notify~~
800 ~~the insurer in what respects it finds that the deviation fails~~
801 ~~to meet such requirements and specify when, within a reasonable~~
802 ~~period thereafter, the deviation shall be deemed no longer~~
803 ~~effective. The notice shall not affect any insurance contract or~~
804 ~~policy made or issued prior to the expiration of the period set~~
805 ~~forth in the notice.~~
806 ~~(5) For purposes of this section, the office, when~~
807 ~~considering the experience of any insurer, shall consider the~~
808 ~~experience of any predecessor insurer when the business and the~~
809 ~~liabilities of the predecessor insurer were assumed by the~~
810 ~~insurer pursuant to an order of the office which approves the~~
811 ~~assumption of the business and the liabilities.~~
812 ~~(6)~~ The office shall submit an annual report to the
813 President of the Senate and the Speaker of the House of
814 Representatives by January 15 of each year which evaluates
815 insurance company solvency and competition in the workers'
816 compensation insurance market in this state. The report must
817 contain an analysis of the availability and affordability of
818 workers' compensation coverage and whether the current market
819 structure, conduct, and performance are conducive to
820 competition, based upon economic analysis and tests. The purpose
821 of this report is to aid the Legislature in determining whether
822 changes to the workers' compensation rating laws are warranted.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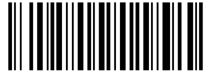
823 The report must also document that the office has complied with
824 the provisions of s. 627.096 which require the office to
825 investigate and study all workers' compensation insurers in the
826 state and to study the data, statistics, schedules, or other
827 information as it finds necessary to assist in its review of
828 workers' compensation rate filings.
829 Section 17. Effective July 1, 2018, section 627.2151,
830 Florida Statutes, is created to read:
831 627.2151 Workers' compensation excessive defense and cost
832 containment expenses.—
833 (1) As used in this section, the term "defense and cost
834 containment expenses" or "DCCE" includes the following Florida
835 expenses of an insurer group or insurer writing workers'
836 compensation insurance:
837 (a) Insurance company attorney fees;
838 (b) Expert witnesses;
839 (c) Medical examinations and autopsies;
840 (d) Medical fee review panels;
841 (e) Bill auditing;
842 (f) Treatment utilization reviews; and
843 (g) Preferred provider network expenses.
844 (2) Each insurer group or insurer writing workers'
845 compensation insurance shall file with the office a schedule of
846 Florida defense and cost containment expenses and total Florida
847 incurred losses for each of the 3 years before the most recent
848 accident year. The DCCE and incurred losses must be valued as of
849 December 31 of the first year following the latest accident year
850 to be reported, developed to an ultimate basis, and at two 12-
851 month intervals thereafter, each developed to an ultimate basis,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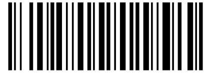
852 so that a total of three evaluations will be provided for each
853 accident year. The first year reported shall be accident year
854 2018, so that the reporting of 3 accident years under this
855 evaluation will not take place until accident years 2019 and
856 2020 have become available.
857 (3) Excessive DCCE occurs when an insurer includes in its
858 rates Florida defense and cost containment expenses for workers'
859 compensation which exceed 15 percent of Florida workers'
860 compensation incurred losses by the insurer or insurer group for
861 the 3 most recent calendar years for which data is to be filed
862 under this section.
863 (4) If the insurer or insurer group realizes excessive
864 DCCE, the office must order a return of the excess amounts after
865 affording the insurer or insurer group an opportunity for a
866 hearing and otherwise complying with the requirements of chapter
867 120. Excessive DCCE amounts must be returned in all instances
868 unless the insurer or insurer group affirmatively demonstrates
869 to the office that the refund of the excessive DCCE amounts will
870 render a member of the insurer group financially impaired or
871 will render it insolvent under provisions of the Florida
872 Insurance Code.
873 (5) Any excess DCCE amount must be returned to
874 policyholders in the form of a cash refund or credit toward the
875 future purchase of insurance. The refund or credit must be made
876 on a pro rata basis in relation to the final compilation year
877 earned premiums to the policyholders of record of the insurer or
878 insurer group on December 31 of the final compilation year. Cash
879 refunds and data in required reports to the office may be
880 rounded to the nearest dollar and must be consistently applied.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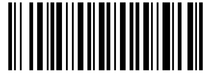
881 (6)(a) Refunds must be completed in one of the following
882 ways:
883 1. A cash refund must be completed within 60 days after
884 entry of a final order indicating that excessive DCCE has been
885 realized.
886 2. A credit to renewal policies must be applied to policy
887 renewal premium notices that are forwarded to insureds more than
888 60 calendar days after entry of a final order indicating that
889 excessive DCCE has been realized. If the insured thereafter
890 cancels a policy or otherwise allows the policy to terminate,
891 the insurer or insurer group must make a cash refund not later
892 than 60 days after coverage termination.
893 (b) Upon completion of the renewal credits or refunds, the
894 insurer or insurer group shall immediately certify having made
895 the refunds to the office.
896 (7) Any refund or renewal credit made pursuant to this
897 section is treated as a policyholder dividend applicable to the
898 year immediately succeeding the compilation period giving rise
899 to the refund or credit, for purposes of reporting under this
900 section for subsequent years.
901 Section 18. Effective July 1, 2018, section 627.291,
902 Florida Statutes, is amended to read:
903 627.291 Information to be furnished insureds; appeal by
904 insureds; workers' compensation and employer's liability
905 insurances.—
906 (1) As to workers' compensation and employer's liability
907 insurances, every rating organization filing prospective loss
908 costs and every insurer which makes its own rates shall, within
909 a reasonable time after receiving written request therefor and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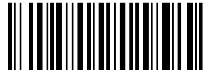
910 upon payment of such reasonable charge as it may make, furnish
911 to any insured affected by a rate made by it, or to the
912 authorized representative of such insured, all pertinent
913 information as to such rate.
914 (2) As to workers' compensation and employer's liability
915 insurances, every rating organization filing prospective loss
916 costs and every insurer which makes its own rates shall provide
917 within this state reasonable means whereby any person aggrieved
918 by the application of its rating system may be heard, in person
919 or by his or her authorized representative, on his or her
920 written request to review the manner in which such rating system
921 has been applied in connection with the insurance afforded him
922 or her. If the rating organization filing prospective loss costs
923 or the insurer making its own rates fails to grant or rejects
924 such request within 30 days after it is made, the applicant may
925 proceed in the same manner as if his or her application had been
926 rejected. Any party affected by the action of such rating
927 organization filing prospective loss costs or insurer making its
928 own rates on such request may, within 30 days after written
929 notice of such action, appeal to the office, which may affirm or
930 reverse such action.
931 Section 19. Effective July 1, 2018, section 627.318,
932 Florida Statutes, is amended to read:
933 627.318 Records.—Every insurer, rating organization filing
934 prospective loss costs, and advisory organization and every
935 group, association, or other organization of insurers which
936 engages in joint underwriting or joint reinsurance shall
937 maintain reasonable records, of the type and kind reasonably
938 adapted to its method of operation, of its experience or the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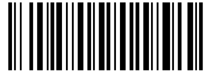
939 experience of its members and of the data, statistics, or
940 information collected or used by it in connection with the
941 prospective loss costs, rates, rating plans, rating systems,
942 underwriting rules, policy or bond forms, surveys, or
943 inspections made or used by it, so that such records will be
944 available at all reasonable times to enable the office to
945 determine whether such organization, insurer, group, or
946 association, and, in the case of an insurer or rating
947 organization, every prospective loss cost, rate, rating plan,
948 and rating system made or used by it, complies with the
949 provisions of this part applicable to it. The maintenance of
950 such records in the office of a licensed rating organization of
951 which an insurer is a member or subscriber will be sufficient
952 compliance with this section for any such insurer maintaining
953 membership or subscribership in such organization, to the extent
954 that the insurer uses the prospective loss costs, rates, rating
955 plans, rating systems, or underwriting rules of such
956 organization. Such records shall be maintained in an office
957 within this state or shall be made available for examination or
958 inspection within this state by the department at any time upon
959 reasonable notice.
960 Section 20. Effective July 1, 2018, section 627.361,
961 Florida Statutes, is amended to read:
962 627.361 False or misleading information.—No person shall
963 willfully withhold information from or knowingly give false or
964 misleading information to the office, any statistical agency
965 designated by the office, any rating organization, or any
966 insurer, which will affect the prospective loss costs, rates, or
967 premiums chargeable under this part.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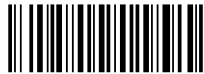
968 Section 21. Effective July 1, 2018, subsections (1) and (2)
969 of section 627.371, Florida Statutes, are amended to read:
970 627.371 Hearings.—
971 (1) Any person aggrieved by any rate charged, rating plan,
972 rating system, or underwriting rule followed or adopted by an
973 insurer, and any person aggrieved by any rating plan, rating
974 system, or underwriting rule followed or adopted by a rating
975 organization, may herself or himself or by her or his authorized
976 representative make written request of the insurer or rating
977 organization to review the manner in which the prospective loss
978 cost, rate, plan, system, or rule has been applied with respect
979 to insurance afforded her or him. If the request is not granted
980 within 30 days after it is made, the requester may treat it as
981 rejected. Any person aggrieved by the refusal of an insurer or
982 rating organization to grant the review requested, or by the
983 failure or refusal to grant all or part of the relief requested,
984 may file a written complaint with the office, specifying the
985 grounds relied upon. If the office has already disposed of the
986 issue as raised by a similar complaint or believes that probable
987 cause for the complaint does not exist or that the complaint is
988 not made in good faith, it shall so notify the complainant.
989 Otherwise, and if it also finds that the complaint charges a
990 violation of this chapter and that the complainant would be
991 aggrieved if the violation is proven, it shall proceed as
992 provided in subsection (2).
993 (2) If after examination of an insurer, rating
994 organization, advisory organization, or group, association, or
995 other organization of insurers which engages in joint
996 underwriting or joint reinsurance, upon the basis of other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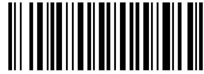
997 information, or upon sufficient complaint as provided in
998 subsection (1), the office has good cause to believe that such
999 insurer, organization, group, or association, or any prospective
1000 loss cost, rate, rating plan, or rating system made or used by
1001 any such insurer or rating organization, does not comply with
1002 the requirements and standards of this part applicable to it, it
1003 shall, unless it has good cause to believe such noncompliance is
1004 willful, give notice in writing to such insurer, organization,
1005 group, or association stating therein in what manner and to what
1006 extent noncompliance is alleged to exist and specifying therein
1007 a reasonable time, not less than 10 days thereafter, in which
1008 the noncompliance may be corrected, including any premium
1009 adjustment.
1010 Section 22. Effective July 1, 2017, the sums of $723,118 in
1011 recurring funds and $100,000 in nonrecurring funds from the
1012 Insurance Regulatory Trust Fund are appropriated to the Office
1013 of Insurance Regulation, and eight full-time equivalent
1014 positions with associated salary rate of 460,000 are authorized,
1015 for the purpose of implementing this act.
1016 Section 23. Effective July 1, 2017, the sum of $24,720 in
1017 nonrecurring funds from the Operating Trust Fund is appropriated
1018 to the Office of Judges of Compensation Claims within the
1019 Division of Administrative Hearings for the purposes of
1020 implementing this act.
1021 Section 24. Except as otherwise expressly provided in this
1022 act, this act shall take effect July 1, 2017.
1023
1024 ================= T I T L E A M E N D M E N T ================
1025 And the title is amended as follows: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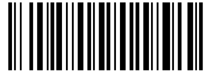
1026 Delete everything before the enacting clause
1027 and insert:
1028 A bill to be entitled
1029 An act relating to workers' compensation insurance;
1030 amending s. 440.02, F.S.; redefining the term
1031 "specificity"; amending s. 440.105, F.S.; revising a
1032 prohibition against receiving certain fees,
1033 consideration, or gratuities under certain
1034 circumstances; amending s. 440.13, F.S.; specifying
1035 certain timeframes in terms of business days, rather
1036 than days; requiring carriers to authorize or deny,
1037 rather than respond to, certain requests for
1038 authorization within a specified timeframe; revising
1039 construction; revising a specified interval for
1040 certain notices furnished by treating physicians to
1041 employers or carriers; amending s. 440.15, F.S.;
1042 revising the maximum period of specified temporary
1043 disability benefits; amending s. 440.192, F.S.;
1044 revising conditions under which the Office of the
1045 Judges of Compensation Claims must dismiss petitions
1046 for benefits; revising requirements for such
1047 petitions; revising construction relating to
1048 dismissals of petitions or portions of such petitions;
1049 requiring judges of compensation claims to enter
1050 orders on certain motions to dismiss within specified
1051 timeframes; amending s. 440.34, F.S.; prohibiting the
1052 payment of certain consideration by carriers or
1053 employers, rather than prohibiting such payment for
1054 claimants, in connection with certain proceedings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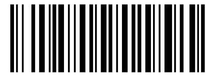
1055 under certain circumstances; requiring judges of
1056 compensation claims to consider specified factors in
1057 increasing or decreasing attorney fees; specifying a
1058 maximum hourly rate for attorney fees; revising
1059 provisions that prohibit such judges from approving
1060 certain agreements and that limit attorney fees in
1061 retainer agreements; providing construction; deleting
1062 a provision authorizing such judges to approve
1063 alternative attorney fees under certain circumstances;
1064 conforming a cross-reference; amending s. 624.482,
1065 F.S.; conforming a provision to changes made by the
1066 act; amending s. 627.041, F.S.; redefining terms;
1067 amending s. 627.0612, F.S.; adding prospective loss
1068 costs to a list of reviewable matters in certain
1069 proceedings by appellate courts; amending s. 627.062,
1070 F.S.; prohibiting loss costs for specified classes of
1071 insurance from being excessive, inadequate, or
1072 unfairly discriminatory; amending s. 627.0645, F.S.;
1073 deleting an annual base rate filing requirement
1074 exception relating to workers' compensation and
1075 employer's liability insurance for certain rating
1076 organizations; amending s. 627.072, F.S.; requiring
1077 certain factors to be used in determining and fixing
1078 loss costs; deleting a specified methodology that may
1079 be used by the Office of Insurance Regulation in rate
1080 determinations; amending s. 627.091, F.S.; defining
1081 terms; requiring insurers or insurer groups writing
1082 workers' compensation and employer's liability
1083 insurances to independently and individually file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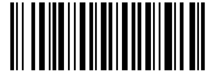
1084 their proposed final rates; specifying requirements
1085 for such filings; deleting a requirement that such
1086 filings contain certain information; revising
1087 requirements for supporting information required to be
1088 furnished to the office under certain circumstances;
1089 deleting a specified method for insurers to satisfy
1090 filing obligations; specifying requirements for a
1091 licensed rating organization that elects to develop
1092 and file certain reference filings and certain other
1093 information; authorizing insurers to use supplementary
1094 rating information approved by the office; revising
1095 applicability of public meetings and records
1096 requirements to certain meetings of recognized rating
1097 organization committees; requiring certain insurer
1098 groups to file underwriting rules not contained in
1099 rating manuals; amending s. 627.093, F.S.; revising
1100 applicability of public meetings and records
1101 requirements to prospective loss cost filings or
1102 appeals; amending s. 627.101, F.S.; conforming a
1103 provision to changes made by the act; amending s.
1104 627.211, F.S.; deleting provisions relating to
1105 deviations; requiring that the office’s annual report
1106 to the Legislature relating to the workers’
1107 compensation insurance market evaluate insurance
1108 company solvency; creating s. 627.2151, F.S.; defining
1109 the term “defense and cost containment expenses” or
1110 “DCCE”; requiring insurer groups or insurers writing
1111 workers’ compensation insurance to file specified
1112 schedules with the office at specified intervals;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1113 providing construction relating to excessive DCCE;
1114 requiring the office to order returns of excess
1115 amounts of DCCE, subject to certain hearing
1116 requirements; providing requirements for, and an
1117 exception from, the return of excessive DCCE amounts;
1118 providing construction; amending s. 627.291, F.S.;
1119 providing applicability of certain disclosure and
1120 hearing requirements for rating organizations filing
1121 prospective loss costs; amending s. 627.318, F.S.;
1122 providing applicability of certain recordkeeping
1123 requirements for rating organizations or insurers
1124 filing or using prospective loss costs, respectively;
1125 amending s. 627.361, F.S.; providing applicability of
1126 a prohibition against false or misleading information
1127 relating to prospective loss costs; amending s.
1128 627.371, F.S.; providing applicability of certain
1129 hearing procedures and requirements relating to the
1130 application, making, or use of prospective loss costs;
1131 providing appropriations; providing effective dates.