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LEGISLATIVE ACTION

Senate	.	House
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Floor: 2/AD/2R	.	Floor: CA
05/05/2017 11:30 AM	.	05/05/2017 02:39 PM
	.	

Senator Farmer moved the following:

1 **Senate Substitute for Amendment (655850) (with title**
2 **amendment)**
3
4 Delete everything after the enacting clause
5 and insert:
6 Section 1. Subsection (40) of section 440.02, Florida
7 Statutes, is amended to read:
8 440.02 Definitions.—When used in this chapter, unless the
9 context clearly requires otherwise, the following terms shall
10 have the following meanings:
11 (40) “Specificity” means information on the petition for

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12 benefits sufficient to put the employer or carrier on notice of
13 the exact statutory classification and outstanding time period
14 for each requested benefit, the specific amount of each
15 requested benefit, the calculation used for computing the
16 requested benefit, ~~of benefits being requested~~ and ~~includes~~ a
17 detailed explanation of any benefits received that should be
18 increased, decreased, changed, or otherwise modified. If the
19 petition is for medical benefits, the information must ~~shall~~
20 include specific details as to why such benefits are being
21 requested, why such benefits are medically necessary, and why
22 current treatment, if any, is not sufficient. Any petition
23 requesting alternate or other medical care, including, but not
24 limited to, petitions requesting psychiatric or psychological
25 treatment, must specifically identify the physician, as defined
26 in s. 440.13(1), who is recommending such treatment. A copy of a
27 report from such physician making the recommendation for
28 alternate or other medical care must ~~shall~~ also be attached to
29 the petition. A judge of compensation claims may ~~shall~~ not order
30 such treatment if a physician is not recommending such
31 treatment.
32 Section 2. Paragraph (c) of subsection (3) of section
33 440.105, Florida Statutes, is amended to read:
34 440.105 Prohibited activities; reports; penalties;
35 limitations.—
36 (3) Whoever violates any provision of this subsection
37 commits a misdemeanor of the first degree, punishable as
38 provided in s. 775.082 or s. 775.083.
39 (c) Except for an attorney who is retained by or for an
40 injured worker and who receives a fee or other consideration

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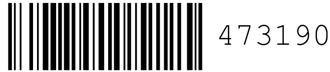
41 from or on behalf of such worker, it is unlawful for any
42 ~~attorney or other~~ person, in his or her individual capacity or
43 in his or her capacity as a public or private employee, or for
44 any firm, corporation, partnership, or association to receive
45 any fee or other consideration or any gratuity from a person on
46 account of services rendered for a person in connection with any
47 proceedings arising under this chapter, unless such fee,
48 consideration, or gratuity is approved by a judge of
49 compensation claims or by the Deputy Chief Judge of Compensation
50 Claims.
51 Section 3. Paragraph (f) of subsection (2), paragraphs (d)
52 and (i) of subsection (3), paragraph (a) of subsection (4),
53 paragraphs (a) and (c) of subsection (5), and paragraphs (c) and
54 (d) of subsection (9) of section 440.13, Florida Statutes, are
55 amended, to read:
56 440.13 Medical services and supplies; penalty for
57 violations; limitations.—
58 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—
59 (f) Upon the written request of the employee, the carrier
60 shall give the employee the opportunity for one change of
61 physician during the course of treatment for any one accident.
62 Upon the granting of a change of physician, the originally
63 authorized physician in the same specialty as the changed
64 physician shall become deauthorized upon written notification by
65 the employer or carrier. The carrier shall authorize an
66 alternative physician who shall not be professionally affiliated
67 with the previous physician within 5 business days after receipt
68 of the request. If the carrier fails to provide a change of
69 physician as requested by the employee, the employee may select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70 the physician and such physician shall be considered authorized
71 if the treatment being provided is compensable and medically
72 necessary.
73
74 Failure of the carrier to timely comply with this subsection
75 shall be a violation of this chapter and the carrier shall be
76 subject to penalties as provided for in s. 440.525.
77 (3) PROVIDER ELIGIBILITY; AUTHORIZATION.—
78 (d) A carrier ~~must respond~~, by telephone or in writing,
79 must authorize or deny ~~to~~ a request for authorization from an
80 authorized health care provider by the close of the third
81 business day after receipt of the request. A carrier authorizes
82 the request if it ~~who~~ fails to respond to a written request for
83 authorization for referral for medical treatment by the close of
84 the third business day after receipt of the request ~~consents to~~
85 ~~the medical necessity for such treatment~~. All such requests must
86 be made to the carrier. Notice to the carrier does not include
87 notice to the employer.
88 (i) Notwithstanding paragraph (d), a claim for specialist
89 consultations, surgical operations, physiotherapeutic or
90 occupational therapy procedures, X-ray examinations, or special
91 diagnostic laboratory tests that cost more than $1,000 and other
92 specialty services that the department identifies by rule is not
93 valid and reimbursable unless the services have been expressly
94 authorized by the carrier, unless the carrier has failed to
95 respond within 10 business days to a written request for
96 authorization, or unless emergency care is required. The insurer
97 shall authorize such consultation or procedure unless the health
98 care provider or facility is not authorized, unless such

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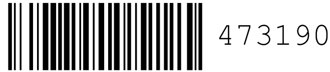
99 treatment is not in accordance with practice parameters and
100 protocols of treatment established in this chapter, or unless a
101 judge of compensation claims has determined that the
102 consultation or procedure is not medically necessary, not in
103 accordance with the practice parameters and protocols of
104 treatment established in this chapter, or otherwise not
105 compensable under this chapter. Authorization of a treatment
106 plan does not constitute express authorization for purposes of
107 this section, except to the extent the carrier provides
108 otherwise in its authorization procedures. This paragraph does
109 not limit the carrier's obligation to identify and disallow
110 overutilization or billing errors.
111 (4) NOTICE OF TREATMENT TO CARRIER; FILING WITH
112 DEPARTMENT.—
113 (a) Any health care provider providing necessary remedial
114 treatment, care, or attendance to any injured worker shall
115 submit treatment reports to the carrier in a format prescribed
116 by the department. A claim for medical or surgical treatment is
117 not valid or enforceable against such employer or employee,
118 unless, by the close of the third business day following the
119 first treatment, the physician providing the treatment furnishes
120 to the employer or carrier a preliminary notice of the injury
121 and treatment in a format prescribed by the department and,
122 within 15 business days thereafter, furnishes to the employer or
123 carrier a complete report, and subsequent thereto furnishes
124 progress reports, if requested by the employer or insurance
125 carrier, at intervals of not less than 15 business days ~~3 weeks~~
126 apart or at less frequent intervals if requested in a format
127 prescribed by the department.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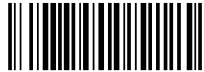
128 (5) INDEPENDENT MEDICAL EXAMINATIONS.—
129 (a) In any dispute concerning overutilization, medical
130 benefits, compensability, or disability under this chapter, the
131 carrier or the employee may select an independent medical
132 examiner. If the parties agree, the examiner may be a health
133 care provider treating or providing other care to the employee.
134 An independent medical examiner may not render an opinion
135 outside his or her area of expertise, as demonstrated by
136 licensure and applicable practice parameters. The employer and
137 employee shall be entitled to only one independent medical
138 examination per accident and not one independent medical
139 examination per medical specialty. The party requesting and
140 selecting the independent medical examination shall be
141 responsible for all expenses associated with said examination,
142 including, but not limited to, medically necessary diagnostic
143 testing performed and physician or medical care provider fees
144 for the evaluation. The party selecting the independent medical
145 examination shall identify the choice of the independent medical
146 examiner to all other parties within 15 business days after the
147 date the independent medical examination is to take place.
148 Failure to timely provide such notification shall preclude the
149 requesting party from submitting the findings of such
150 independent medical examiner in a proceeding before a judge of
151 compensation claims. The independent medical examiner may not
152 provide followup care if such recommendation for care is found
153 to be medically necessary. If the employee prevails in a medical
154 dispute as determined in an order by a judge of compensation
155 claims or if benefits are paid or treatment provided after the
156 employee has obtained an independent medical examination based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157 upon the examiner's findings, the costs of such examination
158 shall be paid by the employer or carrier.
159 (c) The carrier may, at its election, contact the claimant
160 directly to schedule a reasonable time for an independent
161 medical examination. The carrier must confirm the scheduling
162 agreement in writing with the claimant and the claimant's
163 counsel, if any, at least 7 business days before the date upon
164 which the independent medical examination is scheduled to occur.
165 An attorney representing a claimant is not authorized to
166 schedule the self-insured employer's or carrier's independent
167 medical evaluations under this subsection. Neither the self-
168 insured employer nor the carrier shall be responsible for
169 scheduling any independent medical examination other than an
170 employer or carrier independent medical examination.
171 (9) EXPERT MEDICAL ADVISORS.—
172 (c) If there is disagreement in the opinions of the health
173 care providers, if two health care providers disagree on medical
174 evidence supporting the employee's complaints or the need for
175 additional medical treatment, or if two health care providers
176 disagree that the employee is able to return to work, the
177 department may, and the judge of compensation claims shall, upon
178 his or her own motion or within 15 business days after receipt
179 of a written request by either the injured employee, the
180 employer, or the carrier, order the injured employee to be
181 evaluated by an expert medical advisor. The injured employee and
182 the employer or carrier may agree on the health care provider to
183 serve as an expert medical advisor. If the parties do not agree,
184 the judge of compensation claims shall select an expert medical
185 advisor from the department's list of certified expert medical

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186 advisors. If a certified medical advisor within the relevant
187 medical specialty is unavailable, the judge of compensation
188 claims shall appoint any otherwise qualified health care
189 provider to serve as an expert medical advisor without obtaining
190 the department's certification. The opinion of the expert
191 medical advisor is presumed to be correct unless there is clear
192 and convincing evidence to the contrary as determined by the
193 judge of compensation claims. The expert medical advisor
194 appointed to conduct the evaluation shall have free and complete
195 access to the medical records of the employee. An employee who
196 fails to report to and cooperate with such evaluation forfeits
197 entitlement to compensation during the period of failure to
198 report or cooperate.
199 (d) The expert medical advisor must complete his or her
200 evaluation and issue his or her report to the department or to
201 the judge of compensation claims within 15 business days after
202 receipt of all medical records. The expert medical advisor must
203 furnish a copy of the report to the carrier and to the employee.
204 Section 4. Paragraph (a) of subsection (2) and paragraph
205 (e) of subsection (4) of section 440.15, Florida Statutes, are
206 amended to read:
207 440.15 Compensation for disability.—Compensation for
208 disability shall be paid to the employee, subject to the limits
209 provided in s. 440.12(2), as follows:
210 (2) TEMPORARY TOTAL DISABILITY.—
211 (a) Subject to subsection (7), in case of disability total
212 in character but temporary in quality, 66 2/3 or 66.67 percent
213 of the average weekly wages shall be paid to the employee during
214 the continuance thereof, not to exceed 260 ~~104~~ weeks except as

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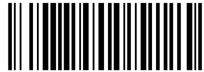
215 provided in this subsection, s. 440.12(1), and s. 440.14(3).
216 Once the employee reaches the maximum number of weeks allowed,
217 or the employee reaches the date of maximum medical improvement,
218 whichever occurs earlier, temporary disability benefits shall
219 cease and the injured worker’s permanent impairment shall be
220 determined.
221 (4) TEMPORARY PARTIAL DISABILITY.—
222 (e) Such benefits shall be paid during the continuance of
223 such disability, not to exceed a period of 260 ~~104~~ weeks, as
224 provided by this subsection and subsection (2). Once the injured
225 employee reaches the maximum number of weeks, temporary
226 disability benefits cease and the injured worker’s permanent
227 impairment must be determined. If the employee is terminated
228 from postinjury employment based on the employee’s misconduct,
229 temporary partial disability benefits are not payable as
230 provided for in this section. The department shall by rule
231 specify forms and procedures governing the method and time for
232 payment of temporary disability benefits for dates of accidents
233 before January 1, 1994, and for dates of accidents on or after
234 January 1, 1994.
235 Section 5. Subsection (2) of section 440.151, Florida
236 Statutes, is amended to read:
237 440.151 Occupational diseases.—
238 (2) Whenever used in this section the term “occupational
239 disease” shall be construed to mean only a disease which is due
240 to causes and conditions which are characteristic of and
241 peculiar to a particular trade, occupation, process, or
242 employment, and to exclude all ordinary diseases of life to
243 which the general public is exposed, unless the incidence of the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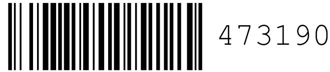
244 disease is substantially higher in the particular trade,
245 occupation, process, or employment than for the general public.
246 “Occupational disease” means only a disease for which there are
247 epidemiological studies showing that exposure to the specific
248 substance involved, at the levels to which the employee was
249 exposed, may cause the precise disease sustained by the
250 employee. Notwithstanding any provision of this chapter, for
251 firefighters, as defined in s. 112.81, multiple myeloma and non-
252 Hodgkin’s lymphoma are deemed to be occupational diseases that
253 arise out of work performed in the course and scope of
254 employment.
255 Section 6. Subsections (2) and (5) of section 440.192,
256 Florida Statutes, are amended to read:
257 440.192 Procedure for resolving benefit disputes.—
258 (2) Upon receipt, the Office of the Judges of Compensation
259 Claims shall review each petition and shall dismiss each
260 petition or any portion of such a petition that does not on its
261 face meet the requirements of this section and the definition of
262 specificity under s. 440.02, and specifically identify or
263 itemize the following:
264 (a) The name, address, and telephone number~~, and social~~
265 ~~security number~~ of the employee.
266 (b) The name, address, and telephone number of the
267 employer.
268 (c) A detailed description of the injury and cause of the
269 injury, including the Florida county or, if outside of Florida,
270 the state ~~location~~ of the occurrence and the date or dates of
271 the accident.
272 (d) A detailed description of the employee’s job, work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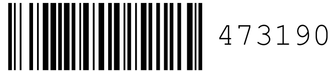
273 responsibilities, and work the employee was performing when the
274 injury occurred.
275 (e) The specific time period for which compensation and the
276 specific classification of compensation were not timely
277 provided.
278 (f) The specific date of maximum medical improvement,
279 character of disability, and specific statement of all benefits
280 or compensation that the employee is seeking. A claim for
281 permanent benefits must include the specific date of maximum
282 medical improvement and the specific date that such permanent
283 benefits are claimed to begin.
284 (g) All specific travel costs to which the employee
285 believes she or he is entitled, including dates of travel and
286 purpose of travel, means of transportation, and mileage and
287 including the date the request for mileage was filed with the
288 carrier and a copy of the request filed with the carrier.
289 (h) A specific listing of all medical charges alleged
290 unpaid, including the name and address of the medical provider,
291 the amounts due, and the specific dates of treatment.
292 (i) The type or nature of treatment care or attendance
293 sought and the justification for such treatment. If the employee
294 is under the care of a physician for an injury identified under
295 paragraph (c), a copy of the physician’s request, authorization,
296 or recommendation for treatment, care, or attendance must
297 accompany the petition.
298 (j) The specific amount of compensation claimed to be
299 accurate and the methodology claimed to accurately calculate the
300 average weekly wage, if the average weekly wage calculated by
301 the employer or carrier is disputed. If the petition does not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302 include a claim under this paragraph, the average weekly wage
303 and corresponding compensation calculated by the employer or
304 carrier are presumed to be accurate.
305 (k) ~~(j)~~ A specific explanation of any other disputed issue
306 that a judge of compensation claims will be called to rule upon.
307
308 The dismissal of any petition or portion of such a petition
309 under this subsection ~~section~~ is without prejudice and does not
310 require a hearing.
311 (5)(a) All motions to dismiss must state with particularity
312 the basis for the motion. The judge of compensation claims shall
313 enter an order upon such motions without hearing, unless good
314 cause for hearing is shown. Dismissal of any petition or portion
315 of a petition under this subsection is without prejudice.
316 (b) Upon motion that a petition or portion of a petition be
317 dismissed for lack of specificity, the judge of compensation
318 claims shall enter an order on the motion, unless stipulated in
319 writing by the parties, within 10 days after the motion is filed
320 or, if good cause for hearing is shown, within 20 days after
321 hearing on the motion. When any petition or portion of a
322 petition is dismissed for lack of specificity under this
323 subsection, the claimant must be allowed 20 days after the date
324 of the order of dismissal in which to file an amended petition.
325 Any grounds for dismissal for lack of specificity under this
326 section which are not asserted within 30 days after receipt of
327 the petition for benefits are thereby waived.
328 Section 7. Section 440.34, Florida Statutes, is amended to
329 read:
330 440.34 Attorney ~~Attorney's~~ fees; costs.—

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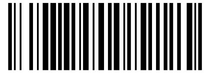
331 (1)(a) A fee, gratuity, or other consideration may not be
332 paid by a carrier or employer for a claimant in connection with
333 any proceedings arising under this chapter, unless approved by
334 the judge of compensation claims or court having jurisdiction
335 over such proceedings. Any attorney fees attorney's fee approved
336 by a judge of compensation claims for benefits secured on behalf
337 of a claimant must equal to 20 percent of the first $5,000 of
338 the amount of the benefits secured, 15 percent of the next
339 $5,000 of the amount of the benefits secured, 10 percent of the
340 remaining amount of the benefits secured to be provided during
341 the first 10 years after the date the claim is filed, and 5
342 percent of the benefits secured after 10 years.
343 (b) However, the judge of compensation claims shall
344 consider the following factors in each case and may increase or
345 decrease the attorney fees, based on a maximum hourly rate of
346 $250 per hour, if in his or her judgment he or she expressly
347 finds that the circumstances of the particular case warrant such
348 action:
349 1. The time and labor required, the novelty and difficulty
350 of the questions involved, and the skill requisite to perform
351 the legal service properly.
352 2. The fee customarily charged in the locality for similar
353 legal services.
354 3. The amount involved in the controversy and the benefits
355 resulting to the claimant.
356 4. The time limitation imposed by the claimant or the
357 circumstances.
358 5. The experience, reputation, and ability of the attorney
359 or attorneys performing services.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360 6. The contingency or certainty of a fee.
361 (c) The judge of compensation claims shall not approve a
362 compensation order~~, a joint stipulation for lump-sum settlement,~~
363 ~~a stipulation or agreement between a claimant and his or her~~
364 ~~attorney,~~ or any other agreement related to benefits under this
365 chapter which provides for attorney fees paid by a carrier or
366 employer ~~an attorney’s fee~~ in excess of the amount permitted by
367 this section. The judge of compensation claims is not required
368 to approve any retainer agreement between the claimant and his
369 or her attorney. ~~The retainer agreement as to fees and costs may~~
370 ~~not be for compensation in excess of the amount allowed under~~
371 ~~this subsection or subsection (7).~~
372 (2) In awarding a claimant’s attorney fees paid by a
373 carrier or employer ~~attorney’s fee~~, the judge of compensation
374 claims shall consider only those benefits secured by the
375 attorney. An attorney is not entitled to attorney ~~attorney’s~~
376 fees for representation in any issue that was ripe, due, and
377 owing and that reasonably could have been addressed, but was not
378 addressed, during the pendency of other issues for the same
379 injury. The amount, statutory basis, and type of benefits
380 obtained through legal representation shall be listed on all
381 attorney ~~attorney’s~~ fees awarded by the judge of compensation
382 claims. For purposes of this section, the term “benefits
383 secured” does not include future medical benefits to be provided
384 on any date more than 5 years after the date the claim is filed.
385 In the event an offer to settle an issue pending before a judge
386 of compensation claims, including attorney ~~attorney’s~~ fees as
387 provided for in this section, is communicated in writing to the
388 claimant or the claimant’s attorney at least 30 days prior to

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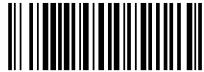
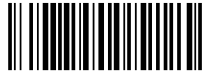
389 the trial date on such issue, for purposes of calculating the
390 amount of attorney ~~attorney's~~ fees to be taxed against the
391 employer or carrier, the term "benefits secured" shall be deemed
392 to include only that amount awarded to the claimant above the
393 amount specified in the offer to settle. If multiple issues are
394 pending before the judge of compensation claims, said offer of
395 settlement shall address each issue pending and shall state
396 explicitly whether or not the offer on each issue is severable.
397 The written offer shall also unequivocally state whether or not
398 it includes medical witness fees and expenses and all other
399 costs associated with the claim.
400 (3) If any party should prevail in any proceedings before a
401 judge of compensation claims or court, there shall be taxed
402 against the nonprevailing party the reasonable costs of such
403 proceedings, not to include attorney ~~attorney's~~ fees. A claimant
404 is responsible for the payment of her or his own attorney
405 ~~attorney's~~ fees, except that a claimant is entitled to recover
406 attorney fees ~~an attorney's fee~~ in an amount equal to the amount
407 provided for in subsection (1) ~~or subsection (7)~~ from a carrier
408 or employer:
409 (a) Against whom she or he successfully asserts a petition
410 for medical benefits only, if the claimant has not filed or is
411 not entitled to file at such time a claim for disability,
412 permanent impairment, wage-loss, or death benefits, arising out
413 of the same accident;
414 (b) In any case in which the employer or carrier files a
415 response to petition denying benefits with the Office of the
416 Judges of Compensation Claims and the injured person has
417 employed an attorney in the successful prosecution of the

 473190

418 petition;
419 (c) In a proceeding in which a carrier or employer denies
420 that an accident occurred for which compensation benefits are
421 payable, and the claimant prevails on the issue of
422 compensability; or
423 (d) In cases where the claimant successfully prevails in
424 proceedings filed under s. 440.24 or s. 440.28.
425
426 Regardless of the date benefits were initially requested,
427 <u>attorney</u> ~~attorney's~~ fees shall not attach under this subsection
428 until 30 days after the date the carrier or employer, if self-
429 insured, receives the petition.
430 (4) In such cases in which the claimant is responsible for
431 the payment of her or his own <u>attorney</u> ~~attorney's~~ fees, such
432 fees are a lien upon compensation payable to the claimant,
433 notwithstanding s. 440.22.
434 (5) If any proceedings are had for review of any claim,
435 award, or compensation order before any court, the court may
436 award the injured employee or dependent <u>attorney fees</u> ~~an~~
437 ~~attorney's fee~~ to be paid by the employer or carrier, in its
438 discretion, which shall be paid as the court may direct.
439 (6) A judge of compensation claims may not enter an order
440 approving the contents of a retainer agreement that permits
441 placing any portion of the employee's compensation into an
442 escrow account until benefits have been secured.
443 (7) <u>This section may not be interpreted to limit or</u>
444 <u>otherwise infringe on a claimant's right to retain an attorney</u>
445 <u>and pay the attorney reasonable attorney fees for legal services</u>
446 <u>related to a claim under the Workers' Compensation Law</u> ~~If an~~

 473190

447 ~~attorney's fee is owed under paragraph (3)(a), the judge of~~
448 ~~compensation claims may approve an alternative attorney's fee~~
449 ~~not to exceed $1,500 only once per accident, based on a maximum~~
450 ~~hourly rate of $150 per hour, if the judge of compensation~~
451 ~~claims expressly finds that the attorney's fee amount provided~~
452 ~~for in subsection (1), based on benefits secured, fails to~~
453 ~~fairly compensate the attorney for disputed medical-only claims~~
454 ~~as provided in paragraph (3)(a) and the circumstances of the~~
455 ~~particular case warrant such action~~.
456 Section 8. Effective July 1, 2018, subsection (10) of
457 section 624.482, Florida Statutes, is amended to read:
458 624.482 Making and use of rates.—
459 (10) Any self-insurance fund that writes workers'
460 compensation insurance and employer's liability insurance is
461 subject to, and shall make all rate filings for workers'
462 compensation insurance and employer's liability insurance in
463 accordance with, ss. 627.091, 627.101, 627.111, 627.141,
464 627.151, 627.171, and 627.191~~, and 627.211~~.
465 Section 9. Effective July 1, 2018, subsections (3), (4),
466 and (6) of section 627.041, Florida Statutes, are amended to
467 read:
468 627.041 Definitions.—As used in this part:
469 (3) "Rating organization" means every person, other than an
470 authorized insurer, whether located within or outside this
471 state, who has as his or her object or purpose the making of
472 prospective loss costs, rates, rating plans, or rating systems.
473 Two or more authorized insurers that act in concert for the
474 purpose of making prospective loss costs, rates, rating plans,
475 or rating systems, and that do not operate within the specific

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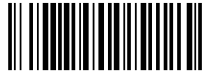
476 authorizations contained in ss. 627.311, 627.314(2), (4), and
477 627.351, shall be deemed to be a rating organization. No single
478 insurer shall be deemed to be a rating organization.
479 (4) "Advisory organization" means every group, association,
480 or other organization of insurers, whether located within or
481 outside this state, which prepares policy forms or makes
482 underwriting rules incident to but not including the making of
483 prospective loss costs, rates, rating plans, or rating systems
484 or which collects and furnishes to authorized insurers or rating
485 organizations loss or expense statistics or other statistical
486 information and data and acts in an advisory, as distinguished
487 from a ratemaking, capacity.
488 (6) "Subscriber" means an insurer which is furnished at its
489 request:
490 (a) With prospective loss costs, rates, and rating manuals
491 by a rating organization of which it is not a member; or
492 (b) With advisory services by an advisory organization of
493 which it is not a member.
494 Section 10. Effective July 1, 2018, subsection (1) of
495 section 627.0612, Florida Statutes, is amended to read:
496 627.0612 Administrative proceedings in rating
497 determinations.—
498 (1) In any proceeding to determine whether prospective loss
499 costs, rates, rating plans, or other matters governed by this
500 part comply with the law, the appellate court shall set aside a
501 final order of the office if the office has violated s.
502 120.57(1)(k) by substituting its findings of fact for findings
503 of an administrative law judge which were supported by competent
504 substantial evidence.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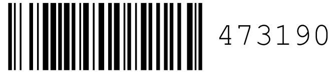
505 Section 11. Effective July 1, 2018, subsection (1) of
506 section 627.062, Florida Statutes, is amended to read:
507 627.062 Rate standards.—
508 (1) The rates and loss costs for all classes of insurance
509 to which the provisions of this part are applicable may not be
510 excessive, inadequate, or unfairly discriminatory.
511 Section 12. Effective July 1, 2018, subsection (1) of
512 section 627.0645, Florida Statutes, is amended to read:
513 627.0645 Annual filings.—
514 (1) Each rating organization filing rates for, and each
515 insurer writing, any line of property or casualty insurance to
516 which this part applies, except:
517 ~~(a) Workers' compensation and employer's liability~~
518 ~~insurance;~~
519 (a)~~(b)~~ Insurance as defined in ss. 624.604 and 624.605,
520 limited to coverage of commercial risks other than commercial
521 residential multiperil; or
522 (b)~~(c)~~ Travel insurance, if issued as a master group policy
523 with a situs in another state where each certificateholder pays
524 less than $30 in premium for each covered trip and where the
525 insurer has written less than $1 million in annual written
526 premiums in the travel insurance product in this state during
527 the most recent calendar year,
528
529 shall make an annual base rate filing for each such line with
530 the office no later than 12 months after its previous base rate
531 filing, demonstrating that its rates are not inadequate.
532 Section 13. Effective July 1, 2018, subsections (1) and (5)
533 of section 627.072, Florida Statutes, are amended to read: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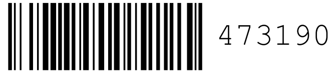
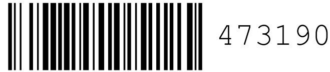
534 627.072 Making and use of rates.—
535 (1) As to workers' compensation and employer's liability
536 insurance, the following factors shall be used in the
537 determination and fixing of loss costs or rates, as applicable:
538 (a) The past loss experience and prospective loss
539 experience within and outside this state;
540 (b) The conflagration and catastrophe hazards;
541 (c) A reasonable margin for underwriting profit and
542 contingencies;
543 (d) Dividends, savings, or unabsorbed premium deposits
544 allowed or returned by insurers to their policyholders, members,
545 or subscribers;
546 (e) Investment income on unearned premium reserves and loss
547 reserves;
548 (f) Past expenses and prospective expenses, both those
549 countrywide and those specifically applicable to this state; and
550 (g) All other relevant factors, including judgment factors,
551 within and outside this state.
552 ~~(5)(a) In the case of workers' compensation and employer's~~
553 ~~liability insurance, the office shall consider utilizing the~~
554 ~~following methodology in rate determinations: Premiums,~~
555 ~~expenses, and expected claim costs would be discounted to a~~
556 ~~common point of time, such as the initial point of a policy~~
557 ~~year, in the determination of rates; the cash-flow pattern of~~
558 ~~premiums, expenses, and claim costs would be determined~~
559 ~~initially by using data from 8 to 10 of the largest insurers~~
560 ~~writing workers' compensation insurance in the state; such~~
561 ~~insurers may be selected for their statistical ability to report~~
562 ~~the data on an accident-year basis and in accordance with~~

 473190

563 ~~subparagraphs (b)1., 2., and 3., for at least 2 1/2 years; such~~
564 ~~a cash-flow pattern would be modified when necessary in~~
565 ~~accordance with the data and whenever a radical change in the~~
566 ~~payout pattern is expected in the policy year under~~
567 ~~consideration.~~
568 ~~(b) If the methodology set forth in paragraph (a) is~~
569 ~~utilized, to facilitate the determination of such a cash-flow~~
570 ~~pattern methodology:~~
571 ~~1. Each insurer shall include in its statistical reporting~~
572 ~~to the rating bureau and the office the accident year by~~
573 ~~calendar quarter data for paid-claim costs;~~
574 ~~2. Each insurer shall submit financial reports to the~~
575 ~~rating bureau and the office which shall include total incurred~~
576 ~~claim amounts and paid-claim amounts by policy year and by~~
577 ~~injury types as of December 31 of each calendar year; and~~
578 ~~3. Each insurer shall submit to the rating bureau and the~~
579 ~~office paid-premium data on an individual risk basis in which~~
580 ~~risks are to be subdivided by premium size as follows:~~
581

582–583 ~~Number of Risks in Premium Range~~	~~Standard Premium Size~~
585 ~~...(to be filled in by carrier)...~~	~~$300-999~~
586 ~~...(to be filled in by carrier)...~~	~~1,000-4,999~~
587 ~~...(to be filled in by carrier)...~~	~~5,000-49,999~~
588 ~~...(to be filled in by carrier)...~~	~~50,000-99,999~~
589 ~~...(to be filled in by carrier)...~~	~~100,000 or more~~

590 ~~Total:~~
591 Section 14. Effective July 1, 2018, section 627.091,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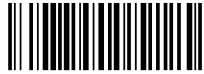
592 Florida Statutes, is amended to read:
593 627.091 Rate filings; workers' compensation and employer's
594 liability insurances.—
595 (1) As used in this section, the term:
596 (a) "Expenses" means the portion of a rate which is
597 attributable to acquisition, field supervision, collection
598 expenses, taxes, reinsurance, assessments, and general expenses.
599 (b) "Loss cost modifier" means an adjustment to, or a
600 deviation from, the approved prospective loss costs filed by a
601 licensed rating organization.
602 (c) "Loss cost multiplier" means the profit and expense
603 factor, expressed as a single nonintegral number to be applied
604 to the prospective loss costs, which is associated with writing
605 workers' compensation and employer's liability insurance and
606 which is approved by the office in making rates for each
607 classification of risks used by that insurer.
608 (d) "Prospective loss costs" means the portion of a rate
609 which reflects historical industry average aggregate losses and
610 loss adjustment expenses projected through development to their
611 ultimate value and through trending to a future point in time.
612 The term does not include provisions for profit or expenses
613 other than loss adjustment expense.
614 (2) ~~(1)~~ As to workers' compensation and employer's liability
615 insurances, every insurer shall file with the office every
616 manual of classifications, rules, and rates, every rating plan,
617 and every modification of any of the foregoing which it proposes
618 to use. Each insurer or insurer group shall independently and
619 individually file with the office the final rates it proposes to
620 use. An insurer may satisfy this filing requirement by adopting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621 the most recent loss costs filed by a licensed rating
622 organization and approved by the office, and by otherwise
623 complying with this part. Each insurer shall file data in
624 accordance with the uniform statistical plan approved by the
625 office. Every filing under this subsection:
626 (a) Must state the proposed effective date and must be made
627 at least 90 days before such proposed effective date;
628 (b) Must indicate the character and extent of the coverage
629 contemplated;
630 (c) May use the most recent approved prospective loss costs
631 filed by a licensed rating organization in combination with the
632 insurer's own approved loss cost multiplier and loss cost
633 modifier;
634 (d) Must include all deductibles required in chapter 440,
635 and may include additional deductible provisions in its manual
636 of classifications, rules, and rates. All deductibles must be in
637 a form and manner that is consistent with the underlying purpose
638 of chapter 440;
639 (e) May use variable or fixed expense loads or a
640 combination thereof, and may vary the expense, profit, or
641 contingency provisions by class or group of classes, if the
642 insurer files supporting data justifying such variations;
643 (f) May include a schedule of proposed premium discounts,
644 credits, and surcharges. The office may not approve discounts,
645 credits, and surcharges unless they are based on objective
646 criteria that bear a reasonable relationship to the expected
647 loss, expense, or profit experience of an individual
648 policyholder or a class of policyholders; and
649 (g) May file a minimum premium or expense constant ~~Every~~

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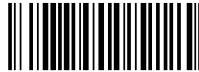
650 ~~insurer is authorized to include deductible provisions in its~~
651 ~~manual of classifications, rules, and rates. Such deductibles~~
652 ~~shall in all cases be in a form and manner which is consistent~~
653 ~~with the underlying purpose of chapter 440~~.
654 (3)~~(2)~~ ~~Every such filing shall state the proposed effective~~
655 ~~date thereof, and shall indicate the character and extent of the~~
656 ~~coverage contemplated.~~ When a filing is not accompanied by the
657 information upon which the insurer or rating organization
658 supports the filing and the office does not have sufficient
659 information to determine whether the filing meets the applicable
660 requirements of this part, the office, ~~it shall~~ within 15 days
661 after the date of filing, shall require the insurer or rating
662 organization to furnish the information upon which it supports
663 the filing. The information furnished in support of a filing may
664 include:
665 (a) The experience or judgment of the insurer or rating
666 organization making the filing;
667 (b) The ~~Its~~ interpretation of any statistical data which
668 the insurer or rating organization making the filing ~~it~~ relies
669 upon;
670 (c) The experience of other insurers or rating
671 organizations; or
672 (d) Any other factors which the insurer or rating
673 organization making the filing deems relevant.
674 (4)~~(3)~~ A filing and any supporting information are ~~shall be~~
675 open to public inspection as provided in s. 119.07(1).
676 (5)~~(4)~~ An insurer may become ~~satisfy its obligation to make~~
677 ~~such filings by becoming~~ a member of, or a subscriber to, a
678 licensed rating organization that ~~which~~ makes loss costs ~~such~~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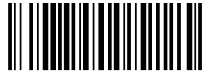
679 filings and by authorizing the office to accept such filings in
680 its behalf; but nothing contained in this chapter shall be
681 construed as requiring any insurer to become a member or a
682 subscriber to any rating organization.
683 (6) A licensed rating organization may develop and file for
684 approval with the office reference filings containing
685 prospective loss costs and the underlying loss data, and other
686 supporting statistical and actuarial information. A rating
687 organization may not develop or file final rates or multipliers
688 for expenses, profit, or contingencies. After a loss cost
689 reference filing is filed with the office and is approved, the
690 rating organization must provide its member subscribers with a
691 copy of the approved reference filing.
692 (7) A rating organization may file supplementary rating
693 information and rules, including, but not limited to,
694 policywriting rules, rating plan classification codes and
695 descriptions, experience modification plans, statistical plans
696 and forms, and rules that include factors or relativities, such
697 as increased limits factors, classification relativities, or
698 similar factors, but that exclude minimum premiums. An insurer
699 may use supplementary rating information if such information is
700 approved by the office.
701 (8)(5) Pursuant to the provisions of s. 624.3161, the
702 office may examine the underlying statistical data used in such
703 filings.
704 (9)(6) Whenever the committee of a recognized rating
705 organization with authority to file prospective loss costs for
706 use by insurers in determining responsibility for workers'
707 compensation and employer's liability insurance rates in this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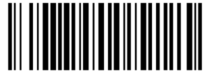
708 state meets to discuss the necessity for, or a request for,
709 Florida rate increases or decreases in prospective loss costs in
710 this state, the determination of prospective loss costs in this
711 state ~~Florida rates~~, the prospective loss costs ~~rates~~ to be
712 requested in this state, and any other matters pertaining
713 specifically and directly to prospective loss costs in this
714 state ~~such Florida rates~~, such meetings shall be held in this
715 state and are ~~shall be~~ subject to s. 286.011. The committee of
716 such a rating organization shall provide at least 3 weeks' prior
717 notice of such meetings to the office and shall provide at least
718 14 days' prior notice of such meetings to the public by
719 publication in the Florida Administrative Register.
720 (10) An insurer group with multiple insurers writing
721 workers' compensation and employer's liability insurance shall
722 file underwriting rules not contained in rating manuals.
723 Section 15. Effective July 1, 2018, section 627.093,
724 Florida Statutes, is amended to read:
725 627.093 Application of s. 286.011 to workers' compensation
726 and employer's liability insurances.—Section 286.011 shall be
727 applicable to every prospective loss cost and rate filing,
728 approval or disapproval of filing, rating deviation from filing,
729 or appeal from any of these regarding workers' compensation and
730 employer's liability insurances.
731 Section 16. Effective July 1, 2018, subsection (1) of
732 section 627.101, Florida Statutes, is amended to read:
733 627.101 When filing becomes effective; workers'
734 compensation and employer's liability insurances.—
735 (1) The office shall review all required filings as to
736 workers' compensation and employer's liability insurances as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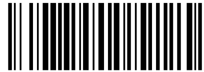
737 soon as reasonably possible after they have been made in order
738 to determine whether they meet the applicable requirements of
739 this part. If the office determines that part of a required ~~rate~~
740 filing does not meet the applicable requirements of this part,
741 it may reject so much of the filing as does not meet these
742 requirements, and approve the remainder of the filing.
743 Section 17. Effective July 1, 2018, section 627.211,
744 Florida Statutes, is amended to read:
745 627.211 Annual report by the office on the workers'
746 compensation insurance market ~~Deviations; workers' compensation~~
747 ~~and employer's liability insurances~~.—
748 ~~(1) Every member or subscriber to a rating organization~~
749 ~~shall, as to workers' compensation or employer's liability~~
750 ~~insurance, adhere to the filings made on its behalf by such~~
751 ~~organization; except that any such insurer may make written~~
752 ~~application to the office for permission to file a uniform~~
753 ~~percentage decrease or increase to be applied to the premiums~~
754 ~~produced by the rating system so filed for a kind of insurance,~~
755 ~~for a class of insurance which is found by the office to be a~~
756 ~~proper rating unit for the application of such uniform~~
757 ~~percentage decrease or increase, or for a subdivision of~~
758 ~~workers' compensation or employer's liability insurance:~~
759 ~~(a) Comprised of a group of manual classifications which is~~
760 ~~treated as a separate unit for ratemaking purposes; or~~
761 ~~(b) For which separate expense provisions are included in~~
762 ~~the filings of the rating organization.~~
763
764 ~~Such application shall specify the basis for the modification~~
765 ~~and shall be accompanied by the data upon which the applicant~~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766 ~~relies. A copy of the application and data shall be sent~~
767 ~~simultaneously to the rating organization.~~
768 ~~(2) Every member or subscriber to a rating organization~~
769 ~~may, as to workers' compensation and employer's liability~~
770 ~~insurance, file a plan or plans to use deviations that vary~~
771 ~~according to factors present in each insured's individual risk.~~
772 ~~The insurer that files for the deviations provided in this~~
773 ~~subsection shall file the qualifications for the plans,~~
774 ~~schedules of rating factors, and the maximum deviation factors~~
775 ~~which shall be subject to the approval of the office pursuant to~~
776 ~~s. 627.091. The actual deviation which shall be used for each~~
777 ~~insured that qualifies under this subsection may not exceed the~~
778 ~~maximum filed deviation under that plan and shall be based on~~
779 ~~the merits of each insured's individual risk as determined by~~
780 ~~using schedules of rating factors which shall be applied~~
781 ~~uniformly. Insurers shall maintain statistical data in~~
782 ~~accordance with the schedule of rating factors. Such data shall~~
783 ~~be available to support the continued use of such varying~~
784 ~~deviations.~~
785 ~~(3) In considering an application for the deviation, the~~
786 ~~office shall give consideration to the applicable principles for~~
787 ~~ratemaking as set forth in ss. 627.062 and 627.072 and the~~
788 ~~financial condition of the insurer. In evaluating the financial~~
789 ~~condition of the insurer, the office may consider: (1) the~~
790 ~~insurer's audited financial statements and whether the~~
791 ~~statements provide unqualified opinions or contain significant~~
792 ~~qualifications or "subject to" provisions; (2) any independent~~
793 ~~or other actuarial certification of loss reserves; (3) whether~~
794 ~~workers' compensation and employer's liability reserves are~~

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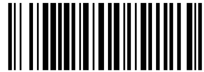
795 ~~above the midpoint or best estimate of the actuary’s reserve~~
796 ~~range estimate; (4) the adequacy of the proposed rate; (5)~~
797 ~~historical experience demonstrating the profitability of the~~
798 ~~insurer; (6) the existence of excess or other reinsurance that~~
799 ~~contains a sufficiently low attachment point and maximums that~~
800 ~~provide adequate protection to the insurer; and (7) other~~
801 ~~factors considered relevant to the financial condition of the~~
802 ~~insurer by the office. The office shall approve the deviation if~~
803 ~~it finds it to be justified, it would not endanger the financial~~
804 ~~condition of the insurer, and it would not constitute predatory~~
805 ~~pricing. The office shall disapprove the deviation if it finds~~
806 ~~that the resulting premiums would be excessive, inadequate, or~~
807 ~~unfairly discriminatory, would endanger the financial condition~~
808 ~~of the insurer, or would result in predatory pricing. The~~
809 ~~insurer may not use a deviation unless the deviation is~~
810 ~~specifically approved by the office. An insurer may apply the~~
811 ~~premiums approved pursuant to s. 627.091 or its uniform~~
812 ~~deviation approved pursuant to this section to a particular~~
813 ~~insured according to underwriting guidelines filed with and~~
814 ~~approved by the office, such approval to be based on ss. 627.062~~
815 ~~and 627.072.~~
816 ~~(4) Each deviation permitted to be filed shall be effective~~
817 ~~for a period of 1 year unless terminated, extended, or modified~~
818 ~~with the approval of the office. If at any time after a~~
819 ~~deviation has been approved the office finds that the deviation~~
820 ~~no longer meets the requirements of this code, it shall notify~~
821 ~~the insurer in what respects it finds that the deviation fails~~
822 ~~to meet such requirements and specify when, within a reasonable~~
823 ~~period thereafter, the deviation shall be deemed no longer~~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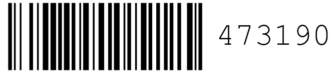
824 ~~effective. The notice shall not affect any insurance contract or~~
825 ~~policy made or issued prior to the expiration of the period set~~
826 ~~forth in the notice.~~
827 ~~(5) For purposes of this section, the office, when~~
828 ~~considering the experience of any insurer, shall consider the~~
829 ~~experience of any predecessor insurer when the business and the~~
830 ~~liabilities of the predecessor insurer were assumed by the~~
831 ~~insurer pursuant to an order of the office which approves the~~
832 ~~assumption of the business and the liabilities.~~
833 ~~(6)~~ The office shall submit an annual report to the
834 President of the Senate and the Speaker of the House of
835 Representatives by January 15 of each year which evaluates
836 insurance company solvency and competition in the workers’
837 compensation insurance market in this state. The report must
838 contain an analysis of the availability and affordability of
839 workers’ compensation coverage and whether the current market
840 structure, conduct, and performance are conducive to
841 competition, based upon economic analysis and tests. The purpose
842 of this report is to aid the Legislature in determining whether
843 changes to the workers’ compensation rating laws are warranted.
844 The report must also document that the office has complied with
845 the provisions of s. 627.096 which require the office to
846 investigate and study all workers’ compensation insurers in the
847 state and to study the data, statistics, schedules, or other
848 information as it finds necessary to assist in its review of
849 workers’ compensation rate filings.
850 Section 18. Effective July 1, 2018, section 627.2151,
851 Florida Statutes, is created to read:
852 627.2151 Workers’ compensation excessive defense and cost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853 containment expenses.—
854 (1) As used in this section, the term “defense and cost
855 containment expenses” or “DCCE” includes the following Florida
856 expenses of an insurer group or insurer writing workers’
857 compensation insurance:
858 (a) Insurance company attorney fees;
859 (b) Expert witnesses;
860 (c) Medical examinations and autopsies;
861 (d) Medical fee review panels;
862 (e) Bill auditing;
863 (f) Treatment utilization reviews; and
864 (g) Preferred provider network expenses.
865 (2) Each insurer group or insurer writing workers’
866 compensation insurance shall file with the office a schedule of
867 Florida defense and cost containment expenses and total Florida
868 incurred losses for each of the 3 years before the most recent
869 accident year. The DCCE and incurred losses must be valued as of
870 December 31 of the first year following the latest accident year
871 to be reported, developed to an ultimate basis, and at two 12-
872 month intervals thereafter, each developed to an ultimate basis,
873 so that a total of three evaluations will be provided for each
874 accident year. The first year reported shall be accident year
875 2018, so that the reporting of 3 accident years under this
876 evaluation will not take place until accident years 2019 and
877 2020 have become available.
878 (3) Excessive DCCE occurs when an insurer includes in its
879 rates Florida defense and cost containment expenses for workers’
880 compensation which exceed 15 percent of Florida workers’
881 compensation incurred losses by the insurer or insurer group for

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882 the 3 most recent calendar years for which data is to be filed
883 under this section.
884 (4) If the insurer or insurer group realizes excessive
885 DCCE, the office must order a return of the excess amounts after
886 affording the insurer or insurer group an opportunity for a
887 hearing and otherwise complying with the requirements of chapter
888 120. Excessive DCCE amounts must be returned in all instances
889 unless the insurer or insurer group affirmatively demonstrates
890 to the office that the refund of the excessive DCCE amounts will
891 render a member of the insurer group financially impaired or
892 will render it insolvent under provisions of the Florida
893 Insurance Code.
894 (5) Any excess DCCE amount must be returned to
895 policyholders in the form of a cash refund or credit toward the
896 future purchase of insurance. The refund or credit must be made
897 on a pro rata basis in relation to the final compilation year
898 earned premiums to the policyholders of record of the insurer or
899 insurer group on December 31 of the final compilation year. Cash
900 refunds and data in required reports to the office may be
901 rounded to the nearest dollar and must be consistently applied.
902 (6)(a) Refunds must be completed in one of the following
903 ways:
904 1. A cash refund must be completed within 60 days after
905 entry of a final order indicating that excessive DCCE has been
906 realized.
907 2. A credit to renewal policies must be applied to policy
908 renewal premium notices that are forwarded to insureds more than
909 60 calendar days after entry of a final order indicating that
910 excessive DCCE has been realized. If the insured thereafter

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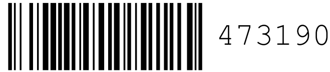
911 cancels a policy or otherwise allows the policy to terminate,
912 the insurer or insurer group must make a cash refund not later
913 than 60 days after coverage termination.
914 (b) Upon completion of the renewal credits or refunds, the
915 insurer or insurer group shall immediately certify having made
916 the refunds to the office.
917 (7) Any refund or renewal credit made pursuant to this
918 section is treated as a policyholder dividend applicable to the
919 year immediately succeeding the compilation period giving rise
920 to the refund or credit, for purposes of reporting under this
921 section for subsequent years.
922 Section 19. Effective July 1, 2018, section 627.291,
923 Florida Statutes, is amended to read:
924 627.291 Information to be furnished insureds; appeal by
925 insureds; workers' compensation and employer's liability
926 insurances.—
927 (1) As to workers' compensation and employer's liability
928 insurances, every rating organization filing prospective loss
929 costs and every insurer which makes its own rates shall, within
930 a reasonable time after receiving written request therefor and
931 upon payment of such reasonable charge as it may make, furnish
932 to any insured affected by a rate made by it, or to the
933 authorized representative of such insured, all pertinent
934 information as to such rate.
935 (2) As to workers' compensation and employer's liability
936 insurances, every rating organization filing prospective loss
937 costs and every insurer which makes its own rates shall provide
938 within this state reasonable means whereby any person aggrieved
939 by the application of its rating system may be heard, in person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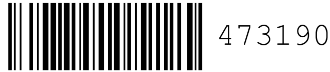
940 or by his or her authorized representative, on his or her
941 written request to review the manner in which such rating system
942 has been applied in connection with the insurance afforded him
943 or her. If the rating organization filing prospective loss costs
944 or the insurer making its own rates fails to grant or rejects
945 such request within 30 days after it is made, the applicant may
946 proceed in the same manner as if his or her application had been
947 rejected. Any party affected by the action of such rating
948 organization filing prospective loss costs or insurer making its
949 own rates on such request may, within 30 days after written
950 notice of such action, appeal to the office, which may affirm or
951 reverse such action.
952 Section 20. Effective July 1, 2018, section 627.318,
953 Florida Statutes, is amended to read:
954 627.318 Records.—Every insurer, rating organization filing
955 prospective loss costs, and advisory organization and every
956 group, association, or other organization of insurers which
957 engages in joint underwriting or joint reinsurance shall
958 maintain reasonable records, of the type and kind reasonably
959 adapted to its method of operation, of its experience or the
960 experience of its members and of the data, statistics, or
961 information collected or used by it in connection with the
962 prospective loss costs, rates, rating plans, rating systems,
963 underwriting rules, policy or bond forms, surveys, or
964 inspections made or used by it, so that such records will be
965 available at all reasonable times to enable the office to
966 determine whether such organization, insurer, group, or
967 association, and, in the case of an insurer or rating
968 organization, every prospective loss cost, rate, rating plan,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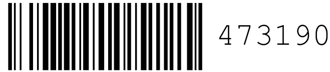
969 and rating system made or used by it, complies with the
970 provisions of this part applicable to it. The maintenance of
971 such records in the office of a licensed rating organization of
972 which an insurer is a member or subscriber will be sufficient
973 compliance with this section for any such insurer maintaining
974 membership or subscribership in such organization, to the extent
975 that the insurer uses the prospective loss costs, rates, rating
976 plans, rating systems, or underwriting rules of such
977 organization. Such records shall be maintained in an office
978 within this state or shall be made available for examination or
979 inspection within this state by the department at any time upon
980 reasonable notice.
981 Section 21. Effective July 1, 2018, section 627.361,
982 Florida Statutes, is amended to read:
983 627.361 False or misleading information.—No person shall
984 willfully withhold information from or knowingly give false or
985 misleading information to the office, any statistical agency
986 designated by the office, any rating organization, or any
987 insurer, which will affect the prospective loss costs, rates, or
988 premiums chargeable under this part.
989 Section 22. Effective July 1, 2018, subsections (1) and (2)
990 of section 627.371, Florida Statutes, are amended to read:
991 627.371 Hearings.—
992 (1) Any person aggrieved by any rate charged, rating plan,
993 rating system, or underwriting rule followed or adopted by an
994 insurer, and any person aggrieved by any rating plan, rating
995 system, or underwriting rule followed or adopted by a rating
996 organization, may herself or himself or by her or his authorized
997 representative make written request of the insurer or rating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998 organization to review the manner in which the prospective loss
999 cost, rate, plan, system, or rule has been applied with respect
1000 to insurance afforded her or him. If the request is not granted
1001 within 30 days after it is made, the requester may treat it as
1002 rejected. Any person aggrieved by the refusal of an insurer or
1003 rating organization to grant the review requested, or by the
1004 failure or refusal to grant all or part of the relief requested,
1005 may file a written complaint with the office, specifying the
1006 grounds relied upon. If the office has already disposed of the
1007 issue as raised by a similar complaint or believes that probable
1008 cause for the complaint does not exist or that the complaint is
1009 not made in good faith, it shall so notify the complainant.
1010 Otherwise, and if it also finds that the complaint charges a
1011 violation of this chapter and that the complainant would be
1012 aggrieved if the violation is proven, it shall proceed as
1013 provided in subsection (2).
1014 (2) If after examination of an insurer, rating
1015 organization, advisory organization, or group, association, or
1016 other organization of insurers which engages in joint
1017 underwriting or joint reinsurance, upon the basis of other
1018 information, or upon sufficient complaint as provided in
1019 subsection (1), the office has good cause to believe that such
1020 insurer, organization, group, or association, or any prospective
1021 loss cost, rate, rating plan, or rating system made or used by
1022 any such insurer or rating organization, does not comply with
1023 the requirements and standards of this part applicable to it, it
1024 shall, unless it has good cause to believe such noncompliance is
1025 willful, give notice in writing to such insurer, organization,
1026 group, or association stating therein in what manner and to what

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1027 extent noncompliance is alleged to exist and specifying therein
1028 a reasonable time, not less than 10 days thereafter, in which
1029 the noncompliance may be corrected, including any premium
1030 adjustment.
1031 Section 23. Effective July 1, 2017, the sums of $723,118 in
1032 recurring funds and $100,000 in nonrecurring funds from the
1033 Insurance Regulatory Trust Fund are appropriated to the Office
1034 of Insurance Regulation, and eight full-time equivalent
1035 positions with associated salary rate of 460,000 are authorized,
1036 for the purpose of implementing this act.
1037 Section 24. Effective July 1, 2017, the sum of $24,720 in
1038 nonrecurring funds from the Operating Trust Fund is appropriated
1039 to the Office of Judges of Compensation Claims within the
1040 Division of Administrative Hearings for the purposes of
1041 implementing this act.
1042 Section 25. Except as otherwise expressly provided in this
1043 act, this act shall take effect July 1, 2017.
1044
1045 ================= T I T L E A M E N D M E N T ================
1046 And the title is amended as follows:
1047 Delete everything before the enacting clause
1048 and insert:
1049 A bill to be entitled
1050 An act relating to workers' compensation insurance;
1051 amending s. 440.02, F.S.; redefining the term
1052 "specificity"; amending s. 440.105, F.S.; revising a
1053 prohibition against receiving certain fees,
1054 consideration, or gratuities under certain
1055 circumstances; amending s. 440.13, F.S.; specifying

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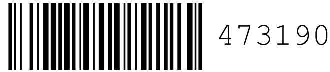
1056 certain timeframes in terms of business days, rather
1057 than days; requiring carriers to authorize or deny,
1058 rather than respond to, certain requests for
1059 authorization within a specified timeframe; revising
1060 construction; revising a specified interval for
1061 certain notices furnished by treating physicians to
1062 employers or carriers; amending s. 440.15, F.S.;
1063 revising the maximum period of specified temporary
1064 disability benefits; amending s. 440.151, F.S.;
1065 providing that specified cancers of firefighters are
1066 deemed occupational diseases arising out of work
1067 performed in the course and scope of employment;
1068 amending s. 440.192, F.S.; revising conditions under
1069 which the Office of the Judges of Compensation Claims
1070 must dismiss petitions for benefits; revising
1071 requirements for such petitions; revising construction
1072 relating to dismissals of petitions or portions of
1073 such petitions; requiring judges of compensation
1074 claims to enter orders on certain motions to dismiss
1075 within specified timeframes; amending s. 440.34, F.S.;
1076 prohibiting the payment of certain consideration by
1077 carriers or employers, rather than prohibiting such
1078 payment for claimants, in connection with certain
1079 proceedings under certain circumstances; requiring
1080 judges of compensation claims to consider specified
1081 factors in increasing or decreasing attorney fees;
1082 specifying a maximum hourly rate for attorney fees;
1083 revising provisions that prohibit such judges from
1084 approving certain agreements and that limit attorney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1085 fees in retainer agreements; providing construction;
1086 deleting a provision authorizing such judges to
1087 approve alternative attorney fees under certain
1088 circumstances; conforming a cross-reference; amending
1089 s. 624.482, F.S.; conforming a provision to changes
1090 made by the act; amending s. 627.041, F.S.; redefining
1091 terms; amending s. 627.0612, F.S.; adding prospective
1092 loss costs to a list of reviewable matters in certain
1093 proceedings by appellate courts; amending s. 627.062,
1094 F.S.; prohibiting loss costs for specified classes of
1095 insurance from being excessive, inadequate, or
1096 unfairly discriminatory; amending s. 627.0645, F.S.;
1097 deleting an annual base rate filing requirement
1098 exception relating to workers' compensation and
1099 employer's liability insurance for certain rating
1100 organizations; amending s. 627.072, F.S.; requiring
1101 certain factors to be used in determining and fixing
1102 loss costs; deleting a specified methodology that may
1103 be used by the Office of Insurance Regulation in rate
1104 determinations; amending s. 627.091, F.S.; defining
1105 terms; requiring insurers or insurer groups writing
1106 workers' compensation and employer's liability
1107 insurances to independently and individually file
1108 their proposed final rates; specifying requirements
1109 for such filings; deleting a requirement that such
1110 filings contain certain information; revising
1111 requirements for supporting information required to be
1112 furnished to the office under certain circumstances;
1113 deleting a specified method for insurers to satisfy

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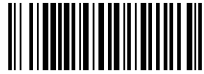
1114 filing obligations; specifying requirements for a
1115 licensed rating organization that elects to develop
1116 and file certain reference filings and certain other
1117 information; authorizing insurers to use supplementary
1118 rating information approved by the office; revising
1119 applicability of public meetings and records
1120 requirements to certain meetings of recognized rating
1121 organization committees; requiring certain insurer
1122 groups to file underwriting rules not contained in
1123 rating manuals; amending s. 627.093, F.S.; revising
1124 applicability of public meetings and records
1125 requirements to prospective loss cost filings or
1126 appeals; amending s. 627.101, F.S.; conforming a
1127 provision to changes made by the act; amending s.
1128 627.211, F.S.; deleting provisions relating to
1129 deviations; requiring that the office's annual report
1130 to the Legislature relating to the workers'
1131 compensation insurance market evaluate insurance
1132 company solvency; creating s. 627.2151, F.S.; defining
1133 the term "defense and cost containment expenses" or
1134 "DCCE"; requiring insurer groups or insurers writing
1135 workers' compensation insurance to file specified
1136 schedules with the office at specified intervals;
1137 providing construction relating to excessive DCCE;
1138 requiring the office to order returns of excess
1139 amounts of DCCE, subject to certain hearing
1140 requirements; providing requirements for, and an
1141 exception from, the return of excessive DCCE amounts;
1142 providing construction; amending s. 627.291, F.S.;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1143 providing applicability of certain disclosure and
1144 hearing requirements for rating organizations filing
1145 prospective loss costs; amending s. 627.318, F.S.;
1146 providing applicability of certain recordkeeping
1147 requirements for rating organizations or insurers
1148 filing or using prospective loss costs, respectively;
1149 amending s. 627.361, F.S.; providing applicability of
1150 a prohibition against false or misleading information
1151 relating to prospective loss costs; amending s.
1152 627.371, F.S.; providing applicability of certain
1153 hearing procedures and requirements relating to the
1154 application, making, or use of prospective loss costs;
1155 providing appropriations; providing effective dates.