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LEGISLATIVE ACTION

Senate . House

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Floor: WD/2R .

05/05/2017 11:23 AM .

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Senator Rodriguez moved the following:

Senate Amendment to Amendment (655850) (with title amendment)

Delete lines 408 - 850

and insert:

Section 8. 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 by a carrier or employer ~~for a claimant~~ in connection with any proceedings arising under this chapter, unless approved by

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the judge of compensation claims or court having jurisdiction over such proceedings. Any attorney fees ~~attorney's fee~~ approved by a judge of compensation 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 $225 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,~~

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~~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 paid by a carrier or employer ~~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 paid by a carrier or employer ~~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


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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 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

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payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in 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) This section may not be interpreted to limit or otherwise infringe on a claimant's right to retain an attorney and pay the attorney reasonable attorney fees for legal services related to a claim under the Workers' Compensation Law ~~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~~


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~~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 9. Effective July 1, 2018, 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 10. Effective July 1, 2018, 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.

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(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 11. Effective July 1, 2018, 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 12. Effective July 1, 2018, subsection (1) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

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(1) The rates and loss costs for all classes of insurance to which the provisions of this part are applicable may not be excessive, inadequate, or unfairly discriminatory.

Section 13. Effective July 1, 2018, subsection (1) of section 627.0645, Florida Statutes, is amended to read:

627.0645 Annual filings.—

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

~~(a) Workers' compensation and employer's liability insurance;~~

(a) ~~(b)~~ Insurance as defined in ss. 624.604 and 624.605, limited to coverage of commercial risks other than commercial residential multiperil; or

(b) ~~(c)~~ Travel insurance, if issued as a master group policy with a situs in another state where each certificateholder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

Section 14. Effective July 1, 2018, subsections (1) and (5) of section 627.072, Florida Statutes, are amended to read:

627.072 Making and use of rates.—

(1) As to workers' compensation and employer's liability insurance, the following factors shall be used in the


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determination and fixing of loss costs or rates, as applicable:

(a) The past loss experience and prospective loss experience within and outside this state;

(b) The conflagration and catastrophe hazards;

(c) A reasonable margin for underwriting profit and contingencies;

(d) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) Investment income on unearned premium reserves and loss reserves;

(f) Past expenses and prospective expenses, both those countrywide and those specifically applicable to this state; and

(g) All other relevant factors, including judgment factors, within and outside this state.

~~(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~~

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~~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 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 15. Effective July 1, 2018, section 627.091, Florida Statutes, is amended to read:

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

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(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, reinsurance, 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.

(c) "Loss cost multiplier" means the profit and expense factor, expressed as a single nonintegral number to be applied to the prospective loss costs, 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 or insurer group 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 most recent loss costs filed by a licensed rating organization and approved by the office, and by otherwise complying with this part. Each insurer shall file data in


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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 90 days before such proposed effective date;

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

(c) May use the most recent 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) Must include all deductibles required in chapter 440, and may include additional 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;

(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; and

(g) May file a minimum premium or expense constant ~~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~~


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~~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 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, shall require the insurer or rating 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).

(5)~~(4)~~ An insurer may become ~~satisfy its obligation to make such filings by becoming~~ a member of, or a subscriber to, a licensed rating organization that ~~which~~ makes loss costs ~~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

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subscriber to any rating organization.

(6) 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.

(7) A rating organization may file supplementary rating information and rules, including, but not limited to, policywriting rules, rating plan classification codes and descriptions, experience modification plans, statistical plans and forms, 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 if such information is approved by the office.

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

(9) ~~(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


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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.

(10) An insurer group with multiple insurers writing workers' compensation and employer's liability insurance shall file underwriting rules not contained in rating manuals.

Section 16. Effective July 1, 2018, 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 17. Effective July 1, 2018, 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~~

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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 18. Effective July 1, 2018, 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~~


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~~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 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.~~

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~~(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 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 19. Effective July 1, 2018, 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


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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; and

(g) Preferred provider network expenses.

(2) Each insurer group or insurer writing workers' compensation insurance shall file with the office a schedule of 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 an insurer includes in its rates Florida defense and cost containment expenses for workers' compensation which 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

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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.

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(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 20. Effective July 1, 2018, 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

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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 21. Effective July 1, 2018, 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 22. Effective July 1, 2018, section 627.361, Florida Statutes, is amended to read:

627.361 False or misleading information.—No person shall willfully withhold information from or knowingly give false or misleading information to the 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 23. Effective July 1, 2018, 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

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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 24. Effective July 1, 2017, the sums of $723,118 in recurring funds and $100,000 in nonrecurring funds from the Insurance Regulatory Trust Fund are appropriated to the Office of Insurance Regulation, and eight full-time equivalent positions with associated salary rate of 460,000 are authorized, for the purpose of implementing this act.

Section 25. Effective July 1, 2017, the sum of $24,720 in nonrecurring funds from the Operating Trust Fund is appropriated to the Office of Judges of Compensation Claims within the Division of Administrative Hearings for the purposes of implementing this act.

Section 26. Section 440.345, Florida Statutes, is amended to read:

440.345 Reporting of attorney ~~attorney's~~ fees.—All fees paid to attorneys for services rendered under this chapter shall be reported to the Office of the Judges of Compensation Claims as the Division of Administrative Hearings requires by rule. A carrier must specify in its report the total amount of attorney fees paid for and the total number of attorney hours spent on services related to the defense of petitions, and the total amount of attorney fees paid for services unrelated to the defense of petitions.

Section 27. Paragraph (b) of subsection (6) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(6) TRAINING AND EDUCATION.—

(b) When an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the


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compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph are ~~shall~~ not ~~be~~ in addition to the maximum number of ~~104~~ weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the department will forfeit any additional training and education benefits and any additional compensation ~~payment for lost wages~~ under this chapter. The carrier shall notify the injured employee of the availability of training and education benefits as specified in this chapter. The Department of Financial Services shall include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40.

Section 28. Section 627.211, Florida Statutes, is amended

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to read:

627.211 Deviations and departures; workers' compensation and employer's liability insurances.—

(1) Except as provided in subsection (7), 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


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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


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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 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


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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 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 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.

(7) Without approval of the office, a member or subscriber to a rating organization may depart from the filings made on its behalf by a rating organization for a period of 12 months by a uniform decrease of up to 5 percent to be applied uniformly to the premiums resulting from the approved rates for the policy period. The member or subscriber must file an informational departure statement with the office within 30 days after initial use of such departure, specifying the percentage of the departure from the approved rates and an explanation of how the departure will be applied. If the departure is to be applied

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over a subsequent 12-month period, the member or subscriber must file a supplemental informational departure statement pursuant to this subsection at least 30 days before the end of the current period. If the office determines that a departure violates the applicable principles for ratemaking under ss. 627.062 and 627.072, would result in predatory pricing, or imperils the financial condition of the member or subscriber, the office must issue an order specifying its findings and stating the time period within which the departure expires, which must be within a reasonable time period after the order is issued. The order does not affect an insurance contract or policy made or issued before the departure expiration period set forth in the order.

Section 29. (1) The Department of Financial Services, in consultation with the three-member panel, shall contract with an independent consultant to evaluate Florida's current reimbursement methodology for medical services provided by hospitals and ambulatory surgical centers pursuant to s. 440.13, Florida Statutes. The study must evaluate the feasibility of adopting other reimbursement methods, including group health outpatient reimbursement rates. The study must include an evaluation of the payments, prices, utilization, and outcomes associated with each of the reimbursement methods. The consultant shall submit a report with findings and recommendations to the Speaker of the House of Representatives and the President of the Senate by November 1, 2017.

(2) Effective July 1, 2017, the sum of $50,000 in nonrecurring funds from the Workers' Compensation Administration Trust Fund is appropriated to the Department of Financial

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Services for the purpose of funding the study.

Section 30. (1) The Office of Insurance Regulation shall contract with an independent consultant to evaluate the competition, availability, and affordability of workers' compensation insurance in Florida, which evaluation must include a review of the current administered pricing rating system, including deviations authorized under s. 627.211(7), to evaluate the advantages and disadvantages of a loss cost system and to evaluate other mechanisms that can be used to increase competition in the marketplace. The consultant shall submit a report of its findings and recommendations to the Governor, the Senate, and the House of Representatives no later than November 1, 2017.

(2) Effective July 1, 2017, the sum of $25,000 in nonrecurring funds from the Insurance Regulatory Trust Fund is appropriated to the Office of Insurance Regulation for the purpose of funding the study.

Section 31. Except as otherwise expressly provided by this act, this act shall take effect July 1, 2017.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 903 - 966

and insert:

under which certain attorney fees attach; amending s. 440.34, F.S.; prohibiting the payment of certain consideration by carriers or employers, rather than prohibiting such payment for claimants, in connection with certain proceedings under certain circumstances;

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requiring judges of compensation claims to consider specified factors in increasing or decreasing attorney fees; specifying a maximum hourly rate for attorney fees; revising provisions that prohibit such judges from approving certain agreements and that limit attorney fees in retainer agreements; providing construction; deleting a provision authorizing such judges to approve alternative attorney fees under certain circumstances; conforming a cross-reference; 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.; prohibiting loss costs for specified classes of insurance from being excessive, inadequate, or unfairly discriminatory; amending s. 627.0645, F.S.; deleting an annual base rate filing requirement exception relating to workers' compensation and employer's liability insurance for certain rating organizations; amending s. 627.072, F.S.; requiring certain factors to be used in determining and fixing loss costs; deleting a specified methodology that may be used by the Office of Insurance Regulation in rate determinations; amending s. 627.091, F.S.; defining terms; requiring insurers or insurer groups writing workers' compensation and employer's liability insurances to independently and individually file their proposed final rates; specifying requirements

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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; requiring certain insurer groups to file underwriting rules not contained in rating manuals; 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; requiring that the office's annual report to the Legislature relating to the workers' compensation insurance market evaluate insurance company solvency; 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;

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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 appropriations; amending s. 440.345, F.S.; revising requirements for a carrier’s reporting of attorney fees to the Office of the Judges of Compensation Claims; amending s. 440.491, F.S.; conforming a provision to changes made by the act; revising a provision that provides for forfeiture of certain compensation if an employee refuses to accept certain training and education; amending s. 627.211, F.S.; authorizing rating organization members or subscribers to depart up a specified percentage from certain filings without approval from the Office of Insurance Regulation for a specified timeframe;

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requiring such members or subscribers to file informational departure statements with the office within a specified timeframe; requiring such members or subscribers, under certain circumstances, to file supplemental informational departure statements within a specified timeframe; requiring the office to issue a specified order if it finds the order violates certain ratemaking principles, would result in predatory pricing, or imperils the financial condition of the member or subscriber; providing construction; requiring the Department of Financial Services, in consultation with the three-member panel, to contract with an independent consultant to conduct a specified study; requiring the consultant to submit a report to the Legislature by a specified date; providing an appropriation; requiring the office to contract with an independent consultant to make certain evaluations; requiring such consultant to submit a report to the Governor and Legislature by a specified date; providing an appropriation; providing effective dates.