By Senator Bradley

5-00827B-17 20171582__

A bill to be entitled

An act relating to workers' compensation insurance; amending s. 440.02, F.S.; redefining the term "specificity"; amending s. 440.102, F.S.; conforming a cross-reference; amending s. 440.105, F.S.; deleting a prohibition against receiving certain fees, consideration, or gratuities under certain circumstances; amending s. 440.13, F.S.; defining the term "business day"; specifying certain timeframes in terms of business days, rather than days; requiring carriers to authorize or decline, rather than respond to, certain requests for authorization within a specified time; revising construction; revising a specified interval for certain notices furnished by treating physicians to employers or carriers; amending s. 440.15, F.S.; revising the maximum period of specified temporary disability benefits; amending s. 440.192, F.S.; revising conditions under which the Office of the Judges of Compensation Claims must dismiss petitions for benefits; revising requirements for such petitions; revising construction relating to dismissals of petitions or portions thereof; requiring judges of compensation claims to enter orders on certain motions to dismiss within specified timeframes; amending s. 440.34, F.S.; requiring judges of compensation claims to consider specified factors in increasing or decreasing attorney fees; specifying a basis for a maximum hourly rate for attorney fees; deleting a provision authorizing such judges to

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approve alternative attorney fees under certain circumstances; conforming cross-references; amending s. 624.482, F.S.; conforming a provision to changes made by the act; amending s. 627.041, F.S.; redefining terms; amending s. 627.0612, F.S.; adding prospective loss costs to a list of reviewable matters in certain proceedings by appellate courts; amending s. 627.062, F.S.; requiring insurers and rating organizations to establish and use prospective loss costs for a specified purpose; requiring copies of prospective loss costs to be filed with the Office of Insurance Regulation; amending s. 627.072, F.S.; deleting a specified methodology that may be used by the office in rate determinations; amending s. 627.091, F.S.; defining terms; requiring insurers writing workers' compensation and employer's liability insurances to independently and individually file their proposed final rates; specifying requirements for such filings; deleting a requirement that such filings contain certain information; revising requirements for supporting information required to be furnished to the office under certain circumstances; deleting a specified method for insurers to satisfy filing obligations; specifying requirements for a licensed rating organization that elects to develop and file certain reference filings and certain other information; authorizing insurers to use supplementary rating information approved by the office; revising applicability of public meetings and records

requirements to certain meetings of recognized rating organization committees; amending s. 627.093, F.S.; revising applicability of public meetings and records requirements to prospective loss cost filings or appeals; amending s. 627.101, F.S.; conforming a provision to changes made by the act; amending s. 627.211, F.S.; deleting provisions relating to deviations; revising requirements for the office's annual report to the Legislature relating to the workers' compensation insurance market; creating s. 627.2151, F.S.; defining the term "defense and cost containment expenses" or "DCCE"; requiring insurer groups or insurers writing workers' compensation insurance to file specified schedules with the office at specified intervals; providing construction relating to excessive DCCE; requiring the office to order returns of excess amounts of DCCE, subject to certain hearing requirements; providing requirements for, and an exception from, the return of excessive DCCE amounts; providing construction; amending s. 627.291, F.S.; providing applicability of certain disclosure and hearing requirements for rating organizations filing prospective loss costs; amending s. 627.318, F.S.; providing applicability of certain recordkeeping requirements for rating organizations or insurers filing or using prospective loss costs, respectively; amending s. 627.361, F.S.; providing applicability of a prohibition against false or misleading information relating to prospective loss

costs; amending s. 627.371, F.S.; providing applicability of certain hearing procedures and requirements relating to the application, making, or use of prospective loss costs; providing an effective date.

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

Section 1. Subsection (40) of section 440.02, Florida Statutes, is amended to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(40) "Specificity" means information on the petition for benefits sufficient to put the employer or carrier on notice of the exact statutory classification and outstanding time period for each requested benefit, the specific amount of each requested benefit, the calculation used for computing the requested benefit, ~~of benefits being requested~~ and ~~includes~~ a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the petition is for medical benefits, the information must ~~shall~~ include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care, including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), who is recommending such treatment. A copy of a

report from such physician making the recommendation for alternate or other medical care must ~~shall~~ also be attached to the petition. A judge of compensation claims may ~~shall~~ not order such treatment if a physician is not recommending such treatment.

Section 2. Paragraph (p) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(p) All authorized remedial treatment, care, and attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self-insurer. However, the carrier or self-insurer must have given reasonable notice to all affected health care providers that payment for treatment, care, and attendance provided to the employee after a future date certain will be denied. A health care provider, as defined in s. 440.13(1) ~~s. 440.13(1)(g)~~, that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. Paragraph (c) of subsection (3) of section 440.105, Florida Statutes, is amended to read:

440.105 Prohibited activities; reports; penalties; limitations.—

(3) Whoever violates any provision of this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

~~(c) It is unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Deputy Chief Judge of Compensation Claims.~~

Section 4. Present paragraphs (c) through (s) of subsection (1) of section 440.13, Florida Statutes, are redesignated as paragraphs (d) through (t), respectively, and a new paragraph (c) is added to that subsection, and paragraph (f) of subsection (2), paragraphs (d) and (i) of subsection (3), paragraph (a) of subsection (4), paragraphs (a) and (c) of subsection (5), and paragraphs (c) and (d) of subsection (9) of that section are amended, to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(1) DEFINITIONS.—As used in this section, the term:

(c) "Business day" means Monday through Friday, excluding the following holidays: New Year's Day, Birthday of Dr. Martin Luther King, Jr., Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day and the Friday after

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Thanksgiving, and Christmas Day. If any of the holidays falls on Saturday or Sunday, the term does not include the day on Monday through Friday on which the holiday is observed.

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(f) Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 business days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(d) A carrier ~~must respond~~, by telephone or in writing, must authorize or decline ~~to~~ a request for authorization from an authorized health care provider by the close of the third business day after receipt of the request. A carrier authorizes the request if it ~~who~~ fails to respond to a written request for authorization for referral for medical treatment by the close of

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the third business day after receipt of the request ~~consents to the medical necessity for such treatment~~. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, unless the carrier has failed to respond within 10 business days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier’s obligation to identify and disallow overutilization or billing errors.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH DEPARTMENT.—

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the department. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment in a format prescribed by the department and, within 15 business days thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 15 business days ~~3 weeks~~ apart or at less frequent intervals if requested in a format prescribed by the department.

(5) INDEPENDENT MEDICAL EXAMINATIONS.—

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. If the parties agree, the examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his or her area of expertise, as demonstrated by licensure and applicable practice parameters. The employer and employee shall be entitled to only one independent medical examination per accident and not one independent medical examination per medical specialty. The party requesting and selecting the independent medical examination shall be responsible for all expenses associated with said examination,

including, but not limited to, medically necessary diagnostic testing performed and physician or medical care provider fees for the evaluation. The party selecting the independent medical examination shall identify the choice of the independent medical examiner to all other parties within 15 business days after the date the independent medical examination is to take place. Failure to timely provide such notification shall preclude the requesting party from submitting the findings of such independent medical examiner in a proceeding before a judge of compensation claims. The independent medical examiner may not provide followup care if such recommendation for care is found to be medically necessary. If the employee prevails in a medical dispute as determined in an order by a judge of compensation claims or if benefits are paid or treatment provided after the employee has obtained an independent medical examination based upon the examiner's findings, the costs of such examination shall be paid by the employer or carrier.

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing with the claimant and the claimant's counsel, if any, at least 7 business days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule the self-insured employer's or carrier's independent medical evaluations under this subsection. Neither the self-insured employer nor the carrier shall be responsible for scheduling any independent medical examination other than an employer or carrier independent medical examination.

(9) EXPERT MEDICAL ADVISORS.—

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee's complaints or the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the department may, and the judge of compensation claims shall, upon his or her own motion or within 15 business days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The injured employee and the employer or carrier may agree on the health care provider to serve as an expert medical advisor. If the parties do not agree, the judge of compensation claims shall select an expert medical advisor from the department's list of certified expert medical advisors. If a certified medical advisor within the relevant medical specialty is unavailable, the judge of compensation claims shall appoint any otherwise qualified health care provider to serve as an expert medical advisor without obtaining the department's certification. The opinion of the expert medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his or her

evaluation and issue his or her report to the department or to the judge of compensation claims within 15 business days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

Section 5. Paragraph (a) of subsection (2) and paragraph (e) of subsection (4) of section 440.15, Florida Statutes, are amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(2) TEMPORARY TOTAL DISABILITY.—

(a) Subject to subsection (7), in case of disability total in character but temporary in quality, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, not to exceed 260 ~~104~~ weeks except as provided in this subsection, s. 440.12(1), and s. 440.14(3). Once the employee reaches the maximum number of weeks allowed, or the employee reaches the date of maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined.

(4) TEMPORARY PARTIAL DISABILITY.—

(e) Such benefits shall be paid during the continuance of such disability, not to exceed a period of 260 ~~104~~ weeks, as provided by this subsection and subsection (2). Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined. If the employee is terminated from postinjury employment based on the employee's misconduct,

temporary partial disability benefits are not payable as provided for in this section. The department shall by rule specify forms and procedures governing the method and time for payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

Section 6. Subsections (2) and (5) of section 440.192, Florida Statutes, are amended to read:

440.192 Procedure for resolving benefit disputes.—

(2) Upon receipt, the Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition or any portion of such a petition that does not on its face meet the requirements of this section and the definition of specificity under s. 440.02, and specifically identify or itemize the following:

(a) The name, address, and telephone number~~, and social security number~~ of the employee.

(b) The name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the Florida county or, if outside of Florida, the state ~~location~~ of the occurrence and the date or dates of the accident.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

(e) The specific time period for which compensation and the specific classification of compensation were not timely provided.

(f) The specific date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking. A claim for permanent benefits must include the specific date of maximum medical improvement and the specific date that such permanent benefits are claimed to begin.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

(h) A specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment. If the employee is under the care of a physician for an injury identified under paragraph (c), a copy of the physician's request, authorization, or recommendation for treatment, care, or attendance must accompany the petition.

(j) The specific amount of compensation claimed to be accurate and the methodology claimed to accurately calculate the average weekly wage, if the average weekly wage calculated by the employer or carrier is disputed. If the petition does not include a claim under this paragraph, the average weekly wage and corresponding compensation calculated by the employer or carrier are presumed to be accurate.

(k) ~~(j)~~ A specific explanation of any other disputed issue that a judge of compensation claims will be called to rule upon.

The dismissal of any petition or portion of such a petition under this subsection ~~section~~ is without prejudice and does not require a hearing.

(5)(a) All motions to dismiss must state with particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. Dismissal of any petition or portion of a petition under this subsection is without prejudice.

(b) Upon motion that a petition or portion of a petition be dismissed for lack of specificity, the judge of compensation claims shall enter an order on the motion, unless stipulated in writing by the parties, within 10 days after the motion is filed or, if good cause for hearing is shown, within 20 days after hearing on the motion. When any petition or portion of a petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section which are not asserted within 30 days after receipt of the petition for benefits are thereby waived.

Section 7. Section 440.34, Florida Statutes, is amended to read:

440.34 Attorney ~~Attorney's~~ fees; costs.—

(1)(a) A fee, gratuity, or other consideration may not be paid for a claimant in connection with any proceedings arising under this chapter, unless approved by the judge of compensation claims or court having jurisdiction over such proceedings. Any attorney fees ~~attorney's fee~~ approved by a judge of compensation

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claims for benefits secured on behalf of a claimant must equal to 20 percent of the first $5,000 of the amount of the benefits secured, 15 percent of the next $5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years.

(b) However, the judge of compensation claims shall consider the following factors in each case and may increase or decrease the attorney fees, based on a maximum hourly rate of $250 per hour, if in his or her judgment he or she expressly finds that the circumstances of the particular case warrant such action:

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly.

2. The fee customarily charged in the locality for similar legal services.

3. The amount involved in the controversy and the benefits resulting to the claimant.

4. The time limitation imposed by the claimant or the circumstances.

5. The experience, reputation, and ability of the attorney or attorneys performing services.

6. The contingency or certainty of a fee.

(c) The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this

chapter which provides for attorney fees ~~an attorney's fee~~ in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any retainer agreement between the claimant and his or her attorney. The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection ~~or subsection (7)~~.

(2) In awarding a claimant's attorney fees ~~attorney's fee~~, the judge of compensation claims shall consider only those benefits secured by the attorney. An attorney is not entitled to attorney ~~attorney's~~ fees for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not addressed, during the pendency of other issues for the same injury. The amount, statutory basis, and type of benefits obtained through legal representation shall be listed on all attorney ~~attorney's~~ fees awarded by the judge of compensation claims. For purposes of this section, the term "benefits secured" does not include future medical benefits to be provided on any date more than 5 years after the date the claim is filed. In the event an offer to settle an issue pending before a judge of compensation claims, including attorney ~~attorney's~~ fees as provided for in this section, is communicated in writing to the claimant or the claimant's attorney at least 30 days prior to the trial date on such issue, for purposes of calculating the amount of attorney ~~attorney's~~ fees to be taxed against the employer or carrier, the term "benefits secured" shall be deemed to include only that amount awarded to the claimant above the amount specified in the offer to settle. If multiple issues are pending before the judge of compensation

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claims, said offer of settlement shall address each issue pending and shall state explicitly whether or not the offer on each issue is severable. The written offer shall also unequivocally state whether or not it includes medical witness fees and expenses and all other costs associated with the claim.

(3) If any party should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed against the nonprevailing party the reasonable costs of such proceedings, not to include attorney ~~attorney's~~ fees. A claimant is responsible for the payment of her or his own attorney ~~attorney's~~ fees, except that a claimant is entitled to recover attorney fees ~~an attorney's fee~~ in an amount equal to the amount provided for in subsection (1) ~~or subsection (7)~~ from a carrier or employer:

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident;

(b) In any case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in

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proceedings filed under s. 440.24 or s. 440.28.

Regardless of the date benefits were initially requested, attorney ~~attorney's~~ fees shall not attach under this subsection until 30 days after the date the carrier or employer, if self-insured, receives the petition.

(4) In such cases in which the claimant is responsible for the payment of her or his own attorney ~~attorney's~~ fees, such fees are a lien upon compensation payable to the claimant, notwithstanding s. 440.22.

(5) If any proceedings are had for review of any claim, award, or compensation order before any court, the court may award the injured employee or dependent attorney fees ~~an attorney's fee~~ to be paid by the employer or carrier, in its discretion, which shall be paid as the court may direct.

(6) A judge of compensation claims may not enter an order approving the contents of a retainer agreement that permits placing any portion of the employee's compensation into an escrow account until benefits have been secured.

~~(7) If an attorney's fee is owed under paragraph (3)(a), the judge of compensation claims may approve an alternative attorney's fee not to exceed $1,500 only once per accident, based on a maximum hourly rate of $150 per hour, if the judge of compensation claims expressly finds that the attorney's fee amount provided for in subsection (1), based on benefits secured, fails to fairly compensate the attorney for disputed medical-only claims as provided in paragraph (3)(a) and the circumstances of the particular case warrant such action.~~

Section 8. Subsection (10) of section 624.482, Florida

Statutes, is amended to read:

624.482 Making and use of rates.—

(10) Any self-insurance fund that writes workers' compensation insurance and employer's liability insurance is subject to, and shall make all rate filings for workers' compensation insurance and employer's liability insurance in accordance with, ss. 627.091, 627.101, 627.111, 627.141, 627.151, 627.171, and 627.191~~, and 627.211~~.

Section 9. Subsections (3), (4), and (6) of section 627.041, Florida Statutes, are amended to read:

627.041 Definitions.—As used in this part:

(3) "Rating organization" means every person, other than an authorized insurer, whether located within or outside this state, who has as his or her object or purpose the making of prospective loss costs, rates, rating plans, or rating systems. Two or more authorized insurers that act in concert for the purpose of making prospective loss costs, rates, rating plans, or rating systems, and that do not operate within the specific authorizations contained in ss. 627.311, 627.314(2), (4), and 627.351, shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

(4) "Advisory organization" means every group, association, or other organization of insurers, whether located within or outside this state, which prepares policy forms or makes underwriting rules incident to but not including the making of prospective loss costs, rates, rating plans, or rating systems or which collects and furnishes to authorized insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished

from a ratemaking, capacity.

(6) "Subscriber" means an insurer which is furnished at its request:

(a) With prospective loss costs, rates, and rating manuals by a rating organization of which it is not a member; or

(b) With advisory services by an advisory organization of which it is not a member.

Section 10. Subsection (1) of section 627.0612, Florida Statutes, is amended to read:

627.0612 Administrative proceedings in rating determinations.—

(1) In any proceeding to determine whether prospective loss costs, rates, rating plans, or other matters governed by this part comply with the law, the appellate court shall set aside a final order of the office if the office has violated s. 120.57(1)(k) by substituting its findings of fact for findings of an administrative law judge which were supported by competent substantial evidence.

Section 11. Paragraph (a) of subsection (2) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use prospective loss costs, rates, rating schedules, or rating manuals that allow the insurer a reasonable rate of return on the classes of insurance written in this state. A copy of prospective loss costs, rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, must be filed with the office under one of

the following procedures:

1. If the filing is made at least 90 days before the proposed effective date and is not implemented during the office's review of the filing and any proceeding and judicial review, such filing is considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings does not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with subparagraph 1., such filing must be made as soon as practicable, but within 30 days after the effective date, and is considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders those portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before May 1, 2012, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and

comprehensive coverages are not considered property coverages.

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

Section 12. Subsection (5) of section 627.072, Florida Statutes, is amended to read:

627.072 Making and use of rates.—

~~(5)(a) In the case of workers' compensation and employer's liability insurance, the office shall consider utilizing the following methodology in rate determinations: Premiums, expenses, and expected claim costs would be discounted to a common point of time, such as the initial point of a policy year, in the determination of rates; the cash-flow pattern of premiums, expenses, and claim costs would be determined initially by using data from 8 to 10 of the largest insurers writing workers' compensation insurance in the state; such insurers may be selected for their statistical ability to report the data on an accident-year basis and in accordance with subparagraphs (b)1., 2., and 3., for at least 2 1/2 years; such a cash-flow pattern would be modified when necessary in accordance with the data and whenever a radical change in the payout pattern is expected in the policy year under consideration.~~

~~(b) If the methodology set forth in paragraph (a) is 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~~

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~~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 Premium Range~~	~~Standard Premium Size~~
~~...(to be filled in by carrier)...~~	~~$300–999~~
~~...(to be filled in by carrier)...~~	~~1,000–4,999~~
~~...(to be filled in by carrier)...~~	~~5,000–49,999~~
~~...(to be filled in by carrier)...~~	~~50,000–99,999~~
~~...(to be filled in by carrier)...~~	~~100,000 or more~~
~~Total:~~	

Section 13. Section 627.091, Florida Statutes, is amended to read:

627.091 Rate filings; workers' compensation and employer's liability insurances.—

(1) As used in this section, the term:

(a) "Expenses" means the portion of a rate which is attributable to acquisition, field supervision, collection expenses, taxes, assessments, and general expenses.

(b) "Loss cost modifier" means an adjustment to, or a deviation from, the approved prospective loss costs filed by a licensed rating organization.

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(c) "Loss cost multiplier" means the profit and expense factor, expressed as a single nonintegral number to be applied to the prospective loss costs other than loss adjustment expenses, which is associated with writing workers' compensation and employer's liability insurance and which is approved by the office in making rates for each classification of risks used by that insurer.

(d) "Prospective loss costs" means the portion of a rate which reflects historical industry average aggregate losses and loss adjustment expenses projected through development to their ultimate value and through trending to a future point in time. The term does not include provisions for profit or expenses other than loss adjustment expense.

(2)~~(1)~~ As to workers' compensation and employer's liability insurances, every insurer shall file with the office every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing which it proposes to use. Each insurer shall independently and individually file with the office the final rates it proposes to use. An insurer may satisfy this filing requirement by adopting the office's approved loss costs and otherwise complying with this part. Each insurer shall file data in accordance with the uniform statistical plan approved by the office. Every filing under this subsection:

(a) Must state the proposed effective date and must be made at least 30 days before such proposed effective date;

(b) Must indicate the character and extent of the coverage contemplated;

(c) May use the approved prospective loss costs filed by a

licensed rating organization in combination with the insurer's own approved loss cost multiplier and loss cost modifier;

(d) May include deductible provisions in its manual of classifications, rules, and rates. All deductibles must be in a form and manner that is consistent with the underlying purpose of chapter 440;

(e) May use variable or fixed expense loads or a combination thereof, and may vary the expense, profit, or contingency provisions by class or group of classes, if the insurer files supporting data justifying such variations; and

(f) May include a schedule of proposed premium discounts, credits, and surcharges. The office may not approve discounts, credits, and surcharges unless they are based on objective criteria that bear a reasonable relationship to the expected loss, expense, or profit experience of an individual policyholder or a class of policyholders ~~Every insurer is authorized to include deductible provisions in its manual of classifications, rules, and rates. Such deductibles shall in all cases be in a form and manner which is consistent with the underlying purpose of chapter 440~~.

(3) ~~(2) Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated.~~ When a prospective loss cost, loss cost multiplier, or loss cost modifier filing is not accompanied by the information upon which the insurer or rating organization supports the filing and the office does not have sufficient information to determine whether the filing meets the applicable requirements of this part, the office ~~it~~ shall within 15 days after the date of filing require the insurer or rating

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organization to furnish the information upon which it supports the filing. The information furnished in support of a filing may include:

(a) The experience or judgment of the insurer or rating organization making the filing;

(b) The ~~Its~~ interpretation of any statistical data which the insurer or rating organization making the filing ~~it~~ relies upon;

(c) The experience of other insurers or rating organizations; or

(d) Any other factors which the insurer or rating organization making the filing deems relevant.

(4)~~(3)~~ A filing and any supporting information are ~~shall be~~ open to public inspection as provided in s. 119.07(1).

~~(4) An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the office to accept such filings in its behalf; but nothing contained in this chapter shall be construed as requiring any insurer to become a member or a subscriber to any rating organization.~~

(5) A licensed rating organization may develop and file for approval with the office reference filings containing prospective loss costs and the underlying loss data, and other supporting statistical and actuarial information. A rating organization may not develop or file final rates or multipliers for expenses, profit, or contingencies. After a loss cost reference filing is filed with the office and is approved, the rating organization must provide its member subscribers with a

copy of the approved reference filing.

(6) A rating organization may file supplementary rating information that includes policywriting rules, rating plan classification codes and descriptions, experience modification plans, and rules that include factors or relativities, such as increased limits factors, classification relativities, or similar factors, but that exclude minimum premiums. An insurer may use supplementary rating information approved by the office.

(7)~~(5)~~ Pursuant to the provisions of s. 624.3161, the office may examine the underlying statistical data used in such filings.

(8)~~(6)~~ Whenever the committee of a recognized rating organization with authority to file prospective loss costs for use by insurers in determining ~~responsibility for~~ workers' compensation and employer's liability insurance rates in this state meets to discuss the necessity for, or a request for, Florida rate increases or decreases in prospective loss costs in this state, the determination of prospective loss costs in this state ~~Florida rates~~, the prospective loss costs ~~rates~~ to be requested in this state, and any other matters pertaining specifically and directly to prospective loss costs in this state ~~such Florida rates~~, such meetings shall be held in this state and are ~~shall be~~ subject to s. 286.011. The committee of such a rating organization shall provide at least 3 weeks' prior notice of such meetings to the office and shall provide at least 14 days' prior notice of such meetings to the public by publication in the Florida Administrative Register.

Section 14. Section 627.093, Florida Statutes, is amended to read:

627.093 Application of s. 286.011 to workers' compensation and employer's liability insurances.—Section 286.011 shall be applicable to every prospective loss cost and rate filing, approval or disapproval of filing, rating deviation from filing, or appeal from any of these regarding workers' compensation and employer's liability insurances.

Section 15. Subsection (1) of section 627.101, Florida Statutes, is amended to read:

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

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

Section 16. Section 627.211, Florida Statutes, is amended to read:

627.211 Annual report by the office on the workers' compensation insurance market ~~Deviations; workers' compensation and employer's liability insurances~~.—

~~(1) Every member or subscriber to a rating organization shall, as to workers' compensation or employer's liability insurance, adhere to the filings made on its behalf by such organization; except that any such insurer may make written application to the office for permission to file a uniform percentage decrease or increase to be applied to the premiums~~

~~produced by the rating system so filed for a kind of insurance, for a class of insurance which is found by the office to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of workers' compensation or employer's liability insurance:~~

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

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

~~Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization.~~

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

~~be available to support the continued use of such varying deviations.~~

~~(3) In considering an application for the deviation, the office shall give consideration to the applicable principles for ratemaking as set forth in ss. 627.062 and 627.072 and the financial condition of the insurer. In evaluating the financial condition of the insurer, the office may consider: (1) the insurer's audited financial statements and whether the statements provide unqualified opinions or contain significant qualifications or "subject to" provisions; (2) any independent or other actuarial certification of loss reserves; (3) whether workers' compensation and employer's liability reserves are above the midpoint or best estimate of the actuary's reserve range estimate; (4) the adequacy of the proposed rate; (5) historical experience demonstrating the profitability of the insurer; (6) the existence of excess or other reinsurance that contains a sufficiently low attachment point and maximums that provide adequate protection to the insurer; and (7) other factors considered relevant to the financial condition of the insurer by the office. The office shall approve the deviation if it finds it to be justified, it would not endanger the financial condition of the insurer, and it would not constitute predatory pricing. The office shall disapprove the deviation if it finds that the resulting premiums would be excessive, inadequate, or unfairly discriminatory, would endanger the financial condition of the insurer, or would result in predatory pricing. The insurer may not use a deviation unless the deviation is specifically approved by the office. An insurer may apply the premiums approved pursuant to s. 627.091 or its uniform~~

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~~deviation approved pursuant to this section to a particular insured according to underwriting guidelines filed with and approved by the office, such approval to be based on ss. 627.062 and 627.072.~~

~~(4) Each deviation permitted to be filed shall be effective for a period of 1 year unless terminated, extended, or modified with the approval of the office. If at any time after a deviation has been approved the office finds that the deviation no longer meets the requirements of this code, it shall notify the insurer in what respects it finds that the deviation fails to meet such requirements and specify when, within a reasonable period thereafter, the deviation shall be deemed no longer effective. The notice shall not affect any insurance contract or policy made or issued prior to the expiration of the period set forth in the notice.~~

~~(5) For purposes of this section, the office, when considering the experience of any insurer, shall consider the experience of any predecessor insurer when the business and the liabilities of the predecessor insurer were assumed by the insurer pursuant to an order of the office which approves the assumption of the business and the liabilities.~~

~~(6)~~ The office shall submit an annual report to the President of the Senate and the Speaker of the House of Representatives by January 15 of each year which evaluates insurance company solvency and competition in the workers' compensation insurance market in this state. The report must contain an analysis of the availability and affordability of workers' compensation coverage and whether the current market structure, conduct, and performance are conducive to

competition, based upon economic analysis and tests. The report must also contain an analysis of each insurer's capital compared to minimum risk-based capital. The purpose of this report is to aid the Legislature in determining whether changes to the workers' compensation rating laws are warranted. The report must also document that the office has complied with the provisions of s. 627.096 which require the office to investigate and study all workers' compensation insurers in the state and to study the data, statistics, schedules, or other information as it finds necessary to assist in its review of workers' compensation rate filings.

Section 17. Section 627.2151, Florida Statutes, is created to read:

627.2151 Workers' compensation excessive defense and cost containment expenses.—

(1) As used in this section, the term "defense and cost containment expenses" or "DCCE" includes the following Florida expenses of an insurer group or insurer writing workers' compensation insurance:

(a) Insurance company attorney fees;

(b) Expert witnesses;

(c) Medical examinations and autopsies;

(d) Medical fee review panels;

(e) Bill auditing;

(f) Treatment utilization reviews;

(g) Preferred provider network expenses; and

(h) Vocational rehabilitation.

(2) Each insurer group or insurer writing workers' compensation insurance shall file with the office a schedule of

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Florida defense and cost containment expenses and total Florida incurred losses for each of the 3 years before the most recent accident year. The DCCE and incurred losses must be valued as of December 31 of the first year following the latest accident year to be reported, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of three evaluations will be provided for each accident year. The first year reported shall be accident year 2018, so that the reporting of 3 accident years under this evaluation will not take place until accident years 2019 and 2020 have become available.

(3) Excessive DCCE occurs when the Florida defense and cost containment expenses for workers' compensation exceed 15 percent of Florida workers' compensation incurred losses by the insurer or insurer group for the 3 most recent calendar years for which data is to be filed under this section.

(4) If the insurer or insurer group realizes excessive DCCE, the office must order a return of the excess amounts after affording the insurer or insurer group an opportunity for a hearing and otherwise complying with the requirements of chapter 120. Excessive DCCE amounts must be returned in all instances unless the insurer or insurer group affirmatively demonstrates to the office that the refund of the excessive DCCE amounts will render a member of the insurer group financially impaired or will render it insolvent under provisions of the Florida Insurance Code.

(5) Any excess DCCE amount must be returned to policyholders in the form of a cash refund or credit toward the future purchase of insurance. The refund or credit must be made

on a pro rata basis in relation to the final compilation year earned premiums to the policyholders of record of the insurer or insurer group on December 31 of the final compilation year. Cash refunds and data in required reports to the office may be rounded to the nearest dollar and must be consistently applied.

(6)(a) Refunds must be completed in one of the following ways:

1. A cash refund must be completed within 60 days after entry of a final order indicating that excessive DCCE has been realized.

2. A credit to renewal policies must be applied to policy renewal premium notices that are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive DCCE has been realized. If the insured thereafter cancels a policy or otherwise allows the policy to terminate, the insurer or insurer group must make a cash refund not later than 60 days after coverage termination.

(b) Upon completion of the renewal credits or refunds, the insurer or insurer group shall immediately certify having made the refunds to the office.

(7) Any refund or renewal credit made pursuant to this section is treated as a policyholder dividend applicable to the year immediately succeeding the compilation period giving rise to the refund or credit, for purposes of reporting under this section for subsequent years.

Section 18. Section 627.291, Florida Statutes, is amended to read:

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

insurances.—

(1) As to workers' compensation and employer's liability insurances, every rating organization filing prospective loss costs and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

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

Section 19. Section 627.318, Florida Statutes, is amended to read:

627.318 Records.—Every insurer, rating organization filing

prospective loss costs, and advisory organization and every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members and of the data, statistics, or information collected or used by it in connection with the prospective loss costs, rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys, or inspections made or used by it, so that such records will be available at all reasonable times to enable the office to determine whether such organization, insurer, group, or association, and, in the case of an insurer or rating organization, every prospective loss cost, rate, rating plan, and rating system made or used by it, complies with the provisions of this part applicable to it. The maintenance of such records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any such insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the prospective loss costs, rates, rating plans, rating systems, or underwriting rules of such organization. Such records shall be maintained in an office within this state or shall be made available for examination or inspection within this state by the department at any time upon reasonable notice.

Section 20. Section 627.361, Florida Statutes, is amended to read:

627.361 False or misleading information.—No person shall

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willfully withhold information from or knowingly give false or misleading information to the office, any statistical agency designated by the office, any rating organization, or any insurer, which will affect the prospective loss costs, rates, or premiums chargeable under this part.

Section 21. Subsections (1) and (2) of section 627.371, Florida Statutes, are amended to read:

627.371 Hearings.—

(1) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer, and any person aggrieved by any rating plan, rating system, or underwriting rule followed or adopted by a rating organization, may herself or himself or by her or his authorized representative make written request of the insurer or rating organization to review the manner in which the prospective loss cost, rate, plan, system, or rule has been applied with respect to insurance afforded her or him. If the request is not granted within 30 days after it is made, the requester may treat it as rejected. Any person aggrieved by the refusal of an insurer or rating organization to grant the review requested, or by the failure or refusal to grant all or part of the relief requested, may file a written complaint with the office, specifying the grounds relied upon. If the office has already disposed of the issue as raised by a similar complaint or believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, it shall so notify the complainant. Otherwise, and if it also finds that the complaint charges a violation of this chapter and that the complainant would be aggrieved if the violation is proven, it shall proceed as

provided in subsection (2).

(2) If after examination of an insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, upon the basis of other information, or upon sufficient complaint as provided in subsection (1), the office has good cause to believe that such insurer, organization, group, or association, or any <u>prospective loss cost,</u> rate, rating plan, or rating system made or used by any such insurer or rating organization, does not comply with the requirements and standards of this part applicable to it, it shall, unless it has good cause to believe such noncompliance is willful, give notice in writing to such insurer, organization, group, or association stating therein in what manner and to what extent noncompliance is alleged to exist and specifying therein a reasonable time, not less than 10 days thereafter, in which the noncompliance may be corrected, including any premium adjustment.

Section 22. This act shall take effect July 1, 2017.

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